Country Profiles from Asia

# *Afghanistan / Pakistan*
# *Burma / Thailand*
# *East Timor*

# Situation in *Afghanistan* and Among Afghan Refugees in *Pakistan*

April 14-21, 2001

*Author's note: This report represents circumstances as they existed during an April 2001 research visit to Pakistan. Although the situation of Afghans, including refugees, has changed dramatically since the events of September 11, 2001, this report's findings and recommendations regarding GBV remain relevant. With the fall of the Taliban regime, the Pakistan and Afghan governments, as well as the humanitarian aid and civil sectors, are able to declaim publicly and aggressively the widespread nature of GBV among the Afghan population and institute appropriate programming to address its prevention and response.*

## Background

### Historical Context

In significant measure, the past twenty-two years of Afghanistan's history have been a history of exploitation: by cold war superpowers waging a proxy war; by neighboring governments exploiting Afghanistan's geographic position to pursue regional interests; and by internal factions competing for hegemony over Afghanistan's multi-ethnic population. The first wave of conflict began in the late 1970s with increasing internal opposition to Afghanistan's ruling elite; against this backdrop of political instability the Soviet Union invaded in 1979. The ensuing ten years of war—during which Afghanistan's economy of rural subsistence was all but destroyed and replaced by black market monetization and dependence on international humanitarian aid—resulted in thousands of casualties and precipitated the flight of millions to refugee camps in Pakistan and Iran. The conflict also resulted in an agglomeration of rebel Islamist groups (collectively referred to as the Mujahideen) that during the cold war was financed primarily by the U.S. and Europe and supported logistically by Iran and Pakistan. Three years after the formal 1989 Soviet withdrawal from the war, which Russian president Mikhail Gorbachev characterized as a "bleeding wound," members of the Mujahideen succeeded in overtaking Afghanistan's capital city of Kabul and instituting a nominal Islamic government.[1]

Factional disputes, which caused pervasive violence among the Mujahideen and against the civilian population, severely undermined the new government's stability, credibility, and popularity, so that when a group of mostly rural Pashtun Islamic fundamentalists, referring to themselves as the Taliban, emerged as a military force, they were able to fight and buy their way to power relatively quickly. With primary support from a Pakistan invested in preserving Afghanistan as a strategic neighbor in its tense standoff with India, the Taliban moved from the south to capture Kabul in 1996, and under leader Mullah Mohammad Omar proclaimed control of the newly declared Islamic Emirate of Afghanistan. Meanwhile, members of the ousted Mujahideen, including President Burhanuddin Rabbani and his military commander Ahmed Shah Massood, regrouped to form an opposition Northern Alliance, also referred to as the United Front. Primarily comprised of Tajik, Uzbek, and ethnic Hazara minorities, and backed by Iran, Russia, Tajikistan, and Uzbekistan, the United Front progressively lost control of all but 10 percent of

Afghanistan, retaining pockets in Afghanistan's central highlands, in the northeast, and in the frontline of combat north of Kabul.

In place of a constitution, Taliban leaders issued edicts curtailing even the most basic human rights. Their Islamic courts and religious police, the Ministry for the Promotion of Virtue and Suppression of Vice (PVSV), were established to enforce violently and summarily the Taliban's ultra-conservative interpretations of Islamic law. These practices, the trafficking of drugs and terrorism, and other isolationist and reactionary policies of Taliban leaders engendered the enmity of world powers. When the Taliban refused to facilitate the handover of Osama bin Laden, the suspected mastermind behind the 1998 attacks on U.S. embassies in Kenya and Tanzania, the U.S. responded with cruise missile strikes on alleged terrorist training camps near the Pakistan border, and the United Nations drafted a resolution imposing international sanctions on Afghanistan. Although targeted at the Taliban, the 1999 sanctions further isolated the whole of Afghanistan. Ongoing internal skirmishes between the Taliban and United Front, whose indiscriminate military tactics led to high rates of civilian death, plus the effects of severe drought, resulted in the internal displacement of a half to one million Afghans, and a refugee population that, as of April 2001, was estimated at around three million, 75 percent of whom were women and children.[2]

Those who fled Afghanistan left a country with some of the most dire health conditions in the world. Infant and maternal mortality are at global highs; life expectancy is 43 years for men and 44 for women[3]; clean water is unavailable to the majority of the population; and vast networks of landmines and unexploded ordnance not only pose immediate threats to life and limb but also limit agricultural production and contribute to high rates of malnutrition.[4] Those who fled Afghanistan also left behind a country with some of the worst human rights abuses in the world. In Taliban-controlled areas, PVSV reportedly carried out stonings, floggings, public executions, extrajudicial murder, and amputations of those in violation of Taliban edicts. For women and girls, the Taliban decrees have been especially devastating.

## Status of Women in Afghanistan

In the years before and during the Soviet occupation, Afghan women enjoyed increased access to the public sphere, including education, professional training, and work, but their liberties were rescinded with the rise of the Mujahideen. Violence against women, especially in Kabul, was pervasive during the Mujahideen's unstable rule, such that the Taliban's police state initially provided a welcome reprieve.[5] However, the Taliban's subsequent and consistent denial of women's rights resulted in some of the most extreme discriminatory regulations against women in the world: girls were officially prohibited from attending school beyond the primary level (female literacy rates are estimated as low as 4 percent[6]); women required accompaniment by a male family member and a cloth sheath (*burqa* or *chadari*) covering their entire body when in public; houses with female occupants had to have opaque windows; and women were forbidden to work outside the home in anything but agriculture and health services, and specifically forbidden from most positions with international agencies, where salaried work is concentrated. The enforced sex segregation of health workers resulted in a drastic reduction in the quality and availability of treatment for women, effectively preventing many women from receiving health care. Although the implementation of these regulations varied widely—tending to be more extreme in Taliban-controlled urban areas—profound institutional and practical discrimination against women nevertheless existed throughout Afghanistan, even in areas controlled by the United Front.[7]

## Status of Afghan Women in Pakistan

Unfortunately, for many women who seek refuge in the camps along Pakistan's border with Afghanistan, conditions—by international standards—are only marginally better than inside Afghanistan. The government of Pakistan originally afforded Afghan refugees fleeing the Soviet occupation *prima facie* refugee status, but in 1995 Pakistan officially discontinued its refugee assistance programs. In 1999 Pakistan rescinded refugee status to newly arriving or re-entering Afghans, whose impetus for migration was perceived as economic rather than political. As of 2001, Afghans without appropriate visas were subject to deportation under the Foreigners Act, though as yet Pakistan has not widely enforced this rule. The government's Commissionerate for Afghan Refugees (CAR) cooperates with the United Nations High Commissioner for Refugees (UNHCR) and other partners in the provision of protection, education, and health care, but international aid is grossly

insufficient to meet basic needs. Although limited assistance is still available to registered refugees in established camps, conditions can be extremely harsh for newer arrivals, and the general climate in Pakistan is unfavorable to refugees, particularly those who are not of ethnic Pashtun origin.

In addition to the lack of assistance and legal rights, refugee women are also affected by continued gender discrimination. The strong presence of the Taliban along Pakistan's border and especially in the Pashtun-dominated Northwest Frontier Province (NWFP)—where 127 of Pakistan's 203 refugee camps are located—continues to buttress the Taliban's declaration that Afghans are nowhere exempt from their edicts. As such, many Afghan refugee women living in Pakistan's refugee camps—and the local and international organizations that assist them—experience severe constraints to their activity and mobility. The marginal status of refugees, compounded by the pervasive discriminatory attitudes against women in Pakistan, significantly inhibits women's access to basic assistance or protection. Refugee women's limited recourse has an acute impact on their vulnerability to GBV.

## Gender-based Violence

### Afghanistan

The Taliban edicts that controlled virtually all spheres of women's lives were a widespread form of institutionalized GBV, reinforced by threats, arbitrary beatings in the street, and formal public lashings by the religious police.[8] Although Afghanistan is a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Taliban rendered that commitment meaningless. In their 2001 investigation of the perceptions and impact of Taliban edicts on Afghan women, Physicians for Human Rights (PHR) found that an overwhelming majority of women—and men—did not support Taliban restrictions on women's human rights. In Taliban controlled areas, women interviewed by PHR reported high rates of depression and correspondingly high rates of suicidal ideation and suicide attempts, which interviewees largely attributed to the effects of Taliban oppression.[9]

Even before the Taliban, particularly in rural areas where tribal customs predominated, patriarchal traditions flourished; those traditions form the basis of the gender discrimination that defines current policies and practices. As repositories of family honor, women and girls have historically been held responsible for abuses committed against them. Under Taliban regulations, unless women reporting rape could prove non-compliance by producing four male witnesses, they were at risk of harsh punishment for fornication and adultery. In fact, repercussions were egregious regardless of whether the sexual conduct was mutually consenting. Not surprisingly, women had no systems for reporting violence or receiving assistance. Apparently the most viable option for an unmarried girl exposed as having had sexual relations was to marry her partner, even if the man had perpetrated the rape. In more severe resolutions, a girl—or woman—and her perpetrator would be killed by the offended family.

In the resulting culture of silence, it is very difficult to determine the extent of war-related or other sexual violence committed against Afghan women. Even so, rape and abductions have been widely acknowledged as an endemic feature of the post-Soviet rise of the Mujahideen.[10] In the years following the Taliban takeover, rates of sexual violence were perceived to have generally decreased. However, human rights organizations have provided anecdotal evidence of ongoing violence, including rape, abductions, and forced marriages carried out by both the Taliban and the United Front, particularly on the front lines. Human Rights Watch recorded accounts of Taliban fighters systematically sexually assaulting and abducting ethnic minority women in the northwest city of Mazar-I-Sharif during its takeover in 1998. In her 1999 visit to Pakistan and Afghanistan, the U.N. Special Rapporteur on Violence Against Women received reports of Taliban abuse—including abduction and forced marriages—of ethnic Hazara and Tajik women perceived to be sympathetic to opposition forces.[11]

There are indications—based on research and commentary by investigators and NGOs operating in Pakistan—that other forms of GBV such as child abuse, trafficking for prostitution, and domestic violence have been perpetrated in Afghanistan. In a 1998 reproductive health survey by the International Rescue Committee (IRC) of over two hundred women living in camps south of Peshawar, Pakistan, 79 percent acknowledged being beaten by husbands, 39 percent by other family members, and 13.4

percent reported that men have the right to beat their wives. Notably, some of the women surveyed also mentioned that violence against them had decreased since becoming refugees. Additional qualitative research by IRC on child sexual abuse carried out in 2001 revealed a case in which a sixteen-year-old Kabul girl, whose father was imprisoned for life after the girl twice reported incest to the authorities, was also imprisoned for four years on the grounds that she should have stopped the abuse earlier.[12] In another incident reported by the Special Rapporteur, a twelve-year-old Afghan girl separated from her parents was trafficked to Pakistan and sold to a Punjabi man.[13]

### Pakistan

The Special Rapporteur also reported concerns about the apparent rise in GBV among the refugee population in Pakistan, where the lack of assistance and protections offered by the government of Pakistan have exacerbated harmful traditional practices and introduced new forms of violence. Despite IRC's 1998 findings that domestic violence decreased for women living in camps, the Special Rapporteur found in 1999 that fatalities in domestic disputes were on the rise, likely resulting from family tensions associated with the precarious status of refugees and high rates of unemployment.[14] Situational and economically driven early marriages may also be increasing; in one camp outside Peshawar, women freely admitted that selling their prepubescent daughters to Pakistani men provided a source of income and was preferable to the child's return to Afghanistan. In some cases, Pakistani security forces within the camp facilitate this process.

Evidence further indicates that Afghan refugee women and girls—and boys—are vulnerable to child sexual abuse, prostitution, and trafficking. In IRC's 2001 research, one camp resident claimed "it was not uncommon for men to rape girls, even in the presence of their wives."[15] Other reports suggest that prostitution of women and girls is facilitated inside the camps by family members, camp leadership, and camp security. Camp security has also been implicated by female refugees in the rape and abduction of encamped women and girls, though these crimes are not reported because of survivors' fears of being harassed or deported by Pakistani police.

Refugee women living outside the camps may be at even greater risk of sexual exploitation, especially if they are widowed or otherwise without male protection; scenarios include forced prostitution by their neighbors or employers, or elective prostitution as a method for supporting their children in an environment that otherwise offers no economic resources. Boys are also at risk, in part because of their comparative visibility and mobility, and in part because of traditions that may lead to their sexual exploitation. In Afghan wedding ceremonies, for example, entertainment may include dancing boys ceremoniously dressed as girls, who in some cases sexually service male guests.[16] Prostitution by young boys exists throughout Pakistan, and it is likely that in the border areas Afghan children are represented.

## Current GBV-related Programming

### The Refugee Population in Pakistan

Although the extent of GBV against Afghan women and children is alarming, the lack of GBV-related services for the refugee community may be even more so. In part, this lack is owing to the constraints imposed by the Taliban along the border. It is also the result of the prevailing disregard for violence against women in Pakistani culture and practice. According to a 1999 Human Rights Watch investigation, "Women in Pakistan face staggeringly high rates of rape, sexual assault, and domestic violence while their attackers largely go unpunished owing to rampant incompetence, corruption, and biases against women throughout the criminal justice system."[17] As in Afghanistan, Pakistan's Hudood Ordinances place women at risk of prosecution if they fail to prove rape allegations, such that men may be acquitted for rape while their victims are held on grounds of fornication and adultery: an estimated one-third of women jailed in Peshawar in 1998 were awaiting trial for adultery.[18] Doctors are ill-trained to conduct forensic exams, often focusing their examination on the virginity status of the victim. Statutory rape is not a crime, nor is rape in marriage. Domestic violence is also not explicitly criminalized in the Pakistani legal code and "virtually never" investigated by police.[19] Special women's police stations that were established in 1994 to avert the problem of police abuses against women—including rape—are too poorly funded to operate effectively.[20] Trafficking in women "is protected by powerful criminal interests and operates relatively openly," with little effort by the government

to stem the tide of the estimated thousands of women who arrive annually from Bangladesh, Afghanistan, Burma, Sri Lanka, and India.[21]

In this climate of impunity, it is virtually impossible for Afghan women refugees to seek redress for gender-based crimes committed against them, even by Pakistani perpetrators. Nor are they generally able to gain access to palliative services. No health care providers working within camps have clear protocols for addressing violence, and no psychosocial programs exist for camp-based refugees that target the issue of GBV. Outside of the camps the situation is only marginally improved. Although GBV-related services are not widely available to refugees, several local Pakistani NGOs provide medical and psychosocial support to victims of violence from which refugees may benefit. In the NWFP, select Afghan women's NGOs working explicitly on issues affecting Afghan refugee women have developed informal networks to address victims of violence. However, their need to operate under the radar of the Taliban and their ability to provide anything other than general emotional support has restricted their impact. Any protective services available to refugees are the result of UNHCR's initiative, and yet the fact that field-based protection officers are, by necessity, men, curtails the extent to which women may seek assistance. In spite of these limitations, select programming that touches—even if only peripherally—on issues of violence against Afghan women is moving forward.

### Islamabad

Pakistan's capital city of Islamabad is home to the head offices of most of the international institutions serving refugees. UNHCR's "Women at Risk" project facilitates resettlement for the most vulnerable Afghan women, many of whom are widows and are in danger of or have experienced sexual exploitation. The project collaborates with IRC, which in turn partners with local NGOs. UNHCR also collaborates with two safe houses in Islamabad to ensure women's security during the transition to resettlement. In one case referred for resettlement, an Afghan woman's widowhood led her to work as a domestic servant, which in turn led to repeated rapes committed by her employer against both the woman and her daughter.

The United Nations Population Fund (UNFPA) has also cooperated with UNHCR in the provision of refugee health care, of which prevention and response to GBV is a stated objective. To meet that objective, UNFPA has supported inconspicuous, brief presentations to Afghan men on the prevention and consequences of GBV. The International Organization for Migration (IOM) is currently working with the Pakistani authorities to develop a strategy for information campaigns addressing trafficking.

A few exemplary local organizations in Islamabad have worked with Afghan survivors of GBV to address their health and psychosocial needs—though in all cases the refugees are not their primary target population. For example, the Pakistani NGO Struggle for Change (SACH) provides rehabilitation and training for survivors of torture through psychotherapy, physiotherapy, and socioeconomic support. It also has an education program for survivors' children, most of whom are Afghan. The women's rights organization Savera provides similarly broad-based services, which are accessible to refugee women victims of violence. Rozan, a comprehensive NGO that provides training and direct services addressing multiple aspects of women's psychosocial health, gender, and GBV also occasionally receives counseling referrals for Afghan refugee women. The children's rights organization Sahil has facilitated education to refugees on child sexual abuse and has been critical in monitoring and publicizing abuse against children in Pakistan.

### Peshawar

The largest city in the NWFP, Peshawar serves as a base of operation for many international and local NGOs working with refugee populations in camps and urban areas along the Pakistan-Afghanistan border. The UNHCR "Women at Risk" program has activities in Peshawar, as does its IRC partner program. Peshawar's UNHCR community services officer was a strong advocate for developing programming to combat GBV in the camps, and served as advisor to an exemplary but short-term effort by IRC to address GBV. Initially conceived to target violence against women, the IRC project generated security concerns and the focus was therefore shifted to research and training on sexual violence against Afghan children, of which education on general issues of GBV was one component. The Women's Commission for Refugee Women and Children (Women's Commission) supports a Peshawar-based

technical advisor to work on broad-based gender issues among Afghans in Afghanistan and Pakistan. The advisor's training, monitoring, and advocacy activities have improved programming for and sensitivity to Afghan women in multiple ways. By highlighting and addressing women's vulnerabilities, the advisor's activities have also acted as a preventive measure against GBV.

Many of the support services available to women refugees exist through local Afghan women's NGOs. None of the programs has specific activities targeting GBV, but several have components that directly or indirectly benefit survivors. The Afghan Women's Council (AWC), which runs health, education, and advocacy programs for refugees, also takes testimony from widows of war and publishes it in a newsletter distributed to women in Afghanistan. This sharing of information provides an opportunity for women—many of whom have experienced some form of GBV—to receive support, and it decreases the silence around the issue of GBV. Because the AWC has heard so many accounts of domestic violence, it is hoping to create support groups and discussion forums for abused spouses. The Center for Street Children and Women (CSCW) has a model component project, Madadgar, that provides supportive services and referrals for "women in crisis," some of whom have been victims of domestic violence, forced prostitution, and sexual harassment. Because CSCW has multiple services such as skills training, medical care, education, and recreation, it can refer women both internally as well as to other organizations with which it networks.

Remarkably, in a political climate hostile to women's rights, a number of organizations at both the international and local level have very active and sophisticated gender training and education programs. International organizations such as Norwegian Church Aid (NCA) and the Swedish Committee for Afghanistan (SCA) subtly incorporate issues of violence against women in their gender trainings, which they provide to large numbers of employees working in both Pakistan and Afghanistan. Local organizations similarly committed to gender training and education include the Center for Humanitarian Affairs and the Cooperation Center for Afghanistan. Although neither has curricula that directly address violence against women, each organization has expressed a desire to expand training to incorporate GBV more overtly. This desire to attend to GBV more overtly is common among agencies serving Afghan women, sounding a clarion call to those invested in promoting the health and welfare of the Afghan refugee community.

## Summary

GBV in Afghanistan may qualify as among the most pervasive—and certainly among the most institutionalized—in the world. Evidence from researchers and human rights advocates suggests that GBV in refugee communities living in Pakistan is similarly pervasive, where the predominant cultures of violence toward women and hostility toward refugees may further exacerbate its prevalence. Despite this evidence, few humanitarian organizations have taken up the issue—largely because of legitimate security concerns within Afghanistan and along Pakistan's western border. Even so, there are several initiatives at both the international and local levels that have successfully, if discreetly and indirectly, addressed GBV. The more vocal and visible are those operating in Islamabad that primarily serve the Pakistani community, such as SACH, Savera, Sahil, and Rozan. However, IRC's research on child sexual abuse, AWC's testimony collection, CSCW's crisis response project, and the gender trainings of NCA and SCA each illustrate the viability of developing GBV programming that specifically targets Afghans, even in the more conservative NWFP.

The above projects may act as models to the many organizations that have not yet instituted GBV activities but have expressed the need, as well as the desire, to confront more aggressively violence against refugee women. Among them is the Committee for the Defense of Afghan Women's Rights (Rawzana), which would like to implement trainings on legal rights for survivors. The Afghan Women's Resource Center would like to incorporate GBV prevention and response into their existing literacy, skills training, and health services for urban and camp-based women. Marie Stopes Society, a local affiliate of Marie Stopes International, would like their doctors working inside camps in the NWFP and their health workers serving urban refugees to receive training in responding to GBV. The local Peshawar organization AWARD participates in a Pakistani violence against women forum, of which the Peshawar police commissioner is supportive. AWARD does not currently engage with

the refugee community, but it is hoping to develop a training manual on GBV and would like to collaborate with Afghan NGOs for its implementation. Other Pakistani NGOs, such as those operating in Islamabad, also have expertise and materials available on issues of violence against women that could be made accessible to international and local organizations wishing to target refugee populations.

Interestingly, a common concern articulated by local organizations was not centered on issues of security but rather on the availability of international organizations to assist, both in terms of technical support and funding, in the development of GBV initiatives. Perhaps because local organizations are accustomed to working in covert ways to promote and deliver services, they feel relatively confident in their ability to design and institute measures to address GBV. The immediate barrier, it would seem, is one of donor support and international commitment.

## Recommendations

1. The donor community should examine its commitment to addressing the health and safety needs of the refugee population and, acknowledging the major impact of GBV on morbidity and mortality, it should finance the institutionalization of broad-based health and other support services to assist survivors, as well as initiatives to reduce the prevalence of violence. These services should be instituted not only in Pakistan but also in Afghanistan to meet the needs of returning refugees and the population at large.

2. UNHCR, in collaboration with members of the CAR in Pakistan and with the newly appointed Minister for Women's Affairs (Dr. Sima Samar) in Afghanistan, should support the development of Afghanistan- and Pakistan-based coordinating bodies to examine and address GBV for both the refugee and returnee populations. The coordinating bodies should operate within their respective countries as a forum for multi-sectoral collaboration, and each body should include members of the Pakistan and Afghan governments, UN representatives, religious and community leaders, and international and local NGOs working with refugee women. The coordinating bodies should also provide security for participating local NGOs which may be at risk by more conservative members of the Islamic community. The forums should have a long-term plan for moving to national government oversight.

3. UNHCR and international NGOs should develop mechanisms for assessing and recording the nature and prevalence of GBV among populations served. They should use that data to bring pressure to bear on the Pakistan government to implement greater protections for women refugees according to the mandate of international refugee protection and according to the Pakistan government's commitment to addressing GBV as a signatory to CEDAW. Any and all efforts of data collection must have mechanisms to ensure absolute confidentiality so as to protect both the survivor and those collecting data.

4. The Pakistan government should take a strong stance against the exploitation and rape of refugee women by Pakistani police and authorities. Similarly, mechanisms should be instituted immediately by the government of Afghanistan to ensure broad-based legal protections for returning women that include safe corridors for return, as well as the availability of protections after repatriation.

5. Religious and community leaders in Afghanistan and along the border of Pakistan should be engaged in the design of widespread education campaigns that incorporate Islamic teachings to promote the prevention of GBV and illustrate the extent to which violence against women is anathema to Islam. Of particular importance to any education efforts will be addressing community attitudes that overwhelmingly "blame the victim."

6. Ministries responsible for social welfare, internal affairs, and the judiciary in both Pakistan and Afghanistan should require trainings within their respective sectors on the existence and application of protective laws. Women should be actively recruited to the police forces, and in Pakistan existing women's police precincts should receive more operational support. Female police officers should be placed in Pakistan's refugee camps. Ministries should require that sex-disaggregated data on violence is collected and monitored at local and national levels.

7. Pakistan's CAR, in collaboration with UNFPA, should significantly expand its health response protocols for refugees to include GBV activities. Standard trainings on all aspects of GBV, including forensic examinations, screening of clients for histories of abuse, and ensuring doctor-patient confidentiality, should be required by CAR for health staff. Efforts should be made to increase the numbers of Afghan health workers in the camps, and to ensure that the current Pakistani health providers are able to speak Dari and Pashto, and can communicate effectively with members of minority groups, including Uzbeks and Turkmen, who may not speak Dari or Pashto. International NGOs with health programs in Afghanistan should similarly introduce protocols to screen for and examine survivors.

8. International NGOs operating in Pakistan and Afghanistan should create and implement strategies for incorporating GBV prevention and response into existing education, skills-building, and psychosocial projects. International NGOs should support local partner organizations to do the same. In Pakistan, expert Pakistani NGOs working in the area of GBV should be called upon to facilitate this goal. Shelters that have been extremely successful in Islamabad should be replicated in the NWFP and in Afghanistan.

9. Local and international NGOs should research and introduce projects that address the concerns of boys, particularly their sexual exploitation. Projects developed in Afghanistan for men—such as demobilization and reintegration activities—should include GBV prevention and response in their education and direct services, as well as psychological and drug-abuse counseling.

## Notes

1 M. Fielden, and J. Goodhand, "Beyond the Taliban: The Afghan Conflict and United Nations Peacekeeping," *Conflict, Security, and Development*, 1:3 (2001), 5-32.

2 U.S. Department of State, *Country Reports on Human Rights Practices: Afghanistan* (Washington D.C., 2001), 2.

3 Physicians for Human Rights (PHR), *Women's Health and Human Rights in Afghanistan: A Population-based Assessment* (Boston, 2001), 3.

4 U.S. Department of State, *Country Reports on Human Rights Practices: Afghanistan*, 12.

5 Oxfam U.K., "Gender and Afghanistan" (unpublished document, Oxford, 2001), 3.

6 U.S. Department of State, *Country Reports on Human Rights Practices: Afghanistan*, 13.

7 United Nations, *Report of the Special Rapporteur on Violence Against Women, Mission to Pakistan and Afghanistan* (Geneva, 2000), 5.

8 Human Rights Watch, *Humanity Denied: Systematic Violations of Women's Rights in Afghanistan* (New York, 2001), 8.

9 PHR, *Women's Health and Human Rights in Afghanistan*, 8-13.

10 A. Pont, *Blind Chickens and Social Animals: Creating Space for Afghan Women's Narratives Under the Taliban*, Report for Mercy Corps, (Portland, 2001), 48.

11 U.N., *Report of the Special Rapporteur*, 5.

12 C. McGinn, "Sexual Abuse of Afghan Refugee Children in Northwest Pakistan: Patterns, Perceptions, and Response" (unpublished report for the International Rescue Committee, Peshawar, 2001), 10.

13 U.N., *Report of the Special Rapporteur*, 11.

14 U.N., *Report of the Special Rapporteur*, 11.

15 McGinn, *Sexual Abuse of Afghan Refugee Children in Northwest Pakistan*, 8.

16 McGinn, *Sexual Abuse of Afghan Refugee Children in Northwest Pakistan*, 13.

17 Human Rights Watch, *Crime or Custom?: Violence Against Women in Pakistan* (New York, 1999), 1.

18 U.S. Department of State, *Country Reports on Human Rights Practices: Afghanistan*, 5.

19 Human Rights Watch, *Crime or Custom?*, 40.

20 U.S. Department of State, *Country Reports on Human Rights Practices: Afghanistan*, 4.

21 U.S. Department of State, *Country Reports on Human Rights Practices: Afghanistan*, 21.

# Situation in *Burma* and Among Burmese Refugees in *Thailand*

April 22-29, 2001

## Background

### Historical Context

Rather than being notable for its diverse ethnic history and rich natural resources, Burma is distinct as the setting of one of the longest-running civil wars in the world. Declared independent from British rule in 1948, Burma's pro-democracy leaders were assassinated even before their Union of Burma was officially established. In a post-independence leadership vacuum, internal conflicts escalated along political and ethnic lines: between democratic and communist militants, and the Burman (who comprise approximately 60 percent of total Burmese) dominated central government and several of the larger of Burma's over one hundred minority groups, including the Mon, Shan, Chin, Karen, and Rohingya (each distinguished by language, cultural and religious traditions, and adaptation to their physical environment). In March 1962 a military coup replaced the unstable civilian government with one-party rule. The policies instituted by Burman dictator General Ne Win included the "Burmese Way to Socialism," which prescribed a nationalized economy and the diversion of natural and human resources to support an expanding military machine, and a violent "Four Cuts Campaign," in which forced relocation, scorched earth tactics, and free-fire zones were employed to withdraw or avert life-sustaining resources from the ethnic civilian population.

In 1988, political resistance swelled into historic student-led demonstrations. The nationwide non-violent protests were met with indiscriminate state violence in which thousands of anti-government protesters were killed. Nobel Peace Prize Laureate and General Secretary of the National League for Democracy (NLD) Aung San Suu Kyi was placed under house arrest in 1989. In 1990 the military junta bowed to public pressure for democratic elections and promised to transfer power. However when the NLD won 59.9 percent of the popular vote and 82 percent of the parliamentary seats the junta reneged on its promise, upholding Suu Kyi's house arrest and further escalating military aggression.

Belying its self-appointed title as the State Peace and Development Council (SPDC), Burma's current military regime has neither brokered peace nor stimulated development. Although cease-fires have been negotiated with some seventeen main insurgent groups since 1989, widespread state-sponsored human rights abuses remain the violent norm.[1] Burma ranks among the poorest countries in the world; its schools and health system have collapsed; and it is home to a rapidly escalating HIV/AIDS epidemic—thanks in part to the fact that Burma has become one of the largest producers of heroin in the world. Ongoing internal skirmishes, military repression of ethnic minorities, forced relocations based on economic strategy, and pervasive poverty have resulted in a constant exodus of political and economic refugees.

### Refugee Situation in Thailand

It is impossible even to approximate the number of internally displaced inside Burma. However, recent estimates of the total number of Burmese who in the last fifteen years have fled to neighboring countries hover around 1.5 million.[2] About 9

percent live in refugee camps along the Thai/Burma border, primarily representing the Karen, Karenni, and Mon ethnic groups.[3] A loose estimate of another several hundred thousand Burmese—inclusive of the ethnic Shan, who have been categorically denied refugee services by the Royal Thai Government (RTG) because of their perceived status as economic refugees—are reported to be living throughout Thailand as "illegal immigrants." Reflecting the global refugee phenomenon, women and girls account for 60 to 80 percent of the Burmese refugee population.

The RTG, whose country's resources and land have been drained by the seemingly intractable refugee crisis, has imposed increasingly severe restrictions on the rights and mobility of Burmese living in Thailand. The protections available to refugees are at best ambiguous and, often, imperiled. Because the RTG has not signed the 1951 United Nations Convention Relating to the Status of Refugees, no Burmese living in Thailand are officially recognized under international refugee law. Only "persons of concern," those evaluated by the RTG as direct victims of Burmese conflict, are officially permitted to receive humanitarian aid, primarily within camp settings. Thus, ethnic Burmese entering Thailand from regions in Burma that are not officially designated as conflict areas are denied services and live under the threat of forced repatriation, despite the fact that their political, civil, and economic rights have been repeatedly disavowed by the SPDC and Burmese military even after declarations of cease-fires.

Food and relief assistance to refugees living in camps is coordinated by the Burmese Border Consortium (BBC), "in cooperation with the RTG and in accordance with the regulations of the Thai Ministry of Interior (MOI)."[4] BBC also cooperates with humanitarian aid partners which provide health and education services. The MOI oversees policing of the camps and refugee compliance in general. Within the last three years, the RTG has enlisted the support of the United Nations High Commissioner for Refugees (UNHCR), whose mandate is registering, monitoring, and protecting refugees within camps and those who are newly arriving or who are being relocated from one refugee camp to another. UNHCR is also responsible for identifying and assisting "persons of concern" in urban areas. However, since the RTG's 1999 crackdown on "illegal immigrants," those judged by UNHCR (but not by the Thai government) to be "persons of concern" may be at increased risk of forced return to Burma.

The limited mandate of UNHCR, the active surveillance of MOI representatives within and without the camps, the necessity of the BBC and its partners to act in accordance with RTG policy, and the failure of the RTG to recognize the rights of all Burmese refugees—together have important implications for survivors of GBV.

## Gender-based Violence

### Burma

According to the international NGO Images Asia's review of the Burmese government's compliance with the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (ratified by Burma in 1997):

> Women have been victims of the well-documented and pervasive human rights abuses also suffered by men, including forced labor on government construction projects, forced portering for the army, summary arrest, torture and extra-judicial execution. These and other human rights violations are committed sometimes in the course of military operations, but more often as part of the army's policy of repression of ethnic minority civilians. Women and girls are specifically targeted for rape and sexual harassment by soldiers. *Many of the areas in Burma where soldiers rape women are not areas of active conflict, though they may have large numbers of standing troops.* There has been little action on the part of the state to reduce the prevalence of sexual abuse by its military personnel or ensure that the perpetrators of these crimes are brought to justice.[5] (Emphasis added.)

As this and other human rights reports attest, Burma is no exception to the rule of military violence against women and girls during conflict. Burma is exceptional, however, in that its military includes the highest number of child soldiers in the world. Use of child soldiers is itself an abuse, and may also be a factor in the abuses committed by the state against the civilian population: children can be more easily manipulated or forced to commit atrocities.

Testimony by survivors and witnesses of military aggression includes reports of gang rape, forced genital penetration by knives and other objects, mutilation of breasts and genitals, and more. Another striking aspect of the state violence perpetrated against women in Burma is that it is not limited to conflict zones; rather, it is an unsparing and unrestrained component of the Burmese military's state-supported reign over ethnic minority civilians. In her comprehensive account of sexual violence perpetrated by the Burmese military, Betsy Apple attributes the culture and prevalence of rape, enslavement, coerced sex, forced prostitution, and forced marriage to a "hierarchy of domination," in which violence, oppression, and exploitation are institutionalized military values, ultimately finding their target among the most vulnerable and disempowered: the bodies of ethnic minority women and girls.[6]

The notion of Burmese women's disempowerment runs counter to the SPDC official stance that in Burma "there is no gender disparity in personal relationships" and "women are accorded equal rights with men."[7] Images Asia's CEDAW review quoted above argues otherwise, suggesting that in virtually all spheres, women are subordinate to men and subject to related gender-based abuses of power. Women victims of sexual harassment and violence within their communities or domestic violence in the home have limited legal recourse or community resources: police and the judiciary are both unreliable and not trusted, and social tradition and family pressure conspire to discourage reporting or otherwise acknowledging abuse.[8]

Prostitution inside Burma has reportedly increased dramatically as a result of the civil war, as has sex trafficking of migrants.[9] In addition to the prevailing culture of men frequenting prostitutes, widespread sexual violence within Burma, the associated stigma of losing one's virginity before marriage, and the breakdown of traditional family structures have precipitated the rise in women and girls entering the sex industry; another precipitant is certainly the lack of economic options, particularly for ethnic Burmese women living in rural areas. In 1997 the World Health Organization estimated the female illiteracy rate within Burma to be 70 percent. Despite the Burmese government's stated commitment to improving female access to education, subsequent calculations place the illiteracy rate even higher, at 80 percent, among women living in conflict zones or remote areas.[10] It is not surprising that of the estimated forty thousand Burmese women trafficked each year into Thailand's factories, brothels, and domestic work, those at greatest risk are reportedly women from remote regions of Burma.[11]

## Thailand

GBV against Burmese refugees in Thailand is as difficult to quantify as violence against women inside Burma. Thailand-based Burmese women's organizations periodically release information on the sexual subjugation and exploitation of women by the Thai military, police, and immigration officials, at checkpoints and border crossings, detention centers, brothels, and in and surrounding camps.[12] One contributing factor to the perpetuation of such violence is the lack of legal protection afforded Burmese refugees in Thailand and survivors' associated fear of further abuse by police officers and military. Another equally pervasive factor is the inconsistent protections available to women under Thai law, reflecting traditions that favor male domination. For example, although non-marital rape is considered a serious crime under Thai law, proof of non-consent falls to the victim. This has especially devastating implications for trafficked sex workers, who are typically treated as offenders, detained, and required to pay fines and finance the expenses of their deportation.

Other Thai legal provisions generally discourage refugee women and girls from seeking protection against violence perpetrated by their host community or fellow refugee community. In cases of statutory rape, an offender may opt to marry his victim, thus avoiding punishment. Financial compensation for the rape of a married woman (by someone other than her husband) is given to the husband rather than to the survivor; the crime of marital rape does not exist, nor is the phenomenon of domestic violence formally recognized in Thai law.[13] In camp settings, more severe cases of domestic or refugee community violence against women are referred to the Burmese camp committees, which are, without exception, male dominated. Rare accounts of Burmese women successfully charging Thai military, police, or Thai civilians with sexual assault, if settled, have been according to customary compensation.[14]

## Current GBV-related Programming

Ethnic Burmese women and girls are at risk for GBV at many stages: in their home country, in flight, in the host country, and during repatriation. As such, Burmese refugees typify the experience of refugee women and girls worldwide. Even so, what was remarkable during site visits along the Thai/Burma border was not the prevalence of violence but rather its invisibility and the lack of standard GBV prevention and response activities. Although Burmese refugees have been living in Thailand some fifteen years, and accounts of sexual abuse by the Burmese military have been recorded by multiple Burmese and international human rights organizations, no camps or organizations have ongoing education, services, or protocols specifically targeting survivors of GBV. Limited activities focus on immediate protection of the victim and are the result of an isolated few international NGOs that have taken it upon themselves to establish links with local women's organizations and with UNHCR to create a network that facilitates UNHCR intervention. Nonetheless, UNHCR options for pursuing cases of GBV are restricted by the lack of protection afforded refugees by the RTG and Thai law.

### Karen Camps: NuPo and Umpiem Mai

Both NuPo and Umpiem Mai have well-developed preventive and curative primary and reproductive health services systems serving the ethnic Karen community inside the camps. Each camp also has an established network of Karen women's representatives, responsible for monitoring the needs of women and communicating those needs to the women's affairs committee and the camp council. In 1999, elected members of the women's network formed the Mae Sot-based Karen Refugee Camps Women's Development Group (KRWDG). Members of KRWDG are currently receiving skills and NGO development training in order to improve their capacity to assist women's representatives within the camps and to respond to the needs of Karen women.

In interviews with those living and working in the Karen camps, as well as with health care providers, women's representatives, and members of the KRWDG, all expressed concern about violence against women, including domestic violence, sexual assault and coercion by Thai military and Thai civilians, domestic servitude, prostitution, and forced marriage. (Notably, reports of Burmese military atrocities were missing from anecdotes of violence, which may reflect low exposure by the Karen. Most Karen living in Nu Po, for example, have been refugees for many years and were not directly subject to Burmese military aggression.) Health care providers from one international NGO designed and facilitated two trainings on general issues of violence against women and human rights, in which many of the women's representatives participated. Still, actual GBV case numbers within the camp populations are impossible to obtain and interventions—even by international and local NGOs that have articulated a real concern about GBV—appear to be ad hoc.

In NuPo camp, women's representatives respond to five to six reports of domestic violence per month, initially providing informal "education" to the couple about mutual respect, and in cases of escalating abuse, reporting the couple to the Burmese camp council. In the last several years, there have been only two instances in which the NuPo camp council placed restrictions on husbands, committing them each to camp labor and confinement for a maximum of one month. The newly assigned leader of the Umpiem Mai camp denied any knowledge of violence, deferring to the chief of the Karen Women's Organization, but nevertheless suggested that training on GBV might be worthwhile. In the recent memory of an Umpiem Mai medical worker, only one reported case of domestic violence resulted in medical treatment (there was no written record of the source of injury). One case of incest by a stepfather concluded with the perpetrator's voluntary departure from the camp. Similarly, Thai authorities resolved two cases of rape by Thai camp police by retiring one rapist and reassigning the other. Neither rape survivor, according to camp medical staff, requested or received medical follow-up. Nor have Karen women living in Umpiem Mai come forward requesting medical assistance related to Burmese military victimizations or sexual injuries incurred during flight. Although all new arrivals in Umpiem Mai receive medical exams, there is no protocol for identifying or supporting victims of GBV. In NuPo, where medical services are provided on an as-requested basis, there are also no protocols for identifying or responding to survivors of any kind of sexual assault. In both camps, rates of sexually transmitted diseases and unwanted pregnancies were reported to be low to negligible.

The existence in the last two years of UNHCR in the NuPo and Umpiem Mai camps has served a preventive function. Though UNHCR does not have a daily presence in the camps, an international camp-based NGO has facilitated links between UNHCR and the women's committees, identifying for UNHCR some of the most vulnerable women so as to help the women circumvent violence or exploitation. However, UNHCR's ability to ensure protection in identified cases of violence is unclear, as is their relationship with the local MOI authorities. For their part, MOI authorities claimed that victims of violence have access to police protection and legal assistance to the same degree as the local Thai community; yet, these same MOI authorities could recall no instances in which a refugee utilized such assistance.

## Mae Sot

The city of Mae Sot is one of several centers for trafficking across the Burmese border. With an estimated sixteen brothels and a strong textile industry, Mae Sot is often a holding ground for "illegal immigrants" crossing into Thailand.[15] Protections for non-registered refugees living in and around Mae Sot are essentially non-existent—instead, they are at fairly constant risk of summary deportation. Support services are similarly limited, with the notable exception of the Mae Tao Clinic. The most well-established and long-standing organization serving the Burmese community in Mae Sot, the clinic's free health services are provided by a large health staff that is supervised by the clinic's director, a Burmese refugee doctor whose commitment to the refugee community (and ability to win their trust as well as the cooperation of the RTG) is legendary. Recognizing the need for increased understanding of and response to issues of GBV, the clinic's director has attempted to facilitate awareness raising and psychosocial trainings for her health staff. The Mae Tao Clinic also supports women's issues by sponsoring the KRWDG and other local Burmese women's organizations. Still, there is no specific programming within the clinic targeting the medical or psychosocial needs of survivors of violence, nor is there any system for documenting violence against women. There is one organization in Mae Sot that provides safe housing for exploited sex workers, but it does not have any supportive interventions specifically addressing the effects of violence, in spite of clients such as the one described below by the organization's director:

> Trafficked into prostitution at 13 years old, she worked at one of the brothels in Mae Sot that is run by a Thai and serves both Burmese and Thai men. The first time she was approached by a customer, she refused but was forced. The superintendent received a higher price for her "deflowering." As punishment for her initial resistance, she was transferred to another brothel. After several sexual relationships, she was taken by one customer and deposited in a field, where she was again raped by several men. Vomiting blood as well as bleeding from her vagina, she made her way to the roadside, where she was picked up by police who returned her to the brothel. The superintendent punished her by shackling her hands.

Given this account, it is perhaps not surprising that one of the primary concerns of refugee women seeking reproductive health services at the Mae Tao Clinic is complications related to abortions. Because abortion is illegal in both Burma and Thailand, Burmese women use traditional methods to stimulate abortions, the most alarming of which involves piercing the uterus with a sharpened stick.[16]

## Karenni Camps: Mae Hon Son Region

The Karenni National Women's Organization (KNWO) is an umbrella NGO whose members live primarily in and around three camps that provide refuge for the ethnic Karenni in Thailand's northern province of Mae Hon Son. The KNWO's mandate is to address the political and human rights of Karenni women living in Burma and in the refugee camps. In an informal focus group, representatives of KNWO roughly estimated the percentage of Karenni refugee women exposed to GBV at 60 percent. Even though this number may seem exceedingly high, it, at the very least, underscores GBV as a problem in the Karenni community. Family quarrels account for the highest percentage of violence, with rape by Burmese military and Thai civilians following second and third. Although the KNWO representatives have no documentation or formal data to confirm their impressions of the high degree of GBV encountered by Karenni refugee women, anecdotal evidence illustrates a range of violence, including sexual abuse and rape by Burmese military, rape and murder by Thai civilians, sexual abuse by Thai police, forced marriage by Thai military, rape by Karenni men

inside the camps, and domestic violence. None of the cases related by the KNWO representatives resulted in prosecution of the perpetrators. Members of the KNWO, like their Karen counterparts, have participated in at least one training on issues of violence against women and human rights. Some also participated in basic training on psychosocial issues affecting survivors and were in the process of establishing a safe house for women and girls within one camp. In situations of domestic violence, the Karenni women's representatives in the camps follow the same general procedure applied by Karen women in the NuPo and Umpiem Mai camps: they address the issue directly with the couple, advising the man "not to be so hard on the woman"; if resolution of the violence is not forthcoming, the case is reported to the camp committee.

A Karenni camp committee leader asserted that domestic violence within his camp was very rare—he could only recall two or three cases within the last six years. He allowed that in domestic violence cases involving serious injury, a perpetrator might be imprisoned for three to seven days, but it was more likely that the majority of cases would be resolved within the family. Other male representatives of the camp committee concurred that physical violence between husbands and wives was a rare occurrence but suggested that verbal arguments regularly flare up because of poor economic conditions within the camp and because wives accuse their husbands of failing to provide for the family. Although requests from women for separations and divorces are high, particularly among new arrivals, the camp committee views them as passing manifestations of extreme stress and rarely grants them. Reports to the camp committee of other forms violence—committed by the Thai authorities or local Thai community—are nonexistent. Similarly, representatives of the Karenni camp Ministry of Health recalled only two or three domestic violence cases and two rape cases during their ten years of providing services. There are no established health protocols for intervening in cases of GBV. Rates of sexually transmitted diseases are low, and the Ministry of Health has received no reports of unwanted pregnancy.

## Summary

An obvious discrepancy exists between women's and human rights organizations' analyses of the extent of GBV experienced by Burmese refugees and the knowledge of GBV among other refugee representatives and service providers. This discrepancy may be the result of a heightened sensitivity to GBV issues among women advocates: Burmese women's rights organizations have proliferated within Thailand and are a major source of information about issues, including GBV, affecting Burmese women. Their accomplishments cannot be underestimated, given that restrictions imposed by the RTG severely undermine their mobility, access to resources, and ability to network with local and international women's organizations. Nevertheless, their reports of violence have not had a significant impact on GBV programming for refugee women living along the Thai/Burma border.

Another factor contributing to this discrepancy may be service providers' discomfort and lack of familiarity with GBV issues. All those interviewed had limited to no training in responding to violence against women; several expressed a desire to expand programming but felt they lacked the experience or knowledge to integrate GBV protocols into existing health and social services. Notably, two health care providers had facilitated seminars on GBV within the camps, but each expressed concerns about how to follow up. Also notable were the attempts of at least one international NGO to establish a basic system of reporting to UNHCR so that survivors could receive protective services, even if nominal.

Yet another factor is the silence about GBV that characterizes the Burmese community's response to victimization. Traditional methods of dealing with violence against women in Burmese society are executed at the family level, and public accounting results in social stigmatization. Virginity is esteemed among unmarried women, and monogamy is a mandate for married women, such that rape is a source of shame for the Burmese victim and her family. Karenni women's representatives recounted several adolescent refugees committing suicide rather than revealing their rapes by MOI officials. Legal recourse is virtually nonexistent in Burma for victims of family or state-perpetrated violence.

Likewise, given the tenuous rights of Burmese refugees, legal recourse is largely unavailable in Thailand. In many instances reporting may increase a refugee's risk of exploitation and forced repatriation. The MOI, border patrol, and Thai military appear to

enjoy relative impunity in cases of sexual violence against refugees, and the laws within Thailand favor patriarchal traditions. UNHCR, international, and local NGOs working with refugees must comply with the regulations and practices of the RTG, a delicate position from which to advocate for GBV survivors' rights if violations are committed by representatives of the RTG.

Additional challenges to designing and implementing GBV services for Burmese refugees include the diversity of ethnic groups represented, variations in exposure to violence in Burma, and variations in exposure to violence in Thailand. The range of traditions and experience represented by the Burmese refugees—as well as the environmental differences among refugees living in camps compared to those absorbed into cities such as Mae Sot—requires creative and highly adaptive GBV interventions.

In spite of the difficulties of addressing GBV among refugees living along the Thai/Burma border, there are existing resources within Thailand that may be exploited to develop programming. The first is the network of refugee women's organizations; each expressed an interest in expanding their knowledge and resources regarding GBV. UNHCR and international NGOs working in the camps similarly appeared interested in developing more concrete programming for refugee survivors. International and Thai women's organizations, mostly based in larger cities such as Bangkok and Chiang Mai, may be able to contribute their expertise to service providers working in camps.

Thailand and Burma are both signatories of CEDAW and thus have formally committed to improve the conditions of women. In February 2000 the two countries' ministries of health agreed to combat health problems along the Thai/Burma border.[17] This spirit of cooperation may provide one portal for advancing programming for GBV, both in Thailand and Burma, and allow for the adoption of legislation that addresses all forms of GBV, especially domestic violence and forced prostitution.

## Recommendations

1. The RTG should develop a specific policy outlining a code of conduct for government security and police representatives working with refugees—including MOI, military, and border patrols—and institute mechanisms for enforcing that policy. Severe penalties should be levied for any members of the Thai security forces, or the Thai community in general, who participate in forced prostitution, or in any other way support the sexual exploitation and assault of Burmese women and girls.

2. The RTG should work with UNHCR in establishing systems of confidential reporting for cases of GBV so as to ensure refugees the right to safety and security. It should also establish mechanisms for prosecution of GBV crimes should the survivors seek prosecution.

3. UNHCR should provide training to all refugee communities on basic refugee rights, including legal recourse in cases of GBV committed by fellow refugees or the host community.

4. Members of the BBC should establish strategies to address GBV throughout refugee camps in Thailand, with specific provisions for: 1) accommodating the needs of culturally diverse refugee populations; 2) creating a sectoral response that identifies paths of intervention for health, psychosocial, education, and security sectors; and 3) coordination among the sectors and with representatives of the women's committees and the camp councils. The strategies should be designed with the full and ongoing participation of all involved in their implementation, with priority attention given to members of the refugee community, especially camp leadership structures and women's committees.

5. For the health sector, strategies should include: methods of confidential and active screening for health providers; conducting rape exams; and collecting and monitoring GBV-related health data. For the psychosocial sector (largely comprised of women's committees) strategies should include: supportive interventions for survivors; creating safe spaces for survivors; establishing links with other sectors; and conducting basic education in the community about GBV-related issues and services. For the education sector, strategies should include sensitization curricula (that may be implemented by youth organizations) introducing basic education to adolescents about healthy relationships, safe touch, and

access to assistance. For the security sector (including UNHCR protection officers and MOI officials) strategies should include methods of immediate assistance, police reporting, referrals for prosecution, data collection, and coordination.

6. Trainings to introduce the strategies should engage the expertise of GBV-related Thai and Burmese organizations in Chiang Mai and Bangkok and should be based on a training of trainers model in which Burmese women and men can provide ongoing trainings to members of their communities.

7. UNHCR, MOI, and the BBC should be responsible for ongoing oversight of implementation of strategies and for coordination of GBV-related activities and data collection. Mechanisms should be introduced to regularly evaluate data and adjust programming accordingly. Data should also be used to conduct ongoing advocacy and facilitate communication with the RTG about the nature and scope of GBV among the refugee population.

8. UNHCR should facilitate ongoing participatory education campaigns targeting refugees living outside of the camps on issues of GBV. UNHCR should also solidify links with health and other organizations providing services to non-camp refugees and support those organizations' capacity to address GBV.

## Notes

1 Women's Commission for Refugee Women and Children, *Fear and Hope: Displaced Burmese Women in Burma and Thailand* (New York, 2000), 3.

2 Images Asia, *Alternative Perspectives, Other Voices: Assessing Gender Equality in Burma* (Bangkok, 1999), 2.

3 Memorandum, Burmese Border Consortium (BBC), *Refugee Population Figures* (Bangkok, 2000), 1.

4 BBC, *Program Report for January-June 2000* (Bangkok 2000), ii.

5 Images Asia, *Alternative Perspectives, Other Voices*, 3.

6 B. Apple, *School for Rape: The Burmese Military and Sexual Violence*, EarthRights International (Bangkok, 1998), 13.

7 *Equality, Development and Peace for Women: National Report;* cited in, Images Asia, *Alternative Perspectives, Other Voices*, 1.

8 Images Asia, *Alternative Perspectives, Other Voices*, 27.

9 National Coalition Government of the Union of Burma, *Burma: The Current State of Women—Conflict Area Specific* (Bangkok, 2000), 27.

10 Images Asia, *Alternative Perspectives, Other Voices*, 28.

11 Human Rights Documentation Unit and Burmese Women's Union, *Cycle of Suffering* (Bangkok, 2000), 10.

12 See the monthly newsletters of the Burmese Women's Union, accessible on-line at www.freeburma.org.

13 World Organization Against Torture, *Violence Against Women in Thailand* (Geneva, 1998), 15.

14 Images Asia, *Alternative Perspectives, Other Voices*, 70.

15 Burmese Women's Union, *Cycle of Suffering* (Bangkok, 2000), 46.

16 Burmese Women's Union, *Cycle of Suffering*, 81.

17 Mae Tao Clinic, *Annual Report 2000* (Mae Sot 2001), 10.

# Post-conflict Situation in *East Timor*

May 7-14, 2001

## Background

### Historical Context

Following its 1975 invasion and unlawful annexing of East Timor, Indonesia occupied the small half-island with a military iron fist, and for almost twenty-five years committed well-documented human rights abuses in its mission to suppress virtually all aspects of East Timorese society. With rare exception, the accounts of ongoing torture, extra-judicial executions, rapes, and disappearances were largely ignored by the international community, until the 1996 Nobel Peace Prize was awarded to two East Timorese rights advocates: José Ramos-Horta and Bishop Carlos Belo. As violence escalated throughout Indonesia, internal and international pressure facilitated the end of Indonesian President Suharto's thirty-two-year reign, and in 1998 Suharto's "adopted son," B. J. Habibie, inherited the presidential mantle. Promising reforms, President Habibie signed an agreement allowing the United Nations to conduct a 1999 ballot referendum on establishing East Timor as an autonomous state within Indonesia. Against a rising wave of violent militia-based intimidation, nearly 80 percent of the East Timorese population turned out to vote, overwhelmingly casting their ballots in favor of independence.[1]

Immediately after the announcement of the referendum's results, pro-Indonesian militia groups across East Timor launched a reprisal campaign of systematic destruction. U.N. personnel were driven out of East Timor, most cities were razed, and mass deaths, disappearances, and displacement went unchecked by the Indonesian military and government. Several hundred thousand East Timorese were relocated at gunpoint to camps in West Timor, and hundreds of thousands more sought refuge in East Timor's hills until Habibie, relenting to international pressure, allowed peacekeeping forces to enter East Timor and quell the violence. On October 20, 1999, Habibie was defeated in a democratic election by Abdurrahman Wahid, whose stated commitment to human rights and Indonesian democratization elicited the provisional support of the international community.

### Current Government

The U.N. established a Transitional Administration in East Timor (UNTAET), whose original protectorate function amounted to almost absolute control over establishing East Timor's basic institutions. UNTAET and the National Council of East Timor Resistance have since shifted to a coalition government referred to as the East Timor Transitional Administration (ETTA), with eight ministries responsible for developing East Timor's infrastructure. A gender representative has been designated within the Social Affairs Ministry to assist women's organizations, but because her position provides community support and not government oversight, she has limited ability to influence government structure and policy. Government advocacy has been a primary concern of the U.N.'s Gender Affairs Unit, which has deployed gender representatives to each of East Timor's districts in order to gain field-level insights about issues affecting women. Despite

its broad reach, the Gender Affairs Unit is marginal to the government structure, and at present there is no provision for the Unit's inclusion in East Timor's permanent government.

### Status of Women

Indonesian law is currently the applicable standard, modified in order to meet international codes, which the U.N.-administered civilian police (CIVPOL) are meant to enforce. As outlined below, Indonesian law explicitly favors the subordination of women, limiting CIVPOL's ability to intervene on behalf of East Timorese women. However, CIVPOL has taken the lead in responding to reports of violence. In one example illustrative of the tradition of violent discrimination against women, a husband who had recently beaten his wife tried to have CIVPOL arrest her for disobedience and was dismayed when CIVPOL arrested him instead. Yet even in cases of violence against women, CIVPOL has limited reach; its Vulnerable Persons Unit (VPU)—the arm responsible for investigating sensitive cases such as sexual assault and domestic violence—is currently only operating in the capital, Dili, because of the lack of expert personnel. Their limited reach is especially alarming given the apparent rates of violence: between July and December 2000, over 260 cases of domestic violence and sexual assault were reported to the Dili Police Unit.[2]

In the absence of strong national programming, several international donor agencies and international and local women's NGOs have taken on the task of advocating for women's rights to equality. They have been especially critical in publicizing, declaiming, and responding to GBV against East Timorese women and girls.

## Gender-based Violence

Gender equality in East Timor—or, rather, its absence—has largely been informed by traditional patriarchal customs reinforced by Indonesian law and practice. Although Indonesia ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1984 and actively participated in the Beijing Conference on Women in 1995, polygamy, male domination within the family, and divorce rights favoring men are explicitly supported within Indonesian law.[3] Because they are not formally recognized within the law as violations of women's rights, marital rape, dowry-related exploitation, and other traditional forms of violence against women receive *de facto* reinforcement.[4] Domestic and community violence, as well as the trafficking of women and girls, are addressed within Indonesia's penal code, yet generally go unreported and unprosecuted because of prevailing mores that stigmatize victims and relegate violence against women to the private sphere, where it remains unresolved, or is traditionally redressed through remuneration to the victim's family.[5] State-perpetrated violence, also recognized in Indonesia's penal code, was reportedly carried out with impunity by Indonesian troops against East Timorese women.[6]

### During Conflict

During Indonesian occupation of East Timor, women were subject to the same types of intimidation, arbitrary arrest, detention, torture, and killing as their male counterparts. Women and girls were additionally exposed to GBV, including violations of reproductive rights (forced or coerced contraception), rape, sexual harassment, enforced slavery, and forced or coerced prostitution servicing Indonesian military troops.[7] Women with an assumed relationship to Falintil, the East Timorese resistance movement, were particular targets for state-sanctioned and perpetrated sexual abuses.[8] Those living in rural areas were at greater risk of enforced slavery and prostitution as a result of their isolation, lack of education, and economic disempowerment.[9] The presence of the military also contributed to a flourishing and well-organized sex industry in East Timor. Although that industry has become more fragmented since the military's departure, it is nevertheless still active, according to an expatriate doctor who suspects that the increase in sexually transmitted infections among his female patients is the result of prostitution.

In the violence and chaos ensuing from the 1999 referendum, militia groups reportedly carried on the Indonesian military's practice of sexual crimes against women, systematically raping women, sometimes in the presence of family members, or forcibly transporting women across the border into West Timor to serve as sex slaves, where thousands are estimated to remain.[10] According to the findings of the U.N. Special Rapporteur on Violence Against Women, the Indonesian military command both implicitly and explicitly supported these crimes.[11]

The U.N. was reputedly slow and clumsy—failing to use female interviewers and ensure confidentiality—in its preliminary investigations of war crimes involving GBV. Nor did the initial report of the United Nations High Commissioner for Refugees (UNHCR) include provisions for a just and rapid response to women victims, such as appropriate investigation into reported cases or efforts to detain and return (primarily from West Timor) suspected perpetrators.[12] However, women's organizations existing before the 1999 siege quickly regrouped—a remarkable feat given that they had only come into formal existence after Suharto's departure in 1998. With financial support and technical assistance from a boom of international donors and NGOs, these women's organizations started responding to GBV survivors. From late 1999 through the end of 2000, the Communication Forum for East Timorese Women (FOKUPERS) identified and assisted 182 women and children survivors of siege-related violence in East Timor's thirteen districts[13]; and the East Timorese Women Against Violence (ET-WAVE) identified and worked with another 232 survivors of militia and military-based sexual abuse perpetrated before and during the siege.[14]

### Beyond Conflict

Among those organizations supporting women, the initial focus on survivors of political violence rapidly expanded to embrace other forms of GBV, particularly domestic violence, which was perceived by East Timorese women's representatives to have escalated after the referendum as a result of stress, unemployment, and dislocation. Pre-existing and burgeoning local women's organizations agreed in early 2000 to form the East Timorese Women's Network (REDE), and in June 2000 convened the first Congress of Women of Timor Loro Sae (East Timor). There they drafted a comprehensive platform of action that identified as one area of critical concern a pervasive East Timorese "culture of violence" resulting from the legacy of occupation. Other highlighted problems relating to GBV included spousal abuse, polygamy, marital rape, incest, violence against women in the workplace and school, and bride price and other inheritance inequities. Among the platform's calls for action was the right of women survivors of Indonesian atrocities to seek justice through an international tribunal; improved protection and services for survivors of community and domestic violence; revisions of laws that currently enforce women's subordinate status; and mass education about women's rights.[15]

## Current GBV-related Programming

Although it has a long way to go before responding to all the concerns outlined in the platform of action of the Women's Congress, East Timor in many ways exemplifies the advances in programming women can make when gender issues are granted even marginal local, national, or international support. The following is a partial representation of activities currently underway in East Timor's capital city of Dili to prevent and respond to GBV. Notably, all have been initiated only in the last several years, and few have operations that extend to other of East Timor's thirteen districts.

### Dili: Local Initiatives

The most prominent Dili-based local organizations working on GBV are FOKUPERS and ET-WAVE. Both have dramatically expanded their scope of activity since receiving post-independence support from multiple international organizations. FOKUPERS's broad objectives are threefold: 1) case management and practical assistance throughout East Timor to women and children survivors of Indonesian and family violence; 2) advocacy regarding survivor and general women's issues; and 3) education and training on human rights with a special orientation toward women's and children's rights. Specific FOKUPERS activities include running a safe house in Dili for victims of violence; legal and economic support to survivors; family mediation in cases of domestic violence; and radio and print media campaigns. ET-WAVE's program has similar objectives and activities. They run a safe house in Ermera District and provide services to women in various districts, including counseling, literacy, and small business funding to survivors of Indonesian and domestic violence.

FOKUPERS and ET-WAVE are also part of a rape response team, along with the Young Women's Groups from East Timor (GFFTL), which is coordinating a 24-hour safe room for rape survivors based out of Dili Hospital. The International Rescue Committee (IRC) has taken the lead in organizing the response team and in building its capacity to provide counseling and case management services for an

average of three to five safe room clients per month. Aside from working on the safe room team, GFFTL has conducted awareness-raising sessions among young women and girls on gender, sexuality, and GBV. The East Timor Commission for Human Rights (CDHTL), a newly developed local NGO, has been trained and financially supported by IRC to provide GBV seminars and investigate abuses of women in districts outside of Dili.

The Timorese Women's Organization (OMT), a politically non-aligned offshoot of the East Timorese women's resistance movement, has not yet developed any activities specific to GBV, but through its countrywide networks it has facilitated data collection on vulnerable women and children for UNTAET. OMT also assisted IRC in conducting focus groups on women's rights and will be supported by IRC to deliver the results of the assessment to participants. Similarly, the Association of Women Jurists (ANEMTIL) has not focused overtly on GBV, but it has worked closely with the Gender Affairs Unit to establish a gender and law group that will be well-positioned to influence draft legislation on the prevention of and response to GBV.

As the coordinating body of the local East Timor women's organizations, REDE's objectives include information sharing, policy development, and advocacy on women's issues. It is currently composed of fifteen member organizations, including those mentioned above. Other organizations such as Timor Aid, Prontu Atu Serbi (PAS), Hermanas Carmelitas, AMST, and HOTFILMA are providing a range of health, economic, and social services that target vulnerable women and children.

## Dili: International Non-Governmental Initiatives

A number of international NGOs that entered East Timor following the referendum have provided technical assistance to local women's organizations on issues ranging from political and gender-based community education to NGO administration and micro-enterprise programming, but only three INGOs have focused on GBV. Caritas-Australia recently initiated six months of training for FOKUPERS and ET-WAVE on sexual assault response skills, police and court procedures, and victims' rights. The Program for Psychosocial Recovery and Development in East Timor has provided a one-time psychosocial training and ongoing information to FOKUPERS, ET-WAVE, churches, and schools in issues of domestic and sexual violence. Although the contributions of these international NGOs have been significant, neither has programs that focus exclusively on issues of violence. The longest-running and most-specialized international program addressing GBV has been facilitated by IRC.

In early 2000, IRC collaborated with OMT, ET-WAVE, GFFTL, and CDHTL to conduct a series of focus groups on women's rights in five target districts, where—anticipating the concerns later identified at East Timor's first Women's Congress—participants variously identified marital violence (including forced sex), family violence (particularly abuse from brothers), polygamy, dowry-based oppression, unequal access to education, and sexual harassment as points of concern. IRC followed this assessment with a broad-based GBV capacity building program whose objectives include providing ongoing coordination of and support to local NGOs that already conduct or wish to undertake GBV-related activities. IRC facilitated the Dili hospital safe room and response team, provided NGO training of trainers on GBV, distributed small-scale financing for GBV outreach activities to organizations in multiple districts, and coordinated and funded an exchange trip for East Timorese women's representatives to Australia, where they met with several organizations addressing GBV in Australia's northern territory. Otherwise notable among IRC's activities were an in-house training on sexual harassment to IRC employees; participatory design and dissemination of multi-media GBV awareness-raising resources; coordination with CIVPOL's VPU on GBV referral procedures; and successful advocacy with the VPU that resulted in sex-disaggregated data on assaults (which currently outnumber all other reported crimes).

## Dili: United Nations and Government Initiatives

A community services representative at UNHCR with expertise in GBV has worked closely with CIVPOL's VPU to improve police response to GBV survivors, taking the exemplary initiative to develop and conduct training for East Timorese police cadets on investigation techniques, attitudes toward GBV, health services for survivors, women's organizations, conducting child interviews, and so forth. UNHCR

has also implemented programs for West Timor returnees through ET-WAVE and FOKUPERS, providing each organization with infrastructural and financial support. The United Nations Development Fund for Women (UNIFEM) is supplying a permanent secretariat for REDE as well as administrative capacity building for REDE staff. The Dili District Administration Gender Office has assisted REDE in coordinating special events, including "16 Days of Activism Against Gender-based Violence," and is co-chairing with REDE four women's affairs committees. The Gender Office has also published a resource listing of women's organizations in Dili, with a useful bibliography of reference materials on general women's issues available for reprint or loan from organizations in Dili. Under the advisement of the ETTA Gender Affairs Unit, the Gender Office also conducted a survey of East Timorese women who had achieved post-secondary high school education—8 percent of the 660 women surveyed—in order to facilitate women's inclusion in civil service by identifying potential candidates. Most notable, the Gender Affairs Unit has recently collaborated with the United Nations Population Fund (UNFPA) to develop a comprehensive nationwide project on GBV in order to collect secondary data (types, prevalence, consequences, existing services); formulate preventive and protective legislation; conduct advocacy and education activities; and establish coordinated community services (among health providers, social services, judiciary, police, and women's advocates) for the prevention of and response to GBV.

## Summary

The comprehensive objectives of the ETTA/UNFPA project are timely. As the programming above suggests, local and international organizations have made a commitment to addressing GBV in East Timor. Some of the most remarkable activities include FOKUPERS and ET-WAVE's rapid response to survivors of Indonesian violence and subsequent attention to domestic violence, the first Women's Congress and resulting Platform for Action, UNHCR's direct investment in police training on GBV, Dili Hospital's safe room, IRC's community-based capacity-building model, and the sex-disaggregated data analysis system of CIVPOL's VPU. Even so, according to those interviewed, most initiatives are limited in scope, temporary, or do not yet have nationwide relevance.

The VPU, for example, currently exists only in Dili, and its investment in GBV is largely a result of the (temporary) presence of expatriates with experience policing GBV. The Dili Hospital's safe room is the only one of its kind throughout East Timor, and the Department of Health Services has no plans to integrate GBV into its national rehabilitation and development program—in spite of one doctor claiming that his top priority would be to establish health clinics for vulnerable women. There are no national government programs or ministries addressing violence against women, and the U.N.'s Gender Affairs Unit anticipates being dislocated from the national government structure before national elections in 2002.

The UNHCR representative committed to supporting GBV programs and police training is unique within UNHCR East Timor. Her activities reflect her personal expertise and interest more than an institutionalized commitment within East Timor's UNHCR offices to addressing GBV. Although there is a women jurists' association (ANEMTIL), all fifteen public defenders in East Timor are men, and traditional justice works against women. In a representative case, a man who claimed that he repeatedly digitally raped his wife's fourteen-year-old sister "by accident" was released and returned home, where he subsequently paid his wife's family five buffalo to settle the matter.

Many U.N. organizations, including the Gender Affairs Unit, have been slow to hire East Timorese for substantive positions, such that capacity building for women has been mostly limited to small-scale local programs and enterprises. (This is in part attributable to the long history of limited education afforded women and girls and the resulting high illiteracy rates, which are being met with large-scale literacy programs and improved schooling.) Most of East Timor's GBV-focused organizations are Dili-based, and therefore have limited impact in other towns or outlying areas.

Moreover, local and international representatives identified several challenges to existing programs. For example, FOKUPERS and ET-WAVE are relatively new NGOs—indeed East Timor's entire civil sector is new—and are still in the process of developing their missions. This task has been complicated by the numerous international NGOs attempting to assist them and has resulted in a diversification in

programming that may undermine their effectiveness in addressing GBV. Similarly, REDE has received support from several international sources, but it has yet to realize its potential as a coordinating and advocacy organization and must contend with inevitable competition from local member NGOs for finite international resources. Although social services existed during the Indonesian occupation, none focused on supportive interventions for women; counseling skills are a relatively new acquisition of the women's groups. The short-term counselor trainings they have had are insufficient to build their full capacity, and the lack of ongoing supervision has resulted in counselors relying on traditional means of giving advice. One counselor reported that she typically tells the survivors with whom she works to "try and forget."

Other aspects of GBV programming are altogether absent in East Timor. An ideal continuum of GBV post-conflict response would begin at the border as returnees cross from West Timor, where GBV survivors would be identified and provided immediate support services. At present, no such services exist (nor are they provided within West Timor, given the unstable security). No central organization has taken the lead in collecting current countrywide statistics on GBV, and there is no national mandate for submitting such data. Only a handful of organizations or institutions have methods for capturing and analyzing GBV data. There are no nationwide education campaigns on various types of GBV, and no clinic-based educational materials. Apparently no programs exist for sex workers, though there was a well-organized brothel system during Indonesian occupation, and an ongoing informal network of prostitutes, some of whom are transported from Jakarta and Portugal, is still active. There are no support programs for male survivors, in spite of testimony by female survivors that East Timorese men were forced by the Indonesian military to commit rapes.

The scope of the ETTA/UNFPA project has the promise of casting GBV issues under a brighter spotlight, thus stimulating existing and future prevention and response activities. And yet, without the support of government institutions committed to integrating GBV concerns into their institutional mandates, issues of GBV will continue to be the peripheral reserve of small-scale programs.

## Recommendations

1. The U.N.'s Gender Affairs Unit should be institutionalized within East Timor's permanent government. The Gender Affairs Unit or its equivalent should be charged with facilitating coordination of multisectoral GBV activities. The model of locally based gender affairs officers should continue under the new government, and those officers should be responsible for monitoring and advising local efforts to address GBV.

2. The health, social services, judicial, and police systems must work to improve their understanding of and coordinated response to GBV, particularly as new legislation is drafted. Ministries responsible for overseeing health, social services, and law enforcement should each mandate data collection and analysis in their respective sectors. The data should be used to facilitate training of personnel and improve intersectoral accountability. Each sector should have specific and standardized protocols for addressing survivor needs.

3. The government should support broad-based, multi-media community education on issues of GBV. Specific campaigns should be introduced to target specific populations and GBV issues. Standard education programs about conflict resolution and healthy relationships should be introduced in the schools.

4. International donors and implementing organizations should continue to financially and technically support women's organizations to implement GBV programming, with special considerations for developing these programs from the emergency post-conflict phase into long-term sustainable development projects. Special consideration should also be given to expanding current Dili-based programming throughout East Timor.

5. Local coordinating bodies such as REDE should develop a GBV task force whose responsibilities include national advocacy as well as monitoring and supporting field-based activities.

6. Initiatives such as IRC's, which have facilitated education of Timorese GBV organizations by experts in Australia, should be expanded so that

local NGO representatives have access to international training and forums.

7. Men, often the most marginalized within GBV programming, should be integrated into all prevention activities. Programs for male survivors of sexual violence perpetrated during the Indonesian occupation should be implemented throughout East Timor.

## Notes

1 East Timor Human Rights Center, *The Right to Be Heard: Documenting Human Rights Violations for Justice* (Melbourne, 1999), 1.

2 International Rescue Committee, "Common Goals, Different Roles: Discussion from Sector-specific Focus Groups on Sexual and Gender-based Violence in East Timor" (unpublished report, Dili, 2001), 3.

3 World Organization Against Torture (OMCT), *Violence Against Women in East Timor: Report Prepared for the Committee on the Elimination of Discrimination Against Women* (Geneva, 1998), 17-19.

4 OMCT, *Violence Against Women in East Timor*, 20-22.

5 OMCT, *Violence Against Women in East Timor*, 20, 23, 28.

6 See East Timor Human Rights Center, *Violence by the State Against Women in East Timor: A Report to the U.N. Special Rapporteur on Violence Against Women* (Melbourne, 1997).

7 M. Sissons, *From One Day to Another: Violations of Women's Reproductive Rights in East Timor* (report for East Timor Human Rights Center, Dili, 1997); see also, Kiyoko Furusawa and Jean Inglis, "Violence Against Women in East Timor Under the Indonesian Occupation," in Lourdes Sojor, ed., *Common Grounds* (Philippines, 1998), 293-300.

8 United Nations, Special Rapporteur on Violence Against Women, *Mission to Indonesia and East Timor* (Geneva, 1998), 17.

9 Sissons, *From One Day to Another*, 31-32.

10 S. Powell, "Rape: Just Another Weapon of War," *Weekend Australian*, 20 March 2001, 20.

11 U.S. Department of State, *Country Report on Human Rights Practices: East Timor* (Washington, D.C., 2000), 2.

12 Human Rights Watch, *Human Rights Watch World Report 2001* (New York, 2001).

13 FOKUPERS, "Rehabilitation Program Final Report" (unpublished report, Dili, November 1999-May 2000), 3.

14 United Nations Population Fund, "East Timor and Gender-based Violence: Project Agreement between East Timor Transitional Administration and the United Nations Population Fund" (unpublished document, Dili, May 2001), 5.

15 East Timorese Women's Network, "Statement of the first Congress of Women of Timor Loro Sae" (unpublished document, Dili, June 2000).