VIOLENCE AGAINST WOMEN LIVING IN SITUATIONS OF ARMED CONFLICT

Report on a WHO/ISS Workshop in preparation for the International Conference: The role of health professionals in addressing violence against women

Naples, Italy
12–13 October 2000

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ABSTRACT

More countries than ever are torn by war and armed conflict, giving rise to an infinite stream of refugees and internally displaced persons. Women are affected as victims of violence in times of war and civil unrest, and in respect of their unmet needs for health care, particularly reproductive health care, in times of crisis. To support capacity-building in conflict and post-conflict countries, the Regional Office and the Istituto Superiore di Sanità in Rome organized this Workshop to take place before the ISS-FIGO-WHO-UNFPA International Conference: The role of health professionals in addressing violence against women, held in Naples. The workshop was conducted in cooperation with WHO headquarters and with UNESCO, UNFPA, UNDP, UNHCR, UNICEF, bilateral agencies and nongovernmental organizations, experts from or working in affected countries, and experts from countries receiving refugees. The experts’ recommendations focused on the care for surviving victims, and on preventing violence through a human-rights-based approach to public health interventions in conflict situations.

Keywords

VIOLENCE – prevention and control
WOMEN’S HEALTH
WOMEN’S RIGHTS
WOMEN’S HEALTH SERVICES
WAR
WORKSHOP ON
VIOLENCE AGAINST WOMEN LIVING IN
SITUATIONS OF ARMED CONFLICT

Naples, Italy, 12–13 October 2000

In preparation for International Conference: The role of health professionals in addressing violence against women, 15–18 October 2000, Naples, Italy

WHO Headquarters,
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WHO Regional Office for
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Copenhagen, Denmark

Istituto Superiore di Sanità (ISS),
Rome, Italy

Department for Violence and Accidents Prevention

Gender Mainstreaming Programme

Segreteria per le Attività Culturali
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PREFACE

The present report addresses the importance of recognizing the extent and prevalence of violence against women in situations of armed conflict, and the urgent need to take concrete action against it. It emphasizes the importance not only of setting up remedial measures, such as counselling services, but also the need to address initial research methods, data collection and to ensure gendered analysis of violence in conflict situations.

The document highlights the existence of many forms of violence, thus deconstructing the stereotype of rape by militaries as the main form of abuse. This report points out the convergence of emotional, physical, sexual and psychological abuse for many women, as perpetrated by strangers, as well as family.

The role of agencies is delineated, and the means by which they may provide assistance in armed conflict situations is discussed through examples of field-specific pilot projects and studies. Thus, this document is a tool for agencies providing humanitarian assistance with which to address violence against women in conflict situations and from which examples of good practice and positive initiatives may be drawn.

This report was edited and compiled by Assia Brandrup-Lukanow, Carol Djeddah, Malika Ladjali, Vanita Sundaram and Ranieri Guerra

1 While fully recognizing the serious and unacceptable nature of such acts.
OPENING REMARKS

Professor Giuseppe Benagiano
Director, Istituto Superiore di Sanità

Dear Friends,

I am always very happy to open a WHO meeting, since I spent some 13 years of my life working for the Organization.

Today however, I have at least three additional reasons to be extremely pleased: First of all, because WHO agreed to hold this Workshop right before a very important meeting we have organized with a number of national and international partners. WHO’s massive presence is definitely strengthening the impact that we all hope the International Conference: The role of health professionals in addressing violence against women will have.

Secondly, because the pre-conference workshop has been organized by my old (not in age, but in years of friendship) friend, Assia Brandrup-Lukanow. It is a pleasure to be here with her today. Thirdly, because this gives all of you the possibility to participate and contribute to the main Conference, which – we hope – will be a turning point in involving health professionals in this holy war against violence.

The topic of the pre-conference workshop nicely complements that of the conference: it focuses on the forms that violence against women takes during armed conflicts. Unfortunately, these are the same forms that are already smearing our societies under normal circumstances; forms however, that take a particularly hideous shape when – as in an armed conflict – hatred dominates the horizon.

It is during those times when humans unleash their worst instincts that violence – and not only that against women – becomes very pervasive, almost ubiquitous. This is why it is during armed conflicts that we must multiply our efforts to at least quench this flowering type of horrendous human behaviour. Allow me to say that fortunately there is another side to the coin: that so many women and men of good will activate themselves under these circumstances to come to the rescue of the victims, of the helpless, of those who have no escape.

This is why we are here: to better organize this crusade of good will. You will be discussing four major topics: collection of evidence, evaluating health consequences, promoting human rights even under these extreme circumstances, and rehabilitation of the victims.

It is a thorough agenda which represents a good prologue for our subsequent Conference. At the end of this five-day itinerary I hope that two major things will happen: first, that not only will we have communicated to all participants the importance of starting this campaign against hatred, violence and dehumanization, but that all participants will go home and act as multipliers for the cry of the victims of violence – such that the feeble voice of all victims is amplified to be heard throughout the world.

Secondly, that we will come up with an agenda to actively fight all forms of violence perpetrated against women; with a strategy to enact the agenda; and an outline of practical ways to begin implementing the agenda. Armed with these instruments, I shall personally go and beat down the
doors of funding agencies to obtain the financial means to start working towards the goal of eliminating all forms of violence against women.

We need all of you, we need your ideas, your experiences, but – above all – we need your commitment. I sincerely hope that we will be able to count upon all of you.

I wish all of you good work.
WELCOME

Dr Assia Brandrup-Lukanow  
Regional Advisor, Reproductive Health/Pregnancy and Gender Mainstreaming Programme

Dear Professor Benagiano, Dr Guerra, colleagues from United Nations Sister Agencies

It is my pleasure to welcome you here in Naples today on behalf of the European Regional Office of the World Health Organization. My colleagues from WHO Headquarters and I would also, on behalf of all of us, like to express my gratitude to Professor Benagiano and his team from the Istituto Superiore di Sanità, who are kindly hosting this meeting, and have made it possible for us to come together here today to discuss an issue which is becoming more and more relevant in an imperfect world. Professor Benagiano has led us so passionately in the topic that all which is left for me is to introduce the Scope and Purpose of the meeting and to start our deliberations.

SCOPE AND PURPOSE

Dr Assia Brandrup-Lukanow  
Regional Advisor, Reproductive Health/Pregnancy and Gender Mainstreaming Programme

More countries than ever are torn by war and social conflict, giving rise to an infinite stream of refugees and internally displaced persons. Women are particularly affected, both as victims of violence in times of war and civil unrest, but also with respect to their unmet needs for health care, in particular reproductive health care, in times of crisis. When humanitarian assistance is provided, this is often haphazard with regard to women’s health needs.

The purpose of this workshop, which brings together representatives of agencies providing assistance in crisis situations and representatives from affected countries, is to develop a framework for an appropriate inter-agency response. This response is to provide a holistic strategy to best meet the health needs of women victims of violence during and after armed conflict, and the health needs of women coming from emergency situations into host countries. This will also include in particular aspects of relevant data and evidence collection and documentation.

The workshop will last two days. The recommendations of the workshop will be fed into the International Conference: The role of health professionals in addressing violence against women, on 15–18 October in Naples.

I would like to wish us all a fruitful meeting and look forward to sharing and learning from experiences of colleagues who have worked in this challenging field.
SESSION I:
GENDER AND VIOLENCE IN CONFLICT AND POST-CONFLICT SITUATIONS

Collective violence and its impact on reproductive health

Dr Carol Djeddah
Department of Violence and Injuries Prevention
WHO Headquarters, Geneva

In today’s globalized world, war violence and its effect worldwide, grab our attention. Conflicts in East Timor, Chechnya, Kosovo or Sierra Leone have been the focus of international attention due to the atrocities committed within their boundaries. Of all the changes that have occurred in health during the 20th century, the growth in reported violence is one of the most complex and far-reaching. On the eve of the 21st century, 4% of all persons who die in the world are intentionally killed by another person or by themselves.

It is estimated that in 1998, 5.8 million people died from injuries, of which 2.3 million deaths resulted from violence. Homicide and violence comprised 13% of the total of injurious deaths, while self-inflicted injuries constituted 16% and war, 10% of the total amount. Yet, data seems to demonstrate that non-fatal outcomes have an even greater impact on human development than mortality may have. The burden of violence has “increased” dramatically in part, probably not in absolute numbers, but because of the increased willingness to render visible what societies and cultures have traditionally kept hidden. In 1998, 16% of disability-adjusted life-years lost (DALYs – the number of years lost from premature death combined with the loss of health from disability), were attributable to injuries, of which homicide and violence represented 10%, self-inflicted injuries 10%, and war also constituting 10%.

In 1990, war, self-directed and interpersonal violence were ranked 16th, 17th and 19th respectively, among the leading causes of the world’s DALYs lost. It is estimated that by 2020, war will rank 8th, interpersonal violence 12th, and self-directed violence 14th, as global causes of DALYs lost. Conflicts are increasingly occurring within states, rather than between states and have as a primary objective – beyond the quest for economic and political power – the undermining of civilian populations associated with opposing ethnic groups. One consequence of conflicts in the past decade has been the rise in numbers of IDPs and refugees. In 1997, there were estimated to be 30 million IDPs and 23 million refugees.

Collective violence may be defined as the use of violence by groups to achieve political, economic or social objectives. There are different definitions of conflicts, such as minor armed conflicts, intermediate and major armed conflicts. Complex humanitarian emergency is a term which describes a situation affecting large civilian populations, and usually involves a combination of factors, including war or civil strife, food shortages and population displacement, resulting in excess mortality. This definition should, however include the characteristic outcomes of wars, namely the destruction of social networks and ecosystems; insecurity affecting civilians, and large-scale violations of human rights.
In this context, if we are to effectively respond to (reproductive) health needs, including violence against women in times of collective violence, we need to:

- develop an understanding of the context in which violence occurs, identify risk factors, and determine the extent to which prevention is possible;
- recognize the value of data and the best way to collect data and evidence;
- better understand the impact of conflicts on health and reproductive health services;
- recognize coping mechanisms and protective factors which assist individuals, families and communities to deal with the trauma;
- highlight the interagency mechanisms currently being developed by humanitarian departments to address violence against women, and to increase accountability not only to donors, but also to affected women and children, families and communities;
- draw attention to the range of interventions and their limitations, also to minimize the long-term damage.

**Indicators of states at risk**

- **Demographic pressures:** High infant mortality; rapid change in population including massive refugee movements, high population density; youth bulge; insufficient food supply or access to safe water; ethnic groups sharing and disputing land, territory or environmental resources.
- **Lack of democratic processes:** Criminalization or delegitimization of the state, human rights violations.
- **Regimes of short duration:** Rapid changes of regimes; kleptocratic and corrupt processes of governance.
- **Ethnic composition of the ruling elite differing from the population at large:** Political and economic power exercised (and differentially applied) through ethnic and religious identity.
- **Deterioration or elimination of public services:** Reduction in the size and performance of social safety nets which ensure a minimum standards of service available to all.
- **Sharp and severe economic distress:** Uneven economic development; differential benefits or losses to one or other group or geographic zone as a result of significant changes in economy.
- **Legacy of vengeance-seeking group grievance:** History of intergroup rivalry with disputes settled through violence.
- **Massive, chronic or sustained human flight:** Sufficiently adverse social, political, economic or environmental conditions to propel large numbers of the population into displacement within or across borders.

Many of these risk factors are identifiable in advance, prior to wars actually occurring.

Increased pressure and competition for resources, within a system which inequitably distributes political and economic power, is a potent input to many conflicts. A key question is how those risk factors are likely to increase the occurrence of violence against women. A particularly important challenge is to identify how best to intervene prior to, during and after the conflict to prevent violence against women. Furthermore, societies emerging from wars seem to be particularly vulnerable to outbreaks of violence. According to recent studies, child abuse and the prevalence of violence against women grow in a consistent was, not only during, but also in the aftermath of wars.
Many forms of sexual violence and abuse are experienced during conflict and mass
displacement, from random acts of sexual assault, to rape as a deliberate weapon of war. Young
girls in some instances are selected for rape, as they are seen as being less likely to be infected
by HIV/AIDS. Children can also be witnesses to family members being tortured, raped and
mutilated, which in itself is a cause of trauma. Research is needed to determine the relative
weight of a combination of factors, resulting in increased incidence of abuse in times of crisis of
family disruption.

Data

Several research groups collect and analyse data on the victims of conflict, however, difficulties
on collecting data in conflict situations is highly contested and plagued by both difficulties of
assessment and efforts to manipulate data by key parties to the conflict. Estimates of the number
of deaths in the Rwanda genocide vary from ½ to 1 million; rape and other forms of violence
against women are only rough estimates based on a few samples. (An example: in a population-
based study conducted by physicians for human rights to establish patterns of human rights
violations among Kosovar refugees by Serbian forces, it was reported that abuses occur in one
third of the households surveyed – with beating, torture, separation and disappearances, threat at
gunpoint, shooting and sexual assault). It is clear that comparisons between studies must be
conducted with caution, because of differences in definitions, sample sizes, data collection
approaches and cultural factors.

Impact on health

The impact on health of war can be extensive in terms of morbidity, mortality and disability.
Infant mortality rises in association with reduced access to health and immunization services,
impairment of basic infrastructure necessary to promote health, poorer nutrition for children
and their mothers, and population displacement. In Zepa (former Yugoslavia), a United-Nations-
controlled “safe-haven” which was subsequently overrun by the Bosnian Serbs, perinatal and
childhood mortality rates doubled after only one year of war. In Sarajevo, deliveries of
premature babies had doubled and average birth weights fallen by 20% by 1993, two years into
the war.

“High risk situations” for HIV transmission may also occur in times of conflict and their
aftermath. HIV infection has reached high levels in many army forces; the ability of these men to
command sexual services from local women, through payment or force, the movement of troops
to different parts of the country, and their ultimate return to divergent regions of the country after
demobilization, present significant risks to women. Peacekeeping forces alone, may stimulate a
market for sexual services, attracting women from other areas, including surrounding states, into
commercial sex work and fuelling HIV and STD transmission.

Increased mortality rates reflect the combined effects of poor nutrition, increased vulnerability to
communicable diseases, diminished access to health services, poor environmental conditions and
psychosocial distress. A study of the impact of the war in Bosnia drew attention to the creation
of new “vulnerable” populations such as those in isolated enclaves, or those forced to flee as a
result of “ethnic cleansing”. Data on war-related disability are scant. A nationwide disability
survey conducted in 1982 after the liberation struggle in Zimbabwe, revealed that 13% of all
physical disabilities, were the direct result of the war.
The mental health impact is influenced by a range of factors including the nature of the conflict, the form of trauma experienced (or directly inflicted, as in the case of torture and other repressive violence), the individual and community responses to these pressures, the cultural context in which they occur, and the psychological health of those affected prior to the event. From different research it is increasingly apparent that recovery is linked to the reconstruction of social and economic networks, cultural institutions and respect for human rights. The gender-based violence that occurred during the genocide in Rwanda took the form of ethnic cleansing, mass rape, torture and forced pregnancies. It is clear that most women in the country have been subjected to some form of violence. Internal displacement and the humanitarian crisis further destroyed the society, leaving most people homeless, with no work and traumatized.

WHO has supported a project in Rwanda since 1996 called “Health Needs of Women and Girls Affected by Violence”. The project aimed to improve access to health and social services for women affected by violence through strengthening institutional capacity; training of counsellors; provision of medicine; supporting local networks and development of appropriate IEC strategies. Among its other activities, the project provided training to 250 counsellors who were dealing with survivors of violence on a day-to-day basis. HIV first came to our attention during discussions with the trained counsellors and NGOs involved in the project because the issue of HIV had been coming up in their counselling sessions. The women survivors of violence started feeling unwell. From their counselling records, we could see that they would eventually go for a HIV test and in many cases find out they were HIV positive.

The women would then return to our counsellors who were not trained in post-HIV test counselling and attempt to have further counselling. Simultaneously, we saw that by 1999 many of the young girls who had been infected by HIV during the mass rape, were occupying the hospital beds, dying of AIDS-related diseases. The following is a story as related by one of our counsellors:

 Maria was a young single girl of 25. During the events of 1994, she was raped by many paramilitaries who are still walking free today. After a bout of illness she presented herself to our health centre. We advised her to take a HIV test. After a positive diagnosis, we talked to her during two counselling sessions and tried to help her overcome her fear of death. When she didn’t appear for the third counselling session, we visited her home only to find that she had died from AIDS.
Why consider gender?

Dr Malika Ladjali
Evaluation and Policy Division, UNESCO

What is gender?

Gender can be defined as the social construction of differences between the male and female biological sexes. Gender is a “dynamic concept which looks at the interrelations between men and women in the context of society. These interrelations vary widely between cultures. Gender roles change over time and over an individual’s life stages.” (WHO/FRH/WHD/98.16)

Interventions should take into account the different phases of conflict situations, which are:

- Initial phase – Exodus
- Emergency establishment of camps
- Camps situation
- Return of Internally Displaced Persons (IDP) and refugees to their home areas and the post-conflict situation.

Significance of gender analysis in conflict situations

Gender analysis enables us to understand the changes occurring in conflict situations.

- “Feminization” of population demography as a result of a disproportionate amount of male casualties.
- Special military laws, including the punishment of war crimes in particular those committed against women and children.
- The disruption of gender structures such that women perform tasks traditionally associated with the male domain, due to the feminization of society.
- Peace treaties which contain specific clauses concerning the protection of communities and family reunification – greater numbers of households run solely by women in conflict situations.
- Additionally, gender analysis is important considering the fact that 80% of internally displaced persons (IDP) and refugees are women and children.
- There is an increase in violence in conflict situations, especially that of a sexual nature which tends to disproportionately affect women and girl children.
- Additionally, women may serve an important purpose as “crisis managers”.

Opportunities

- Women’s skills will necessarily be drawn upon and increase in value
- Adoption of children
- Self-help groups are formed to re-establish the conflict-torn community
• Collaboration with local NGOs and associations such as women’s groups
• Strategic needs – changes in laws, as mentioned above
• Behavioural changes in response to “feminization” and disruption of traditional gender roles
• The social value of girl children and women is augmented, in terms of their potential contribution to rebuilding and maintenance of communities and families

Conclusions and recommendations
• Counselling
• Involvement of NGOs in gender analysis and action
• Peace building in the South
• Women “combatants” to change fixed gender roles and social structure
• Greater focus on value and physical/mental health of adolescents
Country study: Azerbaijan

Ms Mominat Omarova

Deputy Chairperson of the State Committee for Women’s Issues,
Azerbaijan

Background

The Swedish experts on conflicts describe a large-scale armed conflict as any clash that goes for a long time; involves armed forces of two or more states or a government, and an organized armed group and causes a loss of over 1000 lives. The Karabakh conflict fits all the above qualifications and can be defined as a territorial dispute. Such claims are well known in the world, and summarized in a nutshell by an epigraph to Susan Woodward’s Balkan Tragedy: Chaos and Dissolution after the Cold War: “Why should I be a minority in your state when you can be a minority in mine?” Scholarly speaking, it is irredentism that potentially can be viewed in many countries to cause conflicts. In the Caucasus, Karabakh and Nakhichevan in Azerbaijan, Javakhetia in Georgia and Kars in Turkey are all irredentas claimed by Armenia as the “legal heir” of the so-called Greater Armenia.

The sad results of that conflict are well known in the world – over 30 thousand losses on both sides only between 1988–1994. Despite the ceasefire agreement between Armenia and Azerbaijan, there were 116 casualties and 366 wounded between 1994–1997. This is the most cruel and destructive conflict in Europe at the end of the 20th century. As the result of the aggression, Azerbaijan lost Nagorny Karabakh and seven adjacent districts that make up 20 percent of its territory. These are the sad statistics.

- More than 18 thousand were killed. A new strata of society emerged- refugees and IDPs – totalling over one million. Currently, they are settled in tent-towns all over the country.
- It has been acknowledged globally, that women and children constitute the most vulnerable of the refugees and IDPs. Azerbaijan is not an exception: 28.7% of the refugees and 71.3% of IDPs are women.
- Other victims of wars are hostages and war captives. Ethnic “cleansing” conducted by the Armenian armed forces on the territory of the Nagorny Karabakh region reached its climax in February 1992, when more than 800 civilians, including women and children were slaughtered in Khojaly, an Azerbaijan town, in what Human Rights Watch called “the largest massacre of the conflict”.

Table 1. Statistics (for 01.09.2000)

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<th>Category</th>
<th>Number</th>
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<td>Total number of missing people</td>
<td>4,959</td>
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<tr>
<td>Among them:</td>
<td></td>
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<tr>
<td>Children</td>
<td>71</td>
</tr>
<tr>
<td>Women</td>
<td>320</td>
</tr>
<tr>
<td>Elderly people</td>
<td>358</td>
</tr>
<tr>
<td>The incidence of death in Armenian captivity</td>
<td>176</td>
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<tr>
<td>Returned from the Armenian captivity (1992–2000)</td>
<td>1,086</td>
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<tr>
<td>Among them:</td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>67</td>
</tr>
<tr>
<td>Women</td>
<td>243</td>
</tr>
<tr>
<td>Elderly people</td>
<td>246</td>
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Source: State Commission of the Republic of Azerbaijan on Prisoners of War, Hostages and Missing People
Scope of the problem

Wars and military conflicts generate violence as a military tactic, in its most abominable forms. These include: killing; violation of human rights; rape; sexual slavery; forced pregnancy; hostage taking; violation of all international laws. These are forms of abuse to which the women are mostly subject. Women in armed conflicts face the consequences of war: psychological trauma; problems of health, including reproductive health and mental health; poverty; unemployment, etc.

In fact, the entire population of the Republic to a certain extent, has been victimized by the scale of damage caused to the economy, education, social spheres of life and cultural heritage, resulting in massive population displacement, leaving Azerbaijan with one of the largest per capita burden of refugees and IDPs. From the beginning of the aggression over Azerbaijan, more than 877 settlements have been burned down and destroyed. Some 4,366 social and medical establishments, including 690 schools, 855 preschools, 490 hospitals and other public health institutions have fallen into decay.

The economic damage cannot be compared to the moral and psychological damage caused by the violence of war. On the whole, it hampers the development of democracy which is underway, the establishment of a civil society in the Republic. “The state of ceasefire” – no war, no peace state – creates uncertainty and jeopardizes the social stability. According to the survey and research conducted by the World Bank in Azerbaijan, over 80% of the population in Azerbaijan live below the poverty line. A new independent country in transition is not able to satisfy the needs of refugees, IDPs, vulnerable, and unemployed people.

Action taken

The Government of Azerbaijan has been considering the problems of IDPs and refugees seriously and during the last 10 years the President, Parliament and Cabinet of Ministers have adopted over hundred decrees and laws associated with the management and amelioration of IDP and refugees’ conditions. The most important of these are “Law on Refugees and IDPs Status” (1992) and its updated edition “Law on Strengthening the Social Protection of IDPs” (1999).

In implementing Beijing Platform for Action, the Cabinet of Ministers has adopted the National Plan for Action worked out by the State Committee for Women’s Issues, based on 12 strategies. Among them, violence against women in armed conflicts is to be defined as a priority. One of the activities envisaged, is establishment of a Rehabilitation Centre for women subjected to violence. Despite the lack of funds, the Government of Azerbaijan has increased the allowance for IDPs twice, thus IDP families have received plots of land for temporary usage.

Refugees, IDPs, widows and children of those perished during the war are provided with certain benefits such as free medical treatment and support in education (free textbooks for children). Actions are taken by a number of NGOs, including women’s NGOs. There are 34 registered women’s NGOs and they have achieved considerable progress in the provision of employment skills training workshops for women, developing their leadership skills and rehabilitation courses. Actions are taken in supporting the government policy on peaceful solutions for conflict, through the involvement of women, especially victims of war, in peace building and peace-making on the grassroots levels.
In 1998, Baku sub-regional conference on “Women’s rights are human rights: women in armed conflict” was held. The outcome of the conference was the Baku Declaration, which affirmed commitment for the protection of women’s rights at all levels, especially vulnerable groups, such as refugees, IDPs, hostages and victims of torture. In 1999, UNICEF launched the 6th issue of the UNICEF Regional Monitoring Report, dedicated particularly to women. The satellite link with the launch ceremony of the UNICEF Executive Director, Ms. Carol Bellamy in Geneva, was organized with participation of the national mass media representatives. The problems of women, particularly refugee women, were discussed. The press conference was followed by a discussion panel with the participation of the President’s Office, the State Committee on Women’s Problems, NGOs and women.

In 1999, UNICEF initiated the training on Gender Mainstreaming. The training was designed for the gender Focal Points of United Nations organizations (UNICEF, UNDP, UNWFP, UNOCHA, UNHCR); government counterparts in the Ministries of Education, Youth and Sports, Labour and Social Protection; and key NGOs like the Women’s Development Centre; Young Lawyers Association; senior representatives of the GID project, and the State Commission on Women’s Problems.

The national NGOs, namely Azerbaijan’s “Women and Development Centre”, GID Unit together with “Symmetry” NGO, carried out several small-scale qualitative surveys intended to collect information on various aspects of the problem of violence against women in Azerbaijan. For example, the survey on Domestic Violence conducted by the GID Unit together with “Symmetry” NGO in 1999, has revealed that 37% of 16-60 age respondents in 4 selected districts of the country have experienced violence in their lives. 32% of women were subjected to acts of violence in their own families, 58% in the family of their husbands, while 10% were victims of violence in social life (at working place, street).

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<th>Table 2. Age 5–19 female mortality rate due to accidents, poisoning or violence excluding suicide</th>
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Azerbaijan National Committee of Helsinki Citizens Assembly has collected and shared the documents proving the facts of slaughter, violence, and torture against civilians, war prisoners and hostages. It has initiated the idea of creating a database to collect information on: violence against children; violence against women; killing of elderly persons in captivity, etc. In 1988 at the 50 Anniversary session of the “Human Rights Declaration”, the delegation of Azerbaijan spoke on the necessity of establishing an International Court condemning Armenian armed forces in their extermination of the Azerbaijani population and violence towards them.

**Major actors**

- The Government of Azerbaijan: the Cabinet of Ministers of the Azerbaijan Republic; the State Committee on Women’s Issues; the State Committee on IDPs and refugees; a number of ministries.
- United Nations agencies: UNICEF, UNDP, UNFPA, UNHCR, UNWFP.
- NGOs: 34 women’s NGOs; a number of international and national NGOs.
Future actions

The key to solving the problems of refugees and IDPs in Azerbaijan is promoting the peace process.

The following recommendations for future actions need to be implemented.

- **Return and settlement of refugees and IDPS to their place of origin** after de-mining and reconstruction of the liberated territories. Assistance in the restoration and reunification of families and their original communities, and repatriation and rehabilitation in their places of origin.

- **Promote and strengthen women’s employment opportunities** and their participation in economic development.

- **Provide training and re-training for women** related to their entry into the market economy to include them in business activities; entrepreneurship; income generation; financing; production and quality control; marketing and legal aspects of business; new professional skills; financial support and credit.

- **Advocacy for study and monitoring of human rights** to ensure awareness of population, including women and children, on human rights and to establish mechanisms for monitoring their implementation.

- **Strengthen networking and lobbying of women and youth organizations** for their active participation in the implementation of the National Plans of Actions and policies on sustainable development for survival; organizing financial support; food, and psychosocial rehabilitation support for refugees and IDPs, taking into account their gender and age specifics.

- **Work out policies and strategies** for urgent short-term and long-term assistance for refugees and IDPs in their places of residence, including refugee camps.

- **To strengthen partnership to solve the various aspects of the impact of the armed conflict on women** with involvement of the government; United Nations agencies; national and international NGOs; community; mass media, etc.

- **Provide regular baseline surveys for gender and age-disaggregated database** about the number, and mainstream and urgent needs of IDPs, taking into account active re-migration processes.

- **Disseminate knowledge and information** on sexual behaviour, sexual upbringing, on Sexually Transmitted Diseases (STDs), HIV/AIDS, among refugee women and youth, including girls and boys.

- **Identify refugee and IDP women** who have suffered from war, cruelty, torture and violence, to assist them in health and psychological rehabilitation, including hostages-returnees.

- **Publication of regular bulletins** on the situation of refugee and IDP women.
**Children and women in armed conflicts: Humanitarian law aimed at protection of vulnerable groups**

**The need for guidelines to prevent the detrimental health consequences of human rights violations**

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Internationally, the prevention of children and women’s suffering during armed conflicts is of increasing importance. There exists a need for implementation of universal and gender sensitive guidelines for protection of children and women victimized by armed conflicts. Standards for humanitarian aid during armed conflicts must recognize those special efforts that are needed to resolve problems faced by women and children.

Since the armed conflicts in former Yugoslavia started around 1990, much knowledge has been gained of the broad spectrum of violence that women endure during conflicts and displacement. Numerous reports have described rape as a tool in ethnic cleansing and in humiliation of women and girls. Further evidence of the magnitude of sexual violence in armed conflicts towards girls and women was obtained during the conflict in Rwanda. In the last decade, globally there has been an increasing awareness of the importance of ensuring psychosocial support to victims of gender-related violence and to establish proper services within the national health system in order to prevent the long lasting detrimental health effects of violence.

The number of testimonies of violation of children and women in armed conflicts is huge and demonstrate the necessity of increased focus upon their vulnerability. An overview of the problem is found on ICRC’s homepage in May 2000, presented also in reports by UNFPA, UNICEF, and summarized in a publication from London School of Hygiene and Tropical Medicine, among others.

It is well documented that gender-based violence has profound health and socioeconomic consequences. The prevalence of gynaecological complaints, psychiatric symptoms and general illness is significantly higher among female victims of violence than in the general population. Relatively new research has proved that the general health care and a high competence within the medical and legal system are of great importance in preventing the long lasting effects of violence.

In 1998, United Nations included in the Declaration of Elimination of Violence against Women that all member states shall provide medical care and judicial counselling to all victims of violence. However, only few states have established rape centres or other easily accessible professional care for victims of violence in the national health system – and the provision of free legal aid or judicial guidance is only obligatory in a number of states. It is therefore not surprising that the standards for medical, psychosocial and judicial aid and counselling also are sparse for female refugees and internally displaced children and women who have been victimized by armed conflicts.
International Committee of the Red Cross (ICRC) and protection of victims of armed conflicts

The fundamental principles of Red Cross include prevention and alleviation of human suffering wherever it may be found, be it in armed conflicts or in non-armed conflict situations. The Red Cross aims at improving the knowledge about and the respect for the International Humanitarian Law, and to ensure humanitarian assistance to victims of armed conflicts. Attention is given to how the needs of certain vulnerable groups are best met. Children, women, refugees and displaced persons are such vulnerable groups.

In 1999, ICRC estimated to have supported about 5 million persons, most of these was internally displaced persons. UNHCR’s annual statistics 1998 estimates that the total number of refugees is about 11.5 million people and 4.6 million internally displaced persons, and that the majority are women. In 1999, ICRC visited 225 000 detained persons, among them 6 500 women. Many of these were detained due to armed or political conflicts. The Geneva Conventions, or the law of war, were primarily endorsed by IRCR in 1864 to alleviate the suffering of the wounded on the battlefield. However, the Geneva Conventions of 1949, supplemented by the Additional Protocols of 1977, the ICRC today has a mandate to help and protect any victim of armed conflict including refugees and internally displaced persons.

The Geneva Conventions include special guidelines/principles aimed at the protection of women and children. Among these guidelines are:

- The rights of women in internment camps to be interned isolated from men, or in the case that the woman is a member of a family to be interned together with the family (1st Add. Protocol, Art.75);
- Interned women also have the right to be guarded only by women (2nd Add. Protocol, Art.75);
- Female prisoners of war must be isolated from the male prisoners, and must not endure more severe punishment than the armed forces of the involved state (GC III, Art.88);
- Pregnant women and mothers of children below 7 years have a right to favourable treatment (GC IV, Art.38&50);
- Pregnant women, breastfeeding women and women of minors have the same rights of protection as wounded and sick persons (GCIV, Art.389. and 1.Add Protocol, Art.8);
- A pregnant woman must not be sentenced to capital punishment (1.Add Protocol, Art.6).

These principles are primarily relevant to female prisoners of war, and do not deal specifically with the situation of internally displaced women or female refugees during armed conflicts. However, ICRC interprets the wording in the Additional Protocols to include all victims of armed conflicts who are displaced from their homes. According to this, certain internally displaced persons, such as children, especially unaccompanied minors, expectant mothers, mothers with young children and female heads of household, shall be entitled to protection and assistance required by their condition and to treatment which takes into account their special needs.
United Nations High Commission on Refugees: protection of refugees and displaced persons

United Nations’ Refugee Convention of 1951 defines a refugee, whereas an internally displaced person is not defined in the Convention. The Guiding Principles on Internally Displaced Persons of 1995 defines the groups as: “Persons who have been forced to flee their homes suddenly or unexpectedly in large numbers, as a result of armed conflict, internal strife, systematic violations of human rights or natural or man-made disasters; and who are within the territory of their own country”.

During the last decade, the world has witnessed a great number of conflicts within the individual states’ borders. Civilian populations are increasingly involved in these conflicts, and have been subjected to internal displacement or external deportation, ethnic cleansing and violence. Women and children are found to be the groups most vulnerable to forced displacement and violence. United Nations considers that women and children constitute about 80% of the total number of refugees and internal displaced people.

In the 1990s, the number of internally displaced persons has increased considerably. The international community has only limited possibilities to protect these persons if the state in question does not want to co-operate. Serious problems exist with regard to the legal status of internally displaced persons. While there are relatively clear-cut internationally accepted and well-defined legal principles concerning refugees, internal displaced persons are under their own country’s legal system and national legislation, and thus subjected to the willingness of the Government to respect and promote their human rights.

It has been considered to establish new organizations with special duties concerning internally displaced persons or to widen the mandate of UNHRC or other existing organizations. However, due to the seriousness and scope of the problem it is obvious that broad cooperation is needed among all relevant organizations. Red Cross is one of these.

The Guiding Principles on Internal Displacement were prepared by the office of UNHCR in 1991. At present, revisions of the Guidelines are expected to be published by November 2000. The guiding principles reflect the principles of international humanitarian law, and state that these humanitarian laws also include internally displaced persons. The general principles ensure that displaced persons shall enjoy, in full equality, the same rights and freedoms under international and domestic law as do other persons in their country. They shall not be discriminated against in the enjoyment of any rights and freedoms on the ground that they are internally displaced.

Protection of women, children and other vulnerable groups

In the Guidelines of UNHCR it is stated:

*Women share the protection problems experienced by all refugees. Along with all other refugees, women need protection against forced return to their countries of origin, and security against attacks and other forms of violence; protection from unjustified and unduly prolonged detention. They must be ensured a legal status that accords adequate social and economic rights, and access to such basic items as food, shelter, clothing and medical care.*
In addition to these basic needs shared with all refugees, refugee women and girls have special protection needs that reflect their gender: they need, for example, protection against manipulation, sexual and physical abuse and exploitation, and protection against sexual discrimination in the delivery of goods and services.

The Guidelines include principles that are specifically aimed at protection against gender-based violence:

Principle 11:

Rape, mutilation, torture, cruel, inhuman or degrading treatment or punishment, and other outrages upon personal dignity, such as acts of gender-specific violence, forced prostitution and any form of indecent assault shall be prohibited.

Slavery or any contemporary form of slavery, such as sale into marriage, sexual exploitation, or forced labour of children shall be prohibited.

ICRC: Women, health and humanitarian aid in armed conflicts

Humanitarian aid must meet the victims’ need for protection and care, thereby both to safe life and to minimize human suffering. The experience of the last decade is that this task is extremely difficult during armed conflicts. The humanitarian organizations do not easily get access to the victims, and in many situations contact to children and women is even more difficult. It has been found that most often the provisions of resources and services give limited attention to gender. Thus, there is a need for gender-based research into refugees and displaced persons in order to involve women in the planning, provision and implementation of health-care services for refugees and displaced persons to ensure that the provisions also are appropriate for women and children.

The fundamental principles of Red Cross among others are impartiality, neutrality and independence. These principles have been estimated as being essential to facilitating access to all victims of any conflict and ensuring that their basic needs are met. Humanitarian aid in armed conflicts does not only involve securing the basic need for food, housing and medicine, but must also include protection against violations of international humanitarian law and fundamental human rights and those violating these laws must be held responsible.

The working methods of ICRC favour confidential dialogue with all parties to a conflict. The constant presence of delegates in the field makes it possible to monitor a situation as it develops and to take appropriate steps with the competent authorities in order to prevent or suppress possible violations, and guided exclusively by the victim’s interest. ICRC has through a 4-year pledge committed the institution to the effective protection of women. The pledge specifically focuses on dissemination, to parties to an armed conflict, of the protection accorded by humanitarian law to women and girls and the issue of sexual violence.

Minimum standards for gender sensitive humanitarian aid in conflicts

The exacerbation of gender-based violence due to armed conflicts and displacement demands joint efforts of the humanitarian organizations. Children and women are exposed to violence and degrading treatment not only during armed conflict and during flight but also in refugee camps when they have lost the protection of their husbands and are exposed to demands of sex in exchange for food, shelter, protection, and determination of refugee status. The camps are not
always – or only seldom – organized in respect to the vulnerability of children and women who therefore must often endure conditions that harm their culture and demands for privacy.

At present the competence in the health system concerning gender-based violence is increasing, not least due to the efforts of WHO, which since 1995 has put violence on the agenda. The scientifically based knowledge of best practices to prevent the psychosocial damages of violence against women must also be applied whenever possible in armed conflicts.

In March 2000 a national rape centre opened in Copenhagen, Denmark. The tasks of the centre are, besides acute care, examination and medical treatment, to develop national standards for multidisciplinary care in the health and judicial system for victims of violence. The Danish Red Cross will implement the know-how gained of this national centre in discussions and suggestions for future initiatives, both among refugees in asylum centres in Denmark and in refugee camps abroad. These initiatives will primarily aim at creating better protection of children and women in armed conflicts and in the post-conflict phase. It also aims at supporting the increasing global awareness of the necessity to establish professional care for refugees and internally displaced women and children who have been victims of any violence. It might thereby be possible to alleviate lasting injuries and detrimental health effects of violations of their human rights.

The International Law Committee of the Danish Red Cross

The Committee was established in 1995, members are lawyers and physicians who have different expertise within Human Rights, humanitarian law, and the medical aspects of violation of human rights. The Committee puts forward to the Governing Board of the Danish Red Cross, concrete proposals to promote humanitarian law and to improve collaboration with other relevant NGOs. Among the recent initiatives is one to create greater awareness of the need for good practices in refugee camps and in replacement centres that will fulfil the special needs of children and women.

Denmark has by tradition a strong international profile in humanitarian aid. In 1999 the budget of the state’s humanitarian aid was 1 200 million DKK, nearly 161 million Euro – equally distributed among international humanitarian organizations, especially United Nations, and private Danish NGOs. The total population of Denmark is 5.2 million, thus the humanitarian aid is about 31 Euro per inhabitant. In 1999, the Danish Red Cross received from the Government a total of 28 million Euro aimed at support of catastrophes and development projects outside Denmark.

Summary

- An integrated response to women’s health needs has to be achieved – a synthesis of reproductive health services, psychological and social services, as well as information. The integration of these aspects of public health comprise an effective model for treating women who have been victims of conflict and helps to ensure confidentiality, as it may be unclear for what specific treatment a woman is attending a clinic.

- Treating every woman “as if they were raped” reduces stigma and helps ensure appropriate and respectful treatment. However, it is imperative to bear in mind that women may have experienced many forms of violence – including social, economic and physical, of which sexual abuse may not be viewed as the “worst”.

- Role of media useful in attracting attention and educative but tendency to be voyeuristic/exploitative.
• Partnership with men crucial for preventing violence, the role of mothers educating their children, especially sons, must be stressed.

• Psychological trauma must be perceived in the context of the “collective”, it is important to acknowledge/respect the beliefs of victims and their communities, and try to facilitate their return to full membership in their communities.

• Emphasis not only on working for development in emergency situations, but on preventing emergencies/conflict while a country is not involved in a conflict – working with youth on conflict prevention can be key preventive strategy.

• Red Cross will in the future focus more upon on gender-sensitized organization of refugee camps and involving all aspects of violence against women in armed conflicts into their policy, and advocate that guidelines for refugees and internally displaced persons always take account of the special problems for women and children.

• The basic principles of the Red Cross are to maintain impartiality, neutrality and independence and thus to have full access to all detained people, however, these principles may not facilitate reporting of human rights violations, including maltreatment of and violence against women, whether it be detained persons or those in refugee camps. Recently (1998) a survey of the gender-specific strategies of ICRC was initiated in order to ensure that future activities include the special needs of women.

• In March 2001 a seminar will be held in Copenhagen organized by the Committee of Humanitarian Law of the Danish Red Cross and the ICRC initiative concerning surveys of the present practice concerning violence against women (VAW) in armed conflicts by Red Cross, globally.

• Psychological stress may manifest itself in somatic symptoms, doctors must be trained to recognize this situation, and not pursue inappropriate treatments such as surgery.

• Concept of Post-Traumatic Stress useful for interpreting the presentation of somatic symptoms in order to provide appropriate treatment.

• In building models of health care for traumatized women, you need to assist (1) individual healing process (somatic and mental) (2) reconnecting individual with social structure.

• When building models you need to bridge efforts of women activists and women professionals, both local and international.

• Must treat victims and perpetrators, while serving the need to restore justice, justice is not the same thing as revenge, efforts must be made to acknowledge guilt and to rehabilitate perpetrators.

• Experiences for treating women in conflict situations can and should be applied to the improvement of peacetime services for victims of sexual assault, including an integrated approach to mental and physical health.

• It is important to maintain links to family, community to facilitate healing process, reintegration.

• Efforts made in the war may improve situation of women in the aftermath of war, but in other cases women may be further victimized after the war, or put into traditional and subordinate role.
• The position of women in transitional societies – between traditional and modern – should be recognized. The situation may demand a treatment of them as members of a group, not as individuals.

• Effective and sustainable response must take into account the needs of local health care professionals who may experience extremely high stress levels – including economic necessity, fear for their own families and self, exhaustion. Medical workers, especially men, may feel extremely reluctant or even ashamed to admit their own vulnerability.

• In cases of rape, the whole family suffers and must be treated. For men, they may feel shame because they couldn’t protect their wife, anger, frustration, that their wife is “dishonoured”, that their role as family leader and protector has been destroyed. Burden of guilt on the woman will be reduced.

• Conflict situations may demand new, flexible models of counselling – existing structures are destroyed, counsellors may need to go to the site.

• In many societies, particularly Muslim, young people and women may have trouble accessing health services – due to availability, confidentiality.
SESSION II:
APPROPRIATE METHODOLOGIES FOR COLLECTING EVIDENCE

Integrating the problems of violence into research action:
Working with women affected by violence

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This contribution introduces the principles of feminist research methodologies as critical to eliciting the problems that women experience in violent conflicts. Rejecting the single-dimension stereotype of women as only victims of violence, the paper also details the many, varied experiences of women in situations of armed conflict and asks for research that adapts its protocol to the type of conflict. The last section outlines the particular problems associated with evaluating mental health consequences of violence against women in war-torn societies and reviews the debates about Post-Traumatic Stress Disorder (PTSD) as an example of these problems.

Feminist research methodologies

The first principle of feminist research methodology is to put the social construction of gender at the centre of inquiry; in other words, it is important to make gender the basic organizing principle of research. This principle stems from the observation that gender shapes consciousness, skills, and institutions; gender also shapes the distribution of power and privilege.

The need to use feminist methodology in collecting evidence on women affected by violence is demonstrated by women’s testimony of dramatic shifts in roles and relationships during armed conflict. Not only are gender roles and relations between men and women affected, but also relations between generations are altered, affecting the distribution of power and privilege.

These shifts are not always obvious to researchers as they often occur in the private sphere and are hidden from view. To reach these dimensions of the impact of violence on women it is important to use women’s experiences as resources.

Not every research design will enable investigators to access women’s experience. Participatory research and focus groups, two methods that view women as actors, are appropriate. Often qualitative research methods are necessary, as quantitative studies may not be able to capture subtle power shifts.

The last principle of feminist methodology is that research should have a purpose and the goal should be social transformation. Too much research either explains the status quo or rationalizes the existing power distribution.

Field data collection

Before embarking on a study of violence against women, it is necessary to differentiate the type of conflict because each type has a different impact on women. For example, in wars of liberation more women may be active participants, and there may be a higher percentage of
women fighters whose risk of violence is different in kind from that of civilians. In armed civil
civil conflicts, especially those that are disguised as ethnic or religious struggles, women may
experience additional pressure from their affinity group; women in inter-ethnic or inter-religious
marriages may be at increased risk. In the case of regional power struggles among warlords or
armed factions, women may find themselves caught in the middle, under suspicion from both
sides.

**Violence against women and women’s roles in conflict**

Women are not only victims of violence. They may be actors in liberation movements, liberation
armies, and resistance groups; they may be collaborators, informers, black marketers, or camp
followers. Women also actively protest against war and organize peace initiatives at the
grassroots. In refugee camps women are often the organizers of camp life. If they fall into the
hands of the enemy, they may be subjected to unusually harsh punishment.

Women may also be perpetrators of violence, sometimes as willing collaborators, sometimes
because they are forced to participate. Investigators have documented cases of women
organizing prostitution rings, raping, looting, torturing, and committing murder.

Still, the most common experience of women in armed conflict is that they are victims of
violence. The most commonly reported type of violence is social or interpersonal violence, in
which women are subjected to torture, rape, sexual abuse, mutilation, forced marriage, forced
pregnancy, forced abortion, denial of childbearing, and denial of abortion; in some instances
women are forced to act as human shields.

There are two other categories of violence that women report. Political violence refers to
violence that changes women’s status (in addition to inflicting the suffering just described).
Examples are slavery, sexual slavery, kidnapping, detention, and expulsion. Economic violence
refers to acts that appropriate women’s labour for war purposes; examples are sex trafficking,
forced prostitution, and forced labour. Other aspects of economic violence relate to the transfer
of economic assets that occur in wartime: women are frequently victims of theft or forced to
exchange their possessions for protection.

**Mental health**

**WHO definitions**

WHO distinguishes between mental health and mental illness. In mental health, individual, group
and environmental factors work together effectively to ensure subjective well-being, optimal
development and use of mental abilities and achievement of goals consistent with justice and
equality. Mental illness refers to significant impairment of an individual’s thinking processes and
perceptions, emotions, moods and feelings, and ways of interacting with others and with the
environment.

**Field-specific problems**

Some of the general problems related to the study of mental illness associated with experiences
of armed conflict in Africa stem from a legacy of racist and sexist colonial assumptions, which
are detailed in the work of Franz Fanon and critical histories of psychiatry in Africa. One part of
the legacy still not remedied is the dearth of appropriate concepts and diagnostic tools: much of
the work of adaptation of measurements used in industrial countries has yet to be undertaken. A particular problem for evaluations of the impact of violence on women is the lack of baseline data on African women. Fewer than a dozen psychiatric studies on African women have been published and most of those are about the stresses associated with pregnancy. Generally there is a lack of studies of the specific impact of civil war (with the exception of some research in N. Ireland and on the Israel/Palestine conflict). Current research focuses narrowly on trauma in specific groups like refugees and torture victims.

Methodological debates

There are unresolved debates about the appropriate methodology to use in public health studies. On the one hand, epidemiological data fail to convey the effects of war on daily life, especially the way that constant threats of violence rupture everyday routines and the way that violence changes relations between men and women and between generations. Psychoanalytic studies, on the other hand, highlight variation in individual response but often ignore group experience.

Post-Traumatic Stress Disorder (PTSD) as example

A specific methodological debate is occurring around the use of PTSD as a diagnosis in war-torn societies. PTSD is defined as the development of characteristic symptoms after a psychologically traumatic event that is generally outside the range of usual human experience. Some of the questions critics are raising concern the differences between the mental health effects of classical forms of war, in which distress is usually acute and temporary, and the effects of political violence, ethnic strife, and low-intensity war, in which fear and anxiety are generalized and pervasive, and distress is severe and long-lasting. These critics are concerned about the violence of alien diagnoses, which exacerbate feelings of isolation and may further divide communities.

PTSD does not distinguish between subjective distress and objective disorder; it does not differentiate between anxiety, depression, and dissociative experiences; and it leads to neglect of larger social and moral problems. Not everyone is a war victim (some people are actors or perpetrators) and some distress is normal or adaptive. Other questions critics are asking are: what is the norm for trauma where murder and torture are usual? What is post-traumatic stress when trauma is ongoing (as in prolonged warfare, economic insecurity, and sustained states of terror)? There is a need for new, gendered, ways to study lingering social damage caused by forced exile, poverty, hunger, detention, lasting fear, the ubiquitous presence of death, torture, and disappearances.
Kosovo: A qualitative approach towards working with women affected by violence

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Background

At the end of the conflict in Kosovo, WHO in conjunction with several local NGOs, including “Mother Theresa Society”, organized a survey to establish the type of violence being perpetrated, the level of attacks, the perpetrators and where these attacks took place. The survey was conducted with the establishment of pilot, as well as focus groups that were to gather information through debates and discussions from January to March 2000. Four pilot groups, as well as 14 focus groups were established in 7 municipalities of Kosovo, and included a total of 162 participants of varying ages, gender, professional backgrounds and social status.

The main areas of questioning directed at both men and women were:

- how would you define violence?
- types of violence experienced
- places where violence occurs
- does the violence continue in your present surroundings?

Main findings

- Men tended to define violence in abstract, objective terms, whereas women understood violence as occurring in psychological, sexual and economic forms.
- Men had experienced repression by the state, rape and kidnappings (mainly external source of violence), while women had experienced the latter two, as well as beatings and forced marriage (could be perpetrated within family/community).
- Both men and women felt violence occurred in schools and at home, however, men also specified police stations as an arena for violence, while women identified closed premises.
- Both men and women felt that in all probability, violence against women still exists in their present environment.
Pilot survey in Tajikistan on violence against women

Dr Annemiek Richters
University of Amsterdam

Main objectives of the survey

- To identify the different forms of violence occurring against women
- To obtain reliable estimates of the prevalence and frequency of violence against women in Tajikistan
- To obtain information on the health consequences of violence against women
- To identify associations between the different types of violence and sociodemographic variables
- To obtain information for further study of risk factors for violence against women

Development of the survey

- Joint activity between SDC, WID Bureau, UNDP Tajikistan, Open Asia
- Questionnaire development (sociodemographic/violence/health status); field testing; final content and training of interviewers
- Consideration of ethical issues
- Sample design
- Data analysis

Main findings

Personal experiences of different forms of violence (in percentages)
**Impact of violence on health**

- 28% of women reported connections between any present health complaints and experiencing violence; among those women, 76% had been victims of physical violence in their adulthood, and 77% had experienced sexual violence by their husbands.

- 56% of women believed girls to constitute the group most at risk of violence.

- 80% of respondents considered psychological abuse of children to be the dominant form of violence, with physical abuse being rated by 78%, and sexual abuse by 39% as most prevalent form.

- 61% of respondents felt that children were often forced on the street to earn their living, through begging, stealing or drug smuggling.

**Lessons learned**

- Support by government
- The importance of WHO support
- Awareness raising and empowerment of women
- Capacity building of women
- Ethical and safety issues involved in provision of and access to services
- Involvement of government and civil society in various stages of the survey
- Comparison with other research results
- Supervision of the study and accountability of various partners involved
- Choice of implementing partner
- Validity of research results

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[Fig. 3. Adult experiences – by family members](#)

[Fig. 4. Adult experiences – by strangers](#)
Country study: the complexity of risk factors for different types of violence against women in Tajikistan

Dr Annemiek Richters

University of Amsterdam

We have to determine which of the risk factors common in other societies are significant in Tajikistan as well, which additional factors may be at play, and how various factors interact. Risk factors to be added are for instance: type of marriage (civil, traditional, polygamous); level of education/information; refugee status; locality (for instance town, rural area) and traditional Islamic surroundings. Further more, we have to distinguish between acceptable and unacceptable forms and amounts of aggression. Psychological violence which, I am told, is considered to be unacceptable in Tajikistan, is for instance present in such forms as: isolation and restriction of freedom of behaviour by husband or in-laws; restriction on freedom of dress by husband and in-laws; need to ask permission from husband and in-laws to go out and do things; husband refusing to collaborate in house-work and upbringing of children (cf. Harris: involuntary and voluntary violence).

Another issue which bears looking at is what other forms of violence within the family exist, besides violence by a partner. In Tajikistan it is for instance, common that a woman is forced by her parents to marry and is abused by her mother-in-law or her brother. We can question what the specific risk factors for these kinds of violence are. And what the risk factors are for the various types of violence in the community, like the abduction of girls; rape by a stranger; use of women for drug trafficking; women being forced into prostitution, etc.

Societies are not static. Risk factors, types of violence and prevalence of the various types of violence may change. Tajikistan went through serious social crises in the last decade, which is reflected in an increase of violence against women. Women attribute the increase in violence following the war (1992–1993), in particular to deteriorating socioeconomic conditions. However, there are also other factors involved. Right now the situation is such that despite a Soviet-based legislation stating the equality of rights and treatment between women and men, women in the new Tajik state have lost many of the achievements of the Soviet Union, in terms of equity of treatment between men and women. Women are particularly discriminated against with regard to income generation, access to education and health services. Especially in rural areas, women are increasingly bound to “traditional” domestic roles with increased difficulties to access public positions.

Throughout the Soviet era gender norms and relations, the practices of Islam, and the form of Soviet socialism were in a state of flux. Changes in any of these inevitably impinged on others. At moments of strength, the Soviet regime tried hard to suppress religion and to encourage changes to local gender norms. These changes, however took place first of all at the top political levels and it is far from clear what their real effect was at the grass-roots level, particularly in the rural areas where the vast majority of the Tajiks lived. The main significance of the intersection of Islam and socialism with Tajik gender norms, is that this formed the central battleground between the Soviet regime and the local population. This battle is still continuing today, albeit on slightly different ground. It is now being fought between the secular state represented by the post-communist government of Rakhmonow on the one hand, and on the other, the more radical factions of the Islamic opposition.

2 The following text was originally presented by Dr Richters in Session IV.
Summarizing Tajik history of the twentieth century as far as gender relations are concerned, we can say that both the Soviet regime and the Tajik people found gender norms to be the most important facet of cultural identity to be attacked, or conversely, preserved.

The Bolsheviks endeavoured to penetrate Tajik culture and modernize it, chiefly by forcing its women out of seclusion. As this was viewed by the men as an attack on their masculine identity, there was strong resistance. In fact, the Tajik people were able to subvert the might of the Soviet State by their refusal to make significant changes to their gender norms. The result of a long history is that women (still) suffer, in particular from the constraints their family and community force them to live under. Despite all the changes over the last hundred years, what seems to have remained stable is the mentality or habitus of Tajik people.

Both the concepts of mentality and habitus refer to relatively durable internal, embodied dispositions, expressed in attitudes or customs. More or less intuitive dispositions which generate and are generated by relatively enduring schemes of perception and judgement about man’s lifeworld, and his social relations. History has taught us that forced fast-timetrack, top-down approaches often meet with enormous resistance at the level of mentalities of people. Socialism was in essence a human rights movement, but it failed in its implementation. The question now is what other approaches towards the development of a human rights climate in Tajikistan, might be more effective.

The multidisciplinary and multi-sectoral response to VAW in Tajikistan

An overview of all the risk factors associated with violence against women in Tajikistan would make clear that in order to understand their interaction and change over time, a multidisciplinary approach is a must. The survey findings give atomized data which need to be contextualized and interpreted in relation to each other. As far as proposals for interventions are concerned, there are many documents available now which sum up the kinds of interventions which are needed.

- Draft National Plan for the prevention of violence against women and support to victims of violence (drafted by the local NGO Open Asia) has been submitted to the Government for consideration by a coalition of NGOs working in the sphere of violence against women.
- Recommendations of the WHO seminar violence against women March 20003.
- The project proposal of SDC “Mediating Violence against Women”.
- All promote an inter-sectoral approach. Awareness raising at all levels of society crosscuts all the societal sectors.

Mentality change: How to mediate in a bottom-up approach

In order to avoid that again (like in the time of the Soviet regime), a top-down approach is used in the promotion of women’s rights in Tajikistan, it is necessary not only to pay attention to awareness-raising among people at the top and middle layers of society, but particularly among people at the grass-roots level. Change of mentality and habitus often is a long term process.
issue is well put by Tery Kantai, deputy director of the Dutch development organization SNV in Kenya:

Donors sometimes take the priorities of the Western women’s movement or their own government too much for granted. Quick results from a western point of view are thereby put first. Forgotten is that the reaching of women with another cultural background is very difficult. One should be able to precisely define the different forces and interests within a particular society, district or village. This can sometimes take years. Donors generally don’t have the patience for this and search hasty for quantifiable results. A real community approach from the inside is the only correct one. Now the emphasis lies too much on activities such as the support of women who are nominated for parliament and other subjects which do good in the West. To me it is better to start at the base. Try, for instance, for a change to really fathom the situation of women in the countryside or the family structures.

Butegwa (1993) is of a similar opinion as Kantai. She also admonishes donors to be culturally and gender sensitive in their educational approach:

People in developed countries may think that “organizing” or creating legal rights awareness means simply printing and distributing pamphlets. In Africa this is not always practical as many people, especially women, are illiterate. Radio programmes also have a very limited success rate because the radio is a man’s property. In many cases, women do not even have the time to listen to the radio. What is needed in person-to-person contact – being out there, being able to be with the women and talk. But this is not quantifiable and, in terms of most donor criteria, there are few visible outcomes. Sometimes it is difficult to explain that this is slow work, but the resulting social change is an important contribution to the development process.

Kantai’s and Butegwa’s interventionist approach should go hand in hand with detailed study of the fundamental basis of societies and of internalized conceptions of human rights or human dignity in these societies. We need systematic, interdisciplinary research which can demonstrate whether the abstract formulation of external definitions of human rights can chime with indigenous, culturally-specific norms that are based on human dignity, without being detrimental to women. The social sciences are equipped to focus on the analysis of the meaning of social and cultural conditions for the possibility to introduce human rights in such a manner that they are observed de facto and not predominantly acknowledged in a merely normative-rhetorical way.

By doing so they can help to devise the most appropriate strategies for promoting and protecting human rights. Some sort of decentralization is needed to escape the power of the State and the corporation at the local levels. At the same time, however, we need international coordination and cooperation of groups and social movements interested in human rights and democracy. Thus, struggles for democracy and rights at the local level must be coupled with an institutional recognition of the global implications of these struggles at the international level. The question is how development or other agencies can play the role of some sort of mediator in this process.

**Women’s empowerment for the health promotion process in Tajikistan**

Over the last five years there has been a tremendous increase in the number of NGOs in Tajikistan, in particular NGOs working on gender-related issues. Few NGOs are active at the local grass-roots level. Human rights is a concept that is frequently used by all women’s NGOs. (Contrast with Sarajevo at the time where the key concept was PTSD; PTSD as a concept, is
hardly known in Tajikistan). One of those started a Women’s Health Project in 1997 which I consider to be quite successful.

The Kathlon Women’s Health Project (KWHP) is a grassroots based project whose overall goal is to improve the quality of life for the rural inhabitants of some of the most war-torn regions of Southern Tajikistan by enabling them to take control over their own lives. Particular attention is paid to building the capacities of girls and women in this respect. The project concentrates on building the capacity and knowledge of its participants in the matter of health, family relations, interaction with local authorities, and together with a sister project, income generation for women and girls (multi-sectoral project). One expatriate woman acts as a project adviser and trainer. Otherwise all project staff consist of local people: medical staff which provides basic services and teaching staff. The project works in each village one day a week, for a period of six months, during which time it aims to supply the villagers with the tools they need to continue on their own. For the educational sections, the participants are divided into groups by age and sex, and each group defines its own programme.

The villagers typically report the following results after the six months of KWHP’s presence in their villages:

- major improvements in levels of health, including a reduction in infectious diseases such as typhoid and malaria;
- reduction in the numbers of unwanted pregnancies;
- improved levels of nutrition especially for pregnant and lactating women and infants
- a reduction in obstetric emergencies;
- higher income levels for those women working with the sister organization;
- considerably more care in the upbringing of children and greater attention to their educational needs;
- greatly reduced beating of children;
- increased respect on the part of parents for their children and their children’s rights to be heard and have their opinions taken into account, especially in regard to their own futures, and particularly marriage partners;
- greater respect shown by men and boys towards women in their families; and
- considerable reductions in family, and particularly marital quarrelling and gender-based violence in general.

In the last year, increasing attention has been paid to this last matter and a women’s centre has now been established in the central town, providing essentially the same services as the rural programme with additional psychosocial counselling and legal services. Simultaneously, an outreach project has been started to work with male-only organizations such as the fire brigade, the KGB, the police, and the army to make them gender-sensitive, and provide them with information on family planning, STDs/AIDS, and so on. The main aim of this last project is to reduce gender-based violence.

The success of KWHP can be demonstrated not only by what the villagers report but by an attendance of between 10 000 and 12 000 participants annually. Furthermore, statistics from the Ministry of Health show both a real reduction in communicable diseases in the villages in which
KWHP has worked, but also in infant morbidity and mortality and in emergency obstetric interventions for the women attended by the TBAs, trained by KWHP. A further demonstration is given by the enormous waiting list KWHP now has, of villages who have petitioned the organization for it to start work in their locations. Petitions have come in, not only from the surrounding villages, but also from visitors from other areas of Tajikistan who participated in KWHP’s activities. A number of local NGOs from other parts of Tajikistan have also asked to be involved in setting up such a project in their respective areas. KWHP has also attracted the notice of the international organizations working in Tajikistan many of whom have visited the project and reacted favourably to it.

In conclusion, this project is highly receptive to local needs, as well as being gender sensitive both in incorporating women and women’s viewpoints, and in working with men to bring them to accept women’s rights to greater freedom and recognition. It particularly concentrates on those women whose resources are limited in the extreme.
Setting up health services for women in situations of armed conflict

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In war it is quite clear that now rape has become systematically organized on a mass scale and it is used as a deliberate weapon in war.\(^4\)

Limitations of previously existing health services as to addressing rape and sexual abuse in situations of War

The setting up of health services in situations of armed conflict, has traditionally in the past not taken into account the special needs of women and the fact that traumatization of women includes sexual assaults. Rape and sexual abuse have not been addressed as health issues. When services did not explicitly address this type of problem, women themselves have not have had the opportunity to openly express their needs for assistance. In the past, women could then have suffered from consequences of traumas, which might have had great impact on their ability to cope and heal, which in turn, would have had impact on their somatic and mental survival and ability to reconstruct social networks, preserve cultural identity and build a future.

Thus, rape has presently been acknowledged as a weapon of war (see above). The act not only affects the individual woman as to her total health, but it can also affect the social and cultural structures and the potential for reconstruction of future and survival of a whole society. Emergency medical assistance has often been limited in acknowledging that women have special needs in addition to their health needs linked to being childbearers. Overlooking the facts of sexual abuse, might lead to women not getting appropriate health services and worse, might lead to them feeling revictimized by the health services and refrain from seeking assistance for e.g. for sexually transmitted diseases (STDs) and unwanted pregnancies.

Only lately have the needs of women as to reproductive health in general been acknowledged in emergency situations. The international community now recognizes the need for urgent assistance in connection with prevention of unwanted pregnancy, the prevention and treatment of sexually transmitted diseases, including HIV/AIDS. Additionally, there is an increasing acknowledgement of the potential for women having been subjected to sexual violence as well as having been exposed to other types of violence and traumas – e.g. a special edition of Entre Nous addressed reproductive health in emergency situations. The issue of sexual abuse was also addressed as an important fact to take into account when setting up reproductive health services in war situations (UNFPA/WHO. Entre Nous, 46 (2000)).

The limitations of past approaches have also been linked to the underlying structure of health services. By applying a strict biological model of health, sexual abuse and the impact of trauma might be seen as something that does not count as a health problem. Even when recognizing

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trauma as something that affects a woman’s life, these effects are understood to be “only” psychological.

Overlooking the fact that the detrimental effects of sexual trauma include both physical manifestations, somatic diseases and mental changes that indirectly affect a woman’s ability to take care of herself, can thus also lead to the problem being inappropriately addressed when setting up health services in emergency situations. Health services also in emergency situations, have traditionally included only personnel with a medical background without the competence to address psychosocial needs as an integrated part of the service. The lack of interdisciplinary actions also adds to the limitation of the health service to address the problem of sexual trauma in an emergency situation.

How can health services address rape and sexual trauma in war situations?

Integrated or separate health service for victims of rape?

During the 1980s the women’s movements and non-governmental organizations of various kinds brought rape on the agenda of the health care systems in many parts of the world, in particular in the Western countries. In the Nordic countries, this process led to an integrated service within the public health care system. In other parts of the world, a whole range of models of services were developed both within the health care system and outside the established health care. Most of these types of services have specifically targeted raped women and/or battered women. The professional staff have typically included doctors, nurses, social workers and psychologists. In addition, to answer the need for forensic documentation, the medical and psychosocial needs of the victims have been addressed.

During the war in former Yugoslavia, many NGOs with backgrounds in working with rape victims responded to the disclosure of rape, by wanting to set up services which could assist the raped women among refugees, internally displaced persons, and among the inhabitants still trapped in the war situation. Questions which were raised included how to set up services which would both acknowledge the needs of the raped women, and acknowledge the fear of women of being stigmatized when asking for assistance from services which solely provided care for rape victims. Also, it was acknowledged that victims of rape in an emergency situation had suffered other serious traumas, such as being exposed to interpersonal violence; having been detained; having experienced severe losses, and having to flee from their homes and having been separated from their families.

Many of the women had to live with their children under appalling conditions as refugees and internally displaced persons, and also suffered from a lack of basic goods as food, house and clothing. Thus, even when wanting to set up services addressing sexual trauma, it was clear that all women, whether or not victims of rape, were in need of a whole range of services.

Expanding models of service provision

In attempting to address the needs of raped women, it became evident that other health needs of women in emergency situations were poorly addressed, in particular those related to reproductive health. Also, raped women were in need of emergency contraception and treatment to prevent sexually transmitted diseases and other reproductive health trauma caused by the abuse. Hence, the identification of sexual abuse as part of the war situation, highlighted the need for reproductive health services both for the traumatized women and for women in general.
**Post-traumatic stress – a concept with limitations for war situation?**

While the concept of post-traumatic stress has become integrated into mainstream health care in many Western countries, this was often a new area of knowledge among professionals working in the former Yugoslavia.

The emotional responses to trauma are described as including the person experiencing flashbacks of the traumatic event with anxiety, nightmares, panic attacks and sleep disturbance. Also, triggers such as having to face situations in which memories of the traumas are evoked, might lead to behaviours, which would be poorly understood by the individual herself or her surroundings. These “unexplained” behaviours could lead to miscommunication and misunderstanding of situation. Symptoms such as hyper arousal with startled responses could also induce fear and anxiety. Inactivity, sadness and depression leading to an individual becoming isolated and losing contact with the outside world is also included as part of the post-traumatic response.

The person might, in the acute phase of post-traumatic stress disorder (PTSD), feel totally chaotic and display fear of being insane. Among the social consequences, are the feeling of being outside the human community, of being cut off from everyone and everything else and feeling total isolation, with no hope for the future. When the trauma is something “not spoken about” as in the case of sexual trauma, the isolation and feeling of being cut off from social context is believed to be even more severe.

Losing family or friends, even witnessing and experiencing physical violence, can be spoken about to others.

Sharing of stories and the listening of others will then be the bridge for building the new social structure. But the disclosure of sexual abuse is still taboo in the sense that it does not necessarily induce the expected and needed social support. Talking can, especially in cases of sexual abuse by somebody known to the victim and her environment, have the potential to destroy social structure and leave the victim feeling even more isolated. The truth might be a threat to the social structure and order and break up relationships. In order to counteract the detrimental effects of trauma, in particular sexual abuse, numerous types of therapeutic approaches have been developed.

Some of the questions in the debate of caring for abuse victims have been about the role of techniques aimed at encouraging the victim to face painful memories. The term “flooding” is used to describe therapeutic techniques, which are aimed at encouraging the victim to confront the most painful memories from the trauma. The underlying assumption is that “remembering” is mandatory to being able to overcome the trauma and integrating the memories into the individual’s life story, as well as decreasing the fear and anxiety and increasing the individual’s ability to successfully cope with the traumas.

The need to restore social structure in the case of sexual traumas is emphasized by others. Although it is recognized as an important part of any service for traumatized women, the relative importance given to this aspect varies among professionals in the field. The last controversy is related to the usefulness of post-traumatic stress for describing emotional responses to rape: “PTSD in such situations is inappropriate and may miss the most important determinant of eventual outcomes of such experience.” (Bracken et al. Psychological response to war and
atrocity: the limitation of current concepts. *Social Science in Medicine, 40*: 1073–1082 (1995)). The aforementioned paper argues that this concept is based on Western individualism and is biased by the Western notion of universal theories within psychiatry. It also argues that the treatment based on the PTSD concept is blind to the given cultural context.

One of the mistakes highlighted in the paper is that still the PTSD concept, even if it acknowledges somatic symptoms, is founded on a notion of separation of the psychological from the somatic and the cultural, implying that distinctions are easily made between the intrapsychic, the somatic and the interpersonal. Another limitation of the literature on therapeutic approaches to sexual abuse and trauma, is that a large bulk of the empirical material is based on traumas in the person’s history and not on the individual who seeks assistance in the acute phase of PTSD, and is still living in an emergency situation, therefore *continuing* to experience trauma.

However, the usefulness of acknowledging the emotional responses to trauma, is that it identifies trauma as a cause of emotional pain. This stands in contrast to theories based upon the understanding that only, or at least most importantly, the individual’s childhood will determine her psychological health and wellbeing.

Also, the concepts are useful for explaining seemingly unexplainable reactions to trauma. It is also useful to make sense of somatic symptoms which otherwise would have been interpreted as serious diseases. Symptoms of sexual abuse include pelvic pain, and women might have to undergo invasive surgery and may even have her internal organs removed because of misinterpretation/misdiagnosis.

**Lessons learned about the setting up of health services in order to reach out to traumatized women**

Based on the understanding of rape as only one of many traumas experienced by women in war situations, services provided should be comprehensive. This in the sense of providing not only psychotherapy or only medical treatment, but also by looking into the social and cultural needs of women in war situations.

One area of health needs important to all women in this situation is the need for basic provision of reproductive service. Sexually transmitted diseases, unwanted pregnancies and disorders related to the reproductive organs will increase in these situations along with the breakdown of the pre-war health care. To make up for this, a reproductive service has to be part of any services, which are aimed at also reaching out to sexually abused women. The breakup of social structure in which severe losses of families and friends affects most of the women, services provided should facilitate activities which encourage the forming of new networks and social groups. Questions of safety and basic needs will always be important in situations of war, and in particular, traumatized women might be more vulnerable and more easily become subjected to further abuse in temporary accommodations and crises situations.

One example of a comprehensive service set up for women during the war, is Medical Women’s Therapy Centre (Frljak, A. et al. Gynaecological complaints and war traumas. *Acta Obstet Gynecol 76*: 350–354 (1997)). The Centre in Zenica, Bosnia and Herzegovina, provided a range of services for women including medical and gynaecological treatment, psychotherapy, dwellings for women and educational programmes. Also, in order to build comprehensive programmes which can address the needs of traumatized women, cooperation between organizations is central. Since pre-war services are often destroyed, many needs have to be met,
and often one single organization might have neither the resources nor the professional background required to meet the needs. This coordination is particular crucial when addressing the needs of traumatized women. Since one of the detrimental effects of trauma is the lack of initiative and ability to find services, continuous outreach work is needed.

Evaluation – an example

Norwegian People’s Aid, which is a large non-governmental organization, was involved in setting up two projects aimed at traumatized women in Zenica and Tuzla, Bosnia-Herzegovina during the war (Schei, B. & Dahl, S. The burden left my heart: Psychosocial services among refugees women in Zenica and Tuzla, Bosnia-Herzegovina during the war. *Women and Therapy* **22**: 139–151 (1999)). The evaluation studies were conducted in cooperation with the staff in Zenica (Atifa Mutapecic being the psychologist in charge) and the staff in Tuzla (Irfank Pasagic being the psychiatrist in charge). Both of the projects included access to medical treatment, either by having cooperation with other NGOs or by employing doctors and nurses. The main focus for both the projects however, was the mental and psychosocial rehabilitation of traumatized women.

Zenica, a city of 120 000 inhabitants, received approximately 40 000 refuges. Many were accommodated in schools, sports centres, cinemas and other public buildings. There was a need for everything. Even though the NPA project was targeted to reach victims of sexual assault, the needs of so many women were overwhelming, and the project developed in direct response to the needs of women and children living in the appalling conditions. A house was opened with occupational activities in groups, educational and recreational activities were developed and in addition, there was opportunity for women to receive individual and family counselling by the few professionals working there (psychologist and doctor).

Educators or non-professionals who organized and participated in the group – many of who were refugees themselves – delivered the main bulk of the service. The aim of the service was to improve the psychosocial functioning of displaced women by presenting them with an opportunity to move out of a passive, helpless position. A second aim was to identify victims of severe traumas in need of additional psychosocial and medical interventions, either as individuals or families. In June 1994, information was collected by questionnaires handed out to all women attending the Centre over the course of three days. Those who did not want to participate were encouraged to leave an unfilled form or complete just the questions they would like to. Out of the 239 questionnaires handed out, 209 were completed.

The women were asked questions about somatic and psychological symptoms and their answers could be classified as to whether they were at risk of developing severe post-traumatic stress. Additionally, they were asked about events during the war and were also asked to rate all the activities available in the Centres. A comparison group of women not attending the Centre was also questioned about potential symptoms of distress (for details see Dahl, S., Mutapcic, A. & Schei, B. Traumatic events and predictive factors for posttraumatic symptoms in displace Bosnian women in a war zone. *Journal of Traumatic Stress* **11**: 137–145 (1998)).

A small, statistically non-significant difference was found between women exhibiting a high rate of PTSD symptoms, compared with those who were less distressed, as determined by their rating of the activities. This raised the question of whether a more active role should be taken so as to identify women who needed more comprehensive support, and as the project developed following the evaluation, this element was integrated into the model. There was a higher
reporting rate of stress symptoms noted among women not attending the Centre. It is difficult to conclude whether attendees reported less PTSD symptoms due to the benefits of the Centre, or whether these results could be interpreted as an indication that women in most need were not able to even reach to the Centre. It certainly means that outreach work is needed and that in particular, women who have been traumatized and hence suffer from distress, need to be actively encouraged to seek help.

War was raging with its full intensity during autumn 1993. Poverty and total blockade led to the lack of basic conditions for survival. Hunger was our certainty.5

A group of therapists set up groups for women who were most severely traumatized. As such, it was a project that explicitly targeted traumatized women and which offered direct therapy. Staff from the team visited dwellings for refugees and potential participants of groups were assessed. Most of the refugee women were poorly educated, and transitioned from a rural environment into an urban one. There were many widows and single caregivers for many children, a high proportion of who were multi-traumatized. In addition, there was continuous shelling and war activities during the setting up, and also evaluation of this project!

During two weeks in May 1995, women attending groups were asked to participate in the study by filling in forms, procedures following the same principles as in Zenica. Another group of women, those who had completed the group treatment were asked the same questions, thus yielding a comparison group. In short from the results, more women suffered – as expected – from post-traumatic stress. The self-evaluations of the group sessions were overall high, as in Zenica. But in contrast to the women in Zenica, distressed women were even more satisfied with the group sessions compared with the less distressed. This might be an indication that activities such as in Tuzla, with specific group therapy to address trauma, is needed for the most traumatized.

Even though these efforts at evaluation only answer a limited number of questions and are subjected to many difficult methodological questions, they demonstrate that at least it is feasible to undertake such studies. Also, it is a way to continually support staff and encourage a steady discussion about the ongoing activities

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5 Dr Irfank Pasagic, head of a group of psychotherapy projects in Tuzla, starting her presentation of the foundation for the NPA's programme in Tuzla.
The need for a multidisciplinary and multisectoral response to ensure the promotion of women’s rights and women’s security

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One of women’s basic rights is the freedom from violence. It is common knowledge nowadays that violence against women can only be effectively prevented if interventions take place at all levels and in all sectors of society where risk factors for this kind of violence can be identified. For the assessment of the ecological whole of risk and protective factors associated with gender violence in a particular society, a multidisciplinary approach is essential. What an ecological whole of factors may look like and what kinds of interventions are needed to address this whole will be illustrated with reference to Tajikistan. The key to the promotion of women’s rights and security in this country (and in many others) is a change of the mentality of its people, particularly with regard to gender norms. There are indications in Tajikistan that the application of the new health promotion paradigm within public health can bring about at least some of the relevant mentality change.

New public health: from an individual to a societal and human rights approach

Violence against girls and women can occur inside as well as outside the family. The Tajikistan survey, as presented in Session I, showed that also in a society which is still afflicted by war and civil unrest, women have experienced more family violence than violence by a stranger or in society. Both types of violence require analysis by an individual and a society-oriented approach.

The traditional medicinal approach to violence against women starts with caring for the injured, focusing on the physical health – and possibly the mental health – consequences of the violence. At the public health level, the traditional approach will start with epidemiological analysis. Applying classical epidemiological methods to violence against women will predetermine that “risk” is defined with respect to individual determinants and individual behaviours (of both perpetrators and victims). The epidemiological information about individual risk factors will inevitably lead to activities focusing on individuals in order to influence their risk-taking behaviour – through information, education (for instance in schools), and health and social services, such as counselling, hotlines and perhaps “early intervention teams”.

These approaches however, will inherently be quite limited in their effectiveness, unless the societal context of violence is also addressed. Nowadays, this observation is generally acknowledged in major policy documents, resulting in recommendations for inter-sectoral interventions. Thus far, work to address the societal factors which constitute the major determinants of violence against women – governmental, sociocultural and economic – has been quite fragmented. The economist, lawyer, political scientist, anthropologist and sociologist all look at violence against women from their own disciplinary perspectives and give discipline-based recommendations. How to integrate those perspectives and recommendations and subsequently translate them into effective interventions?

Various international organizations or movements in the area of health promotion – like the International Physicians for the Prevention of Nuclear War, Physicians for Human Rights,

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6 Based on Jonathan Mann’s (1996) keynote address to World Congress of International Physicians for the Prevention of Nuclear War.
Doctors Without Borders and the International Women’s Health Movement – nowadays agree that the human rights framework offers a more coherent, comprehensive and practical framework for analysis and action on the root causes of vulnerability to disease and disability than a traditional public health or biomedical model.

According to Jonathan Mann (1996), the modern movement of human rights provides:

- a coherent conceptual framework for identifying and analysing the societal root causes of vulnerability to preventable disease, disability and premature death
- a consistent vocabulary for describing the commonalities that underlie the specific situations of vulnerable people worldwide
- clarity about the necessary direction of societal change that promotes health

The women’s rights movement argues for the indivisibility of human rights for women. It is women’s everyday experience that particularly for women, all human rights have both personal and social dimensions that are intimately connected. Unequal gendered power relations lay at the root of many violations of women’s rights. To regain those rights, reshaping of gender power at the micro level should be linked to broader social, economic and political transformation. This holistic vision asks for a commensurate strategy for change. Easier said than done, especially in a society like Tajikistan where so many of women’s rights are being violated on a daily basis.

Freedom from gender-based violence is only one of women’s basic rights. The occurrence of this kind of violence is often facilitated or promoted by the violation of other women’s rights; therefore a comprehensive strategy for change should address all of those violations and also other factors for violence against women. The ecological model7 for risk and protective factors associated with violence against women in the family may be helpful in identifying the relevant factors in a particular sociocultural context.

The ecological model of risk and protective factors associated with violence in the family

In the ecological model, violence against women results from the interaction of risk and protective factors at different levels of the social environment. The more risk factors that are present and the more interaction between the various risk factors, the higher the likelihood of violence. The model can be visualized as four concentric circles:

- **Individual level:** biological/personal history with regard to perpetrator being abused as a child or witnessing marital violence in the home, extreme use of alcohol or other substances, loss of status
- **Family level:** cross-cultural studies have cited male control of wealth and decision-making within the family and marital conflict as strong predictors of abuse
- **Community level:** women’s isolation and lack of social support, poverty and low economic status, together with male peer groups that condone and legitimize male violence, catalyse higher rates of violence. Possible protective factors within the immediate social context may include the right of women to own land, or maintain custody of children upon separation

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7 As developed by Lori Heise.
• Societal level: global studies have determined that violence against women is most common where gender roles are rigidly defined and enforced and where the concept of masculinity is associated with toughness, male honour or dominance. Other cultural norms associated with abuse include tolerance of physical punishment of women and children, acceptance of violence as a means to settle interpersonal disputes and the perception that men have “ownership” of women

Empowerment as a public health strategy

The health promotion strategy within public health takes as its point of departure the importance of empowerment for the health promotion process. The strategy itself is to facilitate the behavioural, societal and environmental changes necessary for health promotion in communities as a whole. At the heart of this process is empowerment and capacity building at the community level. Communities should be empowered to ownership and control of their own endeavours and destinies. Projects around the world have taught us that community empowerment, especially empowerment of women, is the key to successful programmes for social change that affect the quality of life, and health of poor and powerless families and communities.

A meta-analysis of 40 exemplary case studies from across the world with regard to bottom-up “empowerment of women for health promotion” (1999) found the following. All grassroots movements began with a strong discontent and motivation for change among victims. It was not necessary to persuade or motivate them to action; they needed empowerment opportunities and organized support in their struggle. They received support from their fellow victims, concerned professionals, community and/or religious leaders and organizations sympathetic to their struggle. Such support promotes psychological empowerment of the innovators and enhances their self-efficacy. External recognition and support enhance institutionalization and wider adoption of landmark local initiatives. Recognition from credible national and international organizations legitimizes a struggle that empowers those involved. It also helps to generate resources, stabilize and expand the programme and enhance its diffusion.
Violence against women: State of the art, health and educational interventions

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Introduction

There is no one single definition of what constitutes violence against women (VAW). However, the most commonly cited definition, also employed by the World Health Organization (WHO), is that of Article One of the 1993 United Nations Declaration on the Elimination of Violence against Women, according to which it is:

any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. It includes physical, sexual and psychological violence occurring in the family and in the general community, [...] violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state (United Nations General Assembly, 1993).

In accordance with this definition, the paper at hand takes Violence against Women to be a woman’s experience of physical or mental abuse at any one time throughout her lifecycle. Although structural injustice towards women, such as gender bias in education and access to health care are aggravating factors to the discrimination of women and are violations of women’s rights, it is beyond the scope of this paper to discuss structural violence against women.

The United Nations Declaration on the Elimination of Violence against Women proceeds from the assumption that Violence against Women “is a manifestation of historically unequal power relations between men and women” (ibid.). It is a means of structuring power relations not only between men and women but also among men or indeed among women. While in most cases the perpetrators are men, women may also reproduce violence for instance with regard to harmful “traditional” practices, reproductive obligations, the maintenance of social status or hierarchy within larger households. At the same time, men are also active in fighting VAW. A recent paper by the United Nations Development Fund (UNDP) (Greig et al., 2000) therefore points to the shortcoming of the term VAW as concealing the perpetrator. In this paper, VAW is taken to imply violence induced by men against women.

Violence is a social problem and human rights concern, with severe health consequences, that warrants an immediate co-ordinated response from multiple sectors. Despite the serious health hazards of VAW, research on violence in the health sector is scarce, and best practices of technical co-operation approaches have not been systematically evaluated, partly because it has long been considered a private affair (but see WHO forthcoming). Against this background, the aims of this paper are firstly to give state of the art of VAW in developing countries, based on select development policy papers, and secondly to propose strategies for intervention in the health and education sectors to address VAW.
Problem

Violence affects women North and South from all social backgrounds, regardless of class, ethnicity, education and social status. While a strong correlation between poverty-related factors and violence has long been assumed, it is now known that middle-class women are similarly subject to violence. VAW is caused by an interplay of various factors, with the overwhelming one being the pervasive inequality between women and men. Increasingly, researchers are using an “ecological framework” to understand the personal, situational, and sociocultural factors that combine to cause abuse, and which range from the life history that each individual brings to a relationship to cultural norms (Centre for Health and Gender Equity, 1999). There are various forms of VAW, which may or may not coincide.

Domestic violence

Domestic violence is the most prevalent yet relatively hidden and ignored form of VAW. The term refers to violence committed by an intimate partner, an ex-partner or by other family members, regardless of where it takes place. The vast majority of domestic violence is perpetrated by men against women. This can take a variety of forms, including physical assault such as hits, slaps, kicks, and beatings, psychological abuse, such as constant belittling, intimidation, and humiliation, and coercive sex. It frequently includes controlling behaviours such as isolating a woman from family and friends, monitoring her movements, and restricting her access to resources. Physical violence in intimate relationships is almost always accompanied by psychological abuse and, in one third to half of the cases, by sexual abuse (Centre for Health and Gender Equity, 1999). According to a report by the WHO worldwide between 20 and 50 percent of women have experienced physical violence at the hands of an intimate partner or family member. The fact that women are often emotionally involved with and financially dependent upon those who abuse them has profound implications for how women experience violence and limits the options available to women to escape the relationship. And in any case, leaving an abusive relationship does not guarantee a woman’s safety, for a woman’s risk of being murdered is greatest immediately after separation (Centre for Health and Gender Equity, 1999).

Son preference

Primarily in South Asia, North Africa, the Middle East and China, parents often prefer sons to daughters due to interpretation of economic factors, patriarchal systems, or religion. Son preference may manifest itself in neglect, deprivation or discriminatory treatment of girls vis-à-vis access to family nutrition, health care or education to the detriment of their physical and mental health. In extreme cases, son preference leads to sex-selective abortions or female infanticide. Where destitute families are unable to support their children, they sometimes hire out or sell their daughters as domestic workers, who may then be physically and sexually exploited by their employers.

The United Nations Population Fund (UNFPA, 1997) estimates that at least 60 million girls are “missing” worldwide as a result of sex selective abortions, female infanticide, and systematic differential access to food and medical care or relative neglect. Because violence against girls tends to be perpetrated by relatives, the rights of the child are usually sacrificed in order to protect the name of the family and that of the adult perpetrator. A recent UNICEF study in South Asia testifies the great extent to which also women sanction acts of female neglect.
**Non-consensual sex**

Non-consensual sex includes attempted and completed rape (forced penetration), sexual assault (forced sexual contact), and sexual molestation, like using sexually abusive language. Most non-consensual sex takes place among people who know each other, and much is directed at female minors. They can become easy targets for older male relatives, friends or strangers who obtain sex through force or deception (e.g. “sugar daddies”). Young married girls are especially vulnerable. In addition, sexual exploitation and global sex trade subject tens of millions of girls and women to sexual violence and put them particularly at risk from sexually transmitted diseases (STDs), including HIV infection. UNFPA reports that “each year 2 million girls between 5 and 15 are introduced to the commercial sex market”. A most severe form of non-consensual sex is trafficking in women.

**Harmful “traditional” practices**

There are a variety of “traditional” practices harmful to women across the world and they include early marriage, wife inheritance, wife sharing, certain forms of dowry payments (which in South Asia may sometimes lead to so-called dowry deaths like bride burning or acid attacks), and FGM. For example early marriage is common practice in some societies where girls have a low economic value or where a dowry can be obtained for marrying them off. The practice affects health, nutrition, education and employment opportunities of women and lowers their life expectancy.

It has *inter alia* reproductive health consequences for the girl, such as early childbearing with increased risk of obstructed labour and associated health hazards or maternal death. Worldwide an estimated 130 million women and girls – and every year another two million girls – are victims of FGM, which entails life-long suffering for the women thus violated through severe damage to the reproductive and sexual health, risk of HIV infection, and psychological trauma.

**Situations of armed conflict**

Nearly 80 percent of the 53 million people uprooted by wars today are women and children. Gender-based inequity is usually exacerbated during situations of armed conflict, which is more likely to disempower than empower women by attacking their physical and mental health, impeding their economic self-sufficiency, and reinforcing attitudes that maintain subordination. VAW during armed conflict includes higher incidence of domestic violence due to increased tensions within the family; physical and sexual violence, also as an instrument of genocide; torture and execution; resurgence of harmful traditional practices, like FGM, to reinforce cultural identity; hunger and exploitation in refugee camps, when men take control of food distribution; as well as culturally inappropriate and/or inadequate access to health services.

Indeed, international assistance programmes tend to neglect the special requirements of women or address VAW in situations of armed conflict despite the changing gender roles, and the level of stress and atrocities faced by women. Most ironically, a vast number of women become victims of forced prostitution only with the arrival of peacekeeping forces (*Die Zeit*, 2000).

**Reproductive health care system**

Among the least acknowledged forms of VAW is that which occurs within the reproductive health care system. Forced sterilization, coercion, contraceptive medical trails on unsuspecting,
uninformed and defenceless women as well as forced fertility are examples of violence which have direct implications on women’s reproductive health. Anamnesis and interviews of women patients in a study by the Sexuality and Health Feminist Collective revealed a high prevalence of violence committed by health services (Diniz & d’Oliveira, 1998). Also female health personnel is frequently subjected to violence in the health care system, as a US study reveals: 36 percent of emergency room nurses had been physically assaulted at least once during the year 1998.

**Effects**

Perhaps the most crucial consequence of VAW is the denial of fundamental human rights to women and girls. Moreover, high social, economic and health costs of VAW undermine progress towards human and economic development; by hampering the full involvement and participation of women, countries are eroding the human capital of half its population. The World Bank estimates that in industrialized countries health costs for domestic violence and rape account for nearly one in five disability-adjusted life years lost to women aged 15 to 44; in developing countries, depending on the region, the figures range from 5 to 16 percent of healthy years.

**Physical and mental health**

Mental effects of VAW include post-traumatic stress, depression, anxiety, phobias, eating disorders, sexual dysfunction, and low self-esteem. Research and data on mental effects is scarce, especially in developing countries. Non-fatal effects of VAW on physical health range from negative health behaviour (smoking, alcohol and drug abuse, sexual risk-taking, physical inactivity, overeating, etc.) and physical symptoms (bruises, cuts, burns) to permanent disability and chronic conditions. In most severe cases, VAW may have fatal outcomes, which are either illness-induced, or due to homicide, suicide or maternal mortality. Globally, 40 to 70 percent of homicides of women are committed by an intimate partner, often in the context of an abusive relationship. For other women, the burden of abuse is so great that they take their own lives.

**Sexual and reproductive health**

The threat of violence and violent acts may undermine women’s sexual and reproductive autonomy and affect their ability to protect themselves from gynaecological problems, STDs, unwanted pregnancy, and the dangerous complications that follow from illegal abortions. A woman’s perception of her husband’s attitude towards family planning and her fear of violence ultimately lead to a deference to male decision-making on sexual and contraceptive use. Since condoms are often associated with promiscuity or prostitution, raising the issue of condom use within marriage is especially difficult. Some women consciously withhold positive STD test-results for fear of spousal violence (and stigma) (ibid.). Against this background, the Programme of Action of the United Nations International Conference on Population and Development states that all decisions to do with reproduction should be made in an environment free from discrimination and coercion.

Pregnant women are frequently target of violence. Worldwide, as many as one woman in every four is physically or sexually abused during pregnancy, usually by her partner (though estimates vary greatly). Pregnant women who experience violence are more likely to engage in negative health behaviour, to delay seeking prenatal care, to gain insufficient weight, to have a history of STDs, unwanted pregnancies, vaginal and cervical infections, and bleeding during pregnancy. They run an increased risk of miscarriages and abortions, premature labour, and foetal distress.
**Children’s wellbeing**

Birth complications, low self-esteem, less mobility, weaker bargaining power, and restricted access to resources of mothers in abusive relationships leaves them less able to keep their children healthy. Moreover, children who witness domestic violence may internalize it as an acceptable way of behaving towards one’s partner. They also face increased risk for emotional and behavioural problems. A clear link exists between early sexual victimization and a variety of risk-taking behaviours, including early sexual debut, drug and alcohol use, more sexual partners, and less contraceptive use. Mothers under 15 years of age are seven times more at risk of death during pregnancy and delivery than those in the 20 to 25 year bracket.

**Interventions**

International intervention on VAW should be designed to empower women through a comprehensive and integrated framework, spanning endorsement of relevant conventions and national legislation, addressing the structural causes of VAW, and providing immediate services to those affected by VAW, usually referred to as “survivors”. Of all possible and necessary forms of intervention in VAW, the final part of this paper focuses on concrete initiatives to prevent and combat VAW in programmes supported by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH within the health and education sectors. The recommendations offered should be tailored to take specific sociocultural and economic contexts into account by incorporating voices of women and survivors. Working against VAW may unintentionally increase the risk of violence directed at women and must be carried out in an ethical and sensitive manner to prioritize women’s safety.

**Training for health professionals**

Health care providers can do much to respond to physical, emotional, and security needs of abused women and girls. In fact they have a particular responsibility, because they are strategically placed to help identify survivors of violence and “at risk” families, and connect them with other community support services, as the vast majority of women visit a health facility at some point in their lives. Yet, often they are unaware, indifferent or judgmental in relation to VAW. This is particularly unfortunate because due to a variety of factors, such as fear of the consequences or internalization of violence, the survivors usually do not talk out. However, one study suggests nearly nine out of ten women want to tell their health care provider about the violence in their lives. Therefore, providers need to ask patients sensitively about VAW at least when symptoms indicate violence.

In order to address violence with patients, it is crucial in the first place to have sufficient emancipated female health professionals and counterbalance the clear lack of women doctors in most countries across the world. This requires an equal opportunity policy during education and medical training and at recruitment. Moreover, the work environment has to be conducive to women’s work by providing adequate infrastructure, such as child-care and sanitary facilities, and it must itself be free of violence. Health care providers who are violent towards colleagues or survivors must be held accountable for their own behaviour in order to prevent (secondary) victimization of women at their hands. Female health care providers themselves may be going through violent relationships and need help in their own healing process before they can deal with violence of clients. Instituting a woman’s representative in each health institution may facilitate appropriate response to female health professionals’ experience of violence at home or on the job.
Health care professionals, including officials from the respective Ministries, need to be equipped with relevant skills, tools, guidelines and protocols that will enable them to effectively diagnose the situation, provide services, and support the survivors of VAW. Medical education and in-service training must not only heighten clinical awareness of VAW but also include a non-sexist medical response. In family planning clinics, general practices and casualty, as well as in places where girls socialize, trained and sensitized staff should disseminate information on VAW and reassure women that violence is unacceptable.

Posters and flyers represent useful aids. Apart from awareness raising, support must include empathy, medical treatment and counselling, legal assistance and other services, such as confidential helplines. Therefore, health care providers should work closely with justice and police departments, and community workers to create a web of social support for women, including women’s refuges. For training and sensitization of health care professionals (as well as for community education) relevant to the combating of VAW, new curricula and workshops have to be developed, teaching material designed, and trainers trained. Material and experiences from other sexual and reproductive health approaches, such as on HIV/AIDS or FGM, may represent useful models in this regard.

Community education

Since VAW is often linked with culturally based concepts of sexuality, femininity and masculinity, attempts to tackle it should involve all community members. Intervention should support the development of strategies and training aimed at sensitizing women and men, girls and boys on their private and public roles with regard to gender-issues and VAW. Governmental and non-governmental organizations, the mass media, and different forums of civil society, such as the churches and schools should get involved in Information, Education and Communication activities on VAW, and address cultural forms of behaviour that uphold male aggression, beating, punishment and abuse of women as acceptable.

Formal and non-formal education for children and adolescents, as well as literacy classes and skills training for women and men should teach the detrimental effects of VAW in the family and society, sex education and family roles. Methods of conflict resolution, empathy, human rights and gender issues should variously be integrated into the curriculum. A non-violent learning environment and positive role-models are essential to fostering rejection of violent attitudes and behaviour. At the same time, educational content and methodology should promote the learners’ self-esteem, communication and negotiation skills to effectively challenge violence. Teaching methods could include role plays, videos and discussion groups, and they must be cross-checked for gender-sensitivity.

Life-skills and employment promotion measures for girls and women have the potential to improve their self-sufficiency and employability, and (together with improving access to land and inheritance) can contribute to a woman’s economic independence and thereby facilitate her opposition to violent relationships. Such activities also nourish organized action by women to oppose VAW. International cooperation should advise and financially strengthen women’s grassroots groups, and coordinate decentralized activities to ensure the involvement of “hidden” communities.

Male (as well as female) extension workers and facilitators can be trained to disseminate information on VAW and to strengthen women’s rights, which will simultaneously increase men’s ownership of efforts to combat VAW. Non-violent men ought to act as positive role
models in the community. The battering man must be shown new ways to relate to a woman as well as to handle conflicts. For example in a Swedish Family Planning Association, crisis centres were set up for battering men, where male staff confronted them about their violent behaviour in an effort for the perpetrator to understand, contain and control his frustrations and aggressive emotions and to improve his empathy, communication and negotiation skills.

In leisure clubs, youth camps or workshops, one could train youth promoters or peer-educators on VAW, and equip particularly girls with skills that enhance their participation in leadership roles in the family, school and wider community. Youth leisure activities also help strengthen horizontal ties with friends and siblings and increase peer solidarity. Sports activities should complement formal and non-formal educational measures because of their potential to boost confidence, to channel frustration and aggression, and to help explore and appreciate one’s own body as well as that of the other sex, where culturally appropriate.

In short, all community members have to be part of the development of new cultural norms and definitions of femininity, masculinity and sexuality that foster respect for women and promote their dignity and safety.
Social background

Many refugee women who come to Germany are severely traumatized. They have survived ethnic cleansing, sexual violence, rape, and torture camps. Many of them were present when family members or friends were tortured, killed or disappeared. Additionally, women have experienced extremely bad conditions during their flight from persecution, as they are often victims of sexual violence and other forms of abuse during their escape. For example, a girl from Afghanistan told me that she had to travel two years with her brother until she arrived in Germany. During her flight, she experienced a lot of violence. Additionally, as an unaccompanied woman, in many countries, it is almost impossible to travel alone, whereas women with children cannot hide easily and pregnant women cannot move as quickly.

Especially during civil war, survivors experienced that not only soldiers, but even their neighbours, perpetrated the most cruel crimes against other civilians (e.g. in Bosnia). Therefore, their faith and trust in mankind has been deeply shaken.

Although sexual torture is not only directed towards women, the destructive consequences for the role of women within a traditional society has a particular dimension, such as symbolizing the loss of honour. Sexual violence against women and girls is often employed by war factions as a method by which to destroy the integrity of women, their families and the enemy society/community as a whole. Additionally, due to the social taboo against mentioning sexual violence within a traditional society, most women fear talking about their experiences and openly accusing the perpetrators of abuse. However, this avoidance inhibits the necessary psychological transition from the passive role of “victim” towards an active one which demands rights, justice and social solidarity, which may help in overcoming such trauma.

During my work in the Salvadorian refugee camp, Colomoncagua, in Honduras, the only survivor of the “El Mozote” massacre told me of having to observe the killing of her whole nuclear family and of her entire community. She expressed that she could only live with this experience, with the aid of the social support she received from the community of refugees in the camp, as well as feeling needed for her role as a witness.

The current scientific concepts (e.g. Holocaust research by Hans Keilson or research of torture victims in Latin America by David Becker and Elizabeth Lira) define psychosocial trauma as a process and not as a limited event within the phase of direct persecution. The impact of the trauma and the magnitude of the symptoms do not only depend on the extremity and length of the traumatic experience, but also on the living conditions following the trauma. It is known that stable living conditions after an episode of traumatization will increase chances for the survivor of not suffering from chronic PTSD. Despite this knowledge, the living conditions of refugee women in Germany are often contrary to what they need in order to help them rebuild their lives, in light of the trauma they have experienced.
For the initial period following their arrival to a “host” country, legally accepted refugees or asylum seekers normally live in cramped spaces in collective shelters, with a lack of privacy. The accommodation allocated to refugees in Germany cannot be considered standardized in any respect. Refugees are placed varying types of accommodation, from former barracks to old school buildings, container flats and disused factories. One family may be housed in a room measuring no more than 15 m². German refugees may also suffer from isolation, engendered by mistrust of informers, as well as cultural restrictions imposed on women, which may prevent them from entering “public space”. Thus, measures to enhance integration remain rare.

One of the worst consequences of flight from war for survivors is the uncertainty of their residence status. They live in fear of forced deportation back to the area from which they have fled, and where perpetrators of abuse may still remain in power. This fear creates a permanent tension, for example, some of the patients of Frankfurt Working Group on Trauma and Exile (FATRA), had to pass through about 30 extension procedures for their residence authorization.

Legal background of refugees in Germany

The legal status of refugees is divided into different sub-categories. The differential legal status has implications for the status within or access to the social system.

- **Asylum applicants**: These are refugees who submit an application for political asylum to enter Germany.
- **Asylum holders**: If the application is recognized, the refugees receive a permanent residence permission and have access to the entire social system.
- **De facto refugees**: These are refugees in Germany who officially recognized as such, and therefore have a right to be protected, but cannot or formal reasons, obtain the status of asylum holder. Therefore, they receive a “tolerated residence” status.
- **Refugees protected by the Geneva Convention**: These are people who are outside their home country because of fear of persecution due to their membership in a national or religious group, or their political belief, but who are not entitled to submit an application for political asylum (like de facto refugees).
- **Quota refugees**: They are refugees accepted by the government on the basis of a blanket declaration, according to which, a certain quota of refugees from an area of military conflict or civil war, is received (e.g. from Bosnia or Kosovo).

With the exception of asylum holders, all refugees fall under the “Asylum Applicants Social Benefits Act”. Benefits are generally kept below the level of regular supplies under the Social Security Act. Access to health care is applied in a very restrictive way, treatment being guaranteed only in cases of acute diseases and/or pain. Pregnant women have general access to health services, without exception. The uncertainty concerning residence status, as outlined, renders it impossible for survivors to develop plans for their futures and rebuild their lives. Additionally, as of May 1997, a de facto prohibition on working or learning a new profession has been imposed on refugees entering Germany after this date.

Retraumatization

In order to overcome the traumatic past, stability and the possibility of developing perspectives is extremely important. The continuing uncertainty of status and desperation about the actual reality of their circumstance, is combined for the refugees, with sadness about the loss they have
suffered. This situation may catalyse retraumatization, as survivors are doubly affected by the experience of persecution in their home areas, and degraded status as refugee in the “host” country. In many cases, permission to stay will only be granted if traumatization has been recognized by an official institution and the refugee in question is undergoing treatment for her/his trauma.

At least due to public discussion and pressure concerning traumatization as afflicted by humans on each other, the German government have recognized traumatization of war survivors as a reason to remain in Germany longer. Nevertheless, the government has not conceded refugees the right to stay for an undefined period of time, they are merely “tolerated” for a longer period.

The threat of deportation and being subjected to tormenting interviews at migration offices, leads to a clear increase in symptoms such as panic attacks, sleep disturbance, flashbacks, nightmares, headaches, stomach pains, and suicidal thoughts for a lot of refugees. For survivors of political and sexual violence and persecution, psychotherapy can only be helpful if the host country demonstrates willingness to recognize the extent and impact of such trauma. This willingness is necessary for the communication of the individual’s emotional pain to the outside world.

As Derek Summerfield has argued:

> Some torture victims seek psychological help, but all survivors claim justice for their suffering. Therefore, it is an ethical imperative that a human rights framework should be part of any psychosocial work.

**Recommendations to Governments of Host Countries**

- Recognition should be given to the human right to stay and work in a secure environment.
- A social and political environment to improve the psychosocial wellbeing of migrants in host countries should be created.
- There should exist support of all forms of self-organization, empowerment and community participation of migrants in provision of services, etc.
- Social and health personnel should be trained in dealing with traumatized migrants.
- Free access to all social and health care services for refugees should be guaranteed.
- Increased establishment of psychosocial treatment centres.

**Summary of discussions**

- The allocation of adequate political, economic and social resources are more important than the provision of health care (in the case of industrialized host countries).
- Experiences in countries of refuge are more important than what refugees have lived through in the context of their escape.
- Initiatives which support asylum seekers in European host countries are often carried out by private initiatives, NGOs or church organizations with inadequate funding; this needs to be addressed.
- Is there any follow-up of treated refugees after their repatriation?
- Separate versus integrated services for refugees depending on the concrete circumstances, keep in mind equal treatment for locals and immigrants, avoid exposure of refugees to expulsion mechanisms.

- Interaction of human rights with healing process, refugees have to keep on displaying high levels of trauma symptoms or to talk about the violence they experienced in order to get/keep asylum.

- Prevent hate as a public health issue = prevent mental health problems within the local/host population.

- Provide rights training on law to health workers and on health to legal workers.

- All of the receiving countries at the Cairo conference voted NO on the issue of reunification of families; if we are promoting a human rights-based approach we are to lobby governments to ratify the respective convention (on reunification).
SESSION IV:
RECOMMENDATIONS

Main recommendations of Workshop – to be fed into International Conference: The role of health professionals in addressing violence against women

- To improve research to develop methods for the recognition of early signs and national and local risk factors which would allow the setting up of early warning and intervention systems to prevent violence and abuse of vulnerable population groups.
- To strengthen capacity of local and country agencies to apply these methods and to develop a gender sensitive pre-conflict intervention strategy.
- To include analyses of gender roles and relations as a fundamental part of interventions in situations of armed conflict, and provide services accordingly to reduce gender gaps and stereotypes.
- To recognize the changes that occur in gender and economic relationships.
- To use the expertise of women in the peace process and change laws and traditions which are discriminatory against women.
- To ensure that health and legal professionals involved in the provision of assistance in crisis countries or in countries receiving refugees, are trained and sensitized to the rights-based approach and the applicability of respective international conventions – the Geneva Convention: CEDAW; CRC and others. Training in post-conflict situations should focus on the police, judiciary and educational resources.
- To ensure that health systems provide both separate care where appropriate, and integrated services of assistance to victims of violence and affected family members, and that in treatment, the respect of human dignity and the integration of the traumatized individual into the renewed social network, are crucial elements. External support should not only seek to integrate individual professional, from among the affected population, but also actively promote self-organization.
- To work with women and men to recognize rape as a crime against humanity – as it is for the International Criminal Court – rather than as a matter of “honour and morality”.
- To work with adolescent boys and girls towards the prevention of gender-based violence, whether in times of peace or conflict.
- To ensure support to professional working in the care of victims of violence.
- To ensure a continuation of the sharing of research findings, experience and development of further guidance and exchange of materials to be used regarding situations of conflict, thus ensuring the maintenance and strengthening of an intersectoral and interdisciplinary approach.
Annex I

Working group recommendations

Integrating the problem of violence into research action: working with women affected by the war

Studies from Uganda, Nigeria, Kosovo and Tajikistan were presented, demonstrating the diversity of approaches and also demonstrating that in spite of extremely difficult circumstances, information on various kinds of violence against women could be collected.

The first presenter, Meredith Turshen, focused on violence against women in different kinds of armed conflict in sub-Saharan Africa. She addressed the limitations of prior definitions of violence, presenting three categories of violence: political, social or interpersonal, and economic. She gave two case studies of data collection: a retrospective study by ISIS-WICCE of the Ugandan civil war, which used a participatory design, focus groups and interviews; and a study of the Ogoni crisis in Nigeria which studied the many perpetrators of violence as well as the many kinds of violence, comparing the findings of violence against women during the crisis with violence in the post-conflict period.

She also addressed data collection in the mental health field. She showed the lack of baseline data on African women’s mental health before the emergency situation. The concept of posttraumatic stress was deconstructed: what is the meaning of this diagnosis when traumatic events are the norm and ongoing?

Gendered concepts of mental health in war situation need to be developed. Dr Gani Demolli described the context in which violence against women took place in Kosovo before and during the conflict. After the official ending of the Kosovo conflict, WHO in conjunction with several local NGOs organized a survey and focus group discussions in order to identify the types of violence, the level of attacks, the perpetrators and the places where violence took place. Men differed from women in highlighting what was important for them in the violence of war. Men as well as women were very withholding in the focus group discussions. The value of this approach was briefly discussed and questions were raised whether a different approach than the one followed in the focus groups would have yielded other types of information, if e.g. the topic had been addressed by asking about fear instead of violence.

Dr Annemiek Richters made the third presentation about violence in Tajikistan. She presented data from a population-based survey and raised questions concerning methodology. The lessons learned from this study could be used as a launching point for other studies in the region. Dr Berit Schei presented (in the next session) evaluation studies from different types of programmes and services set up during the war in former Yugoslavia. Her research showed that the type of service offered impacted the outcome for women’s mental health and wellbeing. Based on discussions after the presentations in session I, in the working group I the next day the following broad recommendations were formulated.

Group 1: Recommendations on evidence and policy

- Action research on violence against women (VAW) in war situation should be carried out not only to create eventual positive change but to also give an immediate positive response.
- Government and civil society can be involved in action research on violence against women in partnership with local resources in a constructive way and in emergency situations they can be held accountable and asked to respond to women’s situation.
- More work should be done on the identification of violence against women in conflict and post-conflict situations. This work should be qualitative and feed into larger comparative studies.

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8 In the plenary discussion following the working groups, amendments were made to the above, pointing out that already much research is available and should be used in various ways (see the final version of the recommendations in SESSION IV).
• Action research should be done on the improvement of the health care system to meet the needs of women in war-time as well as possible.

**Group 2: Recommendations on methodologies for evidence collection**

• Monitoring changes in prevalence of VAW should take into account the impact of observed changes contributed by a change in reporting profile. E.g. when domestic violence seems to increase after war this might be due to decreased acceptance of prior accepted behaviours.

• A comprehensive model of VAW should be a framework for evidence collection, however, there is also a need for studies focusing on specific types of VAW.

• Evidence collection of rape in particular during conflict is heavily influenced by selection of groups studied and also the method of information obtained.

• In addition it might be biased by the potential effects estimates of rape might have in the political propaganda. Caution should be taken to assess not only rape but the multiplicity of trauma experienced by women during war.

• The diversity of potential harmful effects on health of VAW should be taken into account when collecting evidence attempting to overcome the conceptual split between somatic and mental health.

• Evidence collection should be conducted based on participatory research design.

• Evidence collection should be putting the social construction of gender at the centre of inquiry.

• Evidence collection should also include description and evaluation of programmes and health services set up to meet women’s particular needs during conflicts.

• In conducting research, one should not only focus on women as victims but also on women as perpetrators, camp followers, soldiers, protestors, peace organizers, etc.

• Comparative work should be done to evaluate which research methods (population-based surveys, focus groups, qualitative interviews, etc.) work best in various phases of the conflict and in various sociocultural and political contexts and what the effects of the research are (in terms of follow-up, policy-making, empowerment of researchers, capacity-building of local organizations conducting the research, etc.).

• Evidence collection should be conducted in partnership with grassroots women’s organizations, in both the field of health and human rights.

• In war situations, ethical and safety issues with regard to the research process might not be optimal, but the value of such research for everyone involved can balance the possible risks.

• There is a need to assess the effect of different models of health care set up for women in war situations.

**Group 3: Recommendations on care and prevention**

• All agencies involved should focus more on the gender-sensitized organization of refugee camps and involving all aspects of violence against women in armed conflicts into their policy, and advocate that guidelines for refugees and internally displaced persons always take account of the special problems of women and children.

• Empowering women economically is a good method to improve their health status.

• Laws should be changed giving equal opportunities and decision-making powers to women. This will greatly enhance their access to existing services and will prevent ill health effects.

• The education of women and men as well as children/adolescents on their rights and responsibilities through different channels (media, school, vocational training etc.) is the single most important violence prevention strategy.
- An integrated response to women’s health needs—including reproductive health, psychological, social services, and information— is an effective model for treating women who have been victims of conflict and helps ensure confidentiality as it is unclear for what treatment she is attending clinic/centre.

- Survivors of sexual violence must have access to emergency contraception (if applicable), safe abortion services—where legal—or post-abortion services. Those services should be provided as part of integrated services.

- Treating every woman “as if they were raped” reduces stigma and helps ensure appropriate and respectful treatment.

- Psychological trauma must be perceived in the context of the “collective”, it is important to acknowledge/respect the beliefs of victims and their communities, and try to facilitate them to return to full membership in their communities.

- Psychological stress may show up in somatic symptoms, doctors must be trained to recognize this situation, and not pursue inappropriate treatments such as surgery (PTSD method might be useful for treatment).

- Must treat victims and perpetrators, while serving the need to restore justice, justice is not the same thing as revenge, efforts must be made to acknowledge guilt and rehabilitate perpetrators.

- Experiences for treating women in conflict situations can and should be applied to the improvement of peacetime services for victims of sexual assault, including an integrated approach to mental and physical health.

- Effective and sustainable response must take into account the needs of local health care professionals who may experience extremely high stress levels— including economic necessity, fear for their own families and self, exhaustion. Medical workers, especially men, may feel extremely reluctant or even ashamed to admit their own vulnerability.

- Conflict situations may demand new, flexible models of counselling.

- Health services have to be made known and accessible to those affected. This may include outreach services and community-based approaches. Privacy and confidentiality are crucial for the positive outcome of treatment.
Annex II

Summary of the activities developed by WHO in Kosovo “violence prevention and care: a multisectoral public health concern”
1999–2000

Introduction

An assessment of the situation of violence against women in Kosovo was carried out by WHO Geneva in August 1999. In Kosovo, reports from different agencies and international and local NGOs recognize that rape of women and girls has taken place before, during and after the crisis. Younger women and girls were specifically selected for rape. The Center for Protection of Women and Children, a local organization, has documented past violence. In a 1996 study, it found that out of 1000 women surveyed in Kosovo, 68% had experienced violence at least once in their lives. In Kosovo, gender-based violence is only one trauma among many. Other traumas include torture, murder or rape of self or family and friends, the disappearance of family members, random violence, bombing and shelling and severe deprivation of food, water, shelter and safety.

In order to respond to the dramatic situation, between December 1999 and April 2000, WHO conducted field work to prepare for the implementation of a strategic planning workshop with multiple stakeholders. Work carried out included:

- networking with UN-agencies, international and local NGOs, as well as other associations working in the area of violence prevention;
- establishing an NGO group that systematically meet to address domestic violence in a coordinated fashion; coordinating the execution of focus groups; and
- coordinating skills-building workshops on “violence, gender and HIV/AIDS”, as requested by local NGOs; assisting UNICEF to develop a training curriculum for a round-the-clock support team of nurses for maternity wards in each hospital in Kosovo. Nurses were trained to detect the at-risk mothers and children, provide first hand counselling and were needed, refer them to the appropriate professional service.

In addition, UNICEF, Organization of Security and Cooperation in Europe (OSCE), UN Mission in Kosovo (UNMIK), International Medical Corps (IMC) and WHO carried out awareness-raising activities on “violence as a public health concern”, using multiple mechanisms including youth drawings from all over Kosovo with the theme “Violence Free Kosovo”.

Focus Groups

Between January and March 2000, WHO pilot tested 4 focus groups and subsequently carried out 14 such groups in seven areas of Kosovo with approximately 162 people. Training of Kosovar moderators and rapporteurs was carried out by Mercy Corps International (MCI) and WHO. The focus groups were carried out separately with women and men; the married and unmarried; urban and rural. The objectives were to:

- Understand the health concerns of men and women with a particular focus on the family and reproductive health;
- Assess women and men's interpretation and attitudes to violence and their coping mechanisms;
- Identify existing /needed health and social services and community support in relation to violence; and
- Define the gaps and necessary resources for future response to violence prevention and care of those affected.
The focus groups highlighted the need for the following:

- Psychosocial support, counselling services, shelter and legal protection for those affected by violence;
- Capacity-building of health and social service workers to respond to and prevent violence;
- Promotion of employment opportunities and economic support for men and women;
- Information campaigns to raise community awareness about violence;
- Investment in programmes that provide young people with sex education as well as heighten their awareness of the links between human rights and violence;
- Development of gathering spaces where men and women of all ages can engage in social activities;
- The need for accurate information on STDs, including HIV/AIDS; and
- The need for reproductive health services, including family planning and female gynaecological services at community level.

**The Workshop**

Based on the needs identified in the focus groups, as well as those recognised by local and international organisations, WHO organised a workshop entitled *Violence Prevention and Care: A multisectoral public health approach* from 6–8 April, 2000. The workshop was carried out together with multiple stakeholders (please see appendix 1 the list of participants) that work on these issues and recognise the limitations of addressing violence from their respective fields of expertise without drawing upon one another's comparative advantages to address this multisectoral problem.

The main goal of the workshop was to develop a strategy on violence prevention that would bring together all actors to respond in a coordinated fashion.

The specific objectives of the workshop were to:

- Develop a working definition of violence within the Kosovo context;
- Define the groups exposed to violence, the types and causes of violence and the places where these occur;
- Highlight the gaps in existing health, social, legal and education services for people who have been subject to violence;
- Develop recommendations for a holistic and multisectoral preventative strategy on violence prevention; and
- Identify appropriate response interventions.

**Day One. Issues addressed:**

- Violence as a public health concern
- Violence in Kosovo, including various studies carried out
- Definition, typology and protective factors related to violence for men and women at different points in their lifecycle

**Second Day**

- Multisectoral approaches to violence
- Definition of roles and responsibilities of different sectors including the legal sector and police; health and social sectors; education and media; community and policy makers
- Identification of gaps and needed resources and develop recommendations
Outcome of the workshop

The summary from the different discussions and the working groups indicated that it is important to come up with rapid, sustainable and multi-disciplinary interventions to prevent violence and support those affected by it. From each of the working groups the following recommendations were identified:

Health and the social sector

Health and social sector play a crucial role in violence prevention. Social services manage a wide array of issues including housing, employment, family welfare, juvenile issues, adoption, and divorce. Health and social sectors can promote violence prevention and identify people at risk. Moreover, the case assessment and/or diagnosis carried out by the health and social sectors constitute the basis for pursuing redress through the legal system. Poorly documented cases negatively affect a just outcome. All sectors must work together to form networks of referral systems to address the complexity of violence. The recommendations by the participants:

- Train health professionals, police and judges;
- Establish recreational activities for children, including a playground;
- Awareness raising activities such as seminars to discuss violence and its prevention i.e. through schools and social centers;
- Establishing of “ambulantas” (local health houses).

Education and media

An informed and responsible media can be part of the solution. Dissemination of information in local languages, about the resources available to those affected by violence, including health, education, and legal sectors as well as other community organizations. Spreading information about constructive solutions and preventive approaches are among the potential contributions of the media. Media must also act responsibly as the images and models portraying violence have influence on the construction of attitudes and beliefs related to violence.

The education sector is in a key position to recognise abuse among students as well as identify the more subtle signs evidenced by behaviour changes. The educational sector can also promote child development, child protection, gender sensitivity and human rights in general, peace building, mentoring through adult education in parenting, stress management among other areas. Recommendations defined by the group:

- Training of teachers and journalists on the issue of violence;
- Awareness raising of the use of the media;
- Updating the school curriculum to include sexual and reproductive health. The last should be made available to adults;
- Improved resources for the library; and
- Completion of school education among girls.

Legal sector and law enforcement

Both the legal sector and the police have a protective role to play in relation to domestic violence. Professionals in both areas should be sensitised about violence, particularly child abuse and intimate partner abuse, so that in dealing with such cases greater harm is not done inadvertently to the affected. Moreover, both sectors should know what other organisations or associations exist in the geographical area that are providing different types of support for such cases. Only the formation of a network of different entities, each providing support from their own area of specialisation, will be able to effectively address a complex issue such as violence. Recommendations of participants included:

- Every case of family violence, including child abuse, should be referred to the proper social agencies;
• Police should be sensitised through training to address issues of domestic violence;
• Hotlines should be established so that victims or those witnessing violence can access help;
• NGOs should be included in the network, and these should refer persons to the appropriate social agencies, as needed; and
• A system should be established so that the legal sector and law enforcement agencies are accountable to the communities they are supposed to serve.

Community and policy-makers
Domestic violence requires a two pronged approach. On the one hand, the community, including NGOs and community associations, should participate in the design and implementation of prevention and response programmes. On the other hand, policy makers need to support community-based actions by ensuring that the legal and administrative foundations are in place to prevent violence, to give persons affected by violence the necessary support, and to punish perpetrators. Recommendations of participants included:
• Raise awareness about violence;
• Advocate for financial support for social services, including those that prevent violence;
• Increase and improve opportunities for information exchange;
• Provide opportunities for local, national and international organisations to review what they are doing, the gaps, and how they can work together on common problems related to violence; and
• Improve the collaboration between the Center for Social Work, the police, courts, the health and education sectors, NGOs and other support groups.

Recommendations to WHO
• Train health professionals on counselling and management of those affected by abuse;
• Using established organisations, raise awareness of the consequences of violence and the resources available in the community to help those affected by violence;
• Provide assistance to develop a national survey on domestic violence, in collaboration with NGOs and other associations;
• Advocate with national institutions and policy-makers for the development of a national plan against violence, to include the infrastructure needed to support that plan (shelters, hotlines, education, remedial programmes for batterers); and
• Advocate for the establishment of ambulantas (local health houses) in order to reach out to isolated communities.
## APPENDIX 1: LIST OF PARTICIPANTS

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PROTECTION WORKING GROUP
DOMESTIC VIOLENCE SUB-GROUP

TERMS OF REFERENCE
Aim: To provide a forum for the discussion/creation of co-ordinated responses and strategies in domestic violence prevention and mitigation among national and international NGOs working in diverse sectors by:

- Information sharing of present and planned activities and assessments.
- Identification of existing gaps in present multi-sectoral domestic violence prevention and mitigation efforts.
- Identification of potential or existing overlap in domestic violence prevention and mitigation efforts.
- Development of integrated, multi-sectoral approach to address the gaps identified by the group.

Strategy/Potential Outputs:

- Interactive and participation bi-monthly meetings.
- The sub-group will periodically report its conclusions, recommendations and activities to the Protection Working Group (by request or under its own initiative, as appropriate).
- Improved communication and co-ordination among agencies working in domestic violence and mitigation.
- Seminars, trainings, speakers and workshops will be provided/developed based on interest/needs.
- Establishment of close links, collaboration, and the development of partnerships among national and international agencies working on domestic violence prevention and mitigation.
WHO Focus Groups on Violence and Health

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WHO Research Team:
Gani Demolli, Sevdje Ahemeti, Beltязare Muharremi, Melhiate, Arta Shuska,
Adam Lushaj, Safet Hoti, Melhiate Juniku,
Assisting: Albert Krasniqi, Skender Rama
Coordinator: Gunilla Backman

Rationale

- Assess local needs in relation to violence and health
- Ensure integration of local concerns and issues in the design and implementation of victim assistance services.
- Needs have been identified for the health, social, education, legal/police, and media sectors. It is imperative that all sectors work together on the issue of violence.
Method

- A comprehensive two-day training on focus group methodology was held by WHO/MCI
- Seven local people were identified to take part in the WHO research team for the project – Gani Demolli, Sevdje Ahemeti, Melhiaj Juniku, Belgiyzare Muharremi, Arta Shuska, Adam Lushaj, Safet Hoti
- Briefing for WHO research team followed by a pilot testing of the question guide developed for this project.
- Technical meeting held for research team to revise the question guide.
- Focus groups carried out between January-March 2000.

Objectives

- Understand the health concern of men and women with a particular focus on family and reproductive health during and after the war
- Assess women’s and men’s interpretation and attitude to violence and their coping mechanisms
- Identify existing/needed health and social services and community support in relation to violence
- Define the gaps, the needs and views for future responses to violence, care and prevention
Participants

- Approx 162 people participated in 14 actual focus groups and 4 pilot groups
- Carried out separately with women and men
- Married (mean age =35) unmarried (mean age = 21)
- Urban and rural
- Regions: Rahovac, Skenderaj, Kacanik Maliseva, Kamenica, Decan and Dragash

Results overview

- Social and structural changes
- Gender roles and social norms
- Health
  - Definition
  - Reproductive health
  - Family planning
  - STDs including HIV/AIDS
  - Psychological wellbeing
- Violence
  - Definition
  - Typology and groups at risk
  - Community perceptions and support
  - Health and social services currently available
  - Health and social services needed
- Turning data into programmes
Turning data into programmes

From these results, the following conclusions and recommendations for programmes and approaches can be drawn:

- The need for psychosocial support services for women, children and men
- The need for the capacity-building of health and social service workers to respond and prevent violence.
- Promotion of employment opportunities and economic support for men and women.
- The need for victim support/protection services, including advising, shelter, and legal protection.
- Investment in education services, including advising and information about violence and sex education in schools.
- Development of social spaces for women, community organizations, space for socialising, and groups for family support, youth and for women.
- The need for accurate information on STDs, including HIV/AIDS.
- The need for reproductive health services, including family planning and female gynaecological services at community level.
- The need for information campaigns to raise community awareness about violence.

World Health Organization

Social and structural changes due to war, forced displacement, migration, and violence?

- Two-thirds:
  - loss of employment as one of the major Difficulties facing society.
  - loss of property or belongings.
- Half of the groups:
  - destruction of public structure including schools, hospitals and destruction of private dwellings.
  - destruction of public/private system, including water, electricity and food supply.
- Approximately one-third of the groups:
  - loss of family members and/or disruption of family structure.
  - increased freedom for women and for men.
- One group reported an increase in criminality.

World Health Organization
Gender roles and social norms

In your community, what do you think are the skills and qualities a good man/boy should have? How have men and boys changed since the war?

- Two-thirds of the groups reported that a good man was one that was helpful to his family and his community.
- Nearly all groups reported consideration, honesty, good manners and respect as traits of a good man while one-third reported patriotism and respect for tradition as being important in order to be a good man.
- One-third of the groups reported education while one reported absence of jealousy as a characteristic of a good man.
- Almost two-thirds of the groups reported that men were in a higher position than women.
- Over one-third of the groups found that men are more understanding, helpful and polite since the war and also that men have more respect for women.
- One indicated a greater need for solidarity and community support by men.

World Health Organization

In your community, what do you think are the skills and qualities a good woman/girl should have? How have women and girls changed since the war?

- Over two-thirds of the groups indicated that honesty, politeness and good manners were the traits of a good woman while nearly all groups reported that a good woman was one who was helpful and caring to her family and community.
- Half of the groups indicated that a good woman should be well educated and over one-third said that a good woman should respect her husband and family.
- One-third of the groups found that women have increased strength and bravery and also that they have more fear and are more sensitive.
- One reported increased freedom for women since the war and increased understanding between women and men.
- One also reported that they felt local women who worked with foreign organisations are low on morals.

World Health Organization
Health

What is health? How the health situation has been affected since the conflict? What do you think are the current health problems your community is facing?

- All groups defined health as physical and mental wellbeing. One-third of the groups also included social well-being as part of a definition of health.
- Throughout all groups psychological trauma was mentioned as a significant health problem.
- Over two-thirds of the groups reported infectious diseases such as influenza, hepatitis and TB and one-third reported water contamination as a cause of increased disease.
- One-third reported high blood pressure, and problems of physical pain, such as headaches, body aches or rheumatism.
- Almost one-third reported spontaneous abortions and increased neonatal mortality while one group reported premature births.
- One group mentioned heart disease and diabetes as well as indicating that STDs, such as syphilis and HIV/AIDS is a health concern.

World Health Organization

How are men, women and children feeling about their psychological wellbeing?

- All groups reported suffering psychological trauma.

Men
- Almost two-thirds of the groups reported depression among men.
- Half of the groups reported nervousness or anxiety.
- Over one-third reported increased anger or aggression among men while one group reported psychosomatic illness and sleeplessness.

Women
- Similar to the findings for men, nearly two-thirds of the groups reported depression among women.
- Half of the groups reported fear as affecting the psychological wellbeing of women while one-third reported that women are particularly affected by trauma.
- One group reported trauma specifically related to rape.

Children
- Over two-thirds of the groups indicated that children have been badly traumatised.
- One-third mentioned increased fear among children while just under two-thirds reported increased anxiety.
- One reported lack of concentration and bad dreams among children.

World Health Organization
**Do you have knowledge of reproductive health?**

- Reproductive health was defined by one group as safe reproduction at appropriate age, whereas another group specified reproductive health was important from puberty.
- Over one-third of the groups said that reproductive health was associated with STDs and HIV/AIDS.
- One group defined reproductive health as pregnancy and one associated it with gynaecological services.

**What services or institutions are available for pregnant women since the war?**

- Two-thirds of the groups reported no specialised services for pregnant women at community level.
- Half of the groups reported availability of local gynaecologists as the only services for pregnant women.
- One-third reported few services and bad delivery conditions for pregnant women and another indicated the need for female gynaecologists.

**Are family planning services available in the community? How is family planning discussed between couples and/or within the family? How is this different from before the war?**

Over two-thirds
- family planning as something that is discussed among men and women in couples.

One-third
- no existing services for family planning in their communities.
- information on family planning available though the printed media.
- difficulties planning for a family because of the current economic situation and the structural constraints.

One half
- recognised the importance of family planning to ensure better economic conditions.

One group
- family planning services available from health houses or gynaecologists.
- family planning as more likely to be discussed among friends.
- the need for more open discussion in general on family planning.
- reflecting on the past situation in Kosovo, one group mentioned the need/mentality to have many children for national survival.
What do you understand about STDs? What do you know about HIV/AIDS and how is transmitted? How are people perceived in the community if they have HIV?

- Two-thirds of the groups had some knowledge of STDs and their transmission through sexual intercourse.
- However, under one-third of the groups had almost no knowledge on causes or modes of transmission HIV/AIDS.
- Almost two-thirds of the groups attributed HIV to sexual intercourse with a foreigner.
- One-third of groups reported that only people who have contact with internationals were at risk of contracting.
- While one group identified women as particularly vulnerable to HIV/AIDS another highlighted the special vulnerability of youth.
- Half of the groups reported that as far as they were aware, there were no cases of HIV in their communities.
- Almost one-third of groups mentioned fear in relation to people living with HIV/AIDS and proposed isolating them and not accepting them within a community.
- HIV and one group indicated that HIV/AIDSs spread through women.

World Health Organization

How and where do people receive information about reproductive and sexual health, STD/HIV/AIDS?

- Two-thirds of the groups reported TV and newspapers as their main source of information on HIV/AIDS.
- Over one-third said they received information from magazines
- One-third of groups reported getting information on HIV/AIDS from schools while three groups reported friends or peers as sources of information.
- One-third of groups identified a need for more information on these areas.

World Health Organization
Violence

What is violence? What type of violence are most present in your community?

- All groups defined violence as the constraint of freedom and choice (4), and being forced to do things against one's will (6).
- **Two-thirds**
  - physical violence, including beatings as the most frequent type of violence.
- **Over two-thirds**
  - domestic violence, including physical violence, constraint of movement and choice, and not being allowed out of the house as types of violence in the community.
- **Two-thirds**
  - sexual violence, including molestation and rape.
- **One-third**
  - community violence, including kidnappings, violence by extremist groups and being thrown out of their houses.
  - psychological violence.
  - alcohol constituted a risk factor for violence.
  - bad economic conditions as a risk factor.

What are the specific types of violence against women and children? What support/alternatives exist to prevent violence against women and children?

- Over two-thirds of the focus groups reported that women were one of the groups most at risk for violence while two-thirds also reported that children were at high risk.
- One group reported that the family was the group most at risk for violence and one reported that men were at risk of violence.
- When speaking about the perpetrators of violence, almost two-thirds of groups reported enemy forces as one of the major perpetrators.
- Two-thirds reported men as one of the major perpetrators of violence, including one-third who qualified the men as being related to their victims.
- One group mentioned relatives as one of the major perpetrators of violence, while another reported women perpetrated violence against their children.
What are the specific types of violence against women and children?

- For violence against women, half of the groups reported that women suffered sexual violence, specifically rape.
- Over one-third said that women suffered physical violence.
- Just under one-third of groups reported that women suffered from lack of freedom of mobility and choice.
- One group reported family violence, another reported women will suffer violence if they take a bad direction, while yet another reported violence from drunk men.
- Two-thirds of the groups reported physical violence against children in the domestic sphere.
- Just under one-third of the groups reported physical violence of children, including beatings and mistreatment, without specific mention of the setting.
- One group reported psychological abuse, while one reported violence as a consequence if a girl does not respond to a man's love.

*World Health Organization*
Services and support

How are these victims of all forms of violence treated by their family and in the community? What kind of support is given to victims of violence in the community?

- Half of the groups reported that victims, especially those of sexual violence, had little community and family support, that they were blamed and that the incident was kept hidden.
- Less than one-third of the groups reported that victims of violence were accepted by the community, who felt sorry for them and tried to help.
- One group reported that victims were supported if they were taken by force, while another group stated that they supported the perpetrator if he had a reason for committing violence.

World Health Organization

How would you describe the health facilities and psychosocial services available to victims of violence? How do you think services could be improved and/or what type of services would you like to see?

- Over two-thirds
  - no services available for victims of violence.
  - need for mental health services, including counselling, spaces to express torment, and psychiatric and psychological support.
- Half of the groups
  - no social services were available.
- One-third
  - requested institutions addressing women's needs, one-third reported that some services did exist but no psychosocial services.
  - indicated the need for victim protection services, including the provision of advice.
  - need for social spaces, including services for families, activities specially for youth, and meeting spaces for women.
  - indicated the need for stronger legal protection of victims and requested investment in education.
- One group
  - indicated the need for investment in infrastructure, including economic and industry development.
  - requested approval of psychosocial training modules and its expansion to villages.
  - only the health houses existed.
  - requested institutions addressing children's needs.

World Health Organization
How can victims actively participate in the prevention of violence and its consequences? What are the best community-based activities that can be promoted for the prevention of violence?

- Over two-thirds of the groups indicated that victims could participate in violence prevention.
- One-third suggested that victims could provide advice to others from their experience and nearly two-thirds reported that victims could raise awareness and make the case for prevention, through sharing their own experiences.
- Half of the groups indicated that community could participate in education of women and children about violence, including through schools and the family.
- Just under one-third of groups stated that the community should provide advice, while three groups indicated the need for the community to provide support to its members.
- One-third indicated the need for tolerance and a positive attitude about violence while one group stated that the community should provide support to the victim.
- One group stated that the perpetrator and the victim should be banished from the community while another suggested the community should get together to accuse the perpetrator.

World Health Organization

In the present time how are women, men and children coping with the social change as a consequence of the war? Use of story to encourage expressions of how women and men cope

- Over two-thirds of the groups indicated the use of economic rehabilitation as a coping mechanism.
- Two thirds reported optimism towards the future and determination as mechanisms used to cope with the situation.
- Two-thirds also identified unity, tolerance and support of each other.
- Half of the groups reported that women could have coped with outside help: psychosocial support, employment and access to social spaces.
- Over one-third reported that the woman should understand the husband and work with him to improve the situation and also that the man should work together with his wife.
- Two-thirds of the groups indicated that man needed to find a job in order to cope with the situation.
- Over one-third of the groups indicated that men need outside help, including psychosocial services and support to find a job.
- Over one-third reported the man needed to show strength to cope with the situation.

World Health Organization
Turning data into programmes

From these results, the following conclusions and recommendations for programmes and approaches can be drawn:

- The need for psychosocial support services for women, children and men.
- The need for the capacity-building of health and social service workers to respond and prevent violence.
- Promotion of employment opportunities and economic support for men and women.
- The need for victim support/protection services, including advising, shelter, and legal protection.
- Investment in education services, including advising and information about violence and sex education in schools.
- Development of social spaces for women, community organizations, space for socialising, and groups for family support, youth and for women.
- The need for accurate information on STDs, including HIV/AIDS.
- The need for reproductive health services, including family planning and female gynaecological services at community level.
- The need for information campaigns to raise community awareness about violence.

World Health Organization
Annex III

Women in conflict: Speakers debate women’s peacemaking role

The UN Security Council held its first ever meeting on women and armed conflict yesterday with a debate on the needs of women in all UN peace operations, as well as women’s role in building and sustaining peace. More than 40 speakers took part in the debate.

UN Secretary-General Kofi Annan said yesterday at the opening that women are often better equipped than men to prevent or resolve conflict. Annan said “for generations, women have served as peace educators, both in their families and their societies”, stressing that women have been instrumental in building bridges instead of walls. Annan urged the council to do everything within its power to protect women and girls in conflict and to give them a role in peace building. He said that while the United Nations is striving to recruit more women for peacekeeping activities, their contributions remain “severely undervalued” and women themselves are “grossly under-represented” as decision-makers. UN Assistant Secretary-General Angela King, who is the world body’s special advisor on gender issues and the advancement of women, also highlighted the absence of women in conflict resolution processes. She said that during peace negotiations, the socioeconomic fabric of a country is a “major focus of attention” and that women’s groups need to be part of the process. King said that women are often less hierarchical in dealing with local communities, and women are more likely to confide in female peacekeepers about rape and other sexual violence. Noeleen Heyzer, Executive Director of the UN Development Fund for Women, added that peace processes suffer when women are not included: “(if) women are half of every community, are they therefore not half of every solution?” she asked. “How can we, in good conscience, bring warlords to the peace table and not women?” (UN Newservice 24 October 2000).

The council is considering a resolution, sponsored by Namibia, that would ask Annan to ensure UN peacekeepers are trained on the protection, rights and needs of women. The resolution also urges equal representation of women at all decision-making levels in trying to settle conflicts. The resolution is expected to be adopted at the end of the month. Special “gender advisors” have so far been appointed to Sierra Leone, Kosovo and East Timor. However, Heyzer said that “there is no acceptable rationale for protection of women in some countries and not others” (Reuters/Non-com, 24 October2000).

Since most conflicts today are internal rather than international wars, civilians – especially women – are more often targets that combatants. More that 80% of casualties worldwide are women and children (Jim Wurst, Inter Press Service/TerraViva, 25 October 2000). Women and children also account for more than 75% of the 40 million people displaced by conflict or human rights abuses (UN Newservice). “Given that women have been particularly victimized during war, special attention should also be given to their needs and potentials in formulation and implementation of national rehabilitation, reconstruction and development programs” UN Ambassador Patricia Durrant of Jamaica told the council yesterday: “in this context, the council must ensure special attention to the needs of women in the reintegration and post-conflict reconstruction” (Wurst, IPS/TerraViva, 25 October 2000).
Annex IV

GTZ - Working paper of the division health, education, nutrition, emergency aid

Reproductive health of refugees

This paper employs the term “refugees” in the context of international discussion to refer to those groups of persons who, in the face of or as a consequence of violent conflict or war, have had to leave their own country for a neighbouring, or even a distant foreign country. They thereby fall under the mandate of the UNHCR. As a rule, they are long-term refugees, who remain in host countries for an average of seven years -often in camps or camp-like situations. These groups thus differ from “internally displaced persons” (IDPs), who have also had to leave their home communities or regions for reasons connected with violent confrontation and national armed conflict, but who remain within their own country. Their problems may -but must not necessarily -be the same as those of refugees. As a rule, they do not come under the mandate of the UNHCR. This group, too, requires external support. However, each case must be assessed individually to determine whether elements of the approach presented in this study are relevant to it or not.

Status of international discussion and activity

The experience of past years has shown that the acute kind of crisis situation that is accompanied by large refugee movements evolves in many cases into a state of chronic crisis, lasting for years. The international community of nations attempts under such circumstances to provide for basic refugee needs through the UNHCR and international aid organisations. The first priority in situations such as these is to secure the refugees' physical survival.

Parallel to discussions about the status of reproductive health and women empowerment in connection with the International Conference on Population and Development (Cairo 1994) and the Fourth World Conference on Women in Beijing in 1995, it became clear that women and their (health) requirements had been neglected in the context of emergency aid. For example, refugee women were often not registered in camps, not consulted in the planning of services and infrastructure, and not included in food-distribution and income-generating activities -and this despite the fact that women refugees are often heads of households and, together with children, make up approximately 80% of the overall refugee population.

In the past five years, increasing efforts have been made to apply, in concrete terms, the management concepts -now developed and presented in manuals -for securing the fundamental right of persons in crisis situations to reproductive health. The integration of refugee assistance into the national health systems of host countries, the inclusion of a minimal “emergency reproductive health”, and the participation of the refugees in devising concepts and planning and implementing aid programmes are promising approaches.

Activities on the political and conceptual level have been introduced by the UNHCR and the UNFPA (Office for Emergency Relief Operations). Since 1995, there has been an Inter-Agency Working Group (IAWG), whose more than 30 members (governmental, non-governmental and international organisations) are attempting to improve services in the field of reproductive health in refugee situations. A UNHCR database has already registered more than 150 related projects world-wide. However, there are some problems in regard to the practical application of the guidelines and concepts and also in regard

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1 Essential elements of reproductive health are: sex education, family planning / prevention of unwanted pregnancies, pre-natal care and child birth, prevention and treatment of sexually transmitted diseases including HIV/AIDS, as well as prevention of sexual violence and genital mutilation of women.
to agreement among the numerous organisations active in emergency aid, whose inter-relationships are also determined by competition.

**Why are reproductive health information and services important for refugees?**

Public awareness of the need for reproductive health services for refugees during periods of armed conflict has increased, primarily as a result of reports about mass rape and the prevalence of HIV/AIDS. Often, however, no reliable data are available concerning a specific (local) need. Therefore, and against the background of competing demands for resources, this need is not actually registered.

Supplies of food, drinking water, shelter, hygienic facilities and basic health services have priority in refugee programmes. Interventions are geared to confronting the main causes of death under the prevailing conditions. These causes are usually: malnutrition, diarrhoeal diseases, measles, acute respiratory infections, and malaria (where prevalent). Although reproductive health care is classified among the basic health services, there are still a number of obstacles to making such information and services available to refugees.

Refugees have an urgent need for assistance in connection with pregnancy and childbirth, prevention of unwanted pregnancy, the prevention and treatment of sexually transmitted diseases (STDs), including HIV/AIDS, as well as sexual violence and abuse. Problems caused by generally poor and unstable living conditions, the generally poor health, and the breakdown of social networks are more serious and more difficult to resolve among refugees than they are among the settled population; and they often result in death.

Reproductive health services have the potential to make marked improvements in the health of whole groups of people at little expense. They benefit not only the individual but whole families, communities and the coming generation. Through the promotion of reproductive health, refugee women, for example, are more likely to be able to come to terms with the task of caring for their children and household. The number of illnesses and deaths caused by frequent pregnancies and other reproductive health risks then decreases. This means that both the expenses incurred by households and the financial appropriations of aid programmes decrease as well.

Since interventions in the field of reproductive health touch upon very personal areas of people's lives, the relevant programmes must be particularly sensitive to social, cultural and religious values and must take into consideration a wide range of customs and modes of behaviour. This is particularly true wherever the country of origin and the host country have disparate rules and customs or variations in the quality of reproductive health services, or where the cultural differences between the settled and the immigrant population are profound.

**Problems and demand for services in the field of reproductive health**

**Family planning**

Refugees, like other people, are sexually active. Under their particular circumstances, the danger of unwanted pregnancy, complications related to it, or unsafe abortion are, however, greater than otherwise.

The same is true of possible infection with STDs, including HIV. These are to be prevented by the ready availability of appropriate contraceptives (e.g., the variety in demand), particularly condoms. In this case,

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2 For a comprehensive description of the problem areas and the respective interventions required, see the IAWG handbook: Inter-Agency Field Manual Reproductive Health in Refugee Situations, December 1998 (available from the sectoral project "Reproductive Health" both electronically and in hard copy). The manual was produced following a two-year test phase in 1999.
fundamental criteria for the quality of family planning services must be observed, such as using such services on a voluntary basis, the offering of counselling, a supply of an appropriate range of methods, and informed choice. Problems are more likely to occur whenever behaviour connected with family planning differs in the refugees' country of origin from that of the host country. Immediate interventions, as an element of emergency aid, should include a sufficient supply of high-quality condoms (including, female condoms, where appropriate) and -as far as is possible with the help of health-care staff or trained assistants -oral contraceptives (both for family planning and as a “morning-after pill” / emergency contraception).

Prevention and treatment of sexually transmitted diseases (STDs). including HIV/AIDS

STDs, including HIV/AIDS, are particularly rapidly spread wherever poverty, powerlessness and social instability prevail. The steady dissolution of social structures during periods of crisis also has an impact on the relationships between partners and on the social norms that govern sexual behaviour. The result is often an increase in the use of sexual force as well as an increase in sexual activity generally, particularly among uprooted young people. STDs increase the risk of infection with HIV. Refugee movements contribute to the spread of HIV and other STDs. Thus in Rwanda, for instance, because of war and mass refugee movements, the rate of HIV infections has increased to the point where every third inhabitant of Kigali is infected. Other transmission routes for HIV (contact with bodily fluids, blood transfusions, mother-child) also flourish in circumstances where there are large numbers of refugees. Particular care must be taken in emergency situations to apply the standard prevention measures against HIV/AIDS consistently and to ensure unlimited access to free condoms for all population groups.

Safe motherhood

There are virtually no data available on pregnancy- and childbirth-related instances of sickness and death in refugee populations. Observers report, however, that when the services needed are not accessible, complications resulting from pregnancy and childbirth are the main causes of sickness and death in refugee women of childbearing age. Not all elements of pre-natal care and obstetrics can be provided in all emergency situations; this applies above all to surgical operations. Practicable interventions are as a rule: availability of trained midwives and/or identification of and support for traditional midwives (by trained midwives); inoculations (tetanus) and other preventive measures; prenatal physical examinations and treatment; supply of delivery kits for traditional midwives and health service centres; emergency obstetric care or, when this is impossible, the setting up of a referral system for emergencies; post-natal medical care for mother and child.

Sexual violence / violence against women

Refugee women are exposed to violence, rape, attempted rape, sexual harassment and threats, and to compulsory prostitution (in exchange for food or protection). This kind of violence can come from husbands, relatives, other refugees, guards, or even policemen or soldiers that have been assigned to protect the refugees. Accordingly, the use of violence is not limited to particular phases of an emergency situation. In cases such as Rwanda and Bosnia, rape was employed systematically as an instrument of war with the aim of what has come to be known as “ethnic cleansing”. Boys, too -and to a lesser extent, grown men -can be subjected to sexual violence. Often occurrences of rape are not reported, and the physical and psychological consequences are not adequately treated. In most of the cases, the emergency aid staff are not aware of the extent of sexual violence in a given situation. However, it may be assumed that it poses a major problem, because this has been demonstrated in a large number of cases.

Immediate interventions as part of emergency aid should include: sensitive and comprehensive physical examination by health staff of the same sex as the victim, the treatment of STDs among other physical consequences, the provision of oral contraceptives as emergency contraception (“morning-after pill”), reference to appropriate counselling. The raising of this issue and measures to avoid (sexual) violence should be made an integral part of emergency aid programmes.

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Unsafe abortion

The danger of unsafe abortions is connected with unwanted pregnancies resulting from rape or a lack or failure of contraceptive methods. Complications in connection with miscarriages and unsafe abortions require follow-up medical attention and instruction on safe contraception methods. Unsafe abortions result in complications that can be considerably reduced by making contraceptive methods available and through early, medically sound treatment.

Reproductive health of young people

Young refugees grow up with the collapse of stable social relationships and an absence of positive role models. The young people are themselves often depressed or disoriented by the traumas they have lived through. In the area of reproductive health, they, too, have particular needs that must be recognised and heeded. Risky behaviour can lead to early pregnancy, abortion, STDs, drug abuse and violence (as both victims and perpetrators). HIV infections, sexual violence and childbirth complications endanger girls and young women in particular.

Female genital mutilation

When refugees come from a country in which the various forms of female genital mutilation are practised, it may be that these practices are continued in the host country. Furthermore, circumcised women are more prone to complications in childbirth than other women are. Emergency aid staff should be prepared to encounter such cases and be able to offer support and to deal with this circumstance when it arises.

Crises and interventions in the field of reproductive health

In general, crises involving refugee movements run their course according to a pattern that repeats itself. The various phases that succeed one another are: the pre-conflict situation, flight, arrival at the place of refuge (acute emergency aid phase), the stabilisation phase, and resettlement. Each one of these stages is characterised by particular dangers and circumstances in regard to reproductive health of refugee populations. The provision of reproductive health services is of particular significance during the acute emergency phase and the stabilisation phase.

Emergency phase

The emergency phase is one in which the lives or well-being of refugees would be threatened unless appropriate measures are taken without delay. This phase demands reactions and activities that go well beyond ordinary care. The United Nations sets as top priorities the provision of shelter, drinking water and food; protection from abuse and violence; and basic health services (including reproductive health services). However, a number of emergency aid organisations turn their attention to reproductive health - if they do so at all -only after other basic needs have been attended to.

The Inter-Agency Working Group (IAWG) has been active since 1995 in the field of reproductive health on improving the realisation of a Minimum Initial Service Package” (MISP), which is to be supplied to persons in crisis situations. This “minimum package” can be used right off, without further ado, and includes both materials and equipment and guidelines for effective use by emergency aid staff on site. It addresses the following topics: prevention and management of the consequences of sexual force, prevention of HIV infection through information campaigns and the availability of condoms, reduction of mother- and infant mortality through provision of adequate medical services, and the integration of reproductive health into a primary health-care system that includes training for members of health staff. The required interventions are listed under the respective problem areas (see above).

The stabilisation phase

These days, refugee situations continue for a number of years on the average, so that most refugees end up living, in fact, not in a state of acute emergency but rather in a state of chronic crisis. Since the MISP is intended to supply only minimal reproductive health services, it is necessary to switch to regular care as
soon as local circumstances permit, as indicated in the field manual (see footnote 2). As a first step, an analysis of target group needs must be undertaken. Aid programmes should be made to evolve into medium-term development programmes. A longer-term solution would include the offering of reproductive health services as a part of all health interventions. The primary goal is no longer, as with the minimum package, to reduce the number of deaths, but to introduce comprehensive and demand-driven information and health care for the refugee population. Included in this is also the production and distribution of appropriate information and educational material in the mother tongue of each respective group.

**A possible task for technical cooperation (TC)**

The term “development-oriented emergency aid” connotes the effort to connect, right from the start and in line with development cooperation criteria, the impact of emergency and refugee assistance measures to the overall socio-economic development of partner countries. Yet with the exception of pure emergency care, health care, including reproductive health, is not yet receiving the attention it deserves during the designing of development-oriented emergency aid programmes. In future TC interventions, this kind of health care should be taken into account right from the initiation of overall concept planning and program design. One possibility is to link the awarding of contracts to NGOs to the readiness of these organisations to ensure the supply of services and information on reproductive health for refugees.

GTZ-supported health projects in Guinea are a good example of the integration of support for refugee populations into existing national structures within the host country and of the integration of reproductive health into their overall health service package. In Guinea, health-care experience already gained in TC, including the provision of reproductive health services, was applied to a host country with a large number of refugees. Particular attention was devoted, parallel to promotion of refugee initiatives, to support for the district health system. Local institutions there are provided with support for coordinating the various measures.

**What needs to be accomplished?**

A trans-sectoral programme concept should be sought for the field of reproductive health. TC can use the experience gained from its own reproductive health programmes to develop and implement long-term concepts for health-care systems. Reproductive health measures should wherever possible be integrated into both on-going and planned emergency aid programmes (e.g., in regard to logistics, the awarding of contracts for health-care components to local or international organisations, and training for local organisations/institutions). The steps and details necessary for this should be clarified through dialogue between the GTZ refugee and emergency aid, and health sections.

Content and procedures in the field of reproductive health must be based on actual refugee needs. The specific religious and cultural characteristics of the target group must be taken into account, as must local health and population policy and, of course, universally acknowledged human rights. The implementation of the measures required can be delegated to local NGOs; medical services can possibly be offered via health-care structures that are already in place. By taking advantage of existing infrastructure, costs for setting up a parallel health-care system can be contained; the measures can take effect more rapidly; local staff, who often speak the language of the target group and are familiar with their socio-cultural context, can be supported through existing structures and not lured away from their jobs. The national health-care system is likewise developed: it is supported in offering family planning services to the local population and in achieving the capacity in terms of both staff and technology/logistics to care for the refugee population. The latter applies particularly to situations in which refugees are not living in camps, segregated from the local population. By integrating reproductive health services into local structures, the danger of setting up a two-class health-care system is also reduced: refugees and local inhabitants receive comparable medical care and can use reproductive health services jointly. This contributes to the reduction of conflict potential among the various population groups.
Action to be taken

1. Further study of the issue by an intersectoral committee (working group, quality circle, task force, etc.) that includes representatives from the fields of emergency and refugee aid, health and reproductive health
2. Integration of and ensuring the supply of reproductive health services in GTZ-assisted emergency aid programmes
3. Supply of the “Inter-Agency Field Manual Reproductive Health in Refugee Situations” to aid programmes currently supported by the BMZ, possibly also consulting on application of the measures, experience exchange
4. Contact and consultation about concepts with the relevant emergency aid organisations (NGOs), e.g., concerning the use of the IAWG manual or the inclusion of condoms, contraceptives, delivery kits, etc. in the equipment made available by emergency aid programmes (procurement)
5. Integration of a “reproductive health component” into all relevant training measures
6. Sensitisation and training of seconded experts (e.g., during their period of orientation in Planning and Development Department).

Compiled by the sectoral project “Promotion of Reproductive Health of Difficult-to-Access population Groups”

November 1999
### Programme

**Thursday, 12 October**

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<td>9.00-10.30</td>
<td><strong>Opening Session</strong></td>
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<td>Opening address: Prof. Giuseppe Benagiano, Director, Istituto Superiore</td>
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<td>Keynote address: Gender Issues in Conflict and Post-conflict situations</td>
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<td>– Why consider gender in emergency situations?</td>
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<td>Dr. Malika Ladjali, UNESCO</td>
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<td>Violence and Reproductive Health during conflict and displacement</td>
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<td>Dr. Carol Djeddah, WHO-HQ</td>
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<td>Purpose and objectives of the workshop</td>
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<td>Dr Assia Brandrup-Lukanow, WHO-EURO</td>
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<td>10:30-11:00</td>
<td><strong>Coffee Break</strong></td>
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<td>11:00-12:30</td>
<td><strong>Session I: Collecting evidence – appropriate methodologies</strong></td>
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<td>Introduction by Dr Meredith Turshen: Integrating the problems of violence</td>
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<td>into research action: working with women affected by violence</td>
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<td>Case Studies by selected countries, lessons learnt from community</td>
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<td>approaches:</td>
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<td>Kazakhstan Survey: Ms Tanya Lary</td>
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<td>Kosovo: qualitative approach/focus groups: Dr. Gani Demolli</td>
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<td>Tajikistan: 1999 Pilot survey in Tajikistan methodologies and findings:</td>
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<td>Dr Annemiek Richters</td>
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<td>12:30-14:00</td>
<td><strong>Lunch</strong></td>
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<td>14:00-15:30</td>
<td><strong>Session II: Violence, health consequences and preventive measures</strong></td>
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<td>Introduction by Dr. Berit Schei: Setting up health services in situations</td>
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<td>Girls and women in armed conflict – a serious concern of Red Cross:</td>
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<td>Ms Karin Helweg-Larsen</td>
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<td>Long-term consequences: facing the double burden</td>
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<td>15:30-16:00</td>
<td><strong>Coffee break</strong></td>
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<td>16:00-17:00</td>
<td><strong>Case Studies from selected countries (care and prevention)</strong></td>
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<td>Algeria: Dr Fatima Karadja – Psychological trauma aggravated by collective ideas in society</td>
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<td>Azerbaijan: Dr Mominat Omarova</td>
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<td>DISCUSSION</td>
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### Friday 13th October

<table>
<thead>
<tr>
<th>Time</th>
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| 9:00-10:30    | **Session III: Public health, human rights and human security**  
The need for a multidisciplinary response to ensure the promotion of human rights and human security: Dr Annemiek Richters  
Protecting women through a community-based approach: Dr Malika Ladjali  
General discussion: What role can public health play in the work of International Agencies and NGOs to include human security  
Statements by UNICEF, UNHCR, UNFPA, UNDP, UNESCO, ICC, GTZ  
DISCUSSION |
| 10:30–11:00   | Coffee break                                 |
| 11:00–12:30   | **Session IV: Rehabilitation**  
Psycho-social situation of refugee women in exile - examples from Germany: Dr. Marita Hecker  
The role of the media: avoiding re-victimisation |
| 12:30-14:00   | Lunch                                        |
| 14:00–15:30   | **Session V: Working Groups**  
Technical recommendations on the issues discussed during the workshop  
Group 1: Evidence and policy (prior, during and post conflict)  
Group 2: Care and prevention  
Group 3: Public health, human rights and human security |
| 15:30-16:00   | Coffee break                                 |
| 16:00–17:30   | **Session VI: Conclusion and Recommendations to the Conference** |
Annex VI

List of participants

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