

THE IMPACT OF CONFLICT ON WOMEN AND GIRLS

A UNFPA Strategy
for Gender
Mainstreaming in
Areas of Conflict
and Reconstruction



Bratislava, Slovakia
13-15 November 2002

The Impact of Armed Conflict on Women and Girls
A Consultative Meeting on Mainstreaming Gender in
Areas of Conflict and Reconstruction

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FOREWORD

The nature of armed conflicts changed dramatically during the latter half of the twentieth century, with casualties among civilians increasingly outnumbering those of military personnel. Women and girls became especially vulnerable in such conflicts. Because of this, significant ethical, analytical and operational challenges have emerged for the United Nations system, not least for the United Nations Population Fund (UNFPA). One of the most critical challenges is the need to develop integrated, gender-sensitive strategies and programme interventions for addressing conflict situations.

UNFPA has been at the forefront of addressing reproductive health issues and gender-based violence during armed conflicts. In collaboration with national and international partners and donors, UNFPA has supported emergency reproductive health projects in more than 30 countries worldwide, most recently in Afghanistan and its neighboring countries. Within the scope of the UNFPA mandate and limited financial and human resources, UNFPA has increasingly played an important advocacy role for reproductive health and human rights of women and adolescent girls in emergency situations.

The impact of conflicts on women and girls' reproductive and sexual health can never be underestimated. Their psychological, reproductive and overall well-being is often severely compromised in times of conflict. Conflicts tend to increase the incidence of sexual violence; rape; sexually transmitted infections (STIs), including HIV/AIDS; and unwanted pregnancies. In addition, essential social services, such as medical facilities, on which women heavily depend for their well-being, are greatly disrupted by armed conflicts.

Despite these negative outcomes, women have acted as peace mediators in families and societies for generations and have proved instrumental in conflict prevention. The international community should reinforce these skills. Women's economic power and social status must be strengthened. By taking into account women's capabilities and vulnerabilities, by supporting initiatives that offer protection from sexual and gender-based violence, by improving the availability of quality health care and reproductive health services, by providing access to education and skills development training and by providing assistance to income-generating and other economic activities for women, the international community can promote the full participation of women in conflict prevention and post-conflict peace-building.

This report of a consultative meeting is intended to contribute to the United Nations study on the Impact of Armed Conflict on Women and Girls, requested by the United Nations Security Council in Resolution 1325, and adopted on 31 October 2000. The Gender Issues Branch of the Technical Support Division,

UNFPA, organized the meeting with overall coordination by Ms. Sahir Abdul-Hadi. The Country Technical Services Team (CST) based in Bratislava, Slovakia, assisted in organizing the consultative meeting.

In today's world, women remain grossly underrepresented in decision-making forums related to conflict prevention and peace-building. This must change. As a multilateral organization committed to all dimensions of women's and girls' health and well-being, UNFPA has clear comparative advantages in helping to strengthen women's contributions. This important meeting has helped UNFPA clarify its role and broaden its possibilities.

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LIST OF ACRONYMS AND ABBREVIATIONS

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHAD	Conflict and Humanitarian Affairs Department (DFID)
CST	Country Technical Services Team
DFID	British Department for International Development
DPKO	Department of Peace-keeping Operations
ECHO	European Community Humanitarian Office
FAO	Food and Agriculture Organization of the United Nations
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IAWG	Inter-agency Working Group
ICPD	International Conference on Population and Development
IDP	Internally displaced person
IEC	Information, education, and communication
ILO	International Labour Organization
INSTRAW	United Nations International Research and Training Institute for the Advancement of Women
IOM	International Organization for Migration
IPTF	International Police Task Force
IRC	International Rescue Committee
KEGME	Mediterranean Women's Studies Center
KFOR	NATO Kosovo Forces
KLA	Kosovo Liberation Army
MISP	Minimum Initial Services Package
MSI	Marie Stopes International
NATO	North Atlantic Treaty Organization
NGO	Non-governmental organization
OCHA	Office Coordinator of Human Affairs
OSCE	Organization for Security and Cooperation in Europe
STI	Sexually transmitted infection
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women

UNMIBH	United Nations Mission in Bosnia and Herzegovina
UNMIK	United Nations Interim Administration Mission in Kosovo
UNOHCHR	United Nations Office of the High Commissioner for Human Rights
WFP	World Food Programme
WHO	World Health Organization

PART I. CONSULTATIVE MEETING

INTRODUCTION

Purpose

A consultative meeting, “The Impact of Armed Conflict on Women and Girls,” was held in Bratislava, Slovakia, on 13-15 November 2001. The purpose of the meeting was twofold: first, to examine and explore the impact of armed conflict on women and girls; and, second, to formulate strategies and tools to ensure that reproductive health programmes accurately reflect this population’s needs, specifically by addressing them through a comprehensive, gender-sensitive approach.

Participants

During the three-day meeting, experts from several areas that had been or were still undergoing conflicts as well as representatives of international agencies and institutions examined issues inherent in planning and implementing programmes to support reproductive health care, women’s empowerment and population and development programmes in conflict and post-conflict settings (see Annex 1 for Agenda, Annex 2 for Working Group Participants and Annex 3 for Participant Contact List).

The Gender Issues Branch of the Technical Support Division, UNFPA, initiated, organized and implemented the meeting’s proceedings and report. In its preparations, the Branch consulted all concerned colleagues at headquarters and field staff levels. Substantial support was received from the Emergency and Humanitarian Cluster as well as field staff in Eastern Europe and Central Asia.

The Country Technical Services Team (CST) based in Bratislava, Slovakia, was also instrumental in organizing the consultative meeting. The CST is part of the Technical Advisory Programme of UNFPA. Its function is to build and improve national capacity through planning and implementation of population programmes.

Rationale

This report is intended to contribute to a United Nations study, The Impact of Armed Conflict on Women and Girls, requested by the United Nations Security Council in Resolution 1325 on Women, Peace and Security, and adopted on 31

October 2000. The Council asked the Secretary-General to “carry out a study on the impact of armed conflict on women and girls, the role of women in peace-building and the gender dimensions of peace processes and conflict resolution.”

Security Council Resolution 1325 called “on all actors involved in negotiating and implementing peace agreements to adopt a gender perspective that included the special needs of women and girls during repatriation and resettlement, rehabilitation, reintegration, and post-conflict reconstruction.”

The Resolution stated that:

“Such a reconstruction would include measures that supported local women’s peace initiatives and indigenous processes for conflict resolution, and that involved women in all the implementation mechanisms of the peace agreements, as well as measures to ensure the human rights of women and girls, particularly as they are related to the constitution, the electoral system, the police and the judiciary.”

The Resolution also called “on all parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict.”

The International Conference on Population and Development (ICPD) Programme of Action underscores that reproductive health is a universal human right and that reproductive health information and services should be available to all men and women, including those in difficult and emergency situations. The Beijing +5 document, *Further Actions and Initiatives to Implement the Beijing Declaration and Platform for Action*, highlighted several forward-looking commitments by Governments that would advance the human rights of women and gender equality, particularly with respect to areas of violence against women, health, trafficking, armed conflict and human rights.

BACKGROUND

Women and girls constitute close to 80 per cent of internally displaced people and refugees worldwide. Although war has always victimized non-combatants, contemporary armed conflict exploits, maims and kills civilians more callously and systematically than ever before. This aspect of armed conflict raises serious ethical, analytical and operational challenges for the United Nations system as a whole, including UNFPA. Not only does a mandate exist to address the pressing issues of the impact of conflict on women and girls but a moral obligation exists as well.

Effects of war on women and girls

Modern warfare has had a devastating effect on the lives and dignity of women and girls, as well as on the health and educational services that are essential to family and community survival. Along with reproductive health complications, the adverse effects of conflict hit women and girls harder than it does their male counterparts, since deliberate gender-based violence and discrimination are rampant in these settings. As such, these gender-specific threats to women and girls compound the challenges of ensuring their protection. This has resulted in gaps in the design and delivery of assistance and protection, short-changing the priority population of women in conflict and post-conflict situations.

Essential services such as basic health care, including reproductive health care and counseling, are often disrupted or become inaccessible during conflict situations. This compounds health risks for all affected populations, at times when public health needs soar. Women and girls become the individual and systematic targets of sexual violence, specifically when rape and sexual assault are used as weapons of war. Efforts responding to the systematic application of gender-based violence must confront the aftermath of previous events, as well as education efforts relative to gender and human rights.

Gender plays a significant role in determining which people are most likely to become infected with STIs, including HIV/AIDS. Armed conflict increases the rate of new infections across affected populations, but women and girls are significantly more likely to become infected than men and boys. A recent post-conflict study in Africa found that the HIV- infection rate of adolescent girls was four times that of adolescent boys. Rape, high-risk behaviors, the inability to negotiate safe sex, and sexual exploitation are risks that have disproportionately impacted women and girls.

Effects of war on adolescents

Even in ideal, peaceful settings, adolescence is a challenging time of life. When conflict erupts, the risks associated with adolescence increase for boys, but multiply for girls. Trauma and lack of social support and services are especially harmful to young people and may have lasting effects on their physical and mental health. When social structures break down in the face of war and instability, young adults frequently engage in high-risk drug use or sexual behavior.

The presence of peacekeeping organizations in post-conflict settings sometimes has negative ramifications on public health, again with severe repercussions for women and girls. Personnel and military forces used for peacekeeping missions are predominantly adult men from differing cultures, health and education statuses and, subsequently, expectations for conduct. Increased demand for the commercial sex trade has serious ramifications for the entire community, particularly through the presence of sexual, physical and economic exploitation.

Despite the perverse hardships facing women in conflict settings, it is important to underscore that positive outcomes for women do exist. A central point of reference is that women have organized themselves in numerous locations to respond to conflict at the grass-roots level, particularly attending to empowerment of women and girls. There are many ways to reap the benefits of women's leadership and to establish them as agents of change in post-conflict redevelopment efforts. Pursuing the most comprehensive reproductive health services in emergencies and clarifying the extent to which those services can be made sustainable are a notable concern for the entire United Nations system, including UNFPA.

Agenda Items

Four areas were highlighted to address the impact of conflict on women and girls:

- **The impact of conflict on reproductive health.** Conflicts expose women to increased vulnerability on range of health threats. Social, cultural and economic disempowerment is compounded by poverty, and their combination produces a context in which women are susceptible to sexual exploitation and drug abuse. Items addressed include the availability of and access to preventive health services, information and treatment, and involve processes of empowerment, gender relations and the impact of HIV/AIDS;
- **Gender-based violence and its sexual dimensions, including trafficking.** More information is needed on gender-based violence. Collection of this

information should include documented human rights violations, discrimination and vulnerability analyses, and community perceptions and responses. Special attention must focus on the intersection of adolescents and gender abuse, the trafficking of women and girls, and the changing role of families and communities relative to gender justice. In addition, HIV/AIDS care services must prevent the abuse of people living with HIV/AIDS;

- **The impact of peacekeeping operations on host populations.** Peacekeeping forces have a significant impact, specifically affecting health systems, economies and local communities. Women are exploited and economically vulnerable, especially as the rise of the commercial sex industry and related abuse is linked to the presence of peacekeeping missions. Advocacy efforts must be directed towards sensitization of peacekeeping forces and towards the provision of education and economic alternatives for host and refugee communities; and
- **The local community's role in rehabilitation.** The local community's role must be addressed, specifically through examining women's individual roles as well as the roles of women's groups. By exploring the polarization of gender identities, the intergenerational balance among women, and community education, information, and dissemination, non-governmental organizations (NGOs) and other international organizations and agencies can introduce and maintain sustainable rehabilitation efforts. Women's expanded roles to male-dominated areas and the identification of role changes and their effects on women and families are key focuses to understanding and expanding rehabilitation efforts.

OPENING SESSION

The consultative meeting began with a welcome by Rainer Rosenbaum, Director of the UNFPA CST in Bratislava. His remarks were followed by statements of H. E. Pal Csaky, Deputy Prime Minister of the Slovak Republic for Human and Minority Rights and Regional Development, concerning the importance of not underestimating issues of violence against women and the impact of conflict on women and girls. He stressed the need to alleviate difficulties in conflict and post-conflict situations; reduce conflict; and promote mutual understanding. Kunio Waki, Deputy Executive (Programme) Director, UNFPA, also addressed participants at the opening session, noting the importance of both short-term solutions and long-term developments, ensuring that women are part of the efforts to achieve sustainability. He noted six areas in which UNFPA can make a difference: analysis and sound research on effects of conflict on women and girls; a review of past experiences in Afghanistan, Kosovo, Bosnia and Herzegovina, Georgia and other countries; identification of strategies; exploration of potential venues in traditional governance structures for reconstruction and development; improved partnerships with NGOs; and the development of regional strategies for broader impact.

H.E. Elisabeth Rehn was the keynote speaker. She noted that Security Council Resolution 1325 gives a platform for the engagement of peace activists and others who have looked forward to solving reproductive health issues. She remarked on the need to continue to look for greater roles for women in leadership, citing examples in Bosnia and Herzegovina, Cambodia, East Timor and Macedonia, among others. She stressed the need for providing education in refugee camps, some of which have as much as 80 per cent illiteracy; recognizing the different ways in which violence against women in conflict is manifested; and addressing the issue of trafficking in women, which is common in Eastern Europe. She recommended having women be involved in camp plans, since most rapes and harassment happen in these settings; narrowing the distance between headquarters and grass-roots levels; having NGOs start a new mission with gender and human rights experts to ensure representation of women's point of view; and appointing women to higher positions to be a role model for their programmes and other NGOs.

Sahir Abdul-Hadi, Chief, Gender Issues Branch, UNFPA, discussed the background papers prepared for the meeting. She underscored the point that the greater the involvement of refugee and internally displaced women in planning, designing and monitoring reintegration plans, the less likely abuse and exploitation will occur. She noted that women, representing half of the population, are the mothers, wives, daughters and sisters of soldiers and rebels, who must be mobilized, but also community opinion holders and potential leaders.

BACKGROUND PAPER SUMMARIES

Background papers were commissioned so that participants would be best informed to examine and reflect upon the issues at hand. (The full text of the background papers appears in Part II of this report.) To address empowerment goals for women in conflict and post-conflict settings, several issues must be considered. In particular, violence perpetuated against women and girls, gender inequalities in control of resources, gender inequalities in power and decision-making, women's human rights, and women reinforced as key actors rather than, as victims and aid recipients are all prerequisites for exploring improvement strategies. Summaries of the background papers framed the starting-point for the meeting's discussions.

The Impact of Conflict on Reproductive Health

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Reproductive health is a fundamental human right. In 1994, the ICPD articulated in the Programme of Action the reproductive health needs of refugees for the first time. It acknowledged that special attention should be given to the specific needs of refugee women and refugee children, who should be provided with adequate accommodations, health services, family planning, education and social services.

Reproductive health care is a vital component of public health care. In refugee settings, it becomes even more important due to a combination of factors. The international community has only recently initiated reproductive health services as part of the response to conflict or natural disaster. An effective programme of reproductive health care is sensitive to gender, sex, age, culture, religion and ethnicity, and must be accessible, comprehensive and readily available. Civilians are increasingly at risk during war, and women and children are particularly vulnerable. The lack of quality reproductive health services in conflict settings leads to negative health outcomes, such as increases in STIs, including HIV/AIDS, increased rates of unsafe abortions, and increased morbidity due to high fertility rates and poor birth-spacing. These result in disproportionately high mortality rates among women and children.

The Inter-Agency Working Group on Reproductive Health in Refugee Situations (IAWG) describes reproductive health in refugee settings as including:

family planning, safe motherhood and emergency obstetrics, the prevention of and response to gender-based violence, and the prevention and treatment of STIs, including HIV/AIDS.

Women play key roles in economic, social and family life, and are most affected by reproductive health problems. Women already have compromised health and social indicators, and the added stresses and experiences of forced migration can result in poorer health outcomes. These stresses can include subjection to sexual violence, abuse, trauma, harassment, starvation, poor water and shelter, chronic illness, loss of family and possessions, and death, among others. Investing in women's reproductive health has positive effects on entire communities, as women are often the sole caretakers for extended families, including children and elders.

Young people are persistently underserved within refugee populations, although they endure profound losses at a crucial developmental stage. Young women are at special risk during forced migration from abduction, forced recruitment into armed forces, sexual violence and abuse and increased risk of STIs and HIV/AIDS. With strains on family systems, many must head households and care for family members. To ensure project successes for this dynamic group, adolescent involvement in planning and implementing rehabilitation and reconstruction programmes is essential.

Male involvement is essential to improve women's status and empowerment, as well as to improve men's health in its own right. Many men are interested in making positive changes towards women's empowerment, and more methods must be investigated and implemented to this end. Men and boys are vulnerable to sexual violence during conflict, although little is known about its incidence. Unique challenges arise when considering male involvement and must be considered for programme implementation in conflict settings. First, male integration can be difficult in conflict situations due to the entrenchment of traditional male values during displacement, especially when communities fear their cultural values will erode. Second, the presence and impact of armed forces and military groups also negatively affect the reproductive health of both host and refugee communities. Both are complex issues that must be addressed with care.

Conflict situations are never identical, since displacement length varies from short-term emergencies to long-term development settings. Refugees may live in large camps or be "integrated" into urban or rural settings. Reproductive health services must be flexible and adaptable to varied circumstances.

Reproductive health in conflict settings is highly politicized. Displaced communities can feel that they are targets of programmes for ethnic reasons. Host populations can feel resentful of refugees who are seen as receiving better services than they are. In the international community, some agencies and

NGOs feel they have the right to withhold reproductive health services as well as to interfere with other agencies' attempts to provide services. In addition, some health agencies believe that the provision of reproductive health lies in the "second phase" rather than the "first phase" of conflict-response activities. All the above reasons have challenged or hampered refugee access to reproductive health care services. Cultural, linguistic, economic and religious barriers, including physical distance, also affect access to refugee reproductive health services more readily than basic health provision.

There are four primary aspects of reproductive health to consider in conflict situations, those of family planning, safe motherhood and emergency obstetrics, gender-based violence and STIs and HIV/AIDS. When family planning services in refugee settings are designed in collaboration with community representatives, and are available and accessible to the community at large, family planning prevalence increases. With pregnancy and childbirth as recognized health risks for women in developing countries, women in refugee settings share these risks. Without safe motherhood interventions, many refugee women and their newborns will die needlessly, and consequences of inaction affect the entire refugee community.

Female genital mutilation is a contributory factor in obstetric complications and is often overlooked. Its incidence can increase in conflict situations when communities heighten traditional practices or seek to integrate with cultural customs of host populations. In addition, links persist between gender-based violence and other areas of reproductive health, including STI and HIV transmission, unwanted pregnancies, unsafe abortions and obstetric complications. Controversy surrounding emergency contraception persists despite being legal in most settings, preventing other life-saving interventions from being implemented. Emergency contraception should be available at all times for all instances of unprotected sex, including sexual violence.

STIs, including HIV/AIDS, spread fastest where poverty, powerlessness and social instability exist; forced migration settings are not exempt. Refugees are exposed to different populations with HIV, including the military. Some work is being done with the United Nations and other armed forces; however, more education about safe sex and the spread of HIV/AIDS must be made available. Interventions should not stop with the military but need to target all men, including adolescents and boys, in implementing behaviour change projects. Condom provision must be ensured.

Conflict brings change, and often this has a negative impact on reproductive health status. There are situations, however, in which conflict has been a force for positive social change. Women take on non-traditional roles during displacement that require learning new skills and greater role development, including vocational, educational or medical training to medics and communities.

The post-conflict setting poses constraints to meeting basic reproductive health needs, yet new needs resulting from the conflict need to be addressed. Health service providers have a role to play in ensuring fair and equitable access to service provision for all members of the community.

Challenges facing the international community include maintaining strategic alliances formed with and among Governments, United Nations organizations and agencies and international and local organizations, as well as the implementation of international policies and guidelines. Progress at the international level must be transferred into practices on the ground to directly engage communities affected by conflict. Development agencies must expand their target audience to refugee populations, and humanitarian agencies must ensure the integration of comprehensive reproductive health care into their service delivery. Ensuring the accountability of agencies that provide health care to refugee and displaced populations is key to making service delivery systematic and comprehensive. Work remains to ensure that policies and strategies implemented at headquarters levels are effectively and efficiently transferred to the field.

Sexual and Gender-based Violence in Post-Conflict Regions: The Bosnia and Herzegovina Case

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The relationships between sex, gender and violence have not been addressed in post-conflict settings. Gender-mainstreaming involves more than understanding the consequences and implications of dictated roles and stereotypes. It entails making women's empowerment central to the development process and ensuring the involvement of women at each juncture. Women's NGOs have employed a bottom-up approach in their power structures, operating from a place of internal power, namely self-esteem and awareness-raising, rather than external power, which seeks to dominate others. As such, NGOs in post-conflict regions have made significant advances in developing civil societies and in furthering capacity-building. In contrast, however, governmental approaches to regional development have been seriously hampered by war.

Conditions in post-conflict regions exacerbate existing problems such as impoverishment and productive infrastructure damage. Transitions from a planned economy to a market economy have negative outcomes for conflict populations, examples being severe ethnic divisions and the flourishing sex trade. Additionally, violence is a global problem that affects both men and women through different perspectives and experiences. Gender-based violence

includes the physical, sexual and emotional abuse of women, sexual abuse of female children, marital rape, sexual assault, forced prostitution, and trafficking in women and young girls. Women's social standing has also been persistently disadvantaged due to entrenched patriarchal cultural values. These values, in turn, dictate roles and behaviours that can result in negative health outcomes.

After the war in the Balkans, women's equality was placed high on the social agenda. In practice, however, integrating a gender framework poses challenges beyond women's discrimination and rights violations. Men have also been victims of violence and abuse, and this must be acknowledged. While male soldiers in conflict settings have previously been at highest risk for exposure to violence, they are also subject to social expectations of male roles such as bravery. If they do not ascribe to these male "norms", they are frequently stigmatized and punished by both men and women.

Women are less inclined to participate in conflict and violence because they are excluded from political and social life and are financially dependent on men. As a result, women are frequently involved with family care and social assistance, which allows them to dominate assistance work during conflict. This can be seen as marking the beginning of civil societies in the Balkans.

Domestic violence has been present throughout war and peace, but it was largely hidden from public awareness and was therefore not addressed. Medica Zenica was one of the first NGOs to address domestic violence in Bosnia and Herzegovina. On the basis of in-depth interviews conducted with women in the Zenica municipality, it found a high prevalence of domestic violence in the region. Other NGOs, including the International Rescue Committee (IRC), implemented important programmes. Hotlines were arranged and refugee women's facilities were established to address domestic violence. Few of the many international NGOs that dealt with domestic violence have remained in Bosnia and Herzegovina, but the need for their programmes persists.

Local police have been encouraged to deal with gender-based violence and to improve attitudes towards victims. Women have been encouraged to become peer counsellors at local police stations and to conduct follow-up investigations. Mass rapes, including rapes of male prisoners in concentration camps, were used as an instrument of war and community erosion. Concentration camp victims initially received aid but are still in great need of food, housing, jobs and financial assistance. Needs assessments must be done for future mental health services.

Trafficking in human beings involves deception, coercion, forced and violent sex, sexual exploitation and forced prostitution. Transition, instability, and disintegrating social networks in receiving and transit countries, which already suffer economic hardship and poverty, foster the trafficking trade. Trafficked women and girls face severely compromised physical and mental health, and

especially their reproductive health due to rape, sexual abuse, STIs including HIV/AIDS, trauma, and unwanted pregnancies. Country-specific assistance is being developed by the International Organization for Migration (IOM) to provide shelter and collect data on regionally trafficked women. Additionally, public education, legal structures and improved policies need to be further established to deal with trafficking. Women are also sold into prostitution as a result of local and international police complacency and, sometimes, active engagement of foreign military troops. The training of officers on all levels must be addressed on this issue.

**Women and Girls in Kosovo:
The Effects of Armed Conflict on the Lives of Women**

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The Kosovo conflict of 1989-1999 had devastating effects on the lives of women and girls. The policy of the Serbian Government in the 1990s greatly limited the freedom of movement of Kosovo-Albanian women and threatened their security. Obtaining an education became difficult for women, curricular standards fell and unemployment rose significantly. Many employed women lost their jobs. During a heightened period of the crisis, in 1998-1999, many women lost family members, became victims of brutal violence and endured intense insecurity and fear. For women, the exodus to neighbouring countries, lengthy stays in refugee camps and widespread displacement in countries worldwide had especially difficult implications. The pressure of having to care for nuclear and extended families compounded these difficulties. Women's NGOs played an important role in refugee camps, focusing their activities on serving women through each phase of the conflict.

After the end of the crisis, Kosovo-Albanians returned home, where the destruction was overwhelming. Reconstruction began under the command of the United Nations, the Organization for Security and Cooperation in Europe (OSCE), the European Union, and under the protection of NATO Kosovo Forces (KFOR). Revenge and additional destruction, however, were common. Serbs and Roma people were killed or forced to leave, and churches and houses belonging to minorities were destroyed. Violence has continued against minorities as well as among Kosovo-Albanians. Women have continued to face multiple losses of family and property. Unemployment has persisted, and poverty has taken a significant toll on women. Following the deaths of their spouses, some women became the only breadwinners in their families.

After the crisis, women's NGOs flourished with international support and cooperation. Women reacted throughout the conflict by offering concrete

services to women and by organizing peaceful acts of resistance. In addition, many women started working in international agencies that provided employment. International agencies and NGOs that worked on gender issues have continued to support women's interventions and programmes. In addition to the issue of the lack of human rights of Kosovar women, other struggles of Kosovo-Albanian women include illiteracy, lack of access to education, unemployment, lack of social services, high birth rates, maternal mortality, health problems, domestic violence against women and the trafficking in women from Eastern Europe. Women are excluded from holding positions of power in society, and this persistent lack of participation and representation in decision-making is unacceptable. Women want to work and participate in decision-making, but their rights and demands continue to be disrespected. The establishment of quotas, as determined by the international community in municipal and general elections, provides hope for improving representation there. Cultural taboos in Kosovar society make many issues difficult to discuss, especially those regarding different forms of violence and sexual abuse of women and girls. Finally, minority women in the region suffer from restrictions of movement, insecurity about the future, unemployment and persistent fear of violence throughout their communities.

The international peacekeeping missions have played important roles in Kosovo's reconstruction, especially in the protection of minorities. Gender perspectives and gender-mainstreaming, however, have not been effectively integrated in the work of the international community according to United Nations and European Union policies. The United Nations Interim Administration Mission in Kosovo's (UNMIK) Office of Gender Affairs lacks the support, authority, expertise and funds necessary for either internal training and policy-making inside UNMIK or for the advancement of Kosovo's women.

The Role of Women's NGOs in Rehabilitation, Reconstruction and Reconciliation

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Armed conflicts have devastating implications on people, societies and economies worldwide, with extreme impacts on the lives of women and girls. While conflict challenges women's survival capabilities and strategies, their capabilities and contributions in all phases are not fully recognized and appreciated. Women shoulder the economic and psychological burdens of their families, play foremost roles in supporting their communities and take on roles in peace-building and reconciliation. In essence, they are becoming key contributors to rebuilding equitable and democratic civil societies.

Gender determines social roles and subsequent interactions between women and men. It is through these roles that women and men perceive their social identities and relationships, among each other and in their communities. These implied social placements have created a pattern of dominance and subordination, often placing men in control and women in often submissive, supportive roles. Armed conflict situations, in particular, are not gender neutral for a variety of reasons. Women and men experience conflicts differently, differ in access to resources and decision-making efforts throughout armed conflict phases, and have different roles in peace-building and violence reduction, as well as different situational needs, interests and peace-building strategies.

Conflict and displacement cause demographic shifts that have serious ramifications that result in: decreased male population and subsequent structural changes of households; decreased fertility and increased infant mortality; civilian dispersion and reallocations; and increased rural-to-urban migration. Health-related consequences for socio-economic sectors include: strains on and destruction of health-care facilities and infrastructures; reallocation of funds from public health to defence purposes; increased private health-sector coverage and subsequent costs; and negative health indicators related to poverty, loss of livelihood, displacement and poor conditions of refugee camps.

Violence against women increases during conflict situations. Mass rape has often been used as a war tactic to erode individual relations and community and family structures. Increased psychological trauma, unwanted pregnancies from rape and high-risk abortion practices severely impact women's reproductive health. Due to lack of funds, Governments and social policies have failed to address the ramifications of poor planning, management and pre-existing cultural norms. Finally, economic sectors suffer from drained community resources, decreased domestic industries and increased black market activity, as well as increased unemployment, impoverishment and migration. Again, these impacts of conflict disproportionately affect women, whose responsibilities and susceptibilities as caretakers increase domestically and abroad. As such, it is imperative to focus on women in all training initiatives.

In the last decade, many women's NGOs have emerged locally and internationally to respond to post-conflict settings. They have common goals; however, they have diverse structures and strategies to achieve these goals. These include: fostering women's empowerment; applying and sustaining democratic practice efforts; initiating inter-ethnic trust in community projects; establishing coalitions and partnerships between civil society groups; becoming involved in reproductive health activities; fostering new political venues for women's involvement; utilizing media for health-promotion programmes; supporting NGO networks and collaborations; strengthening newly established women's grass-roots organizations; and improving communication among all

parties, including national and international agencies, Governments, NGOs and the private sector.

Multiple strategies are employed by women's NGOs, including: empowerment through health education, legal literacy seminars, workshops on policy-making and political participation, training on women's entrepreneurship, the application of action-oriented research methodology, tools-development for monitoring and social auditing, and the production and dissemination of information on relevant concerns of women. Other strategies involve the organization of discussion forums; training seminars for men and women on reconciliation and trust-building; programme development that includes psychological support for victims of violence; formation of alliances with media sources to promote women's issues; organization of round-tables and conferences; increased and improved research on gender-based violence; promotion of women's health initiatives; and identification and improvement of community support for reproductive health services.

Finally, additional strategies for NGOs involve the support of grass-roots women's groups; examination of new legislation and policies; the monitoring of Governments' accountability on gender-mainstreaming; ensuring the reporting of women's human rights violations; and the implementation and monitoring of United Nations Resolution 1325 to ensure women's equal participation in peace negotiations.

Women's NGOs' projects are financed by the international community and are supported primarily by individual Governments. This arrangement provides multiple challenges and constraints to programme implementation. These include the absence of established NGO legislation, poor levels of internal organization, problematic communication with Governments and local authorities, lack of knowledge and tools for empirical project implementation, diminished funds and subsequent antagonism among NGOs, lack of NGO collaboration and coalitions, and inadequate national and international outreach for efficient responses to conflict.

Despite these constraints, women's NGOs are transforming conflict response by initiating changes in community perceptions. Women's NGOs are also reinforcing equitable structural changes for communities and families. Multiple entry-points are used as venues to promote peace and tolerance instead of violence and discrimination. These include the following:

- Targeting men and boys for active participation in promoting equitable values;
- Establishing a quota system to ensure adequate representation of women in leadership;
- Promoting democratic practices and policies;

- Establishing and promoting landmark dates to mobilize public health initiatives;
- Providing continual education on conflict reconciliation; and
- Ensuring direct medical and psychological services in reproductive health programmes, especially for survivors of violence.

WORKING GROUP REPORTS

Working Groups were charged with providing specific recommendations for strategies to be pursued, especially by UNFPA, to support the empowerment of women in conflict situations. Based on its discussions, each Working Group produced a report to address the effects of conflict on women and girls. The four topics that were examined in conflict and post-conflict situations are: reproductive health, gender-based violence, peacekeeping operations and women's NGOs.

Report of Working Group One: Reproductive Health

Introduction

Conflict affects the reproductive health of women, men, and adolescents in myriad ways. UNFPA has a moral imperative to ensure practical public health service provision by providing sustainable reproductive health services and being held accountable for those services. Reproductive health needs must be addressed comprehensively in pre-conflict, conflict and post-conflict settings. In addition, the human rights of girls and women must be addressed throughout the life span for adolescents, the elderly and other vulnerable demographic groups. Specifically, the development of life skills training to help adolescents build responsible adolescent behaviour must be provided.

Male involvement must be addressed and integrated to support and foster improved public health outcomes for all. This includes establishing links to education, empowerment, income generation, and improved access to resources by building on community resilience and residual capacities of women.

Culture and ethnicity must be acknowledged, respected and integrated into development activities. Services and care must be provided through equal and equitable methods. Finally, community participation and partnerships between NGOs must be fostered and sustained through proactive advocacy for common goals.

Recommendations for United Nations Organizations and Agencies

The implementation of the Minimum Initial Services Package (MISP) (Annex 5) should be ensured, in accordance with *Reproductive Health in Refugee Settings: An Inter-Agency Field Manual* (New York: UNHCR, UNFPA, 1999).

Specifically, United Nations organizations and agencies should undertake the following:

1) Advocate for reproductive health services with all stakeholders, including donors, local leaders, local governments, industries, ministries, religious leaders, United Nations organizations and agencies, the media, educators and NGOs through the following types of actions:

- Identify relevant targets for advocacy;
- Develop best practice examples, e.g., through the publication of case studies for regional use;
- Develop advocacy tools that highlight the public health consequences of the lack of reproductive health services, including financial ramifications, in basic, clear language;
- Advocate to prolong funding periods, specifically through the British Department for International Development, Conflict and Humanitarian Affairs Department (DFID-CHAD), European Community Humanitarian Office (ECHO) and the United Nations High Commissioner for Refugees (UNHCR);
- Ensure the continued inclusion of UNFPA in the Emergencies Group, Office Coordinator of Human Affairs (OCHA) and consolidated appeals process;
- Promote Days of Peace for reproductive health activities, for example, STIs- and HIV-prevention, family planning;
- Continue support for a dedicated media and information officer in Humanitarian Response Group;
- Develop policy in support of the reproductive health needs of the elderly;
- Compile demographic data, specifically estimates and projections, to develop accurate information (as possible) to inform advocacy; and
- Establish ongoing collaborations with government officials and local leaders to advocate for reproductive health programmes.

2) Provide technical assistance on best practices:

- Strive for 50 per cent women participants in training;
- Give preference to staff of UNFPA's NGO partners;
- Promote use of the *Inter-agency Field Manual* to guide programmes;
- Facilitate the inclusion of reproductive health training in emergency-focused master's-level public health courses, and list universities offering such courses;
- Support a minimum of two courses annually to train reproductive health specialists and health providers to work in emergency settings;
- Support a minimum of two courses annually to inform UNFPA national staff about reproductive health issues, including ongoing use of emergency reproductive health kits;
- Identify agencies capable of providing reproductive health training, as determined by need;
- Convene annual meeting of educators to review and update training materials;
- Establish training in psychosocial support and counselling in response to trauma, specifically for traumatized clients and staff;
- Guide the development of proposals that incorporate monitoring, implementation protocols and evaluation in project design;
- Contract with specific agencies for training for set periods of time to develop local capacity;
- Adapt standardized training materials to be applied locally (materials such as the IAWG Manual and the Reproductive Health for Refugees Committee's five-day training manual can be downloaded from the Internet) (Annex 4, Resource List);
- Include reproductive health in the primary health care training of local settings; and

- Foster local capacity for the delivery of reproductive health in emergencies.

3) Support, in a timely manner, the position of a reproductive health coordinator, who would, among other things, do the following:

- Establish a roster of suitable contacts and consultants, national and international, for United Nations organizations and agencies;
- Convene regular inter-agency reproductive health meetings for the collection and sharing of information;
- Collect and share information, including assessments, monthly service provision statistics, and situation analyses;
- Monitor coverage, identify and fill gaps in coverage;
- Advocate and monitor use of the standard protocols field manual;
- Coordinate reproductive health within local primary health care training;
- Liaise with agencies regarding reproductive health logistics;
- Employ a support team, including a health information coordinator, a medical logistician, an administrative assistant and a grants manager;
- Manage an operational budget;
- Liaise with the World Food Programme (WFP) and UNICEF regarding the nutrition of women and girls;
- Coordinate mental health referral networks; and
- Link up with all military groups and peacekeeping forces to provide information and services, and to protect the reproductive health of both refugee and host populations.

4) Provide reproductive supplies and equipment:

- Pre-position UNFPA Reproductive Health Kit for Emergency Situations;
- Negotiate space for reproductive health supplies on relief convoys;
- Support the position of a medical logistician in refugee settings;
- Track reproductive health supplies already positioned in-country and local sources of support; and
- Provide additional supplies as needed, such as locally appropriate sanitary hygiene supplies and underwear, and consider local suppliers of these products.

5) Support agencies that deliver reproductive health services:

- Ensure comprehensive coverage, geographically and ethnically, in regard to elderly populations, and other vulnerable groups;
- Encourage international NGOs to partner with local NGOs to facilitate multilevel sustainability;
- Facilitate cross-national staffing via United Nations Volunteers, Government-to-Government, and other links
- Ensure culturally appropriate information, education and communication (IEC) as a part of service delivery;
- Fund projects over extended periods of time, preferably two or more years; and
- Ensure, In emergencies, that UNFPA funds cover salaries and renovation of health facilities.

6) Monitor:

- Quality of care, specifically, health facility staffing levels, supervision, supplies, etc.;
- Coverage, for example, the number of trained reproductive health providers per population and the number of reproductive health facilities per population, including among dispersed populations;

- Utilization of services, such as the number of antenatal visits, the number of births attended by trained assistants, and condom distribution;
- Impact indicators such as maternal mortality, crude birth rates; and
- The inclusion of reproductive health data in the health information system, such as standard indicators as outlined in Chapter 9 of the *Inter-agency Field Manual*.

Report of Working Group Two: Gender-Based Violence – Trafficking, Domestic Violence and Sexual Violence

Introduction

Gender-based violence is an umbrella term for any harm that is perpetrated on a person against her/his will; that has a negative impact on the physical and/or psychological health, development and identity of the person. It is the result of power relationships determined by the social roles ascribed to males and females. Due to the subordinate status of females worldwide, gender-based violence almost always, and across all cultures, disparately impacts women and girls. In periods of conflict, women and girls, who typically constitute the majority of refugee and internally displaced populations, may be at even greater risk of gender-based abuses. Some of the major forms of violence recognized in the United Nations Declaration on the Elimination of All Forms of Violence Against Women include: battering; sexual abuse; marital rape; female genital mutilation and other traditional practices harmful to women; non-spousal violence; 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.

Recent events on the international stage have brought gender-based violence in refugee, internal displacement and post-conflict situations to the forefront of public awareness. There has been an increasing recognition among humanitarian aid organizations that gender-based violence is an affront to public health, to universally accepted human rights guarantees and to the restoration of refugee and internally displaced families and communities. Nevertheless, field tools to facilitate activities to prevent or respond to gender-based violence are limited, as is the capacity of the humanitarian community to address gender-based violence comprehensively in conflict and post-conflict settings. There are no standard methods for evaluating international and local NGOs' programmatic effectiveness, and scant data are available about the prevalence of gender-based violence or about best practices for quantitatively and qualitatively assessing the problem. Attention to many aspects of gender-based violence is needed, including research on the nature and scope of the problem, the creation and maintenance of services for gender-based violence survivors, and education and prevention.

Recommendations

The Working Group identified general strategies to address three types of gender-based violence: trafficking, domestic violence and sexual violence. These include data and research, advocacy, training and education, direct services, and cross-cutting issues. The Group's recommendations follow.

1) Data and Research:

Problem:

- Insufficiency of data and research on gender-based violence, in conflict and post-conflict settings, that identifies both the demographic and the social characteristics of populations at risk, as well as determinants, consequences and appropriate responses to gender-based violence.

Actions:

- Assess existing data and identify data gaps;
- Support and improve the collection and analysis of qualitative and quantitative data;
- Support data dissemination and sharing across sectors and hierarchies;
- Support research studies to enhance understanding of determinants and consequences of gender-based violence, including HIV/AIDS;
- Support relevant ministries in the process of national data collection on the prevalence and incidence of, and response to, gender-based violence;
- Develop protocol for the collection and evaluation of data at the service-delivery level, with special attention given to confidentiality and disaggregation by sex; and
- Include questions on gender-based violence in all UNFPA-supported demographic and health surveys.

2) Advocacy:

Problem:

- Insufficient national policies and programmes.

Actions:

- In conflict and post-conflict settings, initiate and guide dialogue and collaborative efforts with all concerned bodies, including relevant United Nations Theme Groups, and governmental and non-governmental agencies at local, national, and regional levels, using workshops, focus groups, and meetings;
- Involve victims of gender-based violence and local NGOs in all advocacy efforts, for example, through speakers' bureaus;
- Support dialogue with local and national authorities and media on gender-based violence sensitization;
- Support the design and revision of laws for more appropriate protection from and prevention of gender-based violence;
- Advocate for support of stringent laws against trafficking and the sex trade in transit and receiving countries;
- Advocate for alternative penalties for perpetrators where laws are not applied or do not exist, specifically in refugee and internally displaced settings;
- Support the creation and implementation of institutional policies addressing sexual harassment in all United Nations, international and governmental institutions, and in international and local NGOs;
- Advocate for increased representation of women in security and police forces, and the promotion of gender-sensitive IEC, within and among security protection sectors;
- Advocate for special police units that specifically address trafficking, domestic violence and sexual assault; and
- Advocate for long-term financial support to local NGOs that provide gender-based violence services, to facilitate the transition from emergency to development programming.

3) Training and Education:

Problems:

- Lack of knowledge of the determinants and consequences of gender-based violence; and
- Lack of adequate formal and informal training curricula on gender-based violence.

Actions:

- Develop modules and support gender training for all United Nations organizations and agencies, international NGOs and government agencies;
- Develop modules on codes of conduct, and support training for youth on sexual education, to include safety guidelines and conflict resolution, among others;
- Use established peer education programmes against gender-based violence to increase awareness of impact on reproductive health;
- Develop modules on codes of conduct and support training for security and police personnel at international, regional and national levels;
- Adapt and/or develop modules, and support training for survivors, to include safety guidelines, impact of gender-based violence, and treatment information;
- Adapt and/or develop modules and support training of trainers for selected health-care providers and social service workers, forensic doctors and psychologists, to include gender-based violence-related counselling techniques, medical management and referral information;
- Design and distribute targeted IEC materials on gender-based violence for the public, policy makers, health-care providers, social workers, police and teachers;

- Support, for perpetrators of gender-based violence, programmes that address conflict management and behaviour change;
- Design and implement training for local NGOs providing gender-based violence services that include technical and administrative skills-building; and
- Facilitate coordination of local and international NGOs through networking publications, such as service maps.

4) Direct Services:

Problem:

- Lack of comprehensive services to meet the health and psychosocial needs of populations affected by gender-based violence.

Actions:

- Provide universal access to affordable, standardized health services for survivors, including broad-based reproductive health and forensic evidence collection;
- Ensure access to follow-up services for repatriated women and children who are victims of trafficking and support local authorities in this effort;
- Promote hotlines, shelters, and the provision of legal services for providers; consider the development of shelters for perpetrators;
- Support community-based psychosocial programmes that include individual and family counselling, case management and referral;
- Ensure outreach efforts to vulnerable or difficult-to-access and disadvantaged populations through strategies such as home visits; and
- Provide voluntary and free testing for STIs, including HIV.

5) Cross-cutting Issues:

- Consider, when developing programmes on sexual and gender-based violence, the special needs of vulnerable groups, particularly internally displaced persons (IDPs) and refugees;
- Develop MISP and appropriate indicators to formulate, monitor, implement and evaluate programmes continually on sexual and gender-based violence;
- Include men in all gender-based violence prevention and response activities;
- Include survivors in all gender-based violence prevention and response activities; and
- Support long-term local initiatives.

Report of Working Group Three: The Impact of Peacekeeping Operations on Women and Girls

Introduction

The following issues were considered regarding the complexities of the presence of peacekeeping organizations in conflict settings and the subsequent public health effects on women and girls. Issues raised were based on general recommendations, which included implementing gender-sensitization programmes in peacekeeping situations; appointing gender focal points in peacekeeping missions; gathering gender-disaggregated data; and improving cooperation among United Nations organizations and agencies.

United Nations Resolution 1325 supports:

- The incorporation of a gender perspective into peacekeeping operations and urges the Secretary General to ensure that, where appropriate, field operations include a gender component;
- The Secretary-General is seeking to expand the role and contribution of women in United Nations field-based operations, especially among military observers, civilian police, and human rights and humanitarian personnel.

The primary principle emphasized in the following recommendations recognizes that working with peacekeeping organizations is an arena for positive change. It is an opportunity to introduce and exemplify United Nations values through its missions, particularly via gender-sensitive principles that are not readily or consistently embodied in practice. It also serves as a point from which to prevent further detriment to public health in post-conflict settings, and to reinforce United Nations accountability through all of its bodies and activities. The following presents the context of peacekeeping operations, identification of the general problems associated with them and positive opportunities for interventions at global and local levels.

Context of Peacekeeping Operations

In many post-conflict settings, a variety of adverse health outcomes exists for women and girls. Poverty, disrupted economic structures and high levels of unemployment result in the severe economic vulnerability of households and individuals and in high proportions of female-headed households, in particular. The damage to multiple levels of infrastructure, such as transportation, sanitation, service and communications, has negative impacts on the health of the public. In addition, the damage to social services, health facilities and other provisions results in compromised health outcomes. Access to health and social

service facilities can be extremely difficult. Communities are disrupted, civilians are internally displaced and family separations are common, all of which contribute to personal and familial insecurity. Finally, the effects of conflict are compounded, which results in entire populations experiencing various levels of trauma.

In post-conflict settings, the sudden entry of money and foreigners, and specifically peacekeeping organizations, heightens an already precarious situation for refugee and host populations. First, most peacekeeping personnel are men between 20 and 50 years of age. They represent a range of countries, cultures, health and education statuses, and, consequently, expectations for behaviour and conduct. Their presence results in an increased demand for housing, which can, in turn, increase housing costs and decrease the availability of homes for civilian populations. An increased demand for various services and black-market goods has profound effects on the local economy and labour market. The demand for commercial sex increases sharply in settings with peacekeeping organizations, and this has serious social and health implications, particularly for women and girls. In addition, price increases due to a rapid influx of money may increase the vulnerability of the poor. Along these lines, the introduction of new technologies and economies can influence local culture in diverse, and not always positive, ways. Finally, national demobilization and reintegration may accompany the presence of peacekeeping organizations, contributing to a social and cultural erosion that undermines community rehabilitation.

The Group identified and discussed legal and judicial concerns related to peacekeeping operations. First, the accountability of peacekeeping forces is not easy to establish. It is unclear whether standard rules of conduct for the peacekeepers exist and, if they do, whether these rules can be effectively enforced. Second, for peacekeeping forces where codes of conduct have already been established, their gender implications are unclear. In addition, the host population may be unaware of the rules and regulations governing the mission. Finally, law enforcement mechanisms vary on the territories controlled by peacekeeping forces, in terms of women police, ombudsmen and legal counsellors. More effort must be made to understand and potentially collaborate with these elements.

The Group also explored socio-economic and health concerns related to peacekeeping operations. First, the establishment of formal and informal employment of local people by mission members may be exploitative and discriminatory. Such employment, however, may also contribute to improving the economy and the well-being of individual women. Second, the influx of large numbers of men in host populations has reproductive and sexual health implications. As mentioned, the increase in commercial sex activities accompanying military operations has serious health and social consequences for civilian populations. Finally, traditional lifestyles and the behaviour of different

population groups can be disrupted and adversely affected by the presence of peacekeeping troops.

Recommendations

1) Global institutional arrangements and standards-setting, initiated by and addressed predominantly through UNFPA-funded organizations, Departments of Peace-keeping Operations (DPKOs), United Nations organizations and agencies and other donors. The relevant entities are specified directly following each recommendation.

- UNFPA should establish a Memorandum of Understanding with DPKOs to ensure adequate reflection of population and gender concerns in peacekeeping operations. Among other issues, the Memorandum of Understanding should ensure that peacekeeping missions are provided with an expanded scope of essential reproductive health commodities, extending beyond the regular provision of condoms;
- Gender and population issues must be adequately reflected in training of trainers programmes for the DPKO staff (UNIFEM);
- Standard arrangements for cooperation between peacekeeping missions and the United Nations development and humanitarian community should be established, with full participation of UNFPA. Additionally, UNFPA should ensure adequate priority for population and gender concerns in all respective initiatives (Resident Coordinator/OCHA, Secretary-General, Gender Adviser);
- There should be advocacy for the reflection of gender concerns in Security Council and other United Nations resolutions that establish peacekeeping missions (Security Council/UNIFEM);
- There should be advocacy for a review of established codes of conduct to determine whether they are: sufficient, applied and enforced. Following this, a determination should be made as to whether the codes can be revised to reflect a gender-mainstreaming protocol;
- UNFPA should advocate for the increased participation of women as international staff at all peacekeeping mission levels;
- An analysis of women's concerns within peacekeeping operations should be conducted to establish reasons for women's non-

participation in missions and direct areas for improvement and support;

- Support should be provided for the institutionalization of a gender adviser post in each peacekeeping mission. The post should be established at a level appropriate to ensure solid and consistent consideration of gender issues in policy and operations (UNIFEM);
- The operations budget of peacekeeping missions should include provisions for required personnel and activities to support gender-related interventions (Security Council, Secretary-General, Gender Adviser); and
- An information package on the mandate, anticipated scope of interventions, and structure and division of responsibilities within each peacekeeping mission should be provided immediately upon the initiation of operations to all implementing partners (Resident Coordinator, other agencies).

2) Ground-level interventions targeted at the peacekeeping forces, initiated by and addressed predominantly through UNFPA-funded organizations, other United Nations organizations and agencies and other donors. The relevant entities are specified directly following each recommendation.

- Vulnerability analysis should be a mandatory process to identify entry points for action and to guide programming (Resident Coordinator);
- Information and training in gender, reproductive health and population issues, including HIV/AIDS, must be provided through regular training programmes in all peacekeeping operations on a routine and ongoing basis. Additionally, all programmes should underscore that peacekeeping forces should be regarded as community role models. It is important that all United Nations groups reflect established United Nations principles of equality and responsibility (UNIFEM);
- Gender, reproductive health and population issues should be adequately reflected in all communication and information-dissemination activities initiated by the peacekeeping operations (UNIFEM);

- Implementation, monitoring and enforcement of the peacekeeper “code of conduct” should be ensured (Resident Coordinator /UNIFEM /Office of the High Commissioner of Human Rights).
- DPKO medical facilities must provide the required reproductive health services and commodities, including counselling, male and female condoms, diagnostics for STIs and HIV/AIDS, and drugs for STI treatment for men and women (UNAIDS);
- Employment standards of the mission, as well as its members with national and individual entities, must correspond with International Labour Organization requirements (Resident Coordinator, International Labour Organization, UNIFEM).
- The peacekeeping mission must function synergistically with the United Nations Resident Coordinator system and be part of relevant Theme Groups and Task Forces, such as the Gender Theme Group (Resident Coordinator).

3) Interventions to reduce the vulnerability of the host community, with special attention to women, initiated by and addressed predominantly through UNFPA-supported organizations, DPKOs, United Nations organizations and agencies, and other donors. The relevant entities are specified directly following each recommendation.

- Public awareness should be strengthened through the provision of information on legal and human rights, particularly those related to employment, health, education, social protection and housing. Advantage should be taken of mission radio programming in local languages to reach many groups of people with important messages (all agencies);
- Women’s participation in civil society and governance should be stimulated through the provision of NGO support and capacity-building. Note: sustainability is not a primary criterion for support (all agencies, especially UNICEF and UNHCR);
- Peacekeeping missions and Resident Coordinator systems should support the establishment of a formal consultative mechanism to further women’s involvement in decision-making and community life planning during emergency, reconstruction and rehabilitation phases (all agencies);
- The effect of conflict on men and boys can be dramatic, and loss of community status can result in the adoption of negative behaviour.

Vulnerability analysis should identify specific opportunities to increase male involvement and initiate relevant programming by all agencies concerned (all agencies);

- UNFPA should support mechanisms to provide information, education and social rehabilitation for women, families and girls in host communities, such as multipurpose centres (UNHCR);
- Reproductive health and counselling services should be further strengthened to meet increased demands (UNFPA);
- Income generation for vulnerable groups, such as female-headed households, widows, orphans, and war-disabled and sexual violence survivors, should be an integrated part of UNFPA post-conflict relief programming; and
- Programmes that enable sex workers to protect, maintain and improve their reproductive health and reduce their vulnerability to sexual violence should be established or strengthened.

Report of Working Group Four: The Role of NGOs in Post-Conflict Situations for Women and Girls

Introduction

During the last decade, NGOs and other civil-society entities have made significant advances in shaping the global agenda for democratization, development and peace. Women's NGOs have played an especially important role in mainstreaming gender in the outcomes of the United Nations global conferences of the 1990s. They have promoted at all levels women's human rights, family reform legislation, reproductive rights and the end of violence against women. NGOs have also played significant roles in highlighting the adverse consequences of globalization on the quality of life, particularly for vulnerable groups such as women and children. Their vision, organizational flexibility, independence and wide outreach continue to make NGOs major partners for international organizations and bilateral donors.

The last two decades have been a period of increased conflicts and emergencies. NGOs, and increasingly women's NGOs, have been at the forefront of the aid community as it deals with emergencies created by these conflicts. As such, they are well placed to participate in all processes of conflict resolution and peace-building.

In response to emergency situations, NGOs should be involved in needs assessment, service delivery, outreach, human rights advocacy, information dissemination and community feedback. Women's NGOs, in particular, need to be visibly involved to highlight issues of women and girls, whose culturally based gender roles often determine their needs. This is typically overlooked in emergency situations, especially if local and international male agency staffs marginalize women by interacting solely with other male leaders and counterparts.

Even with the experience gained during decades of addressing conflict situations and emergencies, NGOs urgently need to strengthen their capacity to meet challenges of the changing international context, which is characterized by increasing violence, terrorism and nuclear threats.

Given the critical needs of emergency situations in the world, NGOs should be strongly encouraged and supported to adopt preventive and pre-conflict approaches, in addition to wartime and post-conflict interventions for women and girls. For example, such approaches could involve providing education on sexual and gender-based violence and related issues to armed forces and police forces in peacetime. Financial and technical support of NGOs

by UNFPA and other international organizations is critical for building their capacity and ensuring the sustainability of their work.

The following recommendations are directed at initiatives of local NGOs, though certain ones are also applicable to international NGOs. Additional relevant key entities are specified, as applicable.

Recommendations

1) Capacity-building: Capacity-building can be initiated and addressed predominantly through UNFPA-funded training organizations, umbrella grant providers, United Nations organizations and agencies, and other donors. Such organizations can:

- Provide training for local organizations, particularly those run by women, in strategic planning, programme development, organizational and operational management (i.e., financial, logistical, planning, monitoring and evaluation, and accountability);
- In conjunction with the provision of technical assistance, promote advocacy for greater attention to reproductive health issues among NGOs that already provide related services. Such a process should target NGOs run by women and especially those run by men, because men have broader community access in insecure conditions but may have less awareness of the importance of reproductive health issues. These issues can also be addressed through the work of advocacy and networking NGOs;
- Provide assistance to local NGOs to ensure gender-mainstreaming, such as supporting gender-sensitization training and performing gender audits. This assistance would improve the services provided and enhance sustainability in activities with women and girls;
- Support infrastructure and logistics for mobility and equipment, especially data processing and information technology. This should be done to consider the needs of vulnerable groups, such as women in insecure locations and staff with disabilities;
- Build capacity through the use of information technology. NGOs can make links to information available through the Internet, which, in turn, would allow them to network with other organizations conducting similar activities. Organizations can also encourage the use of the World Wide Web as a powerful advocacy tool. Training organizations funded by both UNFPA and donors can work to meet this objective;

- Build advocacy skills, networking and media relations to allow organizations near the grass-roots level to disseminate information on reproductive health issues. Training organizations supported by UNFPA and donors can work to meet this objective;
- Draw on lessons learned to strengthen NGO working environments, with special attention to the security and safety of personnel. This is specifically important for female staff, as they are often primary targets during insecure periods and do not have guaranteed security in post-conflict situations. This task can be coordinated by UNFPA, donors and NGOs.
- Develop common approaches and strategies to obtain timely financial support for operational activities, including emergency needs. This should include mechanisms and provisions to enhance the transparency and accountability of all stakeholders; and
- Take steps, in line with United Nations Security Council Resolution 1325 on Women, Peace and Security, to build and support women's leadership skills and develop their leadership potential.

2) Sustainability: When determining partnerships with local NGOs, UNFPA, donors and umbrella grant providers can initiate and address the following recommendations. Although UNFPA should continue to support NGO sustainability, they should also encourage NGOs to develop their own sustainability. In doing so, however, international organizations should consider the following:

- In conflict situations, UNFPA and NGOs should give priority to NGOs that provide quality services and effective outreach to women and girls. These are often NGOs that are run and staffed by women;
- NGOs must develop their mission statements to ensure that a gender framework is used to provide and maintain services, especially those to women and girls. They should develop and sustain adaptability and flexibility to respond effectively to emerging needs;
- UNFPA should develop a roster of NGOs that have proven experience and accountability in reproductive health and gender issues, especially those applied in emergency situations. New NGOs that demonstrate promise in these areas may need assistance in capacity-building, support for which should also be considered;

- NGOs must focus on mission statements and prioritize long-term programme planning to achieve sustainability without undermining immediate emergency-phase activities;
- NGOs should explore and use multiple opportunities to generate resources, including: social marketing; peer education; training; IEC materials; and the sharing of programmes or projects. They should pursue development at local and NGO levels;
- To ensure the sustainability of relevant and timely services to women and girls, participation and support for local women's groups and organizations should be emphasized;
- NGOs should develop partnerships with both local and international NGOs, Governments and the private sector to achieve sustainability in their programmes;
- To enhance sustainability, NGOs should offer quality and timely services in a fully accountable manner. Educating clients and creating demand for services are essential to this process; and
- The transfer of knowledge, skills and experience to the community should be a fundamental goal of NGOs, with emphasis on women as the prime "educators" in families and communities. (United Nations agencies, UNFPA, other donors, umbrella grant providers, NGOs).

3) Coordination and cooperation: Coordinating bodies and umbrella grant providers should encourage and support NGOs to:

- Ensure coordination, cooperation and elaboration of programmes that are people-oriented and gender-sensitive;
- Promote networking to facilitate effective coordination and cooperation;
- Build coalitions and partnerships as fundamental operating strategies to achieve reproductive health goals, as well as gender equality and equity;
- The value of new partnership developments with NGOs should be acknowledged by UNFPA as a means to achieving quality programmes and effective outreach (donors may also contribute to this process);
- Use all appropriate channels for information exchange with stakeholders;

- Coordinate and promote cooperation among NGOs to facilitate monitoring and utilization of the MISP;
- Increase community participation in coordination and cooperation through community leaders, particularly women leaders, and other means;
- Develop a security agenda to improve safety in the work environment and security in the operating environment. This is especially important for female staff and various ethnic groups; and
- Encourage information exchanges and partnership development among NGOs in pre- and post-conflict settings, to ensure that lessons learned are integrated in all subsequent programming.

CLOSING SESSION

In the closing session of the consultative meeting, participants endorsed the recommendations of the four Working Groups.

UNFPA officers gratefully acknowledged the work of the participants and closed the meeting.

PART II. BACKGROUND PAPERS

THE IMPACT OF CONFLICT ON REPRODUCTIVE HEALTH

Samantha Guy
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“In planning and implementing refugee assistance activities, special attention should be given to the specific needs of refugee women and refugee children. Refugees should be provided with access to adequate accommodation, education, health services, including family planning, and other necessary social services.”

--*Programme of Action*, International Conference on Population and Development, Cairo, September 1994, paragraph 10.25.

Reproductive and sexual rights fit into binding human rights treaties, recognized in national and international laws. Although the ICPD Programme of Action is not legally binding, later international conferences have reinforced the ICPD consensus on sexual and reproductive health rights.

Reproductive health care is a vital component of public health. Yet, only recently has the international community begun to make reproductive health services available as part of the response to conflict or natural disaster. In addition to the public health imperative, reproductive health care becomes even more important in refugee settings, where a combination of factors exacerbates reproductive health needs.

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Reproductive health entails much more than the skeleton maternal and child health services provided in many refugee settings. An effective programme of reproductive health care is sensitive to the different needs of men and women, of various ethnic and cultural groups, and of various age groups. It must be accessible and available to single women, widows, older women, adolescents and men.

Civilians rather than the military are increasingly singled out for attack in the growing number of wars within and between nations. Women and children are particularly vulnerable. Although refugee figures are unreliable, there are at least 35 million displaced people in the world today.¹ One in four is a woman of reproductive age. Most of these women lack access to the most basic reproductive health care.

The lack of quality reproductive health services can lead to high mortality rates among women and children, an increase in the spread of sexually transmitted infections (STIs), including HIV/AIDS, an increase in unsafe abortions, and increased morbidity related to high fertility rates and poor birth-spacing.

The Programme of Action of the 1994 ICPD provides a detailed definition of reproductive health. The Inter-agency Working Group on Reproductive Health in Refugee Situations (IAWG) describes reproductive health in refugee settings as comprising: family planning, safe motherhood and emergency obstetrics, the prevention of and response to sexual and gender-based violence, and the prevention and treatment of STIs, including HIV/AIDS.

Cross-cutting Themes

Gender, human rights and poverty are universal themes. Conflict and displacement impact on these areas, creating a number of new factors which need to be considered, particularly when providing reproductive health services. Just as women, men and adolescents need targeted reproductive health interventions during peacetime, so do they during conflict. In addition, consideration should be given to the particular impact that conflict and displacement have on the differing requirements of these target groups.

Gender

The word "gender" is used to describe those characteristics of men and women that are socially constructed, in contrast to those that are biologically determined. In applying a gender approach to health, the World Health Organization (WHO) goes beyond describing women and women's health in

¹ UNFPA, *State of World Population 2000* (New York, UNFPA, 2000).

isolation and brings into the analysis the differences between women and men. A gender approach examines how these differences determine differential exposure to risk, access to the benefits of technology and health care, rights and responsibilities, and control over one's life.

The importance of a gender approach in programme planning and development is increasingly being recognized. Yet, there is still a strong tendency to neglect gender roles and relationships in emergency situations. This can lead to women, adolescents or marginalized groups becoming more rather than less vulnerable as a result of humanitarian responses. If the humanitarian response is truly to benefit all sections of a community, and if reproductive health services are successfully to meet the needs of all, a gender approach is needed during each phase of conflict and displacement. This means not only paying attention to the needs of women but also examining the relationships between women and men, the structure of society and the impact that conflict has on the roles of groups within that society. Under conditions of conflict, for instance, women may have to assume more responsibility for what were traditionally male activities, children may be expected to emulate the behaviour of adults, and girls may have to assume roles that make them more vulnerable to sexual harassment or that inhibit their development.

It is vital to explore how gender relationships change as a result of conflict or displacement. This experience can have a marked impact on the attitudes of men and women towards all aspects of reproductive health, such as family planning, motherhood, extramarital sex and sexual violence.

"The holding up of women as symbolic bearers of caste, ethnic or national identity can expose them to the risk of attack. The widespread occurrence of rape in times of conflict has been seen as directly related to the position of women in communities as bearers of cultural identity. The rape of women in conflict situations is intended not only as violence against women, but as an act of aggression against a nation or community."²

Human Rights

Reproductive rights embrace certain human rights that are already recognized in national laws, international laws, international human rights documents and other consensus documents. All human rights violations during conflict and displacement, including acts of gender-based and sexual violence, must be documented, reported and prosecuted.

In May 1993, Marie Stopes International (MSI) implemented an emergency programme of psychological support for displaced, refugee and war-

² B. Byrne, *Gender, Conflict and Development, Volume I: Overview* (Brighton, Institute of Development Studies, 1995).

affected women in Bosnia and Croatia. The programme provided psychological, educational and health-care support through a well-established network of women's centres and groups, as well as IEC activities, including radio programmes and publications. The MSI/Stope Nade projects continually expanded the advocacy and advisory component of the programme, providing advice and support on a wide range of refugee-related difficulties and social issues, including violence and human and legal rights. Local experts in Bosnia and Croatia provided all advice and information, making the information as culturally appropriate as possible.

It was also important for the project to link up with legal aid agencies and specialist human/legal rights advocacy agencies to ensure the proper documentation of cases as well as a strong support network empowering women to make informed choices about their lives. Not only did this component of the programme expand but it also evolved; information on legal and human rights issues increased to meet the changing needs of the host and returnee populations.

Gender, Conflict and Poverty

Poverty is a cause and a consequence of conflict. About 1.3 billion people, nearly a quarter of the world's population, live in extreme poverty, surviving on less than \$US 1 a day. Of these, 70 per cent are women. They lack, among other things, education and health provision. Men have more freedom to seek employment and escape poverty. Women are frequently left behind to look after the children, and they remain in the poverty cycle. The "feminization" of poverty has aggravated social, gender and economic imbalances in the developing world. Women also bear the brunt of ill-health.

The links between poverty alleviation and reproductive rights are now well established. If women have access to reproductive health information and services, they can:

- Take control of their fertility and break the cycle of repeated pregnancies, enabling them to seek employment or training and increase family income;
- Improve their own health and the survival rates of their children; and
- Protect themselves against STIs, including HIV/AIDS, and work towards empowerment and gender equality.

As economic situations worsen, it is imperative that reproductive health services remain available and accessible to all women. Services should be free or provided at subsidized rates if the health of refugee communities is not to decline further.

Target Groups

Women

Women and children make up four fifths of the world's refugees and internally displaced people. Yet, only recently has attention been focused on the particular needs and circumstances of women refugees.

Women play a key role in economic, social and family life. Women are most affected by reproductive health problems. For refugee women, who often become sole heads of households, this burden is compounded by the precariousness of their situation. It is imperative that a lack of comprehensive reproductive health services does not add to the suffering of refugee women. Investing in women's reproductive health has a positive effect on the entire community, as women are often the sole carers for extended family units, including children and elders.

People who are forced to flee are, for the most part, from countries with poor health and social indicators. Women and children are particularly adversely affected by forced migration; they face unique hardships during flight, including sexual violence and abuse. Once they eventually reach relative safety, they often face the lack of food, water and shelter; sickness and death; and the loss of family and possessions.

With conflict comes loss of income, home, families and social support, depriving women and girls of security and income. As a consequence, they may be forced into transactional sex to secure their lives or those of their families, escape to safety or gain access to shelter or services, including the distribution of food and services.

Young people

Young people, whether female or male, are an especially underserved group within refugee populations. At a critical time in their development – the transition from childhood to adulthood – young refugees lose their role models; friends; family; their cultural and social system; and access to services, including training and education opportunities. It is important to ensure that reproductive health services meet the specific needs of younger and older adolescents, girls and boys.

Young people, particularly young women, are at special risk during forced migration. Young people are at risk from abduction, forced recruitment into armed forces, sexual violence and abuse and increased risk of STIs and HIV/AIDS. Many are forced to head households and care for family members. Their involvement in project planning and implementation is key, and they are a vital part of rehabilitation and reconstruction programmes.

As the MSI/Stoppe Nade programme in Bosnia and Croatia progressed, the needs of young people, particularly young women, were increasingly addressed. Young people had received minimal education and information on reproductive health-care issues during the war. Increasingly Marie Stopes International saw prostitution, alcohol and drug abuse affecting young people.

To ensure that the specific needs of adolescents were met, special days were set aside in the centres as adolescent days. In one area, a centre solely for adolescents was set up, offering a combination of reproductive health-care, primary health-care and educational activities.

Men

The involvement of men is essential for the improved status and empowerment of women as well as for the health of men. Behaviour change for men includes adopting responsible sexual and reproductive behaviour for themselves and supporting women's right to make reproductive choices, including access to the information to make fully informed choices. Many men would like to be part of the solution. Ways must be found to encourage them to take responsibility and to make positive changes towards women's empowerment. Activities could include condom promotion, peer-group sessions and special health facility times for men.

During conflict, men and boys as well as women and girls are vulnerable to sexual violence. It is recognized that there is clear under-reporting among women of the incidence of sexual violence, less is known about the incidence of violence against men and boys, particularly among those in detention.

Men are also subject to STIs. Although reproductive health services have concentrated on the prevention and control of STIs, more needs to be done in conflict settings to reach men.

Involving men can be more difficult in conflict situations partly because of the tendency for the traditional values of manhood to become more entrenched during displacement, when communities fear that cultural values will become eroded. In addition, many male community members will be involved in armed groups, making access to them more difficult.

Approaches

The Defining Features of Reproductive Health Provision in Conflicts

Conflict situations are never identical. The length of displacement varies considerably from short-term emergencies to increasingly long-term development situations. The settings in which refugees find themselves can also vary enormously, from huge camps to integration in an urban or rural setting.

Forced migration presents a number of challenges in the provision of reproductive health services, in addition to the specific issues pertaining to each of the technical areas of reproductive health for refugees, covered in a later section.

Most refugees are from countries where health indicators are already poor. In addition, many people who end up leaving their home country have already been displaced internally or discriminated against prior to flight. Flight from war, civil or ethnic conflict or natural disaster exacerbates existing health problems. In these situations, women, in particular, are vulnerable to sexual violence and abuse. Even once women reach relative safety, conditions still prevail that further contribute to their ill-health: malnutrition and epidemics; an absence of law and order; increased responsibility for households in the absence of male family members; and the breakdown of family structures.

In addition, the highly political nature of complex emergencies can make the provision of reproductive health care an especially sensitive issue. It is, therefore, important to ensure that services reach the host/local population as well as the displaced population. Doing so will not only reduce the possibility of tension between the communities but also make clear that there is no discriminatory dimension in the provision of services.

Health providers have a duty to provide the highest possible level of care to those they serve; reproductive health is a fundamental human right, and it is an abuse of human rights to withhold reproductive health services. Although reproductive health services are a vital part of humanitarian aid, their provision has become so politicized that some health providers are not only failing to provide services themselves but also trying to prevent others from doing so.

The situation of Kosovar refugees in Albania clearly illustrates many of the issues surrounding the provision of reproductive health care in refugee settings. The UNFPA Reproductive Health Kit for Emergency Situations was specifically designed to facilitate the timely and appropriate delivery of reproductive health services in the initial acute phase of an emergency situation and to allow planning for comprehensive services as the situation develops.

These kits were distributed early in the crisis by NGOs, such as MSI and the International Rescue Committee, which also provided reproductive health services in Albania during the conflict, and the Albanian Ministry of Health. This created an outcry among predominantly Catholic critics, potentially delaying the provision of further life-saving services. Certainly, the provision of reproductive health care through primary health-care services was not addressed by the majority of humanitarian organizations. There was much talk among some health agencies of the provision of reproductive health in the “second phase” of activities. Meanwhile, refugees remained without their rightful access to reproductive health-care services.

Humanitarian aid is by no means always provided by organizations taking part in the development of international policy on reproductive health or other issues. Smaller agencies also provide much needed services but are less likely to be aware of policy changes at the international level and may well be unacquainted with vital developments in the field of reproductive health. This has implications for the timely and appropriate provision of reproductive health services.

Cultural, linguistic, economic and religious barriers as well as physical distance play a huge role in the accessibility of reproductive health services to refugee communities, much more so than in the accessibility of primary health-care services. Service providers must take into account, for example, that translators may be required, preferably of the same sex. Same-sex providers are imperative in cases of STIs and sexual violence. Privacy and confidentiality must be ensured, even in the emergency phase.

Appropriate training for staff in all elements of reproductive health care is another imperative, especially if referral facilities do not exist and one agency is providing all components of reproductive health care.

Coordination is an important element in the provision of health services in any situation. In refugee settings, the provision of reproductive health services requires close collaboration with other sectors involved in the provision of care, for example, protection and community services. Although it is anticipated that agencies will provide reproductive health services as part of a broader package of primary health care, one agency may not always be able to implement the full range of reproductive health services. Providing comprehensive services, therefore, requires cooperation and collaboration between agencies.

Access by refugees and IDPs to host community facilities can be restricted. There are a number of reasons for this, including fear of encouraging displaced populations to remain, integration issues as well as retaliation for actions undertaken by community groups. Women can be especially vulnerable to such reprisals when, for example, male community members have been killed or are involved in fighting. Service providers need to be aware of these issues

and take necessary steps to overcome them. This may involve accompanying refugees to health facilities or undertaking advocacy.

In some situations, however, once the emergency phase has passed, refugees often receive better care than local populations do. International aid can be directed at refugees and the needs of local/host populations can be overlooked, often causing tensions between displaced and local communities. It is preferable to support host-country facilities rather than to establish new ones specifically for refugees, which will not be maintained in the long term.

The MSI programmes in Bosnia and Albania not only provided services to refugees, IDPs and host populations but also supported local facilities with training, human resources and supplies during the emergency and return phases of the conflicts.

Impact of Conflict on Technical Areas of Reproductive Health Service Provision

Refugees and IDPs have the same reproductive health needs as non-displaced populations. However, the impact of conflict and displacement imposes a number of additional factors on the reproductive health requirements of displaced populations.

Minimum Initial Services Package. The concept of the Minimum Initial Services Package (MISP) was developed by the Inter-Agency Working Group (IAWG) as a set of activities needed to respond to the reproductive health needs of populations in the early phase of an emergency. MSI was among the NGOs that contributed significantly to the development of the MISP, following its experience with Reproductive Health Kits in the former Yugoslavia.

MISP activities can be implemented at the outset of a crisis without a needs assessment. The MISP calls for a reproductive health coordinator, who can serve as the focal point for all reproductive health activities, coordinate among agencies, interact with government authorities, introduce standard protocols and provide training to personnel as well to the refugee population. Currently, there are not enough people with the technical skills to serve as coordinators, and the right model has not yet been found. With guidance from UNFPA and support from the Belgian Government, a 10-day course was developed to train health-care practitioners and to improve their reproductive health skills.

Among the resources that the MISP identifies for use in an emergency is the WHO New Emergency Health Kit-98 (NEHK-98), which includes supplies for infection control, safe deliveries and management of obstetric emergencies, and treatment for victims of sexual violence. Additionally, UNFPA took the lead in developing a Reproductive Health Kit for Emergency Situations. This kit

complements that of WHO and is based upon kits created by MSI for use in Bosnia. It comprises 12 subkits for use at different health-care levels, among which are subkits of condoms, oral and injectable contraceptives, and drugs for the treatment of STIs. There are also subkits with emergency contraception for women who have been raped and manual vacuum aspiration equipment for the treatment of post-abortion complications.

Family Planning. One question often asked is whether fertility patterns are different within refugee settings. Is the need for family planning likely to be greater, lower or the same for forced migrants? The response to this is contradictory; many say that women do not want to give birth within the insecurity of a refugee setting. Others suggest that men and group leaders may wish women to produce more children to repopulate a community, especially in situations of ethnic cleansing. Published and unpublished studies on fertility, desired family size and contraceptive use reveal a mixed response to childbearing among those affected by war. As in all communities, when refugee women are surveyed about their fertility intentions, some are currently pregnant, some wish to become pregnant, some wish to delay the next pregnancy for some time and some wish to have no more children. It is, therefore, even more important to work with communities to establish appropriate services.³

If family planning services are not available and accessible, women are at increased risk of unwanted, possibly forced pregnancies leading to increased, often unsafe abortions.

The experience of MSI in refugee settings in Bosnia, Kosovo and Sri Lanka, among others, indicates that when family planning services are available and accessible, family planning prevalence increases. In Bosnia, for example, high abortion rates were replaced with increased contraceptive use once the MSI reproductive health kits were distributed. In refugee camps in Albania, high levels of sexual activity were apparent – indeed rotas were being drawn up to give couples one hour of privacy in tents. However, refugee women were adamant that they did not want to get pregnant or bear children in such conditions, but they had no means of controlling their fertility. The need for family planning and other reproductive health services was clear.

Prior to the displacement of refugees from Kosovo, the contraceptive prevalence rate was 30 per cent, much higher than in Albania, where it was only 10 per cent. Kosovar women continued to require a range of reproductive health services during their displacement. Organizations like UNFPA and MSI provided services within camps and through clinic settings to respond to the need.

³ Therese McGinn, "Reproductive Health of War Affected Populations: What Do We Know?" *International Family Planning Perspectives*, December 2000(The Alan Guttmacher Institute).

Refugees must be involved in defining their own needs and in designing and delivering appropriate family planning services. To encourage joint responsibility for contraceptive choice and to maximize the acceptance of family planning programmes within the community, men should be involved in the process.

Ensuring contraceptive choice and supply is important to the provision of family planning methods. The contraceptive preferences of the host country and the availability of contraceptives may vary from the preferences of refugees, and this must be addressed. Quality services are not possible unless an uninterrupted supply of contraceptives is ensured and staff members are appropriately trained. Refugee women and men should have access to safe and affordable family planning services in settings which are culturally appropriate and convenient. Consideration should be given to contraceptive supply and staff competence during the repatriation phase if human rights abuses are to be avoided.

Safe Motherhood and Emergency Obstetrics. Pregnancy and childbirth are recognized health risks for women in developing countries. UNICEF estimates that 15 million women a year suffer long-term, chronic illness and disability because they do not receive the care they need during pregnancy.

These risks are magnified for women living in refugee settings, in which a majority give birth in temporary shelters where conditions are hazardous both for themselves and their children. Many refugee women are already seriously physically weakened as a result of the trauma and deprivation associated with their flight. The poor nutrition and stressful living conditions often associated with camp settings only compound this problem.

Without safe motherhood interventions, many refugee women and their newborns will die needlessly. The consequences of inaction affect the entire refugee community and exacerbate the difficulties and instabilities of refugee life. In refugee settings, a woman is often the main provider for her family. If she dies her family is left without her care, support and protection.

Obstetrics emergencies include haemorrhage, sepsis, eclampsia, obstructed labour and complications of abortion. These symptoms can be exacerbated in refugee settings due to the trauma of flight and life in exile, the often poor sanitary conditions of camp settings and the generally lower levels of health among refugee women.

In Albania, MSI undertook the training of service providers, including government workers, as well as the strengthening of referral links to ensure that refugees in camps as well as those living within the host community had access to safe motherhood and emergency obstetric services.

When MSI reproductive health kits were distributed in Bosnia in 1994, they provided the first reproductive health supplies received by gynaecology units in two years. It is important to assess locally available facilities and plan appropriate interventions.

Female genital mutilation, which can increase in conflict situations as communities return more strongly to traditional practices or seek to integrate with host populations, is also a contributory factor in obstetric complications.

In many refugee settings access to health facilities becomes a major problem. Refugee camps are sometimes located in remote areas, transport is expensive if existent and movement can be curtailed by the security situation.

Sexual Violence. The paper on sexual violence will deal in much greater detail with the issues. However, it is important to highlight here the impact that conflict has on the prevalence of gender-based violence, its acute physical, psychological and social consequences and its impact on reproductive health status. Gender-based violence causes both mortality and morbidity, and its consequences are linked to all other areas of reproductive health: STI and HIV transmission and unwanted pregnancy, often leading to unsafe abortion and obstetric complications.

The provision of emergency contraception has been a controversial issue in a number of refugee situations despite being legal in most settings. Controversy was profound during the Kosovo crisis. It delayed the provision of integrated reproductive health services and hampered the ongoing provision of services. Although most women from Kosovo who wanted emergency contraception had been in transit for a number of days and therefore were no longer eligible to receive emergency contraception pills, the availability of emergency contraception should continue for women who have experienced sexual violence or for unprotected sexual relations within the camps.

When the international community is faced with the evidence of ethnic rape during conflict, it must ensure that emergency contraception is more widely available and accessible, not just when and if women reach the relative safety of a refugee camp when it may be too late, but within their home communities. Emergency contraception can prevent unwanted pregnancies if used within 72 hours and can thus prevent significant numbers of abortions.

Sexually Transmitted Infections and HIV/AIDS. In developing countries, STIs and their complications rank in the top five disease categories for which adults seek health care. In women of childbearing age, STIs, excluding HIV/AIDS, are the second highest cause of death and disability after maternal causes.

STIs, including HIV/AIDS, spread fastest where there is poverty, powerlessness and social instability. These conditions are characteristic of life in refugee settings. As a consequence, there is an increasing incidence of STIs and HIV among displaced populations. War-affected populations are disproportionately at risk for STIs, including HIV. During flight, refugees are exposed to populations with differing levels of HIV infection. Displacement promotes transmission between high- and low-prevalence groups as well as exposure to the military, which further promotes transmission.

Even in peacetime, soldiers have STI infection rates two to five times higher than those of civilian populations. During armed conflict, their rates can be up to 50 times higher.⁴ In many countries, rates of HIV infection are considerably higher among military personnel than among the general population. The possibility of death in combat may serve to distance men from the more remotely perceived threat of HIV infection.⁵

Although some work is being done with United Nations and other armed forces, more needs to be done to educate the military about safe sex and the spread of HIV/AIDS. Many of the international forces come themselves from areas with high HIV prevalence. Their contribution to the spread of the disease should not be underestimated.

However, interventions should not stop with the military. Behaviour change projects need to target all men, including adolescents and boys.

For physiological reasons, women are more likely than men to be infected through heterosexual contact. Aggravating this physiological vulnerability is the discrimination many women face in the economic, social, civil and political spheres. The Beijing Platform for Action and the ICPD Programme of Action recognize that women's social discrimination and unequal power relations with respect to men are key determinants in their vulnerability to HIV/AIDS. In conflict settings, this vulnerability increases.

One area of reproductive health in refugee situations needing more research is the impact on sexual behaviour of post-genocide/conflict fatalism

⁴ Joint United Nations Programme on HIV/AIDS, *AIDS and the military* (Geneva, UNAIDS, May 1998).

⁵ K. Gordon and K. Crehan, *Dying of Sadness: Gender, Sexual Violence and the HIV Epidemic* (New York, United Nations Development Programme, 2000).

among surviving communities. In Bosnia, the MSI project had to adapt its activities to respond to changing sexual behaviour, particularly of young people, during the return and reintegration phase. The programme noted an increase in unsafe, high-risk sexual activities.

Conflict Resolution, Rehabilitation and Return

Positive Impact of Conflict

Conflict brings change. This can have positive and negative effects on the lives of women and men. In many cases, conflict has a negative impact on women and reproductive health. However, there are examples of how conflict has been a force for positive social change. Women find themselves undertaking non-traditional roles during displacement, requiring new skills which can be built upon and strengthened to enable them to play a greater role on return to home communities.

The vocational and educational components of the MSI Bosnia project, including computer skills, language courses, hairdressing, typing and dressmaking, formed a vital part in the rehabilitation process. These activities allowed women to acquire education and training, raising their self-esteem and empowering them to take control of their lives. Links were developed with potential employers, and many beneficiaries obtained employment as a result of the project.

Providing training to a range of people, including Afghani and Pakistani doctors, medical students and lady health visitors from the communities, is an important component of the programme to improve reproductive health provision among Afghan refugees in Pakistan. Increasing knowledge and acceptability of reproductive health services inevitably leads to increased access for the host and refugee populations. Equally important is the increase in knowledge and awareness which will remain with and strengthen the community on their eventual return.

Not only are new roles undertaken during displacement but new skills learned as well as new lifestyles and opportunities. Access to contraceptives may actually be greater in the country of refuge than in the home community. Access to services can be greater especially in a camp environment. It is essential that women do not lose these advantages gained during displacement on their return. Many communities refuse to return to home villages where services and infrastructure are non-existent. This can severely hamper the rehabilitation process and should be urgently addressed. Women are ideally placed to contribute to the rehabilitation of home areas and should be empowered to do so. This may include ongoing and/or refresher training, education, community awareness, peer support, and the equitable distribution of resources alongside the rebuilding of infrastructure.

Return and Reintegration

In addition to the experiences of communities before and during displacement, the return and reintegration phase has a number of implications for reproductive health status. The post-conflict setting poses constraints to meeting basic reproductive health needs while, at the same time, new needs will have arisen as a result of the conflict.

Women's traditional roles, responsibilities and support networks become dramatically altered by involuntary migration, extended family networks may be completely lost and women may have to face hostilities from the community which did not leave during the conflict. There are many differences between returnees, IDPs and "stayees" which compound the reintegration process for many of these related to reproductive health status; gender relations; STI/HIV/AIDS levels; desired family size; experience of sexual violence; and access to services.

It is imperative that women are part of the peace building process as they play a key role in the health of entire communities, building bridges and preserving social order. As has been shown women will invariably have taken on new roles during displacement, gender attitudes may have changed and it is vital that these advances are not lost in the post-conflict setting but rather are built upon in the rehabilitation of societies.

The disruption to the social fabric with traditional roles within families severely disrupted by the war and its aftermath was a key issue facing the MSI/Stope Nade programme. The challenge was to ensure that social reconstruction needs were not lost in the rush to rebuild physical infrastructure. The programme aimed at facilitating the return and reintegration of displaced women and girls into viable family units and the community by promoting participation, empowerment, self-reliance and self-organization.

Educational activities to empower women to organize themselves in order to articulate their human and social rights and needs and to become active participants in local, national and international institutions were important factors in the reintegration process.

Reconciliation, conflict resolution and reintegration were key aims of the project. Women who visited MSI centres were often instrumental in helping to overcome intolerance between nationalities and trying to improve communication between peoples regardless of nationality or religion. Women were instrumental in helping to overcome difficulties between refugees, IDPs and returnees in mixed-group sessions in the centres.

Refugee women who attended the centres, although displaced, expected a centre on their return to home. In many cases, these women were able to establish such centres using expertise gained during displacement.

As the situation in Bosnia changed, so did the activities and emphasis of the MSI programme. For example, when the return and repatriation process began, services needed to focus on individual counselling sessions as a result of the ensuing instability. In addition, more information on legal and human rights issues was provided to meet the changing needs of the host and returnee populations and aid in reconciliation. Linking activities were undertaken in divided cities to build and cement relationships between women. The programme developed a support package which included basic information on legal and health-care issues as well as about the resettlement process for returnees. Conflict resolution was managed through group work, radio broadcasts and publications.

Stope Nade worked closely with local women's groups and international and local organizations, developing a strong programme of capacity-building. More recent projects have included advocating for a greater representation of women in political roles.

In the post-conflict phase, ways need to be found to ensure that there is fair and equitable access to service provision for all members of the community. Health-service providers have a role to play in this. In Sri Lanka, the MSI IDP project realized the potentially key role its team members played in the building of peace between the ethnic groups displaced by violence in the north and east of the country and the link between meeting reproductive health needs while helping to consolidate peace and supporting rehabilitation. Clinic and outreach teams, including community health promoters, are always comprised of representatives from each ethnic group. In this way community members are able to experience at first hand the cooperation between team members and the different communities.

Concrete Suggestions

The challenge facing the international community is to ensure that reproductive health becomes an integral component of any humanitarian response. Strategic alliances have been formed with and between Governments, United Nations organizations and agencies and international and local organizations, including the Reproductive Health for Refugees Consortium and the Inter-Agency Working Group; policies have been put in place and guidelines developed. What is needed now is a concerted drive to translate progress at the international level into on-the-ground services for communities affected by conflict.

This will involve much more than the rebuilding of infrastructure and the deployment of medical teams. Development-focused agencies need to expand their target audience to refugee populations and those affected by conflict; humanitarian agencies need to ensure that comprehensive reproductive health care is integrated into their service delivery. To achieve this, targeted training is required for humanitarian workers and medical staff; reproductive health supplies need to be accessible and available from the earliest moment; and funding priorities need to incorporate reproductive health services. Although such activities are already occurring, more needs to be done.

The Reproductive Health for Refugees Consortium has identified three key interventions to achieve improved reproductive health services in refugee settings:

- The provision of training and technical assistance to build institutional capacity and leadership;
- The development and dissemination of new materials for programming and advocacy publication and advocacy; and
- The development, evaluation and dissemination, with partner service providers, of replicable service delivery models.

UNFPA has developed a training project on reproductive health in crisis situations. The project has been designed to help key personnel from UNFPA and partner organizations understand the reproductive health needs and concerns of populations in crisis, whether from conflicts, displacements or natural disasters. The project also aims at enhancing understanding of the whole process of introducing specific services in crises.

Recommendations

- Agencies purporting to provide health care to refugee and displaced populations in emergency and post-emergency settings must be held accountable for ensuring women's, men's, and adolescents' access to reproductive health services;
- Increased emphasis should be given to the need for inter-agency collaboration at field level and the inclusion of a reproductive health coordinator in every setting;
- Women should have greater representation in decision-making positions in implementing agencies and refugee organizations;

- Greater involvement from representatives from displaced communities to ensure appropriate, accessible service delivery is needed. This may involve refresher or additional training of community members;
- Programmes must take the long-term perspective in which women are perceived as crucial in the rehabilitation and reconstruction process;
- Increased male involvement is critical to women's health status;
- Greater provision of reproductive health services is needed from the outset of any conflict, with implementation of the MISIP;
- Expanded training in reproductive health care is needed for relief workers;
- Increased capacity-building of local organizations should be undertaken;
- Greater training and awareness among field staff of practical protective measures for preventing and responding to sexual violence are needed;
- Good reproductive health practices should be incorporated into public health awareness campaigns;
- Increased resources, both financial and human, to implement comprehensive reproductive health programmes are imperative;
- Greater representation of women on refugee committees or the development of separate women's committees should be fostered to ensure that the specific needs of women refugees are not ignored;
- Greater access to female protection and medical staff and to female interpreters is needed to help refugee women in their reporting of incidents of sexual violence;
- Greater training and awareness among field staff are needed concerning practical protection measures for preventing and responding to sexual violence;
- Greater understanding of the cultural and traditional values of refugee communities is needed to ensure that culturally appropriate services and resources are available;
- Greater coordination should be promoted between service providers to ensure that the reproductive health needs of refugees are met;

- Greater attention should be given to the needs of adolescents, who should be involved in all stages of the development of projects, including implementation and evaluation;
- Pre-placement gender-sensitization training is needed for humanitarian workers;
- Increased sensitization and assistance to local communities can help reduce tensions between local and refugee populations;
- Increased advocacy is needed to galvanize international, regional and national support for reproductive health services in refugee settings;
- Increased advocacy and awareness-raising among the military and armed forces are needed to prevent unsafe or coercive sexual activity; and
- Further research and study are needed into the health, behaviour and characteristics of refugees and IDPs.

Conclusion

Much has been achieved since 1994 in the field of reproductive health for refugees. However, much remains to be done to ensure that the policies and strategies set in place at the headquarters level are transferred to the field and that the reproductive rights of communities are achieved.

SEXUAL AND GENDER-BASED VIOLENCE IN POST-CONFLICT REGIONS: THE BOSNIA AND HERZEGOVINA CASE

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Introduction

The relationship between three sensitive issues -- sex, gender and violence – is a complex one. The phenomenon connecting these three issues, otherwise known as sexual and gender-based violence, is a reality in post-conflict regions across the world, and it can be analysed against a backdrop of similarities and differences in these regions' sexual and gender-based violence practices. This paper focuses on those practices in the Balkans.

Without defining sex, gender and violence, it is important to look at them within a United Nations theoretical framework. When conceiving of the scope of sexual and gender-based violence, one must be wary of overgeneralizing. One suggestion is to conceive and analyse violence at the societal level through unequal power relations and gender role expectations in post-conflict regions. There are several concrete examples to facilitate an understanding of how violence connects to individual experience. Theoretically, violence can take multiple forms. It exists at several levels and in many social contexts. Linking these experiences is difficult, particularly when determining how much theoretical extrapolation is necessary to determine the root causes of violence.⁶ An effort to do both, however, is essential, as the threat of violence is constant in society and invariably affects reactions to it.

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⁶ J. E. Denious, "Violence and Gender Relations: Theories and Intervention," *Sex Roles: A Journal of Research*, No. 1 (1998).

Post-conflict regions have not effectively addressed violence publicly or institutionally. Divorce has historically been an institutional euphemism for permissible violence that did not exist publicly, since women would live with violence as integral to social and moral orders. Women accepted this as equally as men did. Social and moral orders were established long ago by men in the post-conflict regions and survived, in large part, because women were accomplices to them. Men have been predisposed to abuse women and children which, in turn, has reinforced violence in marriage as a common law practice and unspeakable moral right. With fathers perpetuating domestic violence, its cycle continues through generations and continues through husbands and boys.

Gender

Gender issues are more complicated. Definitions vary and are frequently confused with women's issues relating to equality and equity. The concept of gender implies more than merely women's equality and equity, however. In addition, for the purposes of the meeting at the United Nations discussion on gender empowerment, development and policy implications, the framework will reflect a gender-focused discourse. Gender perspectives and practical standpoints will be kept in focus while addressing diverse forms of violence, such as sexual abuse, physical and psychological violence, organizational violence, and others. With regard to violence, issues concerning different regional habits and practices will be addressed. A consideration of violence through a gender-specific lens, however, involves much more than merely understanding the consequences and implications of gender role expectations and stereotypes.

Empowerment, as opposed to participation, is a feminist vision of development better suited to modern concepts of development. Many United Nations conferences have advocated for women's empowerment to be central to development processes. One example is the ICPD in Cairo, in which the population issue was discussed not only as a technical, demographic problem but also as a woman's empowerment choice in the context of her health and reproductive rights.

This does not mean that men should be omitted from empowerment processes. On the contrary, gender equality discourse embraces the involvement of both men and women in organizations and movements. In the mainstream development discourse, however, empowerment focuses on entrepreneurship and self-reliance and not on challenging power structures which subordinate women. To challenge power structures, women have the task of conceptually developing "power within" rather than "power over" in community settings. "Power within" refers to increased self-esteem, awareness-raising and confidence-building. "Power over" reflects direct confrontation and conflict between the powerful (largely men) and powerless (mainly women).

Gender in context relates to empowerment “within”, reflecting empowerment as a bottom-up process rather than top-down strategy. It is also a device for women to empower themselves. The tasks of developmental agencies are, therefore, not to implement empowerment for women but to facilitate women’s implementation of their own empowerment by providing clear policies, programmes and incentives. Conceiving of gender as a promotional tool that can empower women’s reproductive health can make possible the elimination or reduction of gender and sexual-based violence. Several obstacles to this exist; yet, a positive start can be in changing policy frameworks, organizational structures and processes where women’s empowerment can be realized.

Gender issues are inseparable from development issues. The discussion of development agencies (UNFPA, in this case) and their roles in promoting women’s empowerment in post-conflict regions is strategically very important to decrease and eliminate sexual and gender violence.

Violence

Violence happens everywhere, is locally and globally widespread, and does not discriminate among classes, races, ethnic groups, localities or ages. In both ancient and modern societies, men and women have been abused, exploited, harassed, tortured and killed. Women are beaten up in thatched huts, skyscraper apartments and small trailers. Men are assaulted in concentration camps and prisons. Rape happens to both women and men in a variety of settings. Women are raped in college dormitories, back alleys and bedrooms. All peoples, including children, have been sold into slavery and sexually exploited in multiple ways.

The gender perspective of violence varies, both for women and for men. Women’s perspectives are most often stressed; they involve control issues; violence in emotional, sexual and physical forms; and explicit and implicit dimensions. In contrast, men typically comprehend violence to be isolated, largely physical incidents.

Violence against women is a widespread global problem. Between 20 per cent and 60 per cent of women report having been beaten by their partners, with underestimates common due to underreporting by victims. Gender-based violence is a major issue that includes the physical, sexual and emotional abuse of women; sexual abuse of female children; marital rape; sexual assault; forced prostitution; and trafficking in women and young girls.⁷

⁷ www.unfpa.org/modules/intercenter/role4men/eliminat.htm, “Eliminating violence against women.”

“Although the particular forms of violence may vary from culture to culture, we have come to expect it, make room for it, and accommodate it, as if it were given of the human condition. As a result, women spend most of their lives recovering from, resisting or surviving violence rather than creating and thriving.”⁸

Another view purports that “the life-cycle of violence starts with sex selective abortion and infanticide in countries where girls are valued less than boys or considered an economic burden.”⁹ Notable about these two statements is that women are the focus of violence prevention, although men are equally victims of violence. In concentration camps and prisons, sexual violence is continually used against both male and female prisoners as a strong method of control.

Civil Society and Its Response to Violence

The bottom-up approach of women’s empowerment “within” implies the strong involvement of NGOs that conduct developmental activities in the post-conflict regions. The NGO approach can be understood as a reaction to the frustrating attempts to institutionalize gender into mainstream development policies and programmes worldwide.¹⁰ One such example can be shown in conflict regions, where gender issues are not understood in a cultural context, not envisioned on political or strategic levels and are subsequently introduced within pre-set “packages” of humanitarian aid and development programmes.

In Bosnia and Herzegovina, a governmental initiative exists to establish a Gender Centre. The head of the Centre sits regularly at government meetings, struggling to connect the Government’s role with that of the Centre. The only project at the lower levels of governance involved with the Centre is the Finnish Government’s initiative to undertake institutional gender empowerment. This is one example of how the gender perspective is introduced from outside into governmental policy. The Government of Bosnia and Herzegovina has not achieved its potential in dealing with gender issues in the most effective ways. The society has several developmental problems which have yet to be addressed. Also, the Centre’s cooperation with other NGOs has not yet been considered.

Post-conflict regions have had an advantage in developing parts of civil societies and in working towards furthering ideas and capacities. This is in stark contrast to the Government’s attempts to approach developmental issues for the region, efforts that have been hampered by the war. In Bosnia and Herzegovina,

⁸ www.vday.org, V-Day’s Global Vision.

⁹ C. Spindel, E. Levy and M. Connor, *With an End in Sight, Strategies from the UNIFEM Trust Fund to Eliminate Violence Against Women* (New York, UNIFEM, 2000), p. 12.

¹⁰ S. Razavi and C. Miller, *From WID to GAD: Conceptual Shifts in the Women and Development Discourse*, UNRISD Occasional Paper (Geneva, UNRISD, 1995).

after the infrastructure was almost completely destroyed by the war, humanitarian aid was delivered through groups of volunteers who had quickly aligned themselves with efforts of various NGOs. Numerous NGOs in Bosnia and Herzegovina deal with issues of violence. More than 14 NGOs there deal with women's issues and frequently facilitate gender-based educational activities. These humanitarian agencies are deeply involved in women's issues and specifically violence against women. Yet, family violence remains.

Although women's equality is a long-standing, elusive issue in the Balkans, it was reassessed after the war and placed high on the social agenda. The gender aspect is still new, however, and continues to be implemented. Integrating this concept poses challenges beyond women's discrimination and rights violations to the reality that men have also been abused in the war. The concentration camp torture perpetrated violence against men as much as against women. Of 6,000 concentration camp victims in the Sarajevo Canton, 5,000 were men and 80 per cent of them had reportedly been raped. Substantial literature and research on women confirm their mistreatment during and after the war. Little is said or done, however, for the men who are, like the women, victims of sexual violence.

Since 1997, the Association of Concentration Camp Inmates of Sarajevo Canton has worked with victims to document data about the atrocities. The Centre for Research and Documentation records these testimonies and works closely with The Hague Tribunal. Inmates witnessed the vast majority of atrocious human rights violations, including crimes against humanity. Some of the Association's best work involves the testimony of women brutally raped and/or tortured during the war, which appeared in the moving book *I Begged Them to Kill Me* (Sarajevo, 2000). Why this book focuses only on women victims is not clear, however, since most Association members are men. Possibly the women are more active than men. Women are also more able to talk about torture than men. Men, due to cultural and social "norms," are unlikely to talk about experiences of rape and torture, in part due to shame, or are not as organized as women are with regard to victimization. At present, no NGO or association in the region actively addresses violence against men.

Another aspect of women in post-conflict societies is the persistently disadvantaged position of women, rooted in patriarchy, which defines different roles and behaviours for women and men. Gender identities, namely roles and behaviour assigned to women and men, are ways of distributing power between genders in society and family. As such, "gender identities are largely culturally created and are subject to shifts, changes and manipulations."¹¹

¹¹C. Hooper, "Masculinist practices, multiple masculinities and change in the global gender order," paper given at the Gender and Global Restructuring: Shifting Sights and Sightings Conference, University of Amsterdam, 12-13 May 1995.

A major premise of gender-difference theory based on common feminist thought is that men are exclusively aggressive and violent, whereas women are docile and peaceful. The general view of women's being against war, however, has been challenged many times.¹² The conflicts in the Balkan region have shown that several women supported the war, but did so differently from their partners who were directly involved in the conflict. In 1991, the image of the Serbian women cheering and waving to their husbands, sons, brothers and fathers going to fight in Croatia is a powerful, persistent image in common memories of the war. Another memorable image, however, involves Serbian women who protested the war at Belgrade's main square.

There are also several challenges to the view that men are exclusively pro-conflict. Historically, male soldiers have had the most to lose in conflicts. However, those who fail to live up to social expectations of bravery are frequently stigmatized and severely punished by both men and women.¹³ During conflicts in the Balkan region, many men, particularly young men, left their countries to avoid fighting. These men still bear severe punishment for contributing to the conflict. In Serbia, men who defect are proclaimed ethnic traitors, which is the most serious stigma in Serbian culture. In Bosnia and Herzegovina, these men are often blacklisted, resulting in difficulty finding jobs and open verbal abuse.

Women are less inclined to participate in conflict and violence because they are excluded from political and social life and decision-making, and depend economically on men.¹⁴ Women continue to be aligned with family care and social assistance responsibilities. As a result, women dominated assistance work during the conflict, which marked the beginning of civil societies in the Balkans.

The scope of violence in war is drastic and sometimes beyond comprehension. It is a force, however, that triggers strong response in unifying and organizing those against violence. NGO activities that research and address violence have developed different methods to deal with post-conflict regions. In 1992, the world media news about mass rape of Muslim and other women in Bosnia and Herzegovina resulted in vast initiatives, particularly for women, to assist victims of rape and torture in the camps. In this context, many NGOs encountered a wider range of violence against women, not just rape. Some violence was connected to the war, specifically, traumatized men; some was previously existing violence in the family; and some constituted new types of violence caused by the horrific, unpredictable circumstances of war and displacement. The ways in which post-war violence and long-standing domestic

¹² Byrne, *Gender*, p. 20.

¹³ Ibid.

¹⁴ A. Weir, *Sacrificial Logics: Feminist Theory and the Critique of Identity* (New York/London: Routledge, 1996).

violence interconnect are not yet established; however, increasingly violent attitudes in the region are apparent.

Reproductive Health Issues and the Society

Neither the issue of violence nor the reproductive health of women is publicly addressed in post-conflict societies. They fail to be addressed in both society and the family. With the international community focusing on the Balkans, issues of violence and reproductive health are being seriously considered to benefit their populations.

Post-conflict regions struggle with the exacerbation of issues such as impoverishment, especially when damage occurs to the productive infrastructure. Also included among the struggles in post-conflict settings are transitions from a planned economy to a market economy, exemplified by negative influences such as the sex trade, severe internal ethnic divisions, and political discourse based on nationalistic assumptions. Each has a profound impact on the population's health. During the conflict, women and children were vulnerable to several hardships in the post-conflict setting. Insufficient reproductive health education, inadequate information on contraceptives and unequal access to them, taboo attitudes regarding human sexuality, low quality reproductive health services, uneven distribution of those services, the dearth of modern diagnostic facilities and widespread non-medical abortions (in lieu of available birth control methods) are common problems, ones that have serious ramifications for women's health. HIV/AIDS and other STDs and STIs are seldom tracked or recorded. Services struggle to manage the pre-war quantity and quality level of their health facilities.

Domestic Violence in Bosnia and Herzegovina

A joke in Bosnia and Herzegovina proceeds like this: One man asks another, "Did you beat up your wife last night?" The other replies, "No, I didn't, she did not do anything wrong yesterday." The first replies: "All the same, you should see that she does not forget who is boss in the house." This joke reveals common attitudes held by many men and women in the region that reinforce male power in family structures. The joke also bolsters the notion that men are violent and women are oppressed.

Family violence is not new or rare in Bosnian and Herzegovinian society. Violence against women did not start with the war. It was always present but hidden from public awareness and, therefore, not addressed. It continues to be an issue commonly neglected by society. Several studies on family violence in Sarajevo reflect male participation, but their answers are not elaborated in the analysis. In 2000, Women to Women, an active NGO in Bosnia and Herzegovina, conducted a survey on violence against women in Sarajevo. Only 24 per cent of 160 respondents were men. The reason for such low male involvement was reportedly because most men who had been asked to

participate refused.¹⁵ In the survey, to elucidate gender differences in attitudes, one question asked how the numbers of those who perpetrate violence against women could be reduced. About 15 per cent of the respondents stressed the importance of education for perpetrators of violence. The analysis did not indicate how many of the people in this group were men. All other questions were exclusively about women's needs and their perception of solutions for the problem.

Several studies done in the post-war period address the post-war effects of violence. Medica Zenica, the leading NGO in the field, conducted a large study on violence against women. In the study, the definition of violence is broad, and includes domestic violence, sexual assault, trafficking and sexual harassment. All terms were used to describe the pervasiveness of violence in society as well as their interconnections that "spring from the structure of society, a structure that echoes in the societies around the world."¹⁶ Medica's research focused on domestic violence, sexual assault, sexual harassment, incest and prostitution; however, it omitted other types, such as economic imbalances of power and trafficking in women. There was no documentation that the other types of violence exist in their societies. NGOs were able to investigate them, however, through SOS telephone services conducted in several major cities in Bosnia and Herzegovina.

Medica Zenica was one of the first NGOs to conceptualize and address domestic violence in Bosnia and Herzegovina. It conducted in-depth interviews with 542 women in the Zenica municipality to determine how violence against women had impacted women's lives. The research started with demographic profiles and socio-economic status of the subjects, prevalence of violence against women, assessment of service provision in the community, and concluded with women's reflections on violence against women. A quasi-random stratified sample was used, and all city localities were included. The study concluded that there is a critical level of violence against women in the Zenica municipality. Factors that relate to family violence are family breakdowns, difficulties with post-war family reintegration, alcoholism, war trauma, education, post-conflict economic hardship and moral desolation. Consequences elucidated in the study and less understood in society are devastating for victims' physical and mental health.

The Medica research reflects that domestic violence, excluding child abuse, is highly prevalent. According to the research findings, every fifth woman (23 per cent) in the sample had been beaten by her partner and almost every fourth (24 per cent) had been battered over a long period of time.¹⁷ The sample was only representative for one town, however, and findings for Zenica may or

¹⁵ FeniksFem, *Women to Women*, Survey (Sarajevo, 2000).

¹⁶ Medica Zenica, *To Live Without Violence* (Infoteka Zenica, 1998:35).

¹⁷ *Ibid.*, p. 52.

may not be generalized for the country. It is clearly indicative of the need for further research on the topic.

Another valuable aspect of the Medica study was its addressing the lack of appropriate services that victims could utilize. According to Medica, assistance should ideally exist in three capacities, two of which are worth mentioning. The first requires raising public awareness about women's rights to life without violence, including within the private sphere. This is especially important in the post-conflict Balkans region. The second requires developing contemporary reproductive health services by introducing new services and improving existing ones. This can be achieved through the supplemental education of professionals and policy makers, especially politicians.

Another NGO, Woman of Bosnia and Herzegovina, conducted similar research on violence against women from Mostar. Of 1,000 interviewed women, nearly half (48,8 per cent) had had at least second-hand experience of violence. One third of the women had personally experienced violence.¹⁸

Services and Assistance

SOS Telephones

The first public action of dealing with domestic violence was introduced after the war through the SOS telephone service. In 1997, the International Rescue Committee (IRC) introduced the SOS phone service through the women's NGO, Anima, in the small, central Bosnian community of Gorazde. The service was designed to assist women by providing listening support, advice, counselling, encouragement and referrals. Following this, SOS activities expanded across the country. There are currently eight SOS services in communities across Bosnia and Herzegovina, specifically Banja Luka, Mostar, Zenica, Gorazde, Tuzla and Sarajevo. Two of these have SOS telephone services for children in Sarajevo. The Mostar SOS telephone service was used for a wide range of inquiries, but in 1999 became a service for violence against women only.

In 2001, Women for Women, an NGO from Sarajevo, analysed its 81 SOS client calls and found that the majority of callers had been battered. One third of them are economically dependent of their spouses and 18 of them had found jobs after talking to SOS professionals.

Zenica and Sarajevo SOS telephone service have counselling components in their programmes and help many women find solutions to their

¹⁸ Woman of Bosnia and Herzegovina, *Analysis of the Survey on Violence* (Mostar, 2001).

problems. These SOS centres provide more comprehensive follow-up than other phone services, where only listening services are provided.

Refugees

In Bosnia and Herzegovina, a facility for refugee women victims of violence was recently established in Sarajevo, run by the Embassy of Local Democracy in Barcelona, an international NGO. With extensive help from other NGOs and the local community, it was established to respond to violence in the families.

The Centres of Social Work was one of the only public social benefits institutions in the Balkans whose task was to provide for vulnerable groups. Those who asked for assistance were usually directed to NGOs. The Centres were unable to provide services themselves, as their funds were minimal; in addition, they perceived of the organization more as a research institution than as one that provides direct services. Each of the more than 100 municipalities in Bosnia and Herzegovina has a Centre of Social Work branch.

A.D. Barcelona Refugee was established as a follow-up activity to SOS phone service. On average, 15 to 20 women with children are in the A.D. Barcelona Refugee facility. The reason for being in this facility is to escape violence. Assistance is provided on violence-related issues, but not on reproductive health, notwithstanding that that physical and sexual violence involve serious health consequences. For example, the only question that refers to sexual assault among questions about battering, kicking and taking children away is: "Did your partner ask you to have sex with him without your consent?" The data also do not explain distinctions between sex without consent and marital rape. Women, however, elaborate in their responses that violent sex also occurs. If asked directly whether they have been raped or not, an exceedingly common response is "You may say so." If a victim asks or is offered professional assistance, it is usually through a psychologist/psychiatrist intervention. Ongoing counselling is not practised.

As such, most women are not made aware of the extensive range of violence. Many women who sought assistance reported incidents 10 to 15 years ago.

Support from the International Community

Few of the international NGOs that deal with violence have remained in Bosnia and Herzegovina. One exception is the International Rescue Committee (IRC). From the beginning, a good programme on reproductive health included protocols for dealing with issues of violence. IRC set up the SOS telephone service in Gorazde, and through the local women's NGO, Anima, has assisted the community in awareness of reproductive health and the necessity of high-quality health services. IRC addressed issues of violence against women from the outset. IRC practice is recognized by its grass-roots approach to develop networks among women's NGOs and to include responsible community members in programme implementation. IRC has also fostered reconciliation between different ethnic groups through its educational programmes in reproductive health.

The International Police Task Force (IPTF) is not focused on domestic violence. However, it has initiated certain actions to do so. IPTF Public Affairs Officers conducted a domestic violence campaign in June 2001.

Local police are encouraged to deal with violence and to improve their attitudes towards the victims. Women have been encouraged to take part. Each police station has local women present who are trained in domestic violence issues. A six-month follow-up provides some data on the incidence and prevalence of violence. In each of the seven regions of Bosnia and Herzegovina, on average two cases are reported monthly (14 cases monthly across the country). An IPTF officer noted that domestic violence was underreported.

Concentration Camp Violence

A common practice in concentration camps is to force male prisoners to sexually assault, rape or humiliate one another. In addition, the controlling army's soldiers rape women. Violence is used as a tool to control the enemy's civilian population, indirectly to humiliate the enemy's army and furthermore to destroy their communities. From a sociological point of view, violence in concentration camps is a direct assault on an individual's body and self, the motivation being to "destroy community and demolish the social order upon which the community had thrived for centuries."¹⁹ In Bosnia and Herzegovina, sadistic rape camps were constructed with the aim of shredding the social fabric of society.

The mass rape of women and young girls during the war was not a consequence of the warfare but a design to destroy families and erode

¹⁹ K. Doubt, *Sociology after Bosnia and Kosova* (New York, Lanham, Boulder; Oxford, Rowman & Littlefield Publishers, Inc., 2000) p. 2.

community. It could destroy a victim's relation to both her family and community, by prompting her family to reject her. "The rape sought to destroy the person's sense of identity and connectedness to those whom she loved. Rape was done knowing that it would likely lead to the person being rejected by her parents or husband."²⁰ Organized rape was an effective tool used throughout the war, followed by the crisis of reintegrating families, as emphasized by Medica Zenica.

Estimates differ on how many women and young girls (some as young as six years of age) were raped during the three years of war violence in Bosnia and Herzegovina. The head of the European Commissioner of Inquiry, Dame Ann Warburton, reported in her study in the former Yugoslavia that 20,000 women had been raped. Catharine MacKinnon, the Michigan law professor who worked for the Bosnian victims, put the total at more than 50,000. The *New York Times* correspondent John Burns echoed this total at 50,000 women.²¹

There is a large literature on rape in the Bosnia and Herzegovina rape camps and their implications for victims. The most tragic were women impregnated by rape and their subsequent conflicted attitudes towards their babies. Slavenka Drakulic, a Croatian writer who worked in 1993 with raped Bosnian women in Croatia, published her findings under the title *As if I Am Not There* (2000). She reported the testimony of a mother-to-be -- a girl raped in one of the Serb camps in northern Bosnia. The girl, referred to as S, throughout her pregnancy thought of killing "that alien thing in her." At the same time, she thought of the baby as a small innocent creature who was not responsible for human cruelty and should be treated with kindness. Even when her baby boy was born, S could not get rid of her deeply conflicted thoughts about her mind and her body. She would reject the baby publicly, but alone she would touch and talk to the baby, as any mother would.

In Kosovo, the other conflict area of the Balkans, rape took on an equally horrific turn. It was used to target families of the Kosovo Liberation Army (KLA) supporters. Serbs were keenly aware of rape's devastating effects on the fighters and their communities. They detained women, the main family members of KLA supporters, more than a year before NATO began its air offensive.²²

Concentration camp victims initially received some assistance, but they are still in great need of food, appropriate housing, jobs and financial assistance. Their psychological needs are even greater, since the authorities have done no systematic needs assessment to organize service provisions for this vulnerable group.

²⁰Ibid. p. 63.

²¹G. Halsell, "Women's Bodies: A Batterfield in War for 'Greater Serbia'," *Washington Report on Middle East Affairs* 11, no. 9 (April/May, 1993).

²²G. Igric, "Kosovo Rape Victims Suffer Twice," *Balkan Crisis Report* 48, 18 June 1999.

Trafficking in Women

Eastern Europe

In Eastern and Central Europe, sexual exploitation and trafficking in women has become a major criminal enterprise and, hence, a significant issue in the region. Trafficking in human beings is often defined as a modern form of slavery since it involves deception, coercion, and forced and violent sex. Trafficking in women is generally conducted for sexual exploitation and forced prostitution. One estimate revealed that more than 200,000 women are trafficked annually in Eastern and Central Europe. It is not known how many of them are trafficked into particular countries. Estimates for Bosnia and Herzegovina, for example, range from 4,000 to 20,000 girls and young women. The trafficking business attracts women and young girls through false promises of jobs as dancers, models, nannies, waitresses and others.

The circumstances that contribute to trafficking in Eastern and Central Europe are twofold. Receiving countries in the Balkans (Bosnia and Herzegovina, Macedonia, Kosovo) are the post-conflict transitional regions struggling to reconstruct their economies and their political and legal systems. Eastern European countries from the former Eastern bloc, such as the Republic of Moldova and Romania, gained independence, and with it changed their economic and political systems. Transitional processes in both receiving and sending countries have had devastating consequences for their populations. Economic hardship and poverty are most significant. Traffickers capitalize on huge unemployment and disintegrating social networks in the poorer countries of Central Europe and the former Soviet Union.

Once they are rescued by police and assisted by NGO-based shelters, the main problem trafficked women and girls face is their health, particularly reproductive health conditions. Often they are afraid to address these, as the problems are varied and great. Working in the sex trade industry involves exposure to violent sexual abuse and repeated rapes, which make them extremely vulnerable to STIs, including HIV/AIDS and unwanted pregnancies.

The IOM experience with rescued trafficked women reveals that some women report subjection to repeated violent rapes, beatings, torture and inhumane sexual abuse by clients and traffickers. As such, protection of reproductive health and human rights is addressed as an urgent human rights and public health priority.²³ Also, trafficked women have had scarce access to reproductive health information and services, a fact that increases their vulnerability and need for assistance. This is why UNFPA suggested jointly (with IOM) addressing the reproductive health needs of trafficked women in Bosnia

²³ UNMIBH, Legal and Human Rights Offices, UNOHCHR, *Report on Joint Trafficking Project of UNMIBH/OHCHR* (Sarajevo, Bosnia and Herzegovina, 2000).

and Herzegovina. The IOM response came promptly through prevention of and treatment of STIs and reproductive tract infections, as well as assistance in reproductive health and counseling.²⁴ The UNFPA response was also rapid. At the level of Bosnia and Herzegovina, a unified project was designed to cover reproductive health care, counseling and contraceptives delivery and rebuilt the established national health structure and network. The result is expected to be a coordinated and comprehensive response to the reproductive health care and information needs of trafficked women in Bosnia and Herzegovina. In addition, IOM and UNFPA jointly proposed a regional project to combat trafficking.

The UNMIBH/UNOHCHR report mentions that “obstruction, obfuscation and passivity permeate the law enforcement and policy apparatus of the state at every level.”²⁵ “A right based approach, concentrating on prevention, the protection of victims and prosecution of the traffickers” correlates directly to UNFPA activities in the region, specifically in areas of prevention and protection.

IOM is developing country-specific assistance projects for victims to facilitate the return of women trafficked to the Balkans. Along with providing shelters for victims, IOM is collecting data on the experiences of the women and their trafficked routes. More than 356 women had returned and 21 cases were in the pipeline in Bosnia and Herzegovina, as of 15 October 2001. In Kosovo, 170 women had returned to their countries of origin since IOM started the programme.²⁶ IOM also helped repatriate 300 trafficked women in 10 months, and the Government expelled another 500 in Macedonia.²⁷

Approximately one third of trafficked women are from local communities, in Kosovo; 70 per cent of clients are Kosovar men in Bosnia and Herzegovina; and 90 per cent are from local communities. The traffickers’ modus operandi differs from country to country. For example, women trafficked to Kosovo are sold three to six times on their way to the province,²⁸ whereas women trafficked to Bosnia are frequently sold from place to place once they are in the country.

Millions of dollars are made in the Balkan trafficking business. Women cost between DM 2.500 to 3.000 in Bosnia and Herzegovina. In Macedonia, the price is a bit lower, according to the police in Skopje, costing between DM 1.000 and 2.000. A false passport costs DM 500.²⁹

²⁴ IOM, *Counter Trafficking Strategy for the Balkans and Neighbouring Countries* (2001).

²⁵ UNMIBH, Legal and Human Rights Offices, UNOHCHR, *Report*, p. 17.

²⁶ Schuler-Repp, “Kosovo-IOM and NGO Programme in Kosovo with Women Victims of Trafficking,” Note of Meeting, 15 July 2001.

²⁷ C. Gall, “Macedonia Village Is Center of Europe Web in Sex Trade,” *New York Times*, 28 July 2001.

²⁸ *IOM Quarterly Bulletin*, 2000.

²⁹ Gall, “Macedonia Village.”

Bosnian and Herzegovinian Practices

Trafficking is mixed with prostitution in Bosnia and Herzegovina. Prostitution is an illegal activity, although without serious legal consequences. A woman sold into prostitution is not seen as criminal, since the traditional impression of women is that they do it voluntarily. The population lacks information about trafficking, and official policies and strategies are yet not in place.

An interview with women from the Sarajevo shelter reveals devastating facts about their health conditions. All have persistent nightmares. Almost all feel uncomfortable talking about their conditions. Most of the girls (ages 14 to 22) admit that they know little about sexually transmitted diseases. Many have heard about HIV/AIDS but have no knowledge about the disease, how transmission occurs or how to protect themselves. Each interviewed girl claimed that she uses a condom when seeing clients. At the same time, she pointed out those who did not use protection. All girls without exception smoke, and many claim they would die without cigarettes. All are alternatively restless, aggressive or calm and seem to envy and distrust one another.

The selling of women into prostitution is a result not only of police complacency, particularly local officers, but also that of certain international police and foreign military troops (SFOR). In 14 cases in which UNMIBH/OHCHR were involved, all mentioned had been implicated as clients “though only local police and one SFOR member were apparently involved in buying and selling the women.”³⁰

Soon after the UNMIBH/OHCHR report was released, it produced outrage both internationally and locally. The British journalist John McGhie reported on the issue of selling women on the Channel 4 News Investigation Unit at Just TV. He put blame equally on locals and “UN personnel and staff from the 400 or so non-governmental organizations in Bosnia,” who “either use the trafficked women or, in a significant minority of cases, are actually the traffickers themselves.”³¹

In July 2001, UNMIBH launched a special programme on trafficking called Special Trafficking Operational Programme (STOP). The aim was to improve raids of bars and clubs where trafficked women are abused and forced into prostitution, enabling the officers to gain special investigatory skills (training/education) in searching out locations, identifying suspects and finding out other information.

³⁰ UNMIBH, Legal and Human Rights Offices, UNOHCHR, *Report*, p. 7.

³¹ J. McGhie, “Women for Sale,” 8 June 2000, p. 4.

IPTF operates geographically through seven regions. In each, there is a special officers' team to combat trafficking. To increase the protection side of trafficking, more women are employed at the IPTF and assigned to teams throughout the country. IPTF, as such, has embarked into gender-mainstreaming through STOP.

On the legal side, two legal services, the Criminal Justice Advisory Unit (CJAU) and the International Judiciary Commission (IJC), work together with field teams to pursue trafficking. CJAU explores the best legal steps to take in protecting victims, and IJC ensures that the procedure is respected, specifically, that local police are doing their part. IJC has the power to remove police and prosecutors who are not doing their jobs properly. So far, six people have been moved for issuing false employment visas in trafficked victim's passports.

The IPTF Human Rights Office claims that while policies need improvement, appropriate measures are in place to ensure appropriate action by police and prosecutors. Local staff lack knowledge and effective comprehension of law regulations, as demonstrated in the varied outcomes of cases, determined by the prosecutor's effectiveness and predisposing position of the judge.

Local police stations have established specialized units that consist of up to five people, at least one of whom is a woman. This action has impacted the police staff policy by increasing the demand for women in recruiting procedures.³²

IPTF officers serving in Bosnia and Herzegovina are from different countries. As a result, they have been trained differently on gender violence issues. Before they start missions, their induction training includes these issues, including education on the Standard Operating Procedure that every officer knows. In 2000, after 14 cases of involvement in trafficking, UNMBIH addressed the need for changing the Standard Operating Procedure to introduce stricter measures for officers attending trafficked bars and clubs. The first step involved changing the recording policy. Until now, no incidents had been recorded in an accused officer's file. After the year 2000, each officer's misconduct was recorded in the file.

The health-related policies of testing officers for STIs and HIV/AIDS vary from country to country. Some countries do testing prior to engagement; others do not. Policies with regard to testing are needed, and the practice should be standardized in the United Nations system.

³² Interview with Sonia Cronin, Legal Council CJAU Officer, 7 August 2001.

Recommendations

Gender cuts across issues through a range of UNFPA activities, but reproductive health conditions that are caused by any sexual and gender-based violence should take priority. Many activities are conducted to improve the access to and quality of reproductive health care in post-conflict regions. These should be designed and developed to assist victims of violence. These aspects should be encompassed equally as other aspects of the programmes.

- UNFPA should direct the Ministry of Health in post-conflict regions to aim programmes at victims of violence and assist public health workers as well as policy and decision makers in raising awareness about how violence poses hazardous consequences for health;
- The provision of reproductive health services and improved quality of care in shelters should become an ultimate goal of UNFPA when implementing programmes in the region;
- Counselling should be developed and introduced at all levels of reproductive health service provision. Education on the issue of sexual and gender-based violence should become a major part of population-based family planning programmes;
- NGOs dealing with violence against women and men should be supported, and networking between them fostered;
- Comprehensive programmes involving reproductive health policies and strategies for trafficked women in the region, whether in receiving countries or countries of origin, should be developed. Country-specific projects should also be implemented;
- Testing of HIV/AIDS must be coordinated with other agencies in the region for increased surveillance, and UNFPA should socially market voluntary testing in the region; and
- Standardized procedures that require STI testing for United Nations staff working on trafficking in women should be considered. Training and education about this issue for United Nations staff across the region should be developed.

WOMEN AND GIRLS IN KOSOVO: THE EFFECT OF ARMED CONFLICT ON THE LIVES OF WOMEN

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Introduction

This paper addresses the effects of the Kosovo crisis on the lives of women in the province. It aims at answering the following questions: How did Kosovar-Albanian women react to oppression in the 1990s? What experience did women and girls go through during the conflict, specifically, the fighting in 1996-1999 and the mass exodus to neighbouring countries? How did the conflict change the lives of minority women? What was the extent of violence against women during and after the conflict? What do women who belong to different ethnicities face in today's Kosovo? Has the presence of the international community, specifically the Peacekeeping Forces in Kosovo, changed the lives of women for better or for worse? Is the international community respecting and implementing the United Nations Beijing Platform for Action, the Beijing +5 Platform for Action and United Nations Resolution 1325?

One of the main problems for those confronting issues of women in Kosovo is the lack of reliable data and information. Information that existed before 1999 disappeared, was destroyed during the crisis or was found in Belgrade, where, until recently, it had been impossible to obtain. Publication of the data was an exception. The lack of data makes it difficult to compare the situation of women and the post-crisis development with their situation in the 1980s and 1990s. In addition, the information that is available is rarely disaggregated by sex.

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Since 1999, the UNMIK administration and United Nations organizations and agencies, such as UNFPA, UNIFEM and UNICEF, and international and local NGOs have attempted to gather information and assess certain issues concerning women. The international community and local NGOs have produced reports and held meetings to evaluate work on gender issues, with their main focus on Albanian women. Little information is available about Serbian or Roma women or women belonging to other minority groups.

UNIFEM has published two assessments: *Women at Work: The Economic Situation and Opportunities for Women in Kosovo* (2000), and *No Safe Place: Violence against Women in Kosovo* (2000). Both were based on qualitative research. A large group of women was involved, including local and international activists and specialists. UNFPA prepared a *Demographic and Reproductive Health Survey* (2000) and *Perinatal Health Care Situation in Kosovo: Past, Present and Future* (2001). The United Nations Development Group produced a *Kosovo Common Assessment* (December 2000), and the Swedish NGO, Kvinna till Kvinna, wrote a critical report, *Getting it Right? A Gender Approach to UNMIK Administration in Kosovo* (2001). IOM and OSCE write regular reports on the trafficking of women. Finally, a United Nations Development Assistance Framework (UNDAF) is being developed for Kosovo, including valuable information about Kosovar society and an evaluation of what needs to be done.

This paper is based on these assessments, reports and surveys as well as on the author's experience working for UNIFEM in Kosovo during 2000-2001. The work included attending meetings and seminars, and organizing workshops and training of Albanian women all over Kosovo. The focus of the work was on women and girls in Kosovo. To that end, the author visited small Albanian villages in areas greatly damaged by fighting. Many villages were almost entirely inhabited by women. The work of UNIFEM also involved meetings and workshops with Serbian and Roma women.

On 12 June 1999, KFOR troops and UNMIK staff took over the protection of Kosovo.³³ After more than two years of fighting, a reconstruction period began under the command of the United Nations, OSCE and the European Union. For the first time in history, thousands of soldiers, police, civil staff and NGO workers from in many parts of the world joined with the local population to develop the conflict area (and former Communist province) into a peaceful, democratic society with a market economy.

³³ For the history of the first months of the United Nations mission in Kosovo see Tim Judah, *Kosovo: War and Revenge* (New Haven, Conn., USA, Yale University Press, 2000).

More than two years have passed. On 17 November 2001, the people of Kosovo will elect a General Assembly and form a new “government” consisting of Albanians and probably Serbs. The Kosovars are slowly regaining control. Municipal elections were held last year, and 30 municipal governments are slowly evolving. Most of the main roads have been fixed, the schools are operating and most people have found shelter. However, enormous problems remain and must be solved.

The difference between the cities and villages can be measured in centuries. The dominant agriculture is still based on very old techniques. Many people in the villages, especially old people, live under the poverty line. Unemployment is estimated to be at 60-70 per cent. Access to health-care services is limited and the services need to be improved. A gap must be bridged in providing education. There is a huge demand for new curricula and multiple kinds of training. Pollution is a serious problem. There is still a lot of violence, with efforts to kill or harass minority groups. These people have very limited freedom, many living in enclaves without regular work and often without social services. Trafficking in women and girls is a growing problem. Hatred and demands for revenge are still widespread among Albanians, but there are small signs of hope that reconciliatory times are ahead.

The situation of women in Kosovo is difficult and unique when seen with Northern European eyes. The Albanian houses in the villages are like symbols for the position of women. High walls surround each of them. The women, specifically mothers, daughters and daughters-in law, also live inside “walls” and cannot be seen from outside. The men are typically out in the fields, or just chatting and smoking in the cafés. The worlds of women and men are divided. The same can be said about the society as a whole. Women are rarely seen in the leadership of Kosovo. Few women take part in official policy-making or peace-building. Many women must fight for the daily survival of their families. Active women work at the grass-roots level, building up NGOs and civil society, while simultaneously taking care of their homes, housework and their families. The men do not share family responsibilities, such as housework.³⁴

Most of the Kosovo-Albanians are Muslims, whereas most Serbs belong to the Orthodox Church. The Kosovo-Albanians have tried to protect their old patriarchal culture with isolation, in part refusing to accept legislation and social reforms coming from the Serbs that contradict their traditions. When Kosovar women were asked to describe what they saw as most characteristic of conflict between women and men, they always mentioned lack of respect for women as a dominant pattern in male behaviour.³⁵ Oppressive and disrespectful attitudes towards women, reflected in all areas of society, can at least be traced back to

³⁴ *Women at Work: The Economic Situation and Opportunities for Women in Kosovo* (UNIFEM, 2000), pp. 82-87.

³⁵ UNIFEM workshops 2000-2001.

the heritage of the Ottoman Empire and the Kanun of Lek Dukajini (Albanian laws from 15th century),³⁶ but the roots of women's subordinate position most certainly lie much further and deeper in history.

Historical Background

Kosovo is a province in Southern Serbia. Its area is 11,000 square kilometres, surrounded by mountains on all sides. It has borders with Macedonia, Albania and Montenegro.

The population is estimated to be about 2 million people, Albanians being 90-95 per cent of the population, with minorities constituting 5-10 per cent. In 1971, Serbs and Montenegrins constituted 21 per cent of the population of Kosovo. Half of the population is 25 years of age and younger, 33 per cent are 15 years and younger, while only 8 per cent are 60 years and older.³⁷

The Kosovo crisis can be traced to the fall of the Ottoman Empire, where it has cultural, religious, economic and political roots. Serbs and Albanians have fought over the fertile grounds of Kosovo for a long time. After World War II, Serbian Communists took power. During the 1970s, political changes took place that gave the Albanian population advantageous positions politically, economically and socially. The Yugoslav Constitution of 1974 almost made Kosovo a republic, which would have been represented by the federal presidency. Albanian Communists, however, became more influential than ever in running the province of Kosovo. A few years earlier, in 1970, the University of Pristina was established, giving women chances to pursue new life opportunities.

On 28 June 1989, the Yugoslav president Slobodan Milosevic made a speech to celebrate the 600th anniversary of the battle of Kosovo. It marked the rise of extreme nationalism in Serbia and the beginning of the Kosovo Conflict. The situation that followed began to worsen in Kosovo. Milosevic restricted the autonomy of Kosovo, and thousands of Albanians were expelled from their jobs, which had devastating effects on the Albanian population.³⁸ Many Albanians fled to other countries; others began to organize peaceful acts of resistance under the leadership of the LDK Movement and its chairman Ibrahim Rugova. A parallel governmental system was organized, illegal elections were held, and Kosovo-Albanians tried to survive with financial help from Albanians living abroad.³⁹

Women were active in the LDK movement during the 1990s. A women's branch organized financial help for widows, assisted old people and helped

³⁶ For more about the Lek Dukajini see Noel Malcolm, *Kosovo: A Short History* (Papermac 1998), pp. 17-19.

³⁷ UNFPA Demographic & Reproductive Health Survey, UNFPA Information sheet.

³⁸ *Women at Work*, pp. 24-26.

³⁹ Judah, *Kosovo*, pp. 61-98.

young girls to attend school, among other services. Hundreds of women took part in these often-dangerous activities.⁴⁰

In the mid-1990s, a group of young Kosovo-Albanians, most of them living in Switzerland and Germany, concluded that peaceful resistance was not the right answer. They began to organize and train a guerilla army, the Kosovo Liberation Army (KLA). This caused a serious split among Kosovo-Albanians, reflected through political lines, between those who believed in peaceful methods and those who wanted to fight the Serbs.⁴¹ The guerillas began fighting in 1996 and increased their activities in 1997 and 1998. The Serbs responded by sending more police, paramilitary groups and the army to Kosovo to fight the guerillas. By 1999, the situation had become extremely dangerous, finally drawing the attention of the outside world that a war was occurring in Kosovo. After the horrible massacre of Kosovo-Albanians in January 1999, leading countries in the world decided to intervene to stop the war. Negotiations began with the participation of both Serbs and Kosovo-Albanians, who tried to find an acceptable solution to both sides. A peace conference was held in Rambouillet, France, under the leadership of Britain and France, but without success. At that time, only one woman took part in the conference as an adviser to the Kosovo-Albanian delegation.⁴²

After the breakdown of peace negotiations, the KLA continued to fight. The Serbian Government decided to “clean” Kosovo of Albanians and ordered the police and army to empty houses, forcing many people to leave Kosovo. NATO responded by bombing targets in Serbia and Kosovo for 78 days, until the Serbian Government relented and agreed to call its armies and police back from Kosovo. On 12 June 1999, the United Nations mission in Kosovo began operations based on United Nations Resolution 1244.⁴³

The most difficult experience for many women during the crisis, aside from losses of family members, was their mass exodus to the neighbouring countries. Hundreds of thousands of Kosovo-Albanians were forced to leave their homes and walk or drive to the borders of Kosovo. On the way, many were harassed by Serbian forces, girls were raped, and mass killings took place.⁴⁴ In Macedonia, people lived in refugee camps for weeks. Thousands of people were offered refugee status in other countries worldwide. In Albania, people opened their homes to refugees. There was enormous help from international agencies and

⁴⁰ Accounts of LDK women in the UNIFEM workshops 2000-2001.

⁴¹ The largest party is LDK, under the leadership of Ibrahim Rugova; next is PDK, under the leadership of the former KLA leader Hashim Thaci, followed by AAK, led by the former guerilla commander Ramush Haradinaj. In the municipal elections, LDK got 57 per cent, PDK 27 per cent and AAK 11 per cent of the vote.

⁴² Judah, *Kosovo*, pp. 197-226. The woman was Edita Tahiri from the LDK movement.

⁴³ *Ibid.*, pp. 227-285.

⁴⁴ *No Safe Place: An Assessment on Violence Against Women in Kosovo* (UNIFEM, 2000), pp. 61-65, accounts from UNIFEM workshops 2000-2001.

NGOs, but the fear of not seeing family members again and uncertainty about the future traumatized many. Women had to take care of their children, grandchildren and the elderly, while many men continued to stay in Kosovo to fight, hide or attempt to protect their property. Women's NGOs organized all kinds of activities to support women inside the refugee camps, making life for inhabitants there more bearable.⁴⁵ A group of Kosovo-Albanian women took part in the fighting; others helped with giving the guerillas food and shelter.

UNIFEM and others have encouraged women to write down their memories from the exodus and their time spent in refugee camps, but so far no memories have been published. This is because the accounts could make women more vulnerable, as the needs and dangers facing women under refugee camp conditions would be accessible.

UNFPA, the Albanian branch of the International Planned Parenthood Federation and other organizations did an excellent job responding to the reproductive health needs of women refugees. Contraceptives were distributed, women in need of abortions were assisted and they were brought to health-care centres in case of having births. Women with small babies were supported with diapers and other supplies. The Vatican, however, noted critically that contraceptives had been given to people before blankets and food.⁴⁶

After 12 June, people started returning to Kosovo in large numbers, eager to start the reconstruction. Now it was the turn of Serbs and Roma people to leave Kosovo in order to escape revenge. Since June 1999, hundreds of Serbs and Roma people have been killed to avenge what happened during the crisis.

There are still no reliable figures on how many people were killed during the conflict. In recent months, mass graves have opened in Serbia where the Milosevic regime tried to hide evidence of brutal murders of women, men and children. The destiny of more than 2,000 Kosovo-Albanians is still unknown and more than 1,400 Serbs are still missing.

Women and the Kosovo Crisis

All the events described above had profound effects on the lives of women in Kosovo. Many women lost fathers, husbands, sons or brothers, or daughters, sisters and mothers in the conflict. Houses were destroyed, huge unemployment persisted and poverty became the destiny of many families. There are thousands of widows in Kosovo. Many of them are now responsible for supporting their families, since there are no men to lead the household, as according to tradition. On the other hand, many women have received opportunities to go abroad and live in other countries, where they were exposed

⁴⁵Ibid.

⁴⁶ Report from the European IPPF Regional Meeting in Norway, June 1999.

to different cultural attitudes toward women. Many returned to Kosovo wanting to work towards developing equal opportunities for women.⁴⁷

It was a shock to many women activists to see how women, with all their experiences from the parallel system and the exodus, were totally excluded from decision-making by the Kosovar male leadership.⁴⁸ Women's groups reacted by taking things into their own hands. During the 1990s, a few NGOs were established besides the Women's Forum of LDK. The Centre for Protection of Women and Children and Motrat Qiriazhi, a rural women's group, are the best known of the women's NGOs. Since June 1999, many women's NGOs have been formed all over Kosovo, organizing different kinds of activities to improve women's welfare. These activities have included teaching illiterate women to read and write, creating economic opportunities for women, supporting widows in small villages, and working with traumatized women and children.⁴⁹ The women's movement in Kosovo is diverse and strong, but the NGOs lack support from the international community. The NGOs and women's branches of the political parties have raised their voices on behalf of women, but there is such disrespect towards women that they have difficulty being heard.

Economic Opportunities for Women

Before the crisis, women's participation in the Kosovar workforce was low compared with that in other Communist areas in Eastern Europe. In the 1970s, women's participation was 20-21 per cent, rising only to 23 per cent in 1988. Reasons for this involve traditions; the dominance of the agricultural sector, in which women's work was highly underestimated; the lack of social services; high birth rates and the size of Albanian families which hinders women from having paid jobs.⁵⁰

The women in the labour force worked primarily in education, health care, industry and trade. A small group of women had university educations. During the 1990s, many women lost their jobs because of the Government's policy of firing Albanians. The UNIFEM assessment *Women at Work* estimated that unemployment among women in 2000 was 70 per cent, emphasizing that there was more unemployment among women than men. The UNIFEM assessment also revealed that most women would prefer to hold paid jobs and to be self-sustaining financially.⁵¹

The phased-down presence of international NGOs, from 400 in 2000 to 200 in 2001, and specifically United Nations agencies and UNMIK, has not improved the situation, since the reconstruction of the economy is a slow

⁴⁷ Accounts from UNIFEM workshops 2000-2001.

⁴⁸ Ibid.

⁴⁹ *No Safe Place*, p. 118-119.

⁵⁰ *Women at Work*, pp. 70-73.

⁵¹ Ibid., pp. 24, xiii, 48.

process. A high official in the Kosovo Department of Health stated at a meeting organized by the UNMIK Office of Gender Affairs last August that unemployment is rising as a result. Few programmes are aimed at creating economic opportunities for women, and it seems to be difficult to find money for creating such programmes. UNIFEM had to cancel its project “Economic Opportunities for Women”, which was directed at women in agriculture to support the Women’s Business Association and to raise gender awareness among staff in municipal employment offices. The reason for this programme’s cancellation was not lack of need, but lack of funds.⁵² This is extremely worrisome, given the demographic structure of Kosovo, which is composed largely of widows⁵³ and young women of productive age.

A positive result of the crisis is that the international community created thousands of jobs. It has been official policy to hire equal numbers of women and men wherever possible. This helped many women to get jobs. The policy also created a new phenomenon in Kosovar society: young women who are the sole breadwinners of their families. These young women have both created more respect for women than they usually receive but have also created problems for married women, when their husbands have difficulties accepting this new structure of family income.⁵⁴

A survey by the Department of Democratic Governance and Civil Society (unpublished at the time this paper was written) reveals that more men than women have been hired as officials by UNMIK and that men remain in higher positions, with women on the ground floor. This is a familiar pattern from all over the world. What is striking from the gender perspective is that few women lead UNMIK departments, United Nations organizations and agencies (UNFPA, UNIFEM and WHO are led by women), OSCE departments or European Union projects. As such, for all their attempts to create equal gender opportunities, the international community is not a good role model in creating equality between women and men in their own structures.⁵⁵

The effects of the conflict and its aftermath on women’s economic opportunities were numerous. Many women lost their jobs. Many married women lost their family breadwinners and became totally dependent on their husband’s family or themselves. Unemployment among women is huge; economic opportunities for women are limited and opportunities are not being taken to create jobs or train women to enter the labour market. Moreover, big families and lack of social services greatly limit women’s opportunities to have paid work. However, some women and well-educated women, in particular, have had new

⁵² See the Report on UNIFEM Activities January to June 2001.

⁵³ According to the UNFPA Information sheet 10 per cent of all families consist of one parent, mostly women.

⁵⁴ Accounts from UNIFEM workshops 2000-2001.

⁵⁵ See: *Getting it Right: A Gender Approach to UNMIK Administration*.

opportunities as a result of the United Nations mission, and access to education is improving, which will give more women chances to work in the future.

Women and Education

In Kosovo, women traditionally have less education than men do. Illiteracy is estimated to be 10-15 per cent among women, 2-3 per cent among men, although these numbers are debatable. The UNFPA survey indicates that there is 10.2 per cent overall illiteracy among women.⁵⁶ More thorough research is needed to produce reliable figures.

The Belgrade policy during the 1990s had serious consequences for women's education. The Kosovo-Albanians ran the alleged "Parallel System" during this period. It involved running schools at all levels, but with limited resources. As a result, the education of a whole generation (1989-1999) does not meet European training standards and needs to be improved. Because of the security situation during the 1990s, parents were afraid to send their daughters to school and, subsequently, many girls dropped out.⁵⁷

According to the Kosovo Common Assessment (2000), "[e]vidence suggests that large numbers of teenage women, particularly in rural villages, have never attended or completed secondary school" and "a significant number of children begin to drop out by the age of 13, especially girls."⁵⁸ In UNIFEM workshops, Kosovo-Albanian women said that many parents in rural areas think education for girls is unnecessary. They prefer to send their sons to school rather than their daughters. It is also likely that many parents prioritize the education of sons because of limited family resources. Figures from 1999 indicate that 20-25 per cent of young people aged 19-24 continue their education in schools at higher levels. There is little numerical difference, however, between women and men at higher levels of education. In 1989, women constituted 33.5 per cent of the students in the University of Pristina. If the numbers of men and women are nearing equality, it is a progress worth noting.

There is an enormous need for all kinds of training and retraining in Kosovo to bridge the education gap and to introduce new ideas and techniques. Many people appear to find it difficult and humiliating to go back to school after lapses in education.⁵⁹ The Kosovars are unfamiliar with the concept of "lifelong learning," which needs to be introduced and promoted. There are needs for a new curricula at all stages, including teaching methods, better standards, improved access to education and respect for the equal right to education for all.

Women's Reproductive Health and Reproductive Rights

⁵⁶ UNFPA, *Demographic and Reproductive Health Survey* (New York, 2000).

⁵⁷ *Kosovo Common Assessment*, pp. 6-10.

⁵⁸ *Ibid.*, p. 7.

⁵⁹ Accounts from UNIFEM workshops 2000-2001.

When Kosovo-Albanian women were asked in UNIFEM workshops about the most important issues for women, they mentioned work, education and health. Their meaning: women's reproductive health.

The ratio of maternal death is unknown, but its rate is very high.⁶⁰ About 20 per cent of all pregnant women deliver their babies outside health facilities, 17 per cent without any assistance from trained health professionals, which may partly explain the high death rate. Kosovo has a high birth rate: 2.7, which is among the highest in Europe. The interval between births is on average 2-2.5 years.⁶¹ A group of doctors working in the field of reproductive health is trying to convince people that the best way to have a healthy family is to have longer intervals between births. In the UNIFEM survey *Women at Work*, women were asked whether they alone decided on the use of birth control or if they consulted their husbands: 10 per cent said they did not consult their husbands and 90 per cent said they did.⁶² This has been hotly debated in the UNIFEM workshops, because many well-educated women find it hard to believe that women do not make such decisions on their own.

According to a UNFPA survey, only 8.5 per cent of couples in Kosovo use modern contraceptives.⁶³ Access to contraceptives is difficult and limited. People must visit specialists or health care centres, which are often far away. There have been campaigns to encourage the use of condoms, and they have been distributed throughout Kosovo. Organizations like Doctors of the World have offered reproductive health services to women in rural villages and discovered that there is great need and hunger for education about women's reproductive health and reproductive rights.⁶⁴ The discussion and use of contraceptives is still a cultural taboo and is mostly overlooked by politicians as an important area to consider in fighting poverty, improving health, saving lives and in the necessary empowerment of women.

One Kosovar tradition is to have big families. Many Kosovo-Albanians are still suspicious of birth control campaigns, from times when the Serbian regime promoted the use of family planning. The Albanians perceived that as an attempt to cut down the Albanian population to secure Serbian rule in the province.

Abortions are legal in Kosovo, but there are no figures on their frequency. According to the Kosovo Common Assessment: "One recent indication of the sex ratio at birth [1.15 according to a UNFPA/IOM study] is too high for natural population equilibrium. It suggests a possible boy preference leading to selective abortion practices. A combination of low contraceptive prevalence and an

⁶⁰ *Kosovo Common Assessment*, p. 21.

⁶¹ UNFPA Information sheet.

⁶² *Women at Work*, p. 76.

⁶³ UNFPA Information sheet.

⁶⁴ Information from doctors working for Doctors of the World and UNFPA.

average rate of 2.8 children per woman (1999) strongly suggests that abortion, which was legal up to 12 weeks of pregnancy and up to 22 weeks for medical reasons, may be widely used for fertility control. A recent UNFPA/IOM study confirms that abortion is a common, under-reported practice, possibly as high as 50 abortions per 100 deliveries. Professionals believe that excessive abortions have contributed to Kosovo's high infant and maternal mortality."⁶⁵ UNFPA figures indicate that the perinatal mortality rate for hospital-born babies in the year 2000 was 29.2 per 1,000 babies. The total infant mortality rate was estimated to be 45/1000 in 1999, which was an improvement from the late 1980s.⁶⁶ The paper "Health Policy for Kosovo" notes that "infants accounted for 40 per cent of in-hospital mortality, the mortality of sick neonates being alarmingly high".⁶⁷ It is common knowledge that women do not breastfeed their children, but there exists no reliable information. If true, it may partly explain the poor health of newborn babies. It is certainly a worthy area for further research. There is also no information available about the consequences of losses of children for the health of mothers.

The expected lifetime of women in Kosovo is unknown. Doctors say that women's health in general is too poor. Many women suffer from anemia due to bad food and short interval between births, smoking is terribly common among women and men, which has strong chronic disease implications for the future. Many women suffer from losses of family members and trauma from the Kosovo conflict. Several women, especially in the areas where the fighting was most severe and where most people "disappeared" continue to be traumatized, are still unable to face a new future.⁶⁸

Different sexual orientations are one of the many cultural taboos in Kosovar society. Among women and men, "most [gay people] have decided to ignore, hide, or deny their sexuality."⁶⁹

The author has no information about sex education or sexual diseases, except that six cases of HIV were reported to the Department of Health in 2000.

Trafficking in Women

One of the first issues to be officially addressed by international agencies and NGOs working on gender in Kosovo was trafficking in women. After only three months of an international presence, it became clear that this was a growing problem. A Gender Task Force Meeting was organized by UNIFEM, and resulted in a subgroup that developed the UNMIK Regulation on trafficking in persons. This was later approved by the United Nations after a long process.

⁶⁵ *Kosovo Common Assessment*, p. 21.

⁶⁶ UNFPA Information sheet.

⁶⁷ *Ibid.*

⁶⁸ UNIFEM workshops 2000-2001.

⁶⁹ *No Safe Place*, p. 109.

The UNIFEM assessment *No Safe Place: Violence Against Women* notes that Kosovo, once a transit route for traffickers, is now also a destination point and a new market for sex traders. There is no doubt that the presence of thousands of international troops, UNMIK and other international staff have increased the trafficking. Despite a new regulation and serious efforts by KFOR, police and international agencies that attempt to stop trafficking, the results appear to be limited. There is more awareness of the serious effects of trafficking, the impact on the lives of the women involved and the society, but it is not enough. The women are moved constantly to new places; new clubs and brothels are opened; and there is enough corruption to cover and replace their criminals. So far, there is little evidence of the trafficking of women out of Kosovo.

An IOM report of 15 June 2001 reveals that 160 young women, all victims of trafficking, had been assisted and returned to their home countries between February 2000 and May 2001. Most of these women came from Bulgaria, the Republic of Moldova, Romania and Ukraine. They were 18-24 years of age and single; most had been living with their families. Most had no access to health care, and the use of condoms was alarmingly low.⁷⁰ According to the information given by these women, 70-80 per cent of the “clients” are Kosovo-Albanians, and 20-30 per cent, international staff members. The central questions are how many women died as a result, and how many cannot return to their home countries?

During the summer of 2001, UNFPA and UNIFEM personnel visited the only prison for women in Kosovo to find out about the needs of the prisoners, their health situations and how the prison could be assisted in developing programmes for the women there. To their surprise, they discovered that most of the prisoners had been trafficked women from the above-mentioned countries. They had been arrested for prostitution, captured during police raids on brothels, or because they had false or no documents. Many of them stated that they neither could nor would go back home, either because of shame or because nothing awaited them there. Most of them were imprisoned for short periods of time. IOM was informed about the situation, and the agency will do whatever possible to help the young women.

During the author’s stay, two campaigns were organized to raise awareness on the necessity of stopping trafficking in women. The goal was to inform people about how trafficking is organized and its dangers and implications, and to stress that although “clients” are paying by the hour, women can be paying with their lives.

There have been requests for an international Code of Conduct forbidding all international agency workers in Kosovo to buy sex. Some of the armies have

⁷⁰ IOM Report on Trafficking in Women (Kosovo, June 2001).

strict rules and have punished their soldiers if it is proved that they have visited brothels; others seem to do nothing. The United Nations DPKO has such rules, but they are difficult to enforce. In addition, traditions and attitudes towards prostitution vary from one part of the world to another. According to the international press during the summer of 2001, foreign policemen working in Kosovo have been arrested and sent home for being involved in trafficking, for tipping off “pimps” about police or army raids on clubs and brothels. The fight against trafficking in women must and will continue, but it is obvious that the “sex industry” is powerful and difficult to deal with and that certain people are quite content to use these “services.” One of the best ways to fight trafficking is to raise awareness among the public, and to encourage people not to tolerate trafficking in their communities.

Violence against Women

Violence against women in Kosovo is a widespread but hidden phenomenon. After the end of the crisis, state agents focused on violence against women, and gradually domestic violence and trafficking in women received more attention. Discussion of domestic violence is new in Kosovo, although some women’s groups have been aware of the problem for a long time. As in other countries when the issue has first been raised, it has been difficult for many to acknowledge how widespread the problem is. It is still new to question men’s rights to treat their wives and daughters using corporal punishment. There has been a long debate between international and local lawyers, male lawyers in particular, who are working on a new Penal Code to determine the scope of the law in dealing with domestic violence. International lawyers want to include domestic violence in the code, though some of the Kosovars say domestic violence is a private matter and not public business. At present, work on the Penal Code is not completed, though the United Nations is considering a chapter on domestic violence for its legislative draft.⁷¹

Kosovo-Albanian women stated in the UNIFEM workshops that violence against women is a growing problem. It is impossible to know whether this is the case, since there is no reliable pre-conflict information about domestic violence.⁷² It is likely that the number of victims who are emboldened to seek help and shelter as well as increased discussion about domestic violence gives the impression of a growing problem. It is also possible that the incidence of domestic violence is increasing in response to years of conflict and fighting. As such, further research on this important issue is necessary.

Experiences from the war in Bosnia raised alarm about the rape of Kosovo-Albanian women by the police, paramilitaries and soldiers. It is known that numerous women were raped, but it has been difficult to provide concrete

⁷¹ Information from OSCE lawyers in Kosovo.

⁷² The NGO Center for Protection of Women and Children made a survey in 1996.

evidence of what really happened. Women are afraid to disclose their experiences for a variety of reasons. They suffer from intense feelings of shame and fear of being shunned by their families.⁷³ Many personal stories involving rape exist, but women in Kosovo say that the frequency of rape was much lower than in Bosnia. The UNIFEM assessment *Violence against Women* addresses domestic violence, rape and trafficking in women. Of the women who took part in the survey, 23 per cent disclosed that they were victims of violence by a partner or a family member. This is similar to figures reported from other countries on domestic violence. Of the women interviewed, 18 per cent reported rape by a partner or a family member,⁷⁴ which is at least comparable to evidence from other countries. Further research is needed to find out more about rape inside and outside families, as well as sexual abuse and rape of young girls. Common talk of “honour-killings” of young girls who have been sexually abused still exists in Kosovo. In the city of Prizren, UNMIK dealt with one such case last year, where a girl managed to hide and then escape with the help of international staff.

The UNIFEM assessment shows that women and men have different understandings of what violence is. Men tend to see violence as solely physical; women perceive it to have broader ramifications, including emotional, social, physical, financial and sexual.⁷⁵

The Girl Child

It is interesting to look at the male/female birth ratio in Kosovo. Of hospital-born babies, the ratio is 109.4:100, and 116:100 for Pristina Hospital (33 per cent of all births).⁷⁶ There is an obvious male preference in the society. It would be interesting to analyse the high infant mortality rates to see if girls have higher death rates than boys. In August 2001, between 30 and 40 babies were abandoned in Pristina Hospital, most of them girls. In the Department for Social Welfare, this author was told that it is more difficult to find people willing to adopt girls than boys. In some of the UNIFEM workshops, the women were asked, “What happens in a family when a boy is born versus a girl?” Sadly, many mothers, fathers and other relatives reacted by saying they would embrace a boy, but not a girl.

As mentioned before, girls get less education and have fewer opportunities for going to school than boys. The girls are expected to take part in time-consuming housework from an early age, whereas no such indoor demands are made of boys.⁷⁷

⁷³ *No Safe Place*, pp. 61-71.

⁷⁴ *Ibid.* pp. 35-38.

⁷⁵ *Ibid.*, p. 39.

⁷⁶ UNFPA Information sheet.

⁷⁷ UNIFEM workshops 2000-2001.

One of the issues UNIFEM addressed was violence against children and sexual abuse of children, mainly girls. When this author tried to talk to Kosovo-Albanian women about this serious issue, it was met with silence. Some of them nodded their head, indicating that they knew that this occurred, but they would not or could not talk about it. Violence against children is still a taboo, and there is no information available about its frequency or forms. It is known that teachers have long used violence in their work, as in beating pupils, and now there is some discussion about forbidding such methods.

There is a reason to look at activities offered to boys versus girls in the Kosovar reconstruction process. There appear to be no gender-based programmes and other activities for teenagers, except possibly working, walking around and smoking. One of the things that Westerners notice in Kosovo is the use of child labour, which is forbidden in most European countries. Boys between of six and seven years of age sell cigarettes, lighters, telephone cards and other items across Pristina, late into the night. Girls are rarely seen selling in the streets. It begs the question if young boys have money, while girls have none, or are these boys the breadwinners of their families? Among the Kosovo-Albanian beggars of Pristina, beggars include young boys and girls. While no information about their backgrounds or histories was available, given the strong position of the Kosovar family, one wonders why and how certain people fall outside society's safety net.

Minority Women

The number of people belonging to the minority population in Kosovo is estimated to be about 200,000. Serbs are the largest group, followed by the Roma people, Turks, Goranci and others. After the conflict, thousands of minority people fled the revenge of the returning Kosovo-Albanians. It is estimated that approximately 200,000 Kosovo-Serbs are internally displaced in Serbia. After a decade of conflicts in the former Republics of Yugoslavia, the number of displaced persons in Serbia totals approximately 600,000 people. Efforts by the international community to encourage minorities to return to Kosovo, including those by UNHCR, are so far without much success.⁷⁸

The situation of minority women in Kosovo calls for a special attention. Minority women face serious problems such as isolation, insecurity, high unemployment rates, poverty, lack of freedom of movement, violence against themselves and their children, and limited access to social services. It is known that the birth rate is extremely high among Roma women, but the exact figure is not known. Infant and maternal mortality is also high within the Roma communities, along with poverty and illiteracy among women. Many Roma girls

⁷⁸ UNHCR and OCHA reports from Kosovo 2001.

get married at a young age, and lack of education and economic opportunities are common issues for these women.⁷⁹

Serbian women generally have more education than other women in the province, and many had jobs of some sort before the crisis. The birth rate is much lower among Serbian women than among Kosovo-Albanians, and their position inside the family seems to be more equal than among Albanians. Even so, Serbian women face the same problems as other minorities, and sometimes worse problems, since all Serbs seem to be regarded as responsible for what happened during the conflict throughout the 1990s.⁸⁰

It is obvious that the conflict had a great impact on the lives of minority women and their children. Trauma, pessimism, anger and lack of hope are still typical problems for most of these women. Many had to leave their villages and are living as IDPs in other parts of Kosovo. They complain of lack of support from the international community. It is difficult to raise money for projects in Kosovo due to donor fatigue, although there is great need of support, not least among minority women.

Despite the presence of powerful women among the minorities, the leadership of all minority groups is totally dominated by men. This author never heard or saw a woman representing minorities except at special women's conferences.

Women and Decision-Making -- Women in Politics

Historically, women in Kosovo have played an unequal role to that of men in decision-making structures and in shaping society. Women in Kosovo face enormous economic, social and cultural problems, and they have limited opportunities to address these issues because they are kept out of decision-making. Thus far, women have been underrepresented in the UNMIK "government" as well as in other reconstructive bodies. Only two women are now among the 20 local leaders of the Departments (Ministries) of the Joint Interim Administrative Structures. Six women (16.2 per cent), mostly representing civil society, are members of the Kosovo Transitional Council, which is an advisory body to the "government." These women were all nominated by UNMIK after considerable pressure from local and international women.⁸¹

Most of the women elected to municipal councils, 56 out of 77 women, come from the LDK party. UNIFEM and STAR Network, an NGO from the United States, organized a workshop with the elected women from LDK in August. Most were pleased with their work as members of local governments, dealing with

⁷⁹ Accounts of international women working within Roma enclaves.

⁸⁰ UNIFEM workshops 2000-2001.

⁸¹ Information from the UNMIK Office of Gender Affairs, Kosovo. 2000-2001.

difficult issues such as the budget, city planning and the building of social services. Yet very few of them held leading positions inside the councils.

In the general elections of November 2001, there will be a 33 per cent quota for women in the first 67 per cent of the seats, equally distributed over the lists. This time people can only vote for one party, so the quota should be implemented. In workshops with women from the political parties, they feared that the “party leaders” would somehow be able to manipulate the results and rid themselves of the elected women. Keeping in mind that the parties are being forced by UNMIK to accept a quota, it is possible. Some women are concerned that attempts will be made to press women to step down and give their seats to men. Again, it remains to be seen how women will be represented in the new “government” of Kosovo.

All the biggest political parties, specifically the LDK, PDK and AAK, have women’s branches. The Women’s Forum of LDK is the biggest women’s movement in Kosovo. It has valuable experience from the days of the parallel system (1989-1999), when it organized assistance to women.⁸² However, these women have not been nominated or elected to represent their parties. The women are simply not in the ranks of power and decision-making structures.

Two women are leaders of the two parties of Social Democrats, formerly the Communist party, and both are highly respected based on their work histories. They have little political support, however, and hardly any power.

In the last few years, Albanian women in Kosovo have built up a network of NGOs and women’s groups. Many of the NGOs have strong leadership and are doing good work to empower women. Last year, several NGOs, political parties and the media formed the Women’s Coalition with a board of nine members. The goal of the Coalition has been to address the issue of increasing women’s representation and participation in political and economic life. The Coalition organized a campaign for female candidates last year, but started late and their candidates had little success. The Coalition has faced difficulties in recent months because of internal conflicts. There seems to be a significant gap between some of the women’s NGOs and the women’s branches of the political parties. Instead of solidarity and support greatly needed for women’s empowerment in the male-dominated society of Kosovo, competition and rivalry exists among them.

⁸² Information from the UNMIK Office of Gender Affairs, Kosovo. 2000-2001.

Legislation, Human Rights and Protection of Women

One of the initial problems facing UNMIK was discovering what applicable laws existed and procedures necessary to create new legislation with the Kosovars. According to legislation from the Yugoslav Republic, women had “equal rights” with men, but they were not highly respected by Kosovo-Albanians.⁸³ Yet, how much influence did this legislation have on women in other parts of Yugoslavia? Women in Kosovo currently have the right to vote and to run for elections. Nevertheless, there were many cases during the local elections last year when men in the villages demanded to vote on behalf of their wives, saying that women did not know how to vote. The women running for election received little support.

Divorce is legal but difficult to obtain if children are involved, given Kosovar society’s family-centred focus in society. According to tradition, women do not have the right to keep their children following divorce or the death of their husbands. The children are considered to belong to the husband’s family. This tradition makes it extremely difficult for women to leave violent husbands. There is no legislation on equal opportunities for women and men, and still no such programmes in the departments or in the municipalities. A new labour law is being created to secure the rights of women in many ways, but for the Kosovo women it does not necessarily mean progress. For example, in the Yugoslav Republic, women could have a six-month maternity leave, but the new legislation only gives them three months. The legislation on reproductive rights needs to be strengthened in terms of increasing access to contraceptives, the right to health care, sex education and other resources. In addition, powerful legislation on domestic violence to protect women and children is necessary.

According to the Legal Framework for Kosovo, created in 2001, the new government must implement the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). This gives women an opportunity to press the new assembly and the new government for actions to improve women’s situation. The Convention on the Rights of the Child is not mentioned in the Legal Framework.

A Kosovo Action Plan for the Advancement of Women was under development, led by the UNMIK Office of Gender Affairs. The Action Plan prioritized the most important gender issues and necessary actions to be taken. It was stopped by some local NGOs, however, because of disagreement on the working process and questions about who should lead the process. There appeared to be a major misunderstanding of UNMIK’s role versus that of the local people.

⁸³ UNIFEM workshops 2000-2001.

Legislative reforms are needed in many areas, but the most important need concerning the legal rights of women is for a change of attitudes towards women and increased respect for their human rights. Campaigns and public education are required to make people aware of women's participation as crucial in shaping society as well as of women's rights to pursue change.

Women and the Role of the Family

During the Middle Ages (500-1500 A.D.), the extended family⁸⁴ was a basic institution in Europe, developing slowly towards the nuclear families of the present day. Modern English does not have a word for this concept, whereas many other European languages do (such as the German, Swedish, Danish, and Icelandic). According to old Icelandic traditions and laws, the extended family had three main duties: to protect their family members, to provide them with food and shelter, and for the men to take revenge if any member was killed or seriously harmed.⁸⁵ Although changes are taking place, these traditions are also well known in the Muslim world and are still highly respected among Kosovo-Albanians. Stopping blood feuds and other acts of revenge was, to an extent, successfully attempted, but they still persist.⁸⁶

The extended family is a strong unit culturally and ideologically, as Kosovo-Albanians have great respect for their families and for their duties toward family members. Having a large family is regarded as a blessing by many. Kosovo-Albanians living outside Kosovo show their respect by sending large amounts of money home to support their extended families. It is estimated that as much as DM 750-850 millions (\$350-400 million) comes from the expatriate Albanians annually.⁸⁷ This partly explains how families have survived without jobs and have rebuilt their homes.

The tradition is that women move in with their parents-in-law when they get married. Daughters-in-law are expected to take part in the housework and serve the men in the family, whether they have a paid job or not. There is still a major lack of social services like childcare, support for disabled people and the elderly. It is the family's responsibility to take care of those in need of special services, and it is women who do this kind of work. Arranged marriages still exist in the villages, but are slowly disappearing.⁸⁸ The number of nuclear families is also growing rapidly, especially in the bigger towns.⁸⁹

⁸⁴ According to tradition the extended family means the relatives of a person, his/her children, his/her parents, sisters and brothers and their children and the brothers and sisters of his/her parents, their children, and grandchildren.

⁸⁵ From the old Icelandic law book "Grágás" written in the 12th century.

⁸⁶ Accounts of Kosovar women.

⁸⁷ Draft of a UNDAF for Kosovo, p. 5.

⁸⁸ Accounts from UNIFEM workshops 2000-2001.

⁸⁹ *Women at Work*, p. 45.

At a meeting about violence against women in Pristina, in 2001, the author of this report was one of the speakers. There, a male Kosovar psychologist praised the Albanian family as being unifying, protective and taking collective responsibility. He compared its benefits with the high divorce rates and individualistic families of the West. Many local women attending the meeting, mostly from NGOs working on violence against women, told him that they had experienced enough of authorities telling women what to do, from the collective policies of Communism to the dominating patriarchal power of the family. They said that the traditional family oppresses women, limits their freedom and exists as the main context of violence against women. This debate highlights an intensive future discourse in Kosovar society about the future role of the Albanian family and the right of women to choose their own ways of living.

The situation appeared to be significantly different among the Serbs. Nuclear families are dominant, and it is much more common that children go away to boarding schools, especially for university.

Gender Issues and the Peacekeeping Missions

The United Nations has adopted CEDAW, the Beijing Platform for Action, the Beijing +5 Platform for Action, and Resolution 1325 on Women and Peace. The Beijing Platform for Action contains a special section on mechanisms inside the United Nations and how to implement the Platform for Action within its work and structures. The European Parliament has adopted a Resolution on Participation of Women in Peaceful Conflict Resolution (2000).

How are the United Nations policies on elimination of discrimination against women and equal opportunities between women and men being implemented in the mission in Kosovo? According to the Security Council Resolutions 1244 and 1325, the role of the Peacekeeping Missions is to secure peace and assist local people in reconstruction of the area, developing all policies with a gender perspective. Additionally, the role is also to develop society towards democracy, respect for human rights, equal opportunities for women and men, equity and a safe future. These huge projects are of as much concern for women as for men, and women should be taking part equally in the peace-building and reshaping of society. The question is, is this a feasible goal?

UNMIK, United Nations organizations and agencies and international NGOs have played a significant role in the reconstruction of Kosovo. From the gender perspective there are many lessons to be learned. UNIFEM, UNICEF, UNFPA, IOM, FAO, UNDP, the UNMIK Office of Gender Affairs and others have addressed many issues concerning the situation of women. Much is being done to raise gender awareness among local people and to deal with special matters, such as trafficking in women. Local and international women together managed to get the support for the nomination of six women as members of the Kosovo

Transitional Council and convinced UNMIK and OSCE to institute a quota for women on the lists of the political parties running for elections.

Nevertheless, women are not being involved in policy-making. Gender perspectives are seldom included in policy-making or in the programmes. The international staff seem unaware of the above-mentioned documents and of their duties in implementing them. The UNMIK Office of Gender Affairs, established in late 1999, lacks the authority, support, expertise, staff and money needed to have the necessary influence. In essence, the main role of the Office should have been, from the beginning, to train international staff and promote gender-mainstreaming policies. The training of Gender Focal Points started in late 2000. In 2001, the Office, in cooperation with UNIFEM, started training municipal staff members on gender issues and how to mainstream them into all policies. UNMIK staff, in general, does not have such training in Kosovo. Many UNMIK staff members were unfamiliar with the enormous problems facing Kosovar women, and seemingly had little interest in gender issues. The Swedish NGO Kvinna till Kvinna wrote the report *Getting it Right? A Gender Approach to UNMIK Administration in Kosovo* in 2001. Written by a woman who worked in OSCE in Kosovo for two years, the chapter entitled “The lack of gender awareness among senior staff” states that:

“as the international community began its reconstruction and the work of institution building in Kosovo, it soon became clear that very few, if any, of the senior staff in the international administration (almost exclusively men) had any understanding, either of the notion of ‘gender’ or of ‘gender-mainstreaming’.”⁹⁰

This is one of the biggest obstacles to gender-mainstreaming in the work of reconstruction. Senior staff, and especially the Heads of Missions, need to be gender sensitive so that they can obtain the right kind of information and give appropriate support to mission members who try to use a gender-mainstreaming approach.

The United Nations can improve its work on gender issues, especially to ensure that the United Nations Conventions and Resolutions on the rights of women are being respected and implemented. This said, it is also notable that the presence of UNMIK and other international bodies has had a great influence on the lives of Kosovar women. Most important, the fighting stopped. Life is now more secure for the majority of the Kosovar population. Young people, girls and boys, now have an opportunity to receive education, and health-care services are improving. New ideas about the human rights of women are being introduced and fought for, and local NGOs have had significant support in their work to raise voice of women and civil society.

⁹⁰ *Getting It Right?*, pp. 11-12.

Kosovar women have debated about how to organize and improve work on gender issues. Some say that mechanisms like a Women's Department or some kind of a gender unit is necessary to follow up on equal opportunity programmes. Others say that such units will marginalize women. They think gender perspectives should be implemented into all policies and followed up within each area of concern, without special mechanisms or provisions. It does not seem to be a question of either option, but the integration of both. There must be strong, effective mechanisms at work for Governments and municipalities to develop and follow-up gender policies. This is what can be learned from more than 30 years of experience on equal opportunity programmes in Nordic countries. These programmes have been successful, and effective instruments were created. Some institution must be responsible for the equal opportunity programmes, based on legislation and planned actions. Someone must take initiative in policy-making, raise issues and secure cooperation with the entire administration and civil society. At the same time, gender policies must be mainstreamed into all activities and programmes, in all places, at all times. Finally, the women's movement and other bodies working on equal rights and opportunities for women and men must be integral to the whole process.

Future Strategies for the Peacekeeping Missions

Among the lessons learned from the Peacekeeping Mission in Kosovo and the work on gender issues are the following:

- All international staff members, regardless of origin, must be gender sensitized and trained in gender analyses. This training must be well organized and take place at the beginning of the mission. It should contain an introduction to United Nations policies on gender-mainstreaming and the basic United Nations documents on the human rights of women, and address the situation of women in the country of concern. Follow-up sessions after a few months of experience in the field should be required;
- All programmes must be developed from a gender perspective and include gender analyses;
- All agencies must develop equal opportunity programmes for their work, including policies for the hiring of staff members;
- If applicable, all agencies must appoint Gender Focal Points to follow up on their gender policies and mainstreaming work within the agency;
- All agencies must stress the gathering of sex-disaggregated data and information from the outset of their work in the mission;

- All agencies should have institutional mechanisms to promote the empowerment of women in their field of work. Campaigns must be launched to introduce the United Nations Beijing Platform for Action, the Beijing +5 Platform for Action and United Nations Resolution 1325 in the area of concern;
- United Nations organizations and agencies need to improve their cooperation and sharing of information through regular meetings. They should develop programmes together and use the available expertise as effectively as possible; and
- All agencies must involve local women in all fields of their work, and investigate and explore their needs, which entails listening to the women and supporting their demands for equal representation and participation in decision-making as they shape the future of their own country.

Lessons Learned on Reproductive Health

For detailed recommendations on perinatal health in Kosovo see: *Perinatal Health Care Situation in Kosovo: Past, Present and Future (2001)*.⁹¹

- The media can and must be used in a successful way in sex education and to inform people about reproductive health and reproductive rights;
- It is necessary to concentrate on local politicians, both men and women, to make them aware of the importance of women's reproductive health and reproductive rights and to develop legislation and policies supporting the rights of women. In particular, it is the politicians who make decisions on building up health-care services for women, young people and sex education in schools;
- It is important to raise awareness and build partnerships among local women's NGOs on the reproductive rights of women for their support in running campaigns, and to educate women and young people. Seminars, workshops and training sessions should be organized in cooperation with local and international NGOs;
- It is necessary to initiate discussions among the public about the issues of reproductive health with conferences, workshops and seminars, bearing in mind how sensitive these issues are in most societies;
- More support is needed from donors to develop the above-mentioned programmes. Better reproductive health for women is crucial in fighting

⁹¹ Report of a Consultancy for UNFPA Mission to Kosovo, April 23 - June 15, 2001, pp. 1-2.

poverty, saving lives, developing a more equal society and empowering women; and

- More support should be obtained from other United Nations organizations and agencies so that, if possible, they include reproductive issues in their work.

Conclusions

The Kosovo conflict of 1989-1999 had devastating effects on the lives of women and girls in the area. Kosovo-Albanian women had greatly limited freedom of movement; getting education became difficult; standards fell; and unemployment became a huge problem. Many working women lost their jobs, but they reacted by organizing peaceful resistance and offering help to women. During the worst part of the crisis in 1998-1999, many women lost family members, became victims of violence and went through a period of intensified insecurity and fear. The exodus to neighbouring countries and subsequent stays for weeks in refugee camps, or suddenly becoming refugees in countries all over the world, were new and often difficult experiences for women. The pressure of having several children or grandchildren to care for often compounded these difficulties. Women's NGOs played an important role in the refugee camps, with activities aimed at helping women through these traumatic times.

After the crisis ended, Kosovo-Albanians returned home. Reconstruction began under the command of the United Nations, OSCE and the European Union, under the protection of KFOR. These were also times additional destruction. Women lost family members and property. Unemployment continued, and poverty became the destiny of many women. At the same time, many women began working for international agencies, and some became the only breadwinners in their families. Women's NGOs flourished with international support and cooperation. A few international agencies and NGOs worked on gender issues and have maintained support of women on their agendas.

Many issues concerning the lives of women have been addressed since the beginning of the mission, drawing attention to the difficult situations of Kosovar women and their lack of human rights. Illiteracy, lack of access to education, unemployment, lack of social services, high birth rates, maternal mortality, health problems, domestic violence against women and trafficking in women from Eastern Europe are among the most important problems articulated by Kosovo-Albanian women. Women are deprived of power in society. Women want jobs and they want to participate in decision-making, but their rights and demands are still not respected. Quotas, determined by the international community in municipal and general elections, may improve representation there. There are still cultural taboos that are difficult to discuss in Kosovar society, especially concerning different forms of violence and sexual abuse of women and girls. Finally, minority women suffer from lack of freedom of movement,

insecurity about the future, unemployment and fear of violence from outside and inside the enclaves where they live.

The international Peacekeeping Missions have played important roles in the reconstruction of Kosovo and in the protection of the minorities. Gender perspectives and gender-mainstreaming, however, have not been included in the work of the international community the way they should have been, according to the policies of the United Nations and the European Union. The UNMIK Office of Gender Affairs does not have the support, authority, expertise and funds needed for the necessary training and policy-making inside UNMIK and for the advancement of Kosovar women.

Many lessons are to be learned from the experience in Kosovo. Because new “missions” will arise in different places, it is important to reflect upon and improve the work of Peacekeeping Missions. The most important improvements are:

- To share information, experience and to support one another in mission work;
- To emphasize the gathering of sex-disaggregated data;
- To make a cultural analysis of the area, and to increase the understanding and knowledge of the international staff members, of traditions, laws and religions in the country; and
- To gender sensitize all staff members, train them in gender analysis, introduce them at United Nations conferences, and raise awareness about women and girls in Kosovo and about their central importance and duties in securing human rights for women.

THE ROLE OF WOMEN'S NON-GOVERNMENTAL ORGANIZATIONS IN REHABILITATION, RECONSTRUCTION AND RECONCILIATION

**Ketty Lazaris
President**

Mediterranean Women's Studies Centre (KEGME)

Introduction

Armed conflicts are one of the biggest concerns of the world community today, as their implications on people, societies and economies are devastating. Conflicts leave behind thousands of dead, thousands of widows and orphans and millions of refugees and displaced civilians. They also affect the social, economic and physical infrastructure on which civilian life depends.

For women, armed conflicts involve painful paths of dramatic changes and learning, where living occurs between traumas and new perceptions. Conflicts challenge women's survival capabilities and strategies, yet their capabilities and contributions, both during war and post-conflict reconstruction, are not fully appreciated. There is a strong tendency to present women as suffering victims. The mass media present conflict and refugee situations through images specifically of women, children and old people, who are given assistance mostly by women. This presents a message of men heroically defending community interests and women as victims and caretakers. No attention is given to other factors: that women shoulder the economic and psychological burdens of their families, that they play foremost roles in supporting their communities and that they play extraordinary roles in peace-building and reconciliation.

Ketty Lazaris, President of the Mediterranean Women's Studies Centre (KEGME), has been active in the women's movement for nearly 30 years. She has founded numerous women's NGOs and networks, specifically the Women's Union of Greece (EGE), the Women's Centre for Research and Action for Peace, the European Network for Women's Studies (ENWS) and the Balkan Women's Network for Democratization and Conflict Transformation, on which she is also a Board Member. In addition to representing KEGME in all major United Nations conferences on women, she is the author of several papers on women's issues.

Walking the painful path of conflict and change, women have learned that restructuring, rehabilitation and reconciliation constitute a slow process. They are ready to take up the challenges of being key actors in rebuilding civil societies on more equitable and democratic bases.

This paper outlines the main socio-economic effects of conflict and reconstruction on gender; assesses the roles of women's NGOs and identifies their aims, strategies and challenges in rehabilitation, reconstruction and rebuilding of conflict-torn societies; highlights women's initiatives for transforming conflict; and formulates proposals for action.

Gender and Conflict

“Gender” is a term used to connect social roles and interactions between women and men. Gender roles are a set of social norms for the behaviour of men and women, assigned on the basis of class, race, ethnicity, culture, age and religious beliefs. It is through gender roles, that women and men perceive their social identities and relationships, both to each other and to their communities. Gender implies social placement which, in turn, implies a pattern of dominance and subordination, often placing men in control and keeping women in subordinate and supportive roles. In accordance with their roles, men feel entitled to dominant positions in the family, work and political life. In many parts of the world, men have de facto authority to control or influence decisions about war and peace, legal protection and punishment, political leadership, funds allocation and the control of resources.

Armed conflict is not gender neutral because:

- Women and men experience conflicts differently, both as victims and as perpetrators;
- Women and men differ in their access to resources during armed conflict, including power and decision-making efforts;
- Men and women have different roles and relationships to peace-building and violence reduction;
- Women and men have different needs, interests and strategies in peace-building.

To understand armed conflict, reconstruction, rehabilitation and the rebuilding of war-torn societies, a gender analysis is necessary.

Impact of Conflict on Social and Economic Sectors

Demographic Changes

Conflict and displacement involve large demographic shifts that seriously affect communities and families. Armed conflicts have changed the lives of millions of men and women, not just in the nations involved in conflict but also in bordering countries. The following are among the changes:

- Female population increases as a result of males being killed in battle and/or ethnic cleansing, flight and labour migration. Even after conflict, many men continue working in foreign countries while women and children return home;
- The age structure is affected. Studies carried out in various countries document that during war, fertility rates drop and infant mortality increases. In the Balkan region, however, ethnic minorities such as the Roma have much higher fertility rates than the rest of the population. In many instances, this demographic issue has provoked resentment, which, in turn, has a negative effect on women exercising their reproductive rights. Another contributing factor is that most war casualties are male soldiers in their productive years. According to an ILO assessment of Bosnia, 39.5 per cent of the population is under 16 years old and, in coming years, the 65+ age group will increase. National population policies in war-afflicted countries encourage an increase in the birth rate, with some providing incentives and protective measures towards this aim;
- One of the most significant outcomes of conflict is the change in gender roles and household structures. While men are active in war, women become heads of households and are involved in activities previously allocated to men. When households expand to accommodate additional family members, widows and displaced, abandoned or orphaned children, this results in increased dependency ratios that constrain women's resources, workload and health. Families are often separated for long periods of time, and many marriages are destroyed. Trends in household structures reflect more women living alone or as heads of households, which often leaves them impoverished and socially isolated;
- Communities are heavily affected by dispersion and reallocation. The return of refugees to their places of origin proves to be a difficult operation due to numerous factors such as employment, housing, and the scarcity of arable land, schools and other basic services. In the Balkans, the process is more complicated because most returnees will become minority groups. Of these minorities, the most vulnerable are women of mixed marriages who must

decide to return to their husband's pre-conflict place of residence, or their own; and

- Communities are also affected by urbanization trends. Masses of people from rural areas, mostly women, moved to urban centres for multiple reasons, such as fleeing conflict areas for safer environments or seeking better job opportunities. As a result, communities are faced with rising prejudices between local people and newcomers. Urban residents tend to regard rural people as second-class citizens, while older rural women consider urban culture as threatening to their guarded cultural identities and values, making integration into urban surroundings more difficult.

Health

Armed conflicts have extremely serious effects on health sectors, as basic infrastructures are destroyed. Hospitals, clinics and local health centres are demolished while medicines, equipment and supplies are looted. Electricity and water plants are damaged and health information systems break down. Consequently, the capacity of the health system to cope with war emergencies is crippled. Furthermore, the number of medical staff decreases due to deaths, displacement, injuries or flight to other countries. Numerous doctors and nurses are channelled towards the conflict zones to cater to the military forces, while remaining health workers are demoralized and left without adequate support or payment. Land mines and curfews also limit the mobility of health workers to meet the community needs. Another important factor that affects the health sector is the transfer of public funds from health to defence. This results in declines in the quality of care, lowered standards in HIV testing for blood transfusions and the disruption of health programmes. This gap can be covered by unregulated private-sector health care which, in turn, increases costs to their users.

The breakdown of the health sector and the shift to the private sector providing health-care services exacerbates the health of populations in conflict areas. Decreased income and increased cost of services are prohibitive factors for adequate health-care access, especially for women, large families and rural population.

Displaced persons, refugees and people living in camps face major difficulties related to inadequate accommodation, poor sanitation conditions, shortages of money and humanitarian aid, lost documents, poor health-care provisions and many psychological problems. As a result, malnutrition, anaemia, malaria, dysentery, tuberculosis and other diseases worsen their already precarious situation. Refugee women are considered the most vulnerable group, since they are often exposed to violence, sexual abuse, rape and enforced pregnancy, which require additional specialized care and psychological support.

Violence against Women

Violence against women is a universal problem. In conflict-ridden regions and in post-conflict communities, however, it has much wider social ramifications. Many international agencies and national NGOs have documented that, during wars, violence against women is often applied on a massive scale. Women are systematically raped, intimidated, sexually abused, forced into unwanted pregnancies and killed. The intention behind these brutal actions is: to degrade, humiliate, terrorize and shame the other national group as a whole; to impinge on women's health and well-being; to undermine women's abilities to sustain their families and communities; and to destroy the family-based organization of the enemy group.

Most sexually abused women suffer emotional breakdowns, especially women from rural communities or settings where moral codes are strict. Their husbands, their families and their communities often reject them. Many impregnated women, after rape, have "back-street" abortions that put their lives at risk. Some cannot look at their babies. Still others give them away.

Violence against women in post-conflict communities is reported to extend from the public to private spaces, as ex-combatants tend to bring back their "soldiering" by projecting their traumas and frustrations onto their wives and families.

Socio-economic crises exist in the aftermath of conflict, resulting in the flourishing of the sex industry and especially in the trafficking of women and children. Women who seek employment opportunities outside their own countries are seldom aware of the potential dangers they face. Their lack of information on the nature and conditions of work might make them susceptible to international organized networks that traffic in human beings. The abduction of women and children is also reported from many countries for the purpose of sexual exploitation.

Social and public institutions often do not respond to violence with appropriate attention, immediacy and care. Inadequate legislation and traditional patriarchal cultures still tolerate violence against women in much of the world.

Economic Factors

Long periods of conflict, coupled with subsequent structural reforms that Governments are forced to apply, have devastating effects on the economy. Some of these include the destruction of economic and physical infrastructure, the rapid decline of industrial production, sharp rise in unemployment, the drainage of human resources, a flourishing black market, loss of savings and often total impoverishment.

Crises usually affect more women than men. Unemployment, under-employment, gender pay differentiation, unpaid family work and care provision are some of women's painful experiences in transitioning countries. Women suffer from overt and covert gender discrimination on the labour market, especially for the young, those with small children and middle-aged women. Skilled and professional women assume employment in areas unrelated to or below their skill levels. Highly educated women such as lawyers, architects, engineers, and university professors are forced to accept lower-status, gender-identified positions as secretaries and receptionists. If fortunate, women can find employment with international donors implementing projects in the region. Some women refuse to have children for fear of losing their jobs. Displaced and refugee women resort to petty trades or are obliged to take jobs that urban women will not accept.

Some women who try to find better living situations in foreign countries may become susceptible to organized networks that force them into prostitution and exploitation. These women are in new surroundings without social connections, family support or access to information and services, all of which places them at heightened risk for poor health outcomes.

Most training programmes implemented by international donors target demobilized soldiers in skills-based industries, intending to restructure the market economy. Less attention is usually given to training women in these priority areas, which may undermine their involvement in community rebuilding efforts.

The Role of Women's NGOs in Rebuilding War-Torn Societies

In the last decade, many social movements have emerged in response to growing problems at local, transnational and international levels. United Nations global initiatives triggered an increased mobilization of civil societies, setting political agendas for pressing issues such as environmental destruction, human rights, peace and disarmament, sustainable development, women's rights, trafficking, terrorism, HIV/AIDS and drugs. Among the factors that created large NGO responses to countries in conflict and transition were the slow democratization process as well as responses from available fund donors seeking civil-society partnerships.

NGOs, grass-roots groups and social movements have different organizational structures and goals. They are all committed to representing millions of people and promoting community-based interests. NGOs, and women's NGOs in particular, have bottom-up participatory organizational structures characterized by values-driven, action-oriented commitments and volunteer work. In the 1990s, women's NGOs played a crucial role in the promotion of women's rights, especially in family reform legislation, abortion, reproductive rights and domestic violence. In rebuilding and sustaining conflict-

torn societies, women's NGOs have also played predominant roles by becoming the building blocks of civil societies, contributing to social harmony that paves the road to sustainable peace.

Aims and Goals

The objectives and goals of women's NGOs include the following:

- Empowering women by enabling them to become key actors in conflict mediation, rehabilitation and reconstruction;
- Contributing to the consolidation of democratic practices and support of related activities in securing freedom, human rights, peace-making and just application of laws;
- Building inter-ethnic trust that preserves and strengthens multinational and multi-religious societies, thereby laying the foundation for peaceful and sustainable development;
- Building coalitions and partnerships with other civil-society groups such as the media, trade unions, students, universities and environmentalists to develop common agendas with larger strategic objectives, including peace-building and conflict prevention;
- Bringing voices, concerns and needs of women in conflict areas to the attention of the national and international community and including them in all relevant forums;
- Promoting activities that support women's reproductive health and recovery from psychological traumas;
- Promoting new approaches to politics that include women's perspectives on appropriate governance and their participation as equal partners;
- Involving media as a space for making women's initiatives visible, especially their contributions to peace building and rebuilding of war-torn societies, which will facilitate the elimination of persistent projections that portray women as victims;
- Promoting networking, solidarity and cooperation among NGOs, fostering a sense of community among humanitarian aid agencies;
- Supporting and strengthening newly established women's grass-roots groups, to enable them to participate in community rebuilding, which is especially important in rural areas; and

- Establishing communication channels among NGOs, national authorities, parliaments, international agencies and the private sector to expand their outreach and ensure cooperation in promoting rebuilding activities, which also facilitates procurement of financial support for their projects.

Strategies

To achieve their goals, women's NGOs work on multiple levels to develop various strategies, which may include the following:

- Empowering women, especially young women, through:
 - Health education, including women's reproductive health;
 - Legal literacy seminars that emphasize reproductive rights;
 - Policy-making and political participation workshops;
 - Women's skills training in entrepreneurship development;
 - Action-oriented training in research methodology;
 - Development of tools for monitoring and social auditing; and
 - Identification and production of information material on issues of paramount concern to women.
- Organizing discussion forums on critical issues such as racism, discrimination, marginalization, violence against women and trafficking;
- Conducting training seminars for reconciliation and trust-building between women and men. Many NGOs carrying out such training try to have a balanced number of women and men in both training team and participant groups. Integrating a gender-sensitive approach is extremely important. By hearing each other in such forums, participants can discover ways to resolve conflict constructively. In the Balkan region, B.a.B.e. (Croatia) has involved women and men in its workshops of inter-ethnic dialogue. The Centre for Non-Violent Action conducts training seminars for trust-building and communication between male and female participants, so that people could share their experiences in a safe space. The Centre for Non-Violence and Human Rights (Eastern Slovenia) has contributed to rebuilding multicultural communities in the region by implementing various peace activities, including training for facilitating communication and rebuilding trust among women, specifically teachers and students;
- Developing and implementing programmes for psychological support of women who are victims of violence, especially following armed conflicts;

- Forming alliances with mass media to promote community and women’s issues. The media are key actors in globally transmitting information, news and values, and they have the power to generate “empathy,” “connection” and the “objectification” of women. Women’s NGOs have challenged mass-media reporting on armed conflict situations that focus exclusively on the difficulties of everyday life, specifically images of children and women’s vulnerability. These portrayals show women solely as victims and ignore their contributions during conflicts to family and community survival. For instance, in Croatia, B.a.B.e. secured space for women’s issues in leading weekly magazines. The radio programme “Buenos Tiempos Mujer” in El Salvador provided a space for dialogue between opposing groups to overcome violence in the family and society. In addition, the organization Media Action International used radio to provide education for Afghani girls and women who were relegated to the home and denied access to education under Taliban rule;⁹²
- Organizing round tables and conferences to bring women from different venues and countries together to discuss community problems and develop “sister projects” fostering social and economic growth. An example is the conference “Regional Women’s Economic Networks”, organized by the Association of Business Women in Belgrade, which brought together women entrepreneurs and networks of women’s associations from six Balkan countries to exchange information and experiences, to examine the possibilities of women’s economic empowerment and opportunities in the market economy and to enhance international cooperation;
- Researching and strategizing causes and conditions of gender specific violence;
- Promoting initiatives for the protection of women’s health, such as health education, including family planning, birth control, and prevention and services for sexually transmitted infections (STIs), especially HIV/AIDS. Each has serious effects on women’s health, productive and reproductive capacities, safe motherhood and pregnancy care;
- Identifying ways to support communities and protect reproductive health, which include:
 - Identification of existing service delivery structures, including national and private-sector health services, and women’s and community-based groups;
 - Identification of the needs of women concerning their reproductive health; and
 - Identification of health workers and training of community staff in services management.

⁹² *International Peace Update*, June-August 2000.

- Supporting grass-roots women's groups through organizational skills training crucial for professionalism and sustainability. Training includes teamwork, advocacy, networking, fund-raising, communication skills, the drafting of project proposals and reports, and project management;
- Monitoring new legislation, policies and structures that promote women's equal opportunities, to limit the reintroduction of pre-war gender-biased positions that overemphasize women's reproductive functions;
- Making Governments accountable for their progress in promoting women's rights by drafting alternative country reports to CEDAW;
- Reporting women's human rights violations to the appropriate disciplinary bodies;
- Implementing and monitoring of United Nations Resolution 1325, concerning women's equal participation in policy-making for peace and security;
- Lobbying Governments for:
 - Establishment of national machineries for gender issues to promote women's rights and interests;
 - Effective enforcement of laws to protect women from domestic violence, abuse and exploitation, as well as establishing venues for seeking help and advice;
 - Ratification of CEDAW and the International Convention on the Protection of the Rights of Migrants and Their Families;
 - Mainstreaming of gender issues into all national policies to raise the status of women;
 - Adjustment of the legislative framework to reflect principles of gender equality;
 - Initiation of training for police and border authorities to identify trafficking of women and dismantle networks responsible for this crime; and
 - Reduction of excessive military expenditures and increased control over available armaments.

Challenges and constraints.

Organizations, especially women's NGOs, are participating in planning, implementing, monitoring and evaluating programmes and small-scale community development projects. The projects are financed by the international community and supported by individual Governments. They face many challenges and constraints in their functions and work, the following among them:

- In many countries, the absence of appropriate NGO legislation is a serious constraint to being recognized by international and private donors. Governments should provide a legislative framework for those NGOs working to strengthen societies and those collaborating on population and health issues;
- During post-conflict periods, many newly established NGOs require technical assistance to strengthen their capacities. Often, they have insufficient internal organization, are under-resourced and highly dependent on international funding;
- Communication with Governments and local authorities is sometimes problematic, partly because of limited experience in dealing with them. When addressing controversial topics for women's reproductive health, NGOs working on the ICPD Programme of Action sometimes face difficulties because of cultural taboos and authoritarian attitudes;
- Newer NGOs tend to lack the knowledge and tools for the effective implementation of projects, specifically management, monitoring, evaluation and follow-up. Firmly established NGOs can provide these tools and protocols;
- In most countries, diminishing funds generate strong antagonism among NGOs that view one another as competitors instead of development partners. Antagonism, however, can have a positive side if it inspires NGOs to build their capacities and ensure their sustainability. Lack of cooperation and competition between NGOs can lead to knowledge overlaps and missed opportunities to obtain funds and initiate projects. NGOs must build coalitions to carry out major programmes in partnership. Cooperation and networking among NGOs is absolutely essential for common strategic planning; and
- Often newly established NGOs have difficulty in establishing local, national and international outreach. Thus, their opportunities for obtaining funds to rebuild society are limited. Humanitarian agencies should join NGO networks to further contributions to mutual goals.

Women Transforming Conflict

Women have not only been vulnerable victims of conflict and war throughout history but also played important roles. Women's skills, perspectives and leadership styles can prove extremely useful. Examples of this include changing community perceptions, building relationships and developing common understanding and visions to benefit families, communities and nations worldwide.

Women and men have different approaches and responses to conflict and war, depending on differing experiences and perceived social roles and visions. Men, who constitute the majority of combatants, may be inclined to use weapons and violence to maintain power. Women's war experiences are mostly as victims of violence, and those who struggle for the survival of their families. Therefore, their responses to war and post-conflict periods are often different.

Women everywhere are challenging and rejecting the assumptions that violence is inevitable and is an efficient method of solving problems. Women have developed initiatives and alternative methods for dealing with conflicts. Furthermore, research findings have shown that while "men regard the issues of military power and major infrastructure projects as priority issues, women consider the provision of health care, education, sanitation and social services as issues of paramount importance."⁹³ Women the world over have come together to form coalitions, NGOs and networks with local, national and transnational outreach. These actions promote cooperation in antiwar action, peace-building and post-conflict reconciliation. They build on common experiences, conceptions and visions.

Women have used several entry points to transform the culture of violence and war to a culture of peace, non-violence and tolerance. For some, their entry point was to change the mentality and social roles, targeting men and young adolescent males, assuming that "since war begins in the minds of men, it is in the minds of men that the defence of peace must be created."⁹⁴

International agencies took the lead, and the United Nations Educational, Scientific and Cultural Organization (UNESCO) carried out a major programme on "Male roles and masculinity," while the United Nations International Research and Training Institute for the Advancement of Women (INSTRAW) held an online discussion forum on "The roles of men in transforming gender based violence," to which many women and men contributed worldwide. In Serbia, the Association for Women's Rights and Tolerance is implementing a project, "Masculinity and patriarchal structures", to add to the discourse on changing gender divisions of social roles in the post-war period. The belief is that a change in gender relations is a precondition not only for sustainable peace-building but also for sustainable economic growth and equitable society-building.

Another entry point for action is the remarkable under-representation of women in leadership positions. Given the strong movement for democracy and the even greater women's movement, the paradox is that strong advocacy and lobbying has taken place to increase women's representation in the parliament, government and other executive bodies; yet women are still hardly present when

⁹³ The Ford Foundation, "Women's, Leadership, Gender and Peace."

⁹⁴ UNESCO, *Decade for a Culture of Peace*.

the decisions take place. Women constitute only 12.7 per cent of parliamentary seats all over the world.⁹⁵ Although the United Nations, including UNESCO and the World Bank, and other international organizations such as the Council of Europe and the European Commission have all produced resolutions and formulated policies for the inclusion of women at all levels of decision-making, they have not succeeded in significantly increasing the numbers of women in their own structures. Indicative of this disparity can be shown in the number of seats held by women and men in the Parliament of the Council of Europe where, of 10,183 seats in 43 countries, women hold 1,698 seats, or 16.7 per cent.

Establishing a quota system is strongly recommended as an initial strategy, although there is no guarantee that the increased representation of women in parliament will change the political landscape. Most women tend to side with policies of their political parties. The changing situation in post-conflict areas and transitional countries, however, offers excellent opportunities to develop new and equitable environments. One example is in South Africa, where the use of a 30 per cent quota resulted in considerable increases of women in parliament. This, in turn, had a positive effect on heightening concern about population and gender issues and on the passages of three far-reaching laws, the Termination of Pregnancy Act, the Domestic Violence Act and the Maintenance Act, which improves the positions of mothers who depend on maintenance from former partners). Another significant initiative is the international campaign of the Women's Environmental and Development Organization (WEDO). It has launched a global initiative (Title 50-50) to achieve women's equal representation in decision-making positions by the year 2005.

Democracy-building is also an important entry point, and in all countries, civil society has played a significant role in its promotion. Women's NGOs became especially involved in election campaigns using various strategies to connect democratization with other issues, such as poverty alleviation, health-care provisions and employment. In Bosnia, 140 NGOs built "Coalition Glas 1999," urging citizens to vote. The Institute of Peace and Democracy in Baku produced a "Guide for Journalists" covering the elections in Armenia in 1999, and established an election web site in Serbia. Women in Black were active in the three-month electoral campaign that resulted in the defeat of Milosevic. In Bosnia, B.a.B.e. organized group discussions for citizen participation in the 1999 elections, resulting in and increase in the percentage of women in parliament from 7.5 per cent to 20.5 per cent; Index Foundation in Bulgaria carried out the campaign "Women can do it!", encouraging people to vote for women.

Another entry point for women's mobilization is through established landmark dates. Since 24 May 2000, the International Women's Day for Peace and Disarmament has been an occasion for women's mobilization on a global scale. The Women's Forum for Peace and Unification in the Republic of Korea

⁹⁵ "Cross the Lines," February 2001.

organized meetings to promote reconciliation among all Korean women. In Uganda, women participated in peace marches demanding the withdrawal of Ugandan troops from the Democratic Republic of Congo. In Israel, Arab and Israeli women organized a large protest against nuclear weapons; it demanded that the Government permit arms inspections by local and international NGOs. In the United Republic of Tanzania, the Centre for Human Rights Education organized a seminar on women's human rights in a refugee camp. Finally, in Congo, a day-long workshop entitled "Women: peace in our hands," was organized by Semadev-Femmes.

Another occasion for collective action is 28 May, the International Day of Action for Women's Health. Every year, women's NGOs, health groups and advocates all over the world organize a wide range of activities focusing on reproductive and population issues, including maternal mortality, free abortion, health-care services, HIV/AIDS, "stop harmful practices," population policies and violence. Many women's NGOs focus their activities on education for peace and training on conflict transformation. The International ECO Peace Village, established by Greek Cypriot women, provides training for women and youth on peace education and conflict resolution. This training also includes environmental management training, advocacy action and networking between institutions and countries with common interests. In addition, WINPEACE, a Greek Turkish Women's Peace Network with a mandate to build a culture of peace in the Balkans, organizes seminars on "non-violent communities." It also monitors a bilateral agreement between Greece and Turkey to reduce the defence budget by 5 per cent annually, starting in 2002.

In Rwanda, the women's NGO La Campagne: Action pour la Paix Pro-femmes tried to recreate a public space in a village totally destroyed through genocide. The people of the community gathered there to reintegrate into society men, women and children who were involved in the killings. In another example, the Sudanese Women's Voice for Peace conducted a number of workshops on how to approach war leaders and how to overcome pain experienced during the conflicts. In southern Sudan, the same organization initiated training activities involving Muslim and Christian women working together to address the problems of displacement, poverty and lack of education.

In Colombia, the Organizacion Femina Popular provides medical, legal and social services to civilian women and victims of violence. Because of their unwavering refusal to join sides in Colombia's 40-year-old war between guerillas and paramilitary death squads, the group has been subject to constant harassment and death threats.

In Romania, the Foundation for Democratic Change conducts research on how people react to conflict situations. The Peace Institute in Slovenia conducts research and develops educational materials on the sociology of war, security policies, interpersonal violence, conflict resolution and other aspects of violence.

The Centre for Peace, Non-Violence and Human Rights in Osijek, Croatia, has facilitated cross-border communication and peaceful co-existence in Slavonia and Baranja since 1994. The Mediterranean Women's Studies Centre created the Balkan Women's Network for Democratization and Conflict Prevention within the Royaumont Initiative. Finally, KEGME is uniting women's NGOs from all Balkan countries under the mandate to promote sustainable peace and stability in South- Eastern Europe.

The strongest entry point for collective action is under violence against women. That women in all conflict regions have been subjected to numerous atrocities and indignities has galvanized the international and the local communities. Women's NGOs have taken the lead, organized themselves and put great effort into alleviating the suffering of traumatized women and their families. They have distributed food and medical assistance; set up centres and clinics for women; and provided psychological support, reproductive health education and gynaecological treatment. One example is the Medica Mondiale, which was established by the Albanian NGO Forum gradually to reintegrate Kosovar refugee women into society. In Croatia, the Centre for Non-Violent Action produced posters, leaflets, TV commercials, T-shirts and advertisements in tram-vehicles to raise public awareness and oppose violence against women. B.a.B.e. organized a public awareness campaign on the issue of violence against women entitled "16 days against violence." The campaign involved three years of wide media coverage.

Civil society, NGOs and especially women's NGOs, draw on their experiences and visions to undertake major efforts in conflict transformation and local society-rebuilding. Governments, international agencies and private donors must recognize their efforts and initiatives. The expertise and knowledge of women's NGOs must be utilized and their projects supported. Above all, they should be included in all decision-making processes for peace and security according to United Nations Security Council Resolution 1325.

Recommendations

Post-conflict societies and countries in transition face the great challenges of reconstruction and rehabilitation. They need financial and technical resources in order to meet the demands of rebuilding political, economic and social sectors. Usually, funders target specific sectors, such as education, economic development, democratic governance, energy and environment, population and health. In disbursing funds for civil society building, however, donors must take into consideration the gender dimension in all income-generating activities and development programmes. An integral approach is necessary to implement projects that include men and women, and to strengthen efforts to develop healthy societies. Specifically, funding is needed for:

- Income generation and skills training in micro-enterprises to address unemployment and increase self-sufficiency;
- Health education projects, including reproductive health;
- Education projects with built-in sustainability and prevention for problems such as drug abuse and STIs, including HIV/AIDS, for girls and adolescents;
- Training courses for teachers, social workers and parents on how to identify children's sexual abuse;
- Gender-awareness training, advocacy and leadership skills;
- Training of trainers for health-care provision; and
- Skills development on conflict prevention and transformation.

Donors should include financial aid to provide technical assistance to NGOs, specifically to strengthen their capacities. Donors must also encourage the creation of partnerships between NGOs and local governments so that they can jointly identify priority areas. As such, these partnerships can maximize benefits for both partners, and together they can establish self-sustaining social systems.

ANNEX 1: CONFERENCE AGENDA

“The Impact of Conflict on Women and Girls”

November 13-15

Bratislava, Slovakia

Monday, 12 November

1. Registration (Hotel Lobby) 8:00 – 10:00 AM

Tuesday, 13 November (Day One)

2. Opening Session (Primaciálny Palác) 9:00 – 10:00 AM
 - a) Rainer Rosenbaum, UNFPA-CST, Director
 - b) Pal Csaky, H.E., Deputy Prime Minister of SR for Human and Minority Rights and Regional Development, Slovak Republic
 - c) Maria Demeterová, First Secretary to the Lord-Mayor of Bratislava, Capital of the Slovak Republic
 - d) Kunio Waki, Deputy Executive (Programme) Director, United Nations Population Fund (UNFPA)
3. Coffee Break (Primaciálny Palác) 10:00 – 10:30 AM
4. Key Note Speaker: H.E. Elisabeth Rehn 10:30 – 10:50 AM
5. General Introduction, to the background papers (Sahir Abdul-Hadi), 10:50 – 11:00 AM
6. Presentation and discussion of the First background paper, *Impact of Conflict on Reproductive Health* 11:00 – 12:30 PM
Chair Person: Makbule Ceco
Presenter: Samantha Guy
Discussant: Susan Purdin

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| 7. | Presentation and discussion of the
Second background paper,
<i>Sexual and Gender Based Violence</i>
Chair Person: Sakena Yacoobi
Presenter: Zeljka Mudrovic
Discussant: Jeanne Ward | 12:30 – 2:00 PM |
| 8. | Lunch (at the meeting venue) | 2:00 – 3:00 PM |
| 9. | Presentation and discussion of the
Third background paper,
<i>The Role of Peacekeeping Forces</i>
Chair Person: Mominat Omarova
Presenter: Kristin Astegeisddottir
Discussants:
Jane Schuler-Repp, Olivier Brasseur | 3:00 – 4:30 PM |
| 10. | Coffee Break | 4:30 – 4:45 PM |
| 11. | Presentation and discussion of the
Fourth background paper
<i>The Role of Local NGOs</i>
Chair Person: Galina Karmanova
Presenter: Eleni Stamiris
Discussant: Valentina Leskaj | 4:45 – 6:15 PM |
| 12. | UNFPA Reception at Hradná Vináreň | 8:00 – 10:00 PM |

Wednesday, 14 November (Day Two)

- | | | |
|----|-------------------------------|------------------|
| 1. | Morning Session: | 8:30 – 10:30 AM |
| 2. | Coffee Break: | 10:30 – 10:45 AM |
| 3. | Morning Session (Continue): | 10:45 – 1:00 PM |
| 4. | Lunch: | 1:00 – 2:30 PM |
| 5. | Afternoon Session: | 2:00 – 3:30 PM |
| 6. | Coffee Break: | 3:30 – 3:45 PM |
| 7. | Afternoon Session (Continue): | 3:45 – 5:30 PM |
| 8. | Drafting of the Group Report: | 6:00 – 8:00 PM |

Working Groups

All the participants broke into four working groups. Assignments are further specified in Annex Two.

- 1. Reproductive Health Group**
Moderator: Soudabeh Amiri
Rapporteur: Sarah Sisco
- 2. Sexual and Gender Based Violence Group**
Moderator: Frank Gutmann
Rapporteurs: Javed Ahmad, Jeanne Ward,
Frank Gutmann
- 3. Role of the Peacekeeping Forces Group**
Moderator: Viloyat Mirzoeva
Rapporteurs: Pamela DeLargy, Ramiz Alekperov
- 4. The Role of Local NGOs Group**
Moderator: Manuella Bello
Rapporteurs: Rafiq Chaudhury, Nerina Perea

Thursday, 15 November (Day Three)

- 1. Presentation and discussion:** 9:00 – 10:15 AM
Reproductive Health
Chair: Ali Buzurukov
Presenter: Susan Purdin
- 2. Presentation and discussion:** 10:15 – 11:30 AM
Gender Based Violence (GBV)
Chair: Elena Kabakchieva
Presenter: Jeanne Ward
- 3. Tea Break** 11:30 – 11:45 AM
- 4. Presentation and discussion:** 11:45 – 1:00 PM
The Role of Peacekeeping Forces
Chair: Dilovar Kabulova
Presenter: Olivier Brasseur
- 5. Lunch** 1:00 – 2:00 PM
- 6. Presentation and discussion:** 2:00 – 3:15 PM

The Role of Local NGOs
Chair: Rakhima Nazarova
Presenter: Valentina Leskaj

7. Tea Break: 3:15 – 3:30 PM
8. Adoption of recommendations and closing 3:30 – 5:30 PM

ANNEX 2: WORKING GROUP PARTICIPANTS

Working Group One: *Reproductive Health*

Manuella Bello, UNFPA, Albania
Klaudia Bogyaiova, UNFPA, Slovakia
Ali Buzurukov, UNFPA, Geneva, Switzerland
Maria Chaloupkova, Slovakia
Samantha Guy, Marie Stopes International, London, United Kingdom
Michal Klimant, Slovakia
Alain Mouchiroud, UNFPA, Turkey
Susan Purdin, Columbia University, New York
Rainer Rosenbaum, UNFPA, Slovakia
Sarah Sisco, UNFPA, New York
Kunio Waki, UNFPA, New York

Working Group Two: *Gender-Based Violence – Trafficking, Domestic Violence, and Sexual Violence*

Waleed Alkhateeb, UNFPA, New York
Rafiqul Chaudhury, UNFPA, Nepal
Marta Diavolova, UNFPA, Bulgaria
Dessislava Georgieva, Bulgarian Family Planning Association, Bulgaria
Frank Gutmann, International Organization for Migration (IOM), Bosnia-Herzegovina
Peter Ilicola, United Nations Mission in Bosnia and Herzegovina (UNMIBH), Bosnia-Herzegovina
Dilovar Kabulova, Women's Committee of the Republic of Uzbekistan, Uzbekistan
Galina Karmanova, UNAIDS, Turkmenistan
Hélène Lefèvre-Cholay, World Health Organization (WHO), Denmark
Laura Miranda, UNFPA, Slovakia
Viloyat Mirzoeva, Gender and Development, Tajikistan
Željka Mudrovčić, UNFPA, Bosnia-Herzegovina
Elin Rannenberg-Nilsen, UNFPA, Romania
Aygul Shamchiyeva, Cabinet of Ministers of the Azerbaijan Republic, Azerbaijan
Susanna Vardanyan, Women's Rights Centre (WRC), Armenia
Jeanne Ward, Women's Commission for Refugee Women and Children, New York
Nargis Yurmatova, Government CPD, Tajikistan

Working Group Three:

The Impact of Peacekeeping Operations on Women and Girls

Zukhra Ahmedova, UNFPA, Tajikistan
Bernara Alimbaeva, Woman Support Centre, Kyrgyzstan
Kristin Astegeirsdottir, UNIFEM, Iceland
Olivier Brasseur, UNFPA, Pakistan
Pamela DeLargy, UNFPA, New York
Mominat Omarova, Deputy Chief of the State Committee on Women's
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Jane Schuler-Repp, UNFPA, Kosovo
Victoria Schultz, Kosovo
Anna Vidinova, UNIFEM, Slovakia
Masumi Watase, UNFPA, New York
Eve Weisberg, USAID, New York

Working Group Four:

The Role of NGOs in Post-Conflict Situations for Women and Girls

Javed Ahmad, UNFPA, Slovakia
Sippi Azerbaijani-Moghaddam, Women's Commission
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Makbule Ceco, Deputy Speaker and Member of Parliament, Albania
Elena Kabachieva, Health and Social Development Foundation, Bulgaria
Sahir Abdul-Hadi, UNFPA, New York
Valentina Leskaj, Albanian NGO Forum, Albania
Rakhima Nazarova, Uzbekistan Association for Reproductive Health,
Uzbekistan
Nerina Perea, UNFPA, New York
Constantin Sokoloff, UNFPA, Uzbekistan
Eleni Stamiris, The Mediterranean Women's Studies Centre (KEGME), Greece
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ANNEX 3: PARTICIPANT CONTACT LIST

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Country/City	Participant	Agency	Special Responsibility	Contact	Information	Other
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Iceland	Kristín Ástegeirsdóttir	UNIFEM	Author of Paper: "The Role of Peacekeeping Forces"	Direct		Tel.: 011 354 55 19287 011 354 864 04 93 Email: ast@hotmail.com	Address: Mavahlid 22 105 Reykjavik Iceland
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Kosovo	Victoria Schultz						

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ANNEX 4: RESOURCE LIST

The resource list below is not exhaustive but is intended to provide guidance in implementing reproductive health programmes.

Key Agencies and Organizations

Non-governmental Organizations

The Reproductive Health for Refugees (RHR) Consortium includes the following organizations:

American Refugee Committee (ARC)

Karen J. Elshazly, Huy Pham, Amy-Jo Versolato
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International Rescue Committee (IRC)

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Marie Stopes International (MSI)

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London W1P 5PG, UK

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Women's Commission for Refugee Women and Children (WCRWC)*

Sandra Krause, Julia Matthews

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New York, NY 10168

Tel: (212) 551-3000, Fax: (212) 551-3180

E-mail: juliam@womenscommission.org

*Contact for general inquiries about the Consortium.

United Nations Organizations and Agencies

UNHCR:

OHCHR-UNOG
8-14 Avenue de la Paix
1211 Geneva 10, Switzerland
Tel: (41-22) 917-9000

UNICEF:

For Intergovernmental related issues:

Secretariat for the Special Session on Children
UNICEF House
3 United Nations Plaza
New York NY 10017, USA
Fax: 1 (212) 303-7992

For Non-Governmental Organizations related issues:

The NGO Participation Team
UNICEF House H-8A
3 United Nations Plaza
New York NY 10017, USA
Fax: 1 (212) 303 7990

WHO:

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Fax: (+00 41 22) 791 3111

UNAIDS:

20, avenue Appia
CH-1211 Geneva 27, Switzerland
Tel: (+4122) 791 3666
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UNFPA:

Pamela DeLargy, Emergency and Humanitarian Cluster
UNFPA
220 East 42nd Street
New York, NY 10017

Informational:

- Inter-agency Field Manual on Reproductive Health Settings
- Guidelines for reproductive health during conflict and displacement: A guide for programme managers – WHO, www.who.int/reproductive-health/guidelines
- Needs assessment field tools (focus group discussions, assessment of reproductive health services, qualitative and quantitative measures, etc.)
- Training modules
- UNFPA and Columbia University training courses

Available Guidelines:

Contraceptive Guidelines for Refugee Settings, New York: John Snow International, 1996.

Five-day Training Program for Health Personnel - Reproductive Health Programming in Refugee Settings. New York: CARE on behalf of the RHR Consortium, April 1998.

Guidelines for HIV Interventions in Emergency Settings. Geneva: UNHCR, WHO, UNAIDS, 1996.

One-day awareness building module - Introduction to reproductive health for refugee settings. New York: CARE on behalf of the RHR Consortium, April 1998.

Refugee Reproductive Health: Needs Assessment Field Tools. New York: RHR Consortium, 1997.

Reproductive Health in Refugee Settings: An Inter-agency Field Manual.
New York: UNHCR, UNFPA, 1999.

Sexual Violence Against Refugees, Guidelines on Prevention and Response. Geneva: UNHCR, 1995.

The reproductive health kit for emergency situations. New York: UNFPA, 1998.

Internet resources:

Reproductive Health for Refugees Consortium (RHRC), www.rhrc.org

UNAIDS, www.unaids.org

World Health Organization (WHO), www.who.org

Material Resources:

- Reproductive health kits
- New Emergency Health Kit (NEHK-98) from WHO, New York and IDA, Copenhagen

ANNEX 5: MINIMUM INITIAL SERVICE PACKAGE FOR REPRODUCTIVE HEALTH IN EMERGENCIES

MISP Implementation Checklist

Basic demographic information: (Source: _____)

Total population in area (refugee & host): _____

Refugee population: _____

Number of women of reproductive age: _____

Number of men of reproductive age: _____

Number <5 years of age: _____

Total fertility rate: _____

Maternal mortality ratio: _____

Number of pregnant women: _____

Number of lactating women: _____

Key individuals:

UNHCR or other lead agency:

Health Coordinator: _____

Community Services Coordinator: _____

Gender Specialist: _____

Logistician: _____

Local government officials:

Health Director: _____

Social Services Director: _____

Gender Specialist: _____

NGO's:

Health/Social Services Coordinator: _____

Health/Social Services Coordinator: _____

Health/Social Services Coordinator: _____

Refugee Leaders:

Chairman: _____

Women's Leader: _____

Youth Leader: _____

Others: _____

MISP Implementing agency initial staffing needs:

- Gender violence specialist (90 days)
- Translator/local or refugee counterpart with social work background (90 days)
- Reproductive Health clinical specialist (90 days)
- Translator/local or refugee counterpart with medical background (90 days)
- Medical logistician (90 days)
- MISP project administrator (45 days)
- 2 Drivers and vehicles

These are minimum numbers of staff required for up to 50,000 refugees. Additional staff would be needed for each 50,000 additional refugees. All personnel must be technically qualified, field-experienced and quickly deployed.

Programming According to MISP Objectives:

1) Identify organization(s) and individual(s) to facilitate the MISP:

- Overall Reproductive Health Coordinator in place and functioning under the health coordination team
- Reproductive Health focal points in camps and implementing agencies in place

- Staff trained and sensitized on technical, cultural, ethical, religious and legal aspects of Reproductive Health and gender awareness
- Materials for the implementation of the MISPP available and in use

2) Prevent and manage the consequences of sexual and gender-based violence:

- Systems to prevent sexual violence are in place
- Health service able to manage cases of sexual violence
- Staff trained (retrained) in prevention and response systems for cases of sexual violence

3) Prevent HIV transmission:

- Condoms procured and distributed
- Health workers trained (retrained) in practice of universal precautions
- Materials in place for adequate practice of universal precautions

4) Prevent excess neonatal and maternal morbidity and mortality:

- Clean delivery kits available and distributed
- UNICEF midwife kits (or equivalent) available at the health centre
- Staff competency assessed and retraining undertaken
- Referral system for obstetric emergencies functioning

5) Plan for the provision of comprehensive reproductive health services:

- Basic health information system functioning and monitoring Reproductive Health indicators (mortality, HIV prevalence, CPR)
- Sites identified for future delivery of comprehensive reproductive health services

Contents of the UNFPA reproductive health kit for emergency situations

Block 1: For use at primary health care/health centre level:
10,000 population for three months

- Subkit 0 Training and Administration
- Subkit 1 Condoms
- Subkit 2 Clean delivery sets
- Subkit 3 Post-rape management
- Subkit 4 Oral and Injectable Contraceptives
- Subkit 5 STD Drugs

Block 2: For use at health centre or referral level:
30,000 population for three months

- Subkit 6 Professional midwifery delivery kit
- Subkit 7 IUD insertion
- Subkit 8 Management of the Complications of Unsafe Abortion
- Subkit 9 Suture of cervical and vaginal tears
- Subkit 10 Vacuum aspiration

Block 3: For use at the referral level:
150,000 population for three months

- Subkit 11 A – Referral-Level Surgical (reusable equipment)
B – Referral-Level Surgical (consumable items and drugs)
- Subkit 12 Transfusion (HIV testing for blood transfusion)

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UNFPA

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