A UNAIDS Initiative
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Violence Against Women and HIV/AIDS: Critical Intersections

Sexual violence in conflict settings and the risk of HIV

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Why focus on violence against women in conflict settings and HIV?

"The militia at the barriers said they would protect me, but instead they kept me and raped me in their homes. One militia member would keep me for two or three days and then another would choose me… I managed to flee Kigali and when I returned, I learnt that my husband had been killed." (Survivor of the Rwandan genocide, HIV positive woman from Kigali)

In conflict situations, women and girls are at greatly increased risk of physical and sexual violence. Many women and girls are subjected to rape including gang rape, forced marriages with enemy soldiers, sexual slavery, and other forms of violence (being forced to witness others being raped, mutilations, etc.). Many have fled their homes, have lost their families and livelihoods, and may have little or no access to health care. All these factors create conditions in which women and girls' vulnerability to HIV is disproportionately increased. This information bulletin is the second in a series highlighting the intersections of violence against women and HIV/AIDS and it focuses on sexual violence against women in conflict settings and their risks for acquiring HIV.

Violence against women and girls has been a feature of all recent conflicts, including the ongoing one in the Darfur region of Sudan as well as in the former Yugoslavia, Democratic Republic of Congo, Rwanda, Sierra Leone, Liberia, northern Uganda, and Chechnya (Russian Federation). In many of these conflicts, some of which have been regarded as ethnic cleansing, rape has been and is used as a deliberate strategy to brutalize and humiliate civilians and as a weapon of war or political power. It is also likely that all forms of violence against women, including intimate partner violence, increase during conflicts and this may be linked to a ready availability of weapons, high levels of frustration among men, and a general breakdown in law and order.

Box 1: The extent of the problem: estimates of sexual violence during conflict

- During the 1992-1995 conflict in Bosnia-Herzegovina between 20 000 and 50 0000 Muslim women were raped (about 1.2 % of the total pre-war female population)[1].
- A report by the U.N. (1996) Special Rapporteur on Rwanda estimated that at least 250 000 women were raped during the genocide[2].
- In Liberia, towards the end of the five year civil war, 49% of women (15 to 70 years) who were surveyed reported experiencing at least one act of physical or sexual violence by a soldier or fighter[3].

Where and how do violence against women and HIV/AIDS intersect in conflict settings?

Sexual violence has always led to direct physical harm, emotional trauma, stigma, and social ostracism for women. It also carries an additional risk of unwanted pregnancies, sexually transmitted infections (STI) and increasingly, of acquiring HIV infections. In conflict situations, being displaced facilitates civilian (especially women and girls') exposure to STI and HIV through sexual interactions - often forced - with high prevalence groups (e.g. combatants, military). In Rwanda, the HIV prevalence rate in rural areas dramatically increased from 1% before the start of the conflict in 1994 to 11% in 1997. In one survey, of the women who survived the genocide, 17% were found to be HIV positive[4].
In another survey carried out by the Rwandan Asso-

[1] *UNICEF. 1999. Women in transition. The MONEE project CEE/CIS/Baltics regional monitoring report no. 6. Florence: United Nations Children's Fund, International Child Development Centre.*

[2] *Human Rights Watch. 2004. Struggling to survive: Barriers to justice for rape victims in Rwanda. Vol. 16, No. 10(A). New York: Human Rights Watch.*

[3] *Swiss S, Jennings PJ, Aryee G V et al. 1998. Violence against women during the Liberian civil conflict. JAMA. 279(8):625-629.*

[4] *McGinn T. Reproductive health of war-affected populations: what do we know? International Family Planning Perspectives. 26(4): 174-180.*

ciation for Genocide Widows (AVEGA), 67% of women who survived rape had HIV[5].

The humanitarian crisis brought on by armed conflicts, such as the loss of homes, incomes, families and social support, also puts women and girls in positions where they have to engage in 'survival sex'. Women may be forced to exchange sex in order to secure their or their families' lives and livelihoods, escape to safety, and gain access to food, shelter or services. In the Democratic Republic of Congo, a Human Rights Watch report describes that the civil war has created a context in which abusive sexual relationships are more accepted and where many men - civilian or combatant - regard sex as a service easy to get by using force. As described by a woman in a refugee camp in eastern Congo[6]:

"I have to keep doing bad things like sleeping with men to stay alive. You have to submit to everything they do, get slapped around, and then we're badly paid too."

What are the opportunities to address violence against women and HIV/AIDS in conflict settings?

Programs in conflict and refugee settings: A number of agencies including the International Rescue Committee (IRC), UNHCR, UNFPA, WHO, and the International Medical Corps (IMC) are addressing violence against women in health care programs in conflict settings. Addressing violence against women and HIV/AIDS in conflict settings is challenging because the rule of law is virtually non-existent and police, judicial systems, health and other services are often not functioning.

At minimum, in such settings, health services should actively identify women who have experienced violence and provide medical services in a respectful manner. Such medical services should include treatment for physical injuries, pregnancy prevention and termination where legal, testing and treatment for STI, psycho-social support including counselling, and HIV testing. Rapid HIV test kits should be routinely available, but there may be problems with HIV testing and counseling in such a vulnerable period just after the violence. Where feasible, health workers should also discuss the risks and benefits of HIV post-exposure prophylaxis (PEP)[7] for preventing sexually transmitted HIV infections so that they can help their patients reach an informed decision[8]. However for PEP to work, women who have been assaulted have to access health care services within 72 hours, which may not always be possible in conflict settings.

Conclusions and Key Messages:

Violence against women, particularly sexual violence, is widespread in conflict settings. In such situations, women and girls face increased risks of acquiring STI and HIV by:

- Direct transmission through rape.
- Being placed in situations where they may be forced to exchange sex for survival.
- Experiencing increased levels of overall violence including intimate partner violence, which in turn, makes it difficult for them to negotiate safe sex in their relationships.

There is an urgent need for identifying, testing and implementing effective strategies for integrating programs that address both violence against women and HIV prevention and AIDS treatment and care in conflict settings. The challenges of doing this are immense as immediate needs for food, shelter and security often take precedence over addressing other health concerns.

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[5] *ibid 2.*

[6] *Human Rights Watch. June 2002. The war within the war: Sexual Violence against women and girls in eastern Congo. New York: Human Rights Watch.*

[7] *At present it is unclear how effective post-exposure prophylaxis (PEP) is in preventing sexually transmitted HIV infection. Some programmes routinely offer PEP to survivors of sexual violence, using similar protocols for PEP following needle-stick injury. In situations where HIV prevalence is high, many who are evaluated for sexual assault may already be HIV infected.*

[8] *WHO. 2003. Guidelines for medico-legal care for victims of sexual violence. Geneva, Switzerland: World Health Organization.*