

Human Rights Tribune des droits humains

Volume 11, No.1 (Winter 2005)

Special Feature – Sexual and Reproductive Rights

A Word from the Editor

Eradicating Traditional Practices Harmful to Women in Sub-Saharan Africa: Revisiting Human Rights Strategies and Expectations

By Corinne Packer

Delegates of the Nairobi Conference Discuss Putting an End to Female Genital Mutilation

By Gemma Richardson

Sexual and Gender-Based Violence in Displaced Populations of Serbia

By Melissa Mullan

Godeliève Mukasarasi: Portrait of an Exceptional Women's Rights Advocate in Rwanda

By Corinne Packer

Making the Right to Have a Family a Reality in Botswana

By Natalie Doyle

Contraceptive Shortage Cause for Concern in African Countries

By Gemma Richardson

The Health Status of Roma: Priorities for Improvement

By Corinne Packer

Coercive Sterilization of Romani Women in Former Czechoslovakia

By Michele Vernet

The Denial of Sexual Rights in Botswana: A Threat to the Health of Sexual Minorities

By Natalie Doyle

From the Human Rights Community

Le Réseau Droits et Démocratie au sein des universités canadiennes : la prochaine génération à l'oeuvre pour « Mettre le monde à l'enDROITS »

Par Cynthia Gervais et Lloyd Lipsett

Les jeunes s'organisent contre la peine de mort

Par Maude Hébert et Julie Rivest

Turning the Tide: Preventing Natural and Man-Made Threats in Southeast Asia

By Erik Friberg

La Tribune des droits humains fait peau neuve!

Mot de l'éditrice en chef

La *Tribune des droits humains* fait peau neuve sur la toile ! **Internet des droits humains** (IDH) a décidé de s'approprier ces technologies de la communication et de l'information dont nous faisons la promotion depuis des années, et de lancer une nouvelle version de la *Tribune* désormais présentée en format électronique.

Alors que la *Tribune* continuera d'offrir information et analyse à la communauté de gens travaillant pour les droits humains, nous espérons que ce nouveau format électronique favorisera une plus vaste distribution de notre publication, et facilitera l'échange d'idées avec nos partenaires dans les différentes régions du monde.

Pour cette première édition entièrement électronique de la *Tribune des droits humains*, nous avons choisi la question des droits en matière de santé sexuelle et reproductive comme thème. En donnant un caractère thématique à la *Tribune*, nous espérons désormais être en mesure d'offrir à nos lecteurs et lectrices l'occasion d'approfondir leurs connaissances et réflexion sur des problématiques qui animent les activistes et défenseurs des droits humains de par le monde.

Ceci dit, nous continuerons de faire une place importante aux contributions venant de la communauté d'individus et d'organisations travaillant pour et auprès des victimes de violations, afin qu'ils puissent mettre en lumière, nous informer et nous aider à comprendre divers faits et événements qui font notre monde.

Nous vous invitons donc à nous contacter pour nous faire part d'idées d'articles sur des sujets qui vous préoccupent ou vous intéressent, et pour nous soumettre vos écrits pour publication.

Evelyne Paradis
Éditrice en chef

A New Look for the *Human Rights Tribune*

A Word from the Editor-in-Chief

The *Human Rights Tribune* had a new look on the Web! Using information and communication technologies that it has been promoting for years, **Human Rights Internet** (HRI) is launching a new version of the *Tribune* now published online.

While the *Tribune* will continue to offer information and analysis to the human rights community, we hope that this new electronic format will facilitate dissemination of our publication and promote exchange of ideas with our partners around the world.

We are marking this first online issue of the *Human Rights Tribune* with a thematic special feature on sexual and reproductive rights. By giving a thematic focus to the *Tribune*, we want to give our readers the opportunity to deepen their knowledge and understanding of issues which are of concern to human rights activists and defenders in different parts of the world.

This being said, we will continue to make an important place to written submissions from individuals and organisations working for and with victims of human rights violations, in order to shed light, inform us and help us understand facts and events that make our world.

We invite you to contact us to share your ideas on articles that would be of interest to you, and to submit your articles for publication.

Evelyne Paradis
Éditrice en chef

[HRI Home](#)

[List of Volumes](#)

Eradicating Traditional Practices Harmful to Women in Sub-Saharan Africa: Revisiting Human Rights Strategies and Expectations

By Corinne Packer

We are still in the process of discerning the most effective strategies to challenge harmful traditional practices in the specific context of sub-Saharan Africa. To this end, it is important to examine the strengths and weaknesses of our approaches and strategies used to date to face this challenge. The first step of consciousness-raising or sensitization with regard to harmful traditional practices is well underway at the grassroots level and is steadily growing. Individuals have been trained to proceed with sensitization programmes at the community level, with other awareness-raising activities, such as in schools and government, being carried out in various parts of sub-Saharan Africa. However, while not wanting to diminish the excellent work achieved in this regard, these activities do not necessarily mean that harmful traditional practices are being eliminated, as some activists and organizations claim. While more time is needed to see if these claims are true – and if so, why – in the meantime, an inductive approach assessing the appropriateness of the international human rights discourse — emphasizing law and empowerment of African women — is needed.

Why have we used Human Rights?

In an article entitled *Compassion: The Basic Social Emotion*, published in 1996, M.C. Nussbaum touched the nerve behind the global human rights campaign against harmful traditional practices, particularly against female circumcision. It is in our human nature, she submits, to feel compassion for others when suffering. This compassion may be heightened when a harmful practice such as female circumcision is so far removed from the traditions of one's own society, such as in the West, and is therefore all the more incomprehensible, or indeed reprehensible. Other reasons may motivate our 'intervention' to stop these traditional practices. For instance, it may be argued that modes of HIV transmission are the concern of the entire international community. Female circumcision, early marriage, incisions in pregnancy and some traditional birthing practices present in sub-Saharan Africa, for instance, all introduce a risk of such transmission. Infection and ill-health (limiting women's potential and dignity) and premature death (leaving children

orphaned, family structures in tatters and family incomes reduced) are also arguably the concern of a caring world community.

But the argument of global well-being need not be the only basis for condemnation of harmful traditional practices and intervention. We can also legitimately channel our compassion and concern through the human rights paradigm because the traditions have been established as negatively affecting women's health, threatening their lives, discriminating, interfering with their freedom of thought and belief, or diminishing their right to pursue education — all violations of their universally protected human rights. By 'processing' this concern through multiple international (i.e. culturally and religiously pluralistic) human rights plenaries we can seek to assure that criticisms are based on valid and universally accepted principles and not merely a reflection of our fear and ignorance of others or, worse yet, sentiments of cultural superiority. The fact that much criticism and condemnation of harmful traditional practices has come from within the African continent and that the human rights treaty specific to the region supports such a stance confirms the validity of condemnation of harmful traditional practices on the basis of *universal* human rights.

This partly answers the question why we have turned to the human rights approach as a means of eliminating harmful traditional practices. Importantly, it legitimizes our concern for the health and status of African women and criticism of these practices, both of which could easily be construed negatively as neo-colonialism, cultural elitism or plain and simple racism. In effect, the language and discourse of human rights empowers those eager to see the eradication of harmful traditional practices and protects and reinforces their views. This somewhat explains why we have seen the health professions, development agencies and even economic institutions such as the World Bank employ the language of human rights in their conventional work — human rights essentially providing them added protection and ammunition.

There is a second reason for using the human rights approach. Human rights treaties demonstrate the interconnected nature of the family of human rights and establish how discriminatory patterns of conduct bolster prejudicial practices. The fact that these treaties are instruments of law places an obligation on States (African and all others) to act toward their elimination. Moreover, some of these instruments actually provide strong recommendations on how to do so. For instance, the Convention on the Elimination of Discrimination Against Women (CEDAW) encourages the revision of school textbooks to ensure the elimination of stereotyped negative roles for women. Human rights law, and activists and organizations seeking enforcement of these rights, have further spawned a multitude of plans of action filled with recommendations as to how States and various partners in civil society can work to eliminate violence and discrimination against women, including harmful traditional practices as forms of these. Importantly, the international standards have also inspired a wide variety of programmes doing practical work.

Limitations of the Human Rights Campaign

While the human rights approach has empowered us to challenge harmful traditional practices in sub-Saharan Africa from outside the culture, it has arguably yet to succeed in its ultimate goal to empower those from within. Few African women are able to assert their rights within the framework of social and cultural norms which influence their daily lives. For the most part, women, even if knowledgeable of their human rights, are not able to negotiate real or perceived opposition of parents, husbands, male figureheads, religious authorities and influential members of their communities when it comes to harmful traditional practices, or many other injustices for that matter. In addition it must be kept in mind that not all African women, not even those who are knowledgeable of their human rights, necessarily view harmful traditional practices as violating their rights or as needing to be abandoned.

While the effort to empower African women as a means, *inter alia*, to end harmful traditional practices has received significant support and attention, it is still weak and, barring rapid and widespread societal change, will remain so for a long time to come. Despite our knowledge of this, our response has been generally one-sided, focusing on helping African women empower themselves at the local level, rather than assisting the State (and broader society) grapple with changing attitudes. It is not surprising, therefore, that while we may have convinced some women to seek assistance and redress before the police and the courts, these institutions have not always responded in a positive manner. This is principally owing to the fact that those opinion makers and leaders with the power to change attitudes (village elders, customary chiefs, religious leaders, etc.) have largely been overlooked or excluded from strategies for change. However, the Tostan experience in Senegal is a wonderful example of how women within a community can work together with indigenous (and largely male) institutions with the cultural authority to make and enforce laws and change social norms. These women may not have been 'empowered' by human rights education or acted to protect their human rights in a conventional sense, i.e. by contesting authority. But, after sharing as a group their concerns about the harmful effects of female circumcision and their doubts on the need for the practice to continue, they sought the help of the village chief and Imam who took on the challenge to end this practice. The chief and Imam did so successfully not only in their village of Malicounda Bambara, but in surrounding ones as well. In this sense, the women of Malicounda Bambara 'empowered' themselves in a manner which was culturally appropriate and effective.

Measures to Bolster the Human Rights Campaign and Stimulate Change

Challenges to traditional practices harmful to African women posed in the language of human rights could be strengthened in the region of sub-Saharan Africa in various ways.

One way would be to increase popular knowledge of the existence of a treaty and mechanism formed uniquely for the promotion and protection of human rights in Africa. States could endeavour to do so, for example, by placing the treaty and human rights education in general on the school curriculum and placing information bites on television, radio and in the press. Knowledge of this ‘home-grown’ mechanism — created by Africans, situated in Africa, and staffed by Africans — could increase the legitimacy of the human rights discourse in the region, since it could no longer be claimed to be an ‘imported good’ or imposed body of law.

The African Commission’s Special Rapporteur on the Rights of Women should be informed by local NGOs and interest groups of the prevalence of traditional practices harmful to women, how the State is failing to challenge these or is obstructing such challenge, and what improvements could be made. The Rapporteur should follow-up by issuing public reports containing this information and petitioning the State accordingly. These groups could also submit reports directly to the African Commission, perhaps in conjunction with other groups which follow more broadly the status of the rights of women in their countries. At present States rarely submit their mandatory reports on the situation of human rights in their countries in a timely fashion. Indeed, a good number of them have failed ever to submit a report. As a result, the Commission is highly dependent on reports by NGOs and other interest groups to assess the situation in a given country. From a positive perspective, this means that these organisations can make themselves and their concerns heard. Therefore, it would be worth their time and effort to report to the Commission on harmful traditional practices. Similarly, it is vital that the Commission make public and widely disseminate both the reports of States and its own observations on these, which it has been reticent to do until now. Only through such public processes can we establish whether States are cognizant of, and acting upon, their duties in relation to the elimination of harmful traditional practices and devise our own priorities and strategies accordingly.

Concomitantly, such processes would heighten awareness of the work of the Commission and the legitimacy of human rights in the region. Of course, the chronic under-funding of the Commission must be addressed if submissions are not to become wasted paper; increased funds must come from African States, non-African States and private donor groups alike. Finally, groups concerned with harmful traditional practices should immediately involve themselves in the evaluating and implementing the Protocol to the African Charter on Human and Peoples’ Rights Relating to the Rights of Women. The instrument, which was adopted by the African Union in July 2003 but remains to enter into force, prohibits all traditional and cultural practices physically and/or morally harmful to women and girls and provides extensively and very specifically for their end.

Beyond improvements in the international human rights discourse and machinery as suggested above, I would argue that it is possibly even more important to develop and implement strategies and programmes for change through indigenous institutions with

social and cultural relevance. Certainly, many sensitization initiatives already have been undertaken to challenge popular beliefs and turn these against harmful traditional practices, and many more must be taken. But the situation is synonymous with many other human rights and welfare projects in Africa: too scattered, inadequately targeted and desperately under-funded. Sub-Saharan Africa is a vast region with many languages and many isolated communities.

Organizing sensitization efforts and offering human rights education at the micro-village level will be a painfully slow and uncertain process toward the eradication of these practices. For instance, it is difficult to imagine thousands of other villages in Mali following the example of the nine which have been reported as having abandoned female circumcision without the same presence, time and effort invested by the Inter-African Committee (IAC). Moreover, there is no guarantee that once the IAC stops their involvement in these villages the practice will not resurface (as has reportedly happened in the case of others). It is therefore recommendable to focus sensitization and human rights education programmes on those individuals and institutions which are permanently present in the community, already have well-established channels of communication, and carry authority. It is also easier to keep in touch with and, if necessary return to, this smaller target group. In this regard, the individuals and institutions which are important are both the usual candidates (i.e., government ministries, health professionals, and the media and other popular mechanisms of communication) and the unusual ones (institutions of customary law, village elders, chiefs, and other influential - and largely male - individuals).

Fundamentally, this is a matter of focusing energies and funds into those efforts with the greatest likelihood of sustainable success. It may require concerned NGOs and interest groups combining their work and funds so that they may reach further, a development with which donors may be pleased. Finally, if human rights in general are to gain greater credibility in the region, African States, for their part, will have to clean up and invigorate their own institutions of law and order with a view to treating human rights seriously.

Finally, it may be necessary to re-evaluate some of our core assumptions about women's empowerment in terms of the actual roles of formal schooling for girls, human rights education, women's groups and legislation on the elimination of harmful traditional practices in Africa - all of these being strategies advanced by international human rights treaties and platforms of action for the advancement and empowerment of women. For instance, it would be helpful to explore our (not so) common definition, and expectations, of women's empowerment and inquire whether these are overly influenced by the culture of, and dependent upon the level of development in, the Western world, where the institutions of police, judiciary and State administration are in relatively good working order and comparatively more responsive to the experiences and realities of women; where women have comparatively better access to these; and where they are not culturally precluded from doing so.

Similarly, with regard to the formal education of girls, it remains to be proven definitively that increased formal schooling *alone*, even with a ‘gendered’ curriculum, contributes to an increased level of empowerment for girls. More scientific research is needed in this regard. But, it is possible for instance that the type of schooling a girl’s father obtains is more likely to determine whether she is circumcised or her level of autonomy (reflected in her status within the family unit). We may certainly ask ourselves whether the total mean period of schooling of children in sub-Saharan Africa is substantial enough to influence positive norms, attitudes and stereotypes. No doubt, more and better general education would make a positive contribution. However, and more specifically, while according to the Western model co-education *may* be more conducive to fostering equality between the sexes, the research of Heward and Bunwaree suggests this to be precisely the reverse in patriarchal societies. If this is so, we may want to revisit and qualify Article 10 c) of the Women’s Convention, which recommends co-education as a means of eliminating ‘any stereotyped concept of the roles of men and women.’

In summary, human rights advocates may have succeeded in incorporating a gender perspective into human rights discourses, but there is still much research and work to be done to incorporate a cultural perspective into the use and implementation of human rights standards, and even more to fundamentally changing the socio-cultural norms which bolster harmful traditional practices in sub-Saharan Africa.

Bibliography

C. Heward and S. Bunwaree, eds., *Gender, Education and Development: Beyond Access to Power* (1999)

M.C. Nussbaum, *Compassion: The Basic Social Emotion*, *Journal of Social Philosophy and Policy*, Vol. 13, No. 1, 1996.

Corinne Packer is HRI’s Coordinator of Internship Programs. Prior to joining HRI, she specialized in health, gender and human rights law, and more recently on human rights in Africa. She holds a Doctorate in Human Rights Law from Utrecht University, The Netherlands.

Delegates of the Nairobi Conference Discuss Putting an End to Female Genital Mutilation

By Gemma Richardson

At the age of eight, she was dragged, kicking and screaming, and then pinned down on the ground by several women. An old woman with many blades performed the procedure, making it the day she will never forget.

When a young teenaged Somali girl recounted this story of her experience of undergoing Female Genital Mutilation (FGM), the delegates of the International Conference on FGM sat silently, listening in horror. Unfortunately, her story is one that millions of women around the world are familiar with. "If you love and really care for us, stop subjecting us to this horrible cruelty," the young Somali girl pleaded to all mothers.

The purpose of this international conference, which took place in Nairobi from September 16-18, 2004, was to develop a political, legal and social environment to implement the Maputo Protocol, and in particular Article 5 of the document which specifically prohibits and condemns FGM. Adopted by the African Union in 2003, the Protocol, which covers a range of women's rights issues, has only been ratified by three countries (Comoros, Libya and Rwanda), despite having been signed by 53 heads of state. Fifteen ratifications have to take place for the Protocol to come into effect.

The conference was organized by the Italian non-governmental organization No Peace Without Justice and the Kenyan government, and was supported by a number of other NGOs and government agencies. Delegates came from all over Africa and the Middle East, as well as Europe. Many international organizations were represented, including UNICEF, the UN Development Program (UNDP) and the UN Population Fund (UNFPA).

Speaking at the conference, Waris Dirie, Goodwill Ambassador of the UNFPA and former international model, said: "FGM is not a tradition, it's not a culture, and it has nothing to do with religion. It's nothing by a crime." Having gone through the procedure herself in her native Somalia, Dirie said she felt very proud to be on African soil talking openly about the issue.

FGM is used to describe several types of mutilating operations performed to the external genitalia of girls and women, which causes disfigurement and results in the loss of function. Some of the myths surrounding FGM are that it preserves virginity, improves fertility and contributes to genital cleanliness. Yet none of these hold true in any medical sense. The types of procedures can be broadly classified into four groups, ranging from the removal of a small part of the clitoris, all the way to infibulation, where the clitoris and labia minora are completely excised, the wound sewn shut, and just a small opening is left for urine and menstrual flow. In Djibouti and Somalia, 98 per cent of FGM procedures are infibulations.

While FGM is now sometimes carried out in hospitals under sterile conditions and anesthesia, tools used outside of the hospital include sharp stones, knives, thorns, razor blades, broken glass and scissors. The unhygienic conditions under which the procedure is usually conducted can contribute to the further spread of HIV/AIDS when the same unsterilized materials are used on several girls one after the other. Haemorrhage is a common and almost unavoidable immediate result of the procedure, as well as shock not only due to the bleeding, but also from severe pain and anguish. Infection due to unhygienic conditions can spread internally and cause chronic pelvic infection and infertility. Damage to adjacent tissue can result in incontinence and there are many other long-term implications, especially involving problems with pregnancy and childbirth. Yet, because of the deep-rooted myths surrounding FGM, the practice endures, despite the serious health implications.

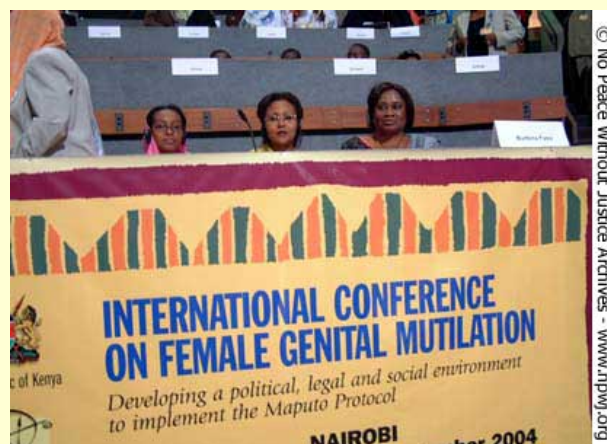
According to No Peace Without Justice, between 120 million and 130 million women have undergone FGM around the world. Every year, another two million young girls and women are subjected to this practice, which takes place in 28 African and Arab countries. FGM is not only performed on young girls before marriage, but also on married women and mothers. There have been cases of women being forcibly circumcised after their community or their own children discovered that they had not undergone the procedure before marriage. For some women, saying "no" to FGM is simply not an option. In societies where marriage is a woman's only means of survival, she has no choice but to undergo FGM, which is too often a prerequisite for marriage. As Sister Euphemia Gachiri said during a thematic session on FGM practices among the Kikuyu tribe in Kenya, FGM is aimed at making women sexually subservient.

This being said, some small steps in the right direction were taken at the conference. To the delight of the conference organizers and delegates, the Vice-President of Kenya, Moody Awori, announced that Kenya will ratify the Maputo Protocol and encouraged other nations to follow suit. "By no means is [FGM] an isolated problem," he said. "This is a global issue deserving the attention of us all." However, while such political initiative is encouraging, it is also apparent that legislation and policy are not enough to overcome the problem.

Indeed, the situation in Kenya is a good example of how laws alone cannot eradicate a harmful traditional practice. Kenya has prohibited FGM for girls under 17 since 2001, but with little support for enforcement of the law, FGM is still taking place in many rural communities. Of 42 ethnic communities in the country, only 4 do not practice FGM, and it is believed that 38 per cent of Kenyan women have undergone the procedure. A study by the Kenyan women's group Maendeleo ya Wanawake Organization (MYWO) showed that more than 65 per cent of circumcised women said they would circumcise their own daughters, despite the health complications most of them encountered after the procedure. The study also showed that the average age to undergo the procedure, usually between 7 and 14 years, is lowering to prevent girls from running away before it is done. Girls who do not go through the procedure are often ridiculed and made to feel that they don't belong to their community. On a more positive note however, the study also concluded that, in four districts where the practice is very common, 78 per cent of teenage girls had been circumcised, compared to 100 per cent of women over 50 years old, suggesting a downward trend due to education and religious opposition.

It is apparent that laws alone cannot eradicate FGM, as it is outlawed in many countries and still endures, and that a concerted effort is needed to educate communities that still practice FGM of its harmfulness. Awareness-raising strategies need to be diverse, reaching women, men, youth, health care practitioners, religious leaders and community elders. A change in attitude, especially among older women, is crucial because they are often the ones who play a large role in perpetuating the practice.

This is why many delegates at the FGM conference felt it was necessary to incorporate awareness-raising on sexuality and the rights of the child into school curricula. There also seemed to be a general consensus that a grassroots, community-level approach to the issue was best, as a top-down legal approach has shown to be ineffective in changing people's attitudes. Several delegates echoed the need for alternative celebrations for girls "coming of age", along with programs to build girls confidence and educate them about their bodies. While FGM is a deeply rooted cultural tradition, culture is not static and some changes are inevitable. Women can be empowered to make the choices that impact their lives and health by themselves.



'a girl's group performing to the conference a skit about dangers of female genital mutilation'

'delegates mingling in the conference hall'

The final communiqué of the conference stated that: "Girls and women who are willing to refuse to undergo FGM,

for themselves or for their children, and religious leaders and community members who are willing to take a firm stand against the practice of FGM [...] need to be supported and encouraged. In addition, support and encouragement should be provided for men and women who are willing to denounce the practice..." In addition, it was declared that: "Governments and international actors should provide political support and where possible, financial resources to empower NGOs in their struggle to stop FGM." This is something that all governments are able to contribute to, whether FGM is practised in their countries or not.

While there is still a great deal of work to be done in order to eradicate FGM, conferences like this one help to focus attention on the issue and allow those fighting against the practice to network and share success stories.

Gemma Richardson is currently working with the Planned Parenthood Federation of America - International in Nairobi, Kenya. She graduated from Carleton University (Ottawa, Canada) with a combined honours degree in journalism and human rights.

Sexual and Gender-Based Violence in Displaced Populations of Serbia

By Melissa Mullan

Sexual and gender-based violence (SGBV) is a significant problem in Serbia and Montenegro. Unfortunately, documentation and statistics of the prevalence of SGBV are virtually non-existent. Especially lacking are reliable data about the prevalence of SGBV within refugee and internally displaced persons (IDP) communities, who are often the most marginalized and at-risk sectors of the population. While SGBV is a problem that affects the entire population, the needs of refugees and IDPs differ from those of the general population, as does their access to help, and for that reason they should be taken into special consideration when discussing SGBV.

Difficult Living Conditions Underlying Violence

Serbia and Montenegro contains a large refugee and IDP population, as a result for the most part of the wars of the 1990s in the Former Yugoslavia and Kosovo. According to statistics from the UN High Commissioner for Refugees (UNHCR), there were over 197,000 IDPs and 377,181 refugees living in Serbia in 2002. During the wars in the Former Yugoslavia, women and children refugees were generally the first to be able to flee their houses. These women left their husbands and families with few belongings and had to start life again. They were forced to become independent, all the while not knowing whether their husbands would join them. Husbands on the other hand were left behind to fight in the wars, and when they joined their families, found that they had significantly changed. Wives were now independent and husbands suffered from post-traumatic stress disorder. Neither adults nor children were prepared for the changes in their families.

The living conditions that many refugees and IDPs find themselves in today are difficult; the unemployment rate is high among them, forcing IDPs and refugees to take low-paying temporary jobs with wages too low to ensure a basic quality of life. Insecurity about the future adds to the stress of daily life, especially when it comes to individuals' capacity to return their home town or country of origin. Indeed, many refugees and IDPs are not able to return to their homes because of legal barriers – some people do not hold identification

cards – or security problems. Under these conditions, the role of the family has changed and an increase in depression, alcoholism and suicide has been noted amongst IDPs, especially men. Men, who are generally responsible for providing for the family, are not able to fulfill their roles. In fact, women are often able to gain employment more easily than men in certain occupations, such as housecleaning. This disruption in gender roles, on top of stress and uncertainty, creates an environment in which spouse abuse is more likely.

Inadequate housing conditions increase the risk of SGBV, as there is no privacy for family members, which can cause an increase in stress. Overcrowding is a serious problem in collective centres, where whole families must live in one small room, as well as in private housing. While the majority of refugees and IDPs have moved out of collective centres and into private houses, this type of housing is also often overcrowded as refugees and IDPs have moved in with family members or friends. In addition to being stressful, the crowded nature of refugee and IDP accommodation also means that there is an ease of access to victims. For instance, a grandfather or uncle may be able to abuse a granddaughter or niece more easily when she lives in close quarters with him. Another problem with overcrowded housing is that parents are often unable to control the situation of their own family as information is easily spread through the household or collective centre. If a young girl is raped, the whole community could easily find out. At the same time, if parents try to control their children or to seek help they can be faced with extreme pressure from the community not to do so. This may make families less likely to report abuse as they may face threats or even violence from the community.

Sexual and Gender-Based Violence Going Unreported

Many women are afraid to report cases of SGBV because they may face retribution from the perpetrator, especially if it is a husband or household member, and they have few options for escaping such violence. Women receive little protection from the perpetrator once cases of domestic violence have been reported. Cases brought to trial can last as long as four years, during which time, the woman either stays in the house with the perpetrator or she leaves to live in a shelter, sometimes with her children. The perpetrator may continue to beat or violate his wife and use the fact that she reported the violence as an excuse for increased violence. In certain cases, women who own their own homes are forced to leave and live in shelters while the perpetrator stays in his wife's house. So women often continue to live with the perpetrator because they have few other options available to them. Married women are often not welcomed back within their family after their marriage. Refugee women face the additional barrier of not being able to travel back to their country of origin. Women are also tied to their homes because they cannot make enough money to support themselves and their children. As a result, they stay in an abusive household.

Few witnesses of SGBV report cases of violence, despite the fact that it often occurs in crowded surrounding. In one instance, the neighbours of a woman who was beaten to death claimed not to have heard anything, and only after being pressured did they admit that she had been beaten repeatedly over a period of time. In another instance, a mother prostituted her daughter and, while even the authorities were aware, they did not report it. Under Serbian Law, witnesses of violence have a moral obligation to react, but there are no legal costs for not doing so. Violence in the home is considered taboo and most people do not feel it is their responsibility to react to that which happens behind closed doors.

Moreover, refugee and IDP women victims of SGBV often do not recognize themselves as victims. Either they are unaware of their rights, or they keep silent because it is better for the family. In general, women only report violence when it is affecting their children. But many women believe that keeping silent in the face of abuse is better for their children.

Access to Assistance for Refugees and IDPs

While SGBV is a serious problem in the entire population, refugees and IDPs are more vulnerable because of the greater trauma that they have experienced following the flight from their homes. In addition, refugees and IDPs are never fully welcomed into their new communities. They are often seen as more privileged than the local population because they receive economic and material support and are guaranteed rights under international law while the local population is living in similar conditions of poverty.

In these circumstances, receiving adequate counselling and professional assistance to deal with the trauma caused by SGBV as well as the trauma of being a refugee, is very important. Several Centres for Social Welfare offer psychological, material and legal help to victims of SGBV, including refugees that hold the proper documents – which entitles them to medical care and assistance as per the status of refugees – and IDPs who are in effect citizens of Serbia. However, many IDPs do not hold their current personal documents because they were left behind when they fled their homes. Those with documents face the problem of registering them regularly. Most IDPs do not have the financial means necessary to travel to newly-established municipal centres to pick-up and regularly register their personal documents. Without the documents, IDPs cannot receive subsidized health care and social services.

In order to end sexual and gender-based violence in displaced populations in Serbia, a number of reforms must be undertaken. Victims must be educated about their rights, how to recognize violence and how to seek help. Laws that protect the victim, not the perpetrator, must be passed. Medical and psychological help must be made available to all victims, regardless of whether they hold identification documents or not. And facilities that provide help to victims of SGBV must be given adequate funding to carry out their

work. Only when viable alternatives are given to those living as victims of violence will there be a decrease in the number of cases of violence.

Melissa Mullan currently works with Grupa 484, an NGO dealing with migrants' rights, in Belgrade, Serbia and Montenegro

[HRI](#) [Table of](#) [Previous](#) [Next](#)
[Home](#) [contents](#) [Article](#) [Article](#)

Godeliève Mukasarasi: Portrait of an Exceptional Women's Rights Advocate in Rwanda

By Corinne Packer

On December 8th, 2004, the Canadian-based human rights organization Rights & Democracy awarded the John Humphrey Freedom Award to Godeliève Mukasarasi. She was selected as the 2004 laureate of the award, which is presented each year to an organization or individual from any country or region of the world for exceptional achievement in the promotion of human rights and democratic development. It was awarded this year to Mrs. Mukasarasi in recognition of her tireless work as an exceptional advocate for women victims of sexual violence and rape during the 1994 genocide in Rwanda and to those who consequently contracted HIV/AIDS.

A survivor of the Rwandan genocide, Mrs. Mukasarasi has been campaigning for women's rights in Rwanda for years. Following the genocide, Godeliève Mukasarasi founded SEVOTA (Structure d'Encadrement des Veuves et des Orphelins de Taba), a support group for widows and orphans of the genocide, and later set up Brianna to provide a place for Tutsi and Hutu women survivors of violence and rape to join together in dialogue. In addition to providing support to women, Godeliève has also been working against impunity and at ensuring that women obtain justice and compensation. She was instrumental in breaking the silence surrounding sexual violence, facilitating and documenting the testimonies of women survivors. These testimonies were presented to the International Criminal Tribunal for Rwanda (ICTR) and helped set a legal precedent on October 2, 1998, when the International Criminal Court imposed the first-ever sentence for sexual violence perpetrated in the context of civil war and recognized rape as an act of genocide and torture.

Nothing in Godeliève's life prior to 1994 foretold that she would come to play an important role in the lives of women and children victims of what would be one of Africa's greatest human tragedies. Born in a well-off farming family who took her education seriously, she was one of only two students in her village admitted and financially able to attend secondary school, where she chose to study social work. After completing her studies, she got married to a small business man, started a family, and worked in her village as a social worker and animator, having a good rapport with her colleagues at work. Her life, she explains, was easy, without financial worries. The family

had work, a car, a house, other properties and farm stock which brought in regular income, children in school, good health; in short, all she could ever ask for.

Then, Godeliève's life changed dramatically, as did that of her country. Attacks on her village began slowly, taking place over a period of days. It began with Hutu men coming into the village one day, burning down houses and property, and coming back the next to destroy others. Their intention was clear: instill fear, destroy and make flee. It was not long before the Mukasarasi house was targeted and set afire. Most of her family was at home at the time of the attack. Amidst the panic, Godeliève, her husband and children fled in different directions, not knowing for days where each other were and whether every one of them was still alive. Using scraps of cigarette cartons as paper, she managed to pass messages around, and a few days later, found out that every one was indeed safe; her husband and some of her children were in another village while she was hiding in her office with the others. Then, the killings began with villagers being forced to the river and drowned. Godeliève decided to flee to the West of the country where she and her family lived for some time; they were displaced but together. Strangers would share their clothes, their food and their shelter with them.

Despite the terror and chaos around her, Godeliève already set her mind to reconstructing her surroundings and helping families who were less fortunate than her own; at least, they were alive and together. She began to collect objects and furniture to reequip her rampaged office. As soon as the genocide seemed to have ended, she put her thoughts to creating a space, a forum, where she could meet with women, widows and victims of the violence, to help them work through their emotional and physical pain. Some of the women had been raped or otherwise sexually violated. Others had been mutilated. Some had lost their husbands, some their children. And children had been left orphaned.

Using her old office space, she created SEVOTA in October 1994, to offer counseling and assistance to widows and orphans in her community. It required paperwork and authorizations from different authorities, but that did not stop her. It took some time and great patience, but she managed to find small funds from the community, from churches, from funders, enough funds to offer counseling to, and provide clothing and materials for the widows and orphans. She began organizing activities and sought out her old social work colleagues to join her in rebuilding the centre. Priests and teachers joined. They used parks, churches, schools or any other place they could find to hold their meetings. In the meantime, she and her husband were able to scrape together just enough to feed the family. They did not have enough money for soap or sugar, but she was happy that her family was alive and well, and that she was able to help others.

Godeliève also formed another group called Urunana, to act as a forum where women could speak about the sexual violence they had suffered. It was very difficult, Mukasarasi explains, to get the women to trust her and others, and to speak about the sexual violations they had endured. But, realizing that reporting sexual violence would be needed to

influence legislation and to give redress to women, she convinced them of the need not only to speak about their ordeal but to have it documented. Most of the women also had to be convinced that they should feel no shame for what had happened to them and that the perpetrators of sexual violence merited being punished. Through Urunana she began the painstaking process of documenting each of the women's ordeals. At Urunana, women were offered counseling and provided information on the symptoms of STDs, including HIV – which a number of women had contracted from their violators – and on what could, or more realistically could not, be done to help them. She also helped women who were pregnant as a result of being raped.

During all of this, Godeliève's husband not only stood by her side but also sought justice in his own way, agreeing to be a witness before the international court. For this, he paid the ultimate price. Some two years after the genocide ended, he began receiving death threats because of his testimonies before the court. Not long after, the threats became reality. He and eleven others were brought to a field near the village and killed. Among the victims was one of Godeliève's young daughters. Although to the outside world the genocide had stopped, retributions had not, and so Godeliève, like the women she had been tirelessly counseling, had herself been made widow by the genocide.

Despite her personal tragedy and increasing hardships, Godeliève Mukasarasi continues to this day to run SEVOTA and Urunana for, while the genocide has ended, its impact on human lives continues perhaps more markedly so. Much of her work today is devoted to helping women living with HIV and AIDS. Some of the women she had counseled in the early years following the genocide have since died, victims of the epidemic. Others are living with the virus. Mukasarasi estimates that, for every hundred HIV positive women, only four are able to obtain the necessary medication, and they are often women who can afford to pay for it privately. Humanitarian funds and medicines have subsided long ago, yet there are still widows without enough money to feed their families or to rebuild their homes. But Mukasarasi has not abandoned her community, which needs her perhaps more than ever. Through her organizations, she continues to work to improve socio-economic conditions for women in Rwanda and rural development. Her contribution to reconstructing Rwandan society has been nothing short of extraordinary, meriting the recognition granted by the 2004 John Humphrey Freedom Award.

For more details on Godeliève Mukasarasi's work and organizations, visit www.dd-rd.ca particularly the special issue of *Libertas* devoted to Mrs. Mukasarasi and the John Humphrey Freedom Award 2004.

Corinne Packeris HRI's Coordinator of Internship Programs. In December 2004, she sat down with *Godeliève Mukasarasi* in Ottawa, Canada, to talk about her life and work.

[HRI](#) [Table of](#) [Previous](#) [Next](#)
[Home](#) [contents](#) [Article](#) [Article](#)

Making the Right to Have a Family a Reality in Botswana

By Natalie Doyle

Individuals have a right to have a family. Couples, whether HIV positive or not, are entitled to found a family. The Access to the Prevention of Mother to Child Transmission (PMTCT) program launched by the government of Botswana in 2002 can allow couples start a family in the safest possible conditions. The first such program to be put in practice, the Botswana PMTCT program, which was made free of charge to all nationals and non-nationals married to a Botswana, has proven to be effective in preventing mother to child transmission of HIV. While the program may help HIV positive individuals have healthy children, the right to have a family for HIV positive couples is not yet a reality.

Unrightfully, some individuals systematically discourage people living with HIV/AIDS from establishing a family, claiming that they are not fit to take care of a child or that they will automatically transmit the virus to the infant. In many cases, this is simply not true. It is proven that consulting a physician throughout pregnancy, enrolling in the PMTCT program, using Anti-Retroviral (ARVs) treatment if necessary, eating well and receiving emotional support can lead to a safe childbirth and the birth of a healthy baby. People living with HIV/AIDS should be informed of the many options available to them, and should know that, regardless of what people say, the decision to have a child is theirs.

The Botswana Network on Ethics, Law and HIV/AIDS (BONELA) has met with women who have benefited from the PMTCT program. BONELA interviewed an HIV positive woman, who has had three healthy children. She described how the program effectively worked for her. Closely followed by a physician throughout the pregnancy and after childbirth, the woman explained that she was put on ARVs eight months into her pregnancy, and was administered drugs like Nevirapine and Zidovudine during labour and delivery. The woman interviewed underlined the importance of involving the husband or boyfriend from the beginning with the PMTCT program, as they can provide good support and help prevent re-infection by accepting to use condoms. She said that when the baby is born, he or she is also administered AZT. To prevent infection through breastfeeding, free formula is provided to the parents for the first six to twelve months, depending on the couple's financial situation. In Botswana, the very suggestion of formula feeding instead of breastfeeding is a thought provoking idea that many consider unacceptable, unnatural and foreign imposed. Women who formula feed often draw attention to themselves and

can be accused of being ‘unhealthy’ or HIV positive. Among others, this stands as one of the barriers to the PMTCT program.

Although the woman interviewed welcomed her babies and is very happy with the outcome of her pregnancies, she had to face judgements from others as an HIV positive mother. While most people do not know your status, she said, those who do sometimes “give you that look: Why did she go and get pregnant when she’s HIV positive?” She found that even people who were supposedly well informed on HIV/AIDS asked her that very question. Nonetheless, she stressed that people living with HIV should have the right to have a family because they are the ones that will take care of, and love the baby. When asked what message she would send to a pregnant woman living with HIV, she responded: “they should accept their status [and] accept themselves as they are.”

Each person may have a different set of circumstances, and couples should make an informed decision to have or not to have a child and enrolling in programs like the PMTCT program. What is certain is that couples who are living with HIV and decide to have a child should not be victims of discrimination. Yet, discrimination against people living with HIV/AIDS is pervasive at various levels: at the family level, in the workplace and in society. People who chose or who happen to have children while HIV positive are sometimes overtly or implicitly discriminated against. Discrimination can be as simple as receiving disapproving looks that make you feel uncomfortable, or as severe as losing your job. In any case, discrimination is painful and it is high time that it stops.

The Botswana’s National Policy on HIV/AIDS acknowledges that “cognizance is taken of the public health rationale for respecting the human rights, privacy and self-determination of persons living with HIV/AIDS”. In light of this policy, people living with HIV/AIDS should not only be free from discrimination and have their status and medical files remain confidential. They should also be allowed to exercise their right to self-determination by being the only ones capable of making the decision to have or not have a child, and this regardless of their HIV status. Unfortunately, as BONELA often points out, Botswana lacks formal legislation on HIV/AIDS, which would make the afore-mentioned policy a legal document rather than a mere guideline.

At the international level, human rights documents classify the right to found a family as one of the fundamental rights. With regards to the right to have a family, Article 16 of the Universal Declaration of Human Rights notes that “men and women of full age, without limitation due to race, nationality or religion, have the right to marry and to found a family” and that “the family is the natural and fundamental group unit of society and is entitled to protection by society and the state”. People living with HIV/AIDS or affected by the virus are also entitled to this fundamental right. Likewise, couples or individuals who choose not to have a family, regardless of their HIV status, are also entitled to do so.

Stigma, discrimination and misunderstanding around the topic of HIV/AIDS deter people from testing and seeking care, even when it comes to pregnancies. While the PMTCT program is widely publicized through billboards and preventative campaigns, the message does not always reach couples. The lack of community ownership of the program, the limited involvement of men, and the stigma surrounding HIV/AIDS are some of the barriers to increasing enrolment in Botswana's PMTCT program, and ultimately, to helping HIV positive people have a healthy family.

BONELA is a non-governmental organization committed to integrating an ethical, legal and human rights approach into Botswana's response to the HIV/AIDS epidemic. For more information on BONELA, visit the website at <http://www.bonela.botsnet.co.bw/>

Natalie Doyle is currently working with BONELA on media relations. She is writing a chapter on sexual minorities for a human rights training manual.

[HRI](#) [Table of](#) [Previous](#) [Next](#)
[Home](#) [contents](#) [Article](#) [Article](#)

Contraceptive Shortage Cause for Concern in African Countries

By Gemma Richardson

Every year more than 500,000 women die from complications of pregnancy and childbirth, almost all in developing countries where women do not have access to vital services and supplies. With the current contraceptive shortage facing several developing countries, even more women risk losing their lives because of pregnancy or childbirth-related complications.

Poor women in countries such as Kenya are finding their preferred method of contraceptive is out of stock at clinics, or even that clinics are reducing services or shutting down all together. After successfully bringing down the fertility rate from 8.1 in 1977 to 4.9 in 2002, Kenya risks seeing it rise again as women's contraceptive choices are becoming limited. Last year the fertility rate in the country crept up to 5.0, perhaps a sign of what is to come. At a time when Kenyan women are expressing considerable interest in controlling the timing and number of births they have, as demonstrated in the 2003 Kenya Health and Demographic survey, access to contraceptives appears to be more restricted than it was just a few years ago.

Several other African countries have also reported to be out of contraceptives. According to the United Nations Population Fund (UNFPA), more than 350 million women worldwide do not have access to a choice of safe and effective contraceptive methods. There are several factors behind this contraceptive shortage, such as diminishing donor support, the Bush administration's global gag rule, and the growing demand for contraceptive services, which many developing countries are unable to provide for.

The Global Gag Rule

In 2001, President George W. Bush introduced the Mexico City Policy – widely referred to as the “global gag rule” – which in essence cut off USAID family planning funds to many organizations that provide family planning services in the developing world. The global gag rule denies U.S. family planning funds to non-governmental organizations that provide legal abortion services, refer and counsel women for abortion services, or that lobby for changes to abortion laws. This applies even to organizations that are not using U.

S. funds to provide these services.

Family planning organizations such as International Planned Parenthood Federation and Marie Stopes International refused to comply with the gag rule and lost millions in funding, resulting in them having to reduce services and even close some clinics. The Family Planning Association of Kenya, which provides family planning services, treatment for Sexually Transmitted Infections (STIs), and pre- and post-natal care, also refused to comply with the gag rule, forcing them to close some clinics.

As Florence Machio, regional coordinator for Africa Woman and Nairobi-based journalist specializing in gender and development issues, explains: “Most poor women cannot afford to buy contraceptives. They rely on going to these clinics and health facilities for their family planning services.” Yet poor women have had their access to vital services greatly restricted by the U.S. decision to penalize organizations that have any association to abortion services or advocacy. Ironically, the clinics run by pro-choice organizations in Kenya are mainly offering family planning services, not abortion, as it is illegal in the country.

Donor Indifference

However, it is not just the U.S. that has reduced funding; many other countries and donors have pulled back in financial support as well. While the demand for contraceptive commodities is increasing, donor support is decreasing. In 2002, donor support for contraceptives amounted to USD 197.5 million, which was a 12 per cent decrease from the USD 224.2 million in 2001. “We rely so much on donors,” says Machio. “We have to wait for the donor supply, even if we have a shortage.”

According to the UNFPA, every shortfall of USD 1 million in funding results in 360,000 unwanted pregnancies, 150,000 additional induced abortions, and the deaths of 800 women. Meeting the contraceptive demand in developing nations requires a continuing commitment of funds. Yet, while from 1992-1996 donors provided about 41 per cent of the amount required each year for contraceptive commodities, that level of support fell to only 25 per cent in 1999. This being said, donors have often in the past made additional contributions when shortfalls in funding threaten supplies. “When someone doesn’t step up and it comes down to the last minute, usually someone will come through,” explains John Skibiak of Population Council. However, steady funding is vital to the long-term planning required for successful family planning programs. The UNFPA says that most developing countries, especially the poorest countries in Africa, will continue to rely on contraceptives supplied by international donors for the foreseeable future.

While many developing countries lack the capacity to ensure the supply and distribution of contraceptive commodities, even a small scale investment in family planning would

inevitably lower the number of women who die from pregnancy and childbirth-related complications. Women need to be given a full range of reproductive health information and services, as well as a full range of contraceptive choices, yet the technical, financial, and human resources systems that are needed for this are not in place in many poor countries.

Greater Demand

The fact that there are more young people in the world than ever before also contributes to the gap between supply and demand. More than one billion people in the world are between the ages of 15 and 24, and entering their reproductive lives. Due to population growth and the success of family planning programs, there is an increased demand for contraceptives, which is estimated to increase by more than 40 per cent in the next 10 years. The UNFPA estimates that between 2000 and 2015, commodity costs for contraceptives, HIV/AIDS, and STI prevention will increase from USD 811 million to over USD 1.8 billion.

So while the contraceptive shortage cannot be attributed to one particular cause, it is clear that poor women are the ones who stand to lose most. Access to contraceptive and reproductive health services is literally a matter of life and death in many developing countries, where the risk of dying in childbirth is one in 48. Unless there is an increase in financial support by donors and governments worldwide for contraceptives, a rise in the numbers of deaths and illnesses related to poor reproductive health can be expected. Poor women are being denied the little choice they have in their lives in deciding if and when they will become pregnant. Until donors and governments decide to step up, many of these women will pay for the contraceptive shortage with their health and even with their lives.

Gemma Richardson is currently working with the Planned Parenthood Federation of America - International in Nairobi, Kenya. She graduated from Carleton University (Ottawa, Canada) with a combined honours degree in journalism and human rights.

[HRI](#) [Table of](#) [Previous](#) [Next](#)
[Home](#) [contents](#) [Article](#) [Article](#)

The Health Status of Roma: Priorities for Improvements

By Corinne Packer

Roma communities and those who work closely with them are well aware of two pressing health concerns for Roma. As remarked by the High Commissioner on National Minorities of the Organization for Security and Co-operation in Europe (OSCE), the first concern is the generally poor health status of Roma across the European region. Inextricably linked to this is their inadequate access to health care. These issues are particularly pressing in post-Communist societies which have shifted towards privatization of public services and the promotion of a free market economy. In their article “Romani Women - A Priority for European Public Health Policy”, authors Anna Pomykala and Sally Holt note that “several countries are in the process of reforming their health care systems. In this climate, care is required to ensure that the most disadvantaged and vulnerable in society are given the same opportunities in these developments as other members of the population.” They are quick to add that Roma in Western Europe equally face significant barriers to adequate health care.

The General Health Status of Roma

Roma is the common name given to what is in fact a variety of ethnic groups located mainly in Central and Eastern Europe, and who identify themselves as Romani. They are also found in smaller numbers across Western Europe, where they are referred to by various names including Roma, Sinti, Gypsies and Travellers. All share similar aspects of culture and history. They also share similar experiences of systematic and systemic prejudice, discrimination, economic hardship and social exclusion.

Although there is relatively little information on the specific health status of Roma, existing studies on Roma in both Eastern and Western Europe create a broad picture of higher rates of illness, lower life expectancy and higher infant mortality than the population at large. A 2001 study from the Open Society Institute found that, in Slovakia for instance, the life expectancy of Roma women is 17 years shorter than the majority of the population. For Roma men, life expectancy is 13 years less than that of other men. According to the same study, the infant mortality rate for Roma in Bulgaria is six times greater and in Italy almost three times greater than the wider population. In Hungary and

Ireland, it is double the national average.

Low rates of vaccination among Roma are evident across Europe. Tuberculosis breeds in overcrowded houses that have no heat in the wintertime, and Roma children are disproportionately affected by polio, diphtheria and meningitis. High rates of smoking among teens and adults, stress or mental ill-health, and chronic diseases like heart and asthmatic ailments are common problems for which they do not easily find help. There is generally little knowledge about proper nutrition and a lack of means to secure it. Many Roma women are not aware of the need to modify their lifestyle and diet during pregnancy; meat, milk, fruits and vegetables are insufficiently consumed. Roma children suffer from vitamin deficiencies, malnutrition and anemia to a greater degree than non-Roma.

To varying degrees, the Roma across Europe are amongst the poorest and most marginalized of populations. Housing and living conditions in Roma settlements leave much to be desired. Practical problems, such as a lack of infrastructure within the settlements, prevent Roma from accessing both health care and health education and further contribute to their poor health. Most sites lack proper sanitation, garbage collection, running water and electricity. All of these factors encourage the breeding of bacteria and infection while reducing opportunities to access and maintain adequate hygiene and curative conditions. It is no surprise that there also exist higher rates of contagious diseases such as hepatitis, scabies, pediculosis and other skin problems in Roma settlements.

Sexual and Reproductive Health Concerns

While Roma women generally exhibit high fertility rates and begin childbearing at a young age, studies paint a broader picture of a scenario wherein Roma women are less likely to have access to preventive sexual and reproductive health information and care. For instance, a study of rural Roma communities in Romania conducted by UNICEF Romania and the Roma Center for Social Intervention and Studies in 1999, revealed that many Roma women have not been able to access gynecological care and family planning due to a lack of doctors and nurses; women generally cannot afford transportation to seek these services even in nearby towns. Another study conducted by Médecins du Monde in 2001 found that 65 per cent of migrant Roma living in irregular circumstances have never had recourse to contraception.

High rates of infant mortality, birth and abortion among Roma women have been attributed in large part to a lack of access to family planning and natal care. In 1999, the Autonomous Women's Center in Belgrade reported that, of 272 women between the ages of 16 and 50 living in the city's settlements, nearly 28 per cent had 6 to 10 children and 6.7 per cent had more than 10 children. Almost half of these had had induced abortions,

83.5 per cent of them having had up to 5 abortions and over 9 per cent having had 6 to 10 abortions. Few studies exist concerning the prevalence of sexually transmitted diseases, including HIV/AIDS, among the Roma population. But the findings of the 2001 Open Society Institute report, which showed that nearly one in three Roma living in a settlement in Romania were HIV positive, suggests at the very least the need for more research and action.

A number of attitudes and practices among the Roma are specifically detrimental to women's sexual and reproductive health. First among them is their apparently poor understanding of the value of preventive screenings or of what constitutes a serious health risk or problem. Women also tend to postpone attention to personal well-being in the interest of attending to family care and the home. This means that obtaining contraception for themselves ranks low on their list of medical priorities, even if they are commonly the ones responsible for family planning. Moreover, Roma women are likely to feel shame when they seek help, especially if this requires a break in social codes of modesty. All these reasons prevent women from getting assistance when it comes to matters of sexual and reproductive health. Other customs may deter women from asking questions about reproductive health matters or from seeking any care during or after pregnancy.

Unequal gender relations may also impede women's access to sexual and reproductive health care. Rigidly defined gender roles, including the subordination of women to men in many aspects of daily life, appear characteristic in many Roma communities. In this context, Roma women feel little power to choose when, with whom and with what form of protection, if any, to have sex. Suggesting that partners use condoms risks being understood as encouraging infidelity. Some do not seek medical attention because they fear violence, abandonment or ostracism from their partner, family and community. On the other hand, some Roma women claim that doctors do not provide this information, suggesting an element of gender, and/or ethnic, discrimination. The stereotypical view that Roma women do not think of the future might cause health care workers not to offer family planning information and services. Some might provide information only on certain kinds of contraception on the stereotypical assumption that Roma women are unable to follow directions or need to use contraception in a clandestine fashion. In so doing, health care providers are complicit in reinforcing ethnic stereotypes and gender inequality.

Another concern arises in the context of fears of sterilization – a sensitive topic with a documented history in a number of countries – a practice that is still being reported in some countries like Slovakia and the Czech Republic. (See article by Michele Vernet in this issue of the Tribune.) Roma girls, in both rural and urban settings, traditionally marry early, between the age of 14 and 16. Early marriage is typically quickly followed by early pregnancy. The age at marriage and childbearing appears to be increasing in some communities, but much has yet to be done to achieve widespread and systematic change. Traditional beliefs and practices, coupled with isolationism, within these communities still

reinforce the suppression of information on reproduction and family planning.

Discrimination in Accessing Health Care

Roma populations in Europe generally have lower access to health care than the population at large. The physical, economic and information-based barriers to health care that many Roma confront result from the complex and interrelated effects of poverty, discrimination and unfamiliarity with government institutions generally, and health services in particular. As noted by Pomykala and Holt, Roma experience discrimination in accessing health care in different ways depending on a variety of factors, including whether a community is urban or geographically isolated, or whether the Roma population is sedentary or nomadic. They may experience direct discrimination in, for example, the refusal of physicians or health care institutions to treat them.

At a non-governmental organization meeting on Roma women and access to health care held in Vienna in 2002, women gave testimony of being denied basic health services on the basis of their ethnicity. For example, authorities were said to have refused to send ambulances to persons calling under a Roma name or under an address in a Roma settlement. Roma are reportedly often the last in line to receive medical aid and devices, even if disabled. Cases were also reported of Roma women suffering abuse by local authorities and being unable to receive help and redress. For example, women who suffered sexual or physical abuse by police were refused medical certificates of injuries suffered.

Involving Women in Family and Community Health Planning

The effects of inadequate and discriminatory access to health care are felt disproportionately by women. It is women who typically bear principal responsibility for family health care and form the contact between Romani communities and public health services. And yet it is they who are often overlooked in policies devised on behalf of Roma. The underlying values of public interest, social inclusion and responsibility form the basis for concrete steps which should be taken to improve the health of Roma women and their families, including their sexual and reproductive health. Any success in this direction can only be welcome.

Bibliography

“Improving Primary Health Care: Public Health and Cultural Research with Roma Communities in Romania”, The Roma Center for Social Intervention and Studies (Romania CRISS) and UNICEF

Romania, April-May 1999.

“Minority Protection in the EU Accession Process”, Open Society Institute, 2001

Pomykala, Anna & Sally Holt, “Romani Women – A Priority for European Public Health Policy”. Available at www.eumap.org/journal/features/2002

“ROMEUROPE Project Final Report, 1999-2000”, Médecins du Monde, March 2001.

Reports made at the NGO Meeting on Romani Women and Access to Health Care, Vienna, 28-29 November 2002. See Report by General Rapporteur, EUMC, MG-S-ROM (2002) 21.

Zoon I., “On the Margins: Roma and Public Services in Slovakia”, Open Society Institute, 2001.

Corinne Packer is HRI's Coordinator of Internship Programs. Prior to joining HRI, she specialized in health, gender and human rights law. She also worked as a consultant to the Netherlands Ministries of Foreign Affairs and Social Welfare as well as to Europe-based NGOs.

[HRI](#) [Table of](#) [Previous](#) [Next](#)
[Home](#) [contents](#) [Article](#) [Article](#)

Coercive Sterilization of Romani Women in Former Czechoslovakia

By Michele Vernet

During the 20th century, persons suffering from diseases, physical and mental impairment, people considered of “low moral character” – such as prostitutes and criminals – and the ambiguously defined “feebleminded”, were the targets of eugenics programs in Europe and North America. In most countries, the process of eliminating such “negative” traits was performed through sterilization of women of low social status. While coerced sterilization was banned in many countries in the 1970s, sterilization for non-medical purposes is still practiced in parts of the world. In Central and Eastern Europe, the tenets of eugenics continue to be applied in a more covert form to women of Romani nationality. The Czech Republic and Slovakia have recently come under fire for their failure to adequately address past and recent incidences of uninformed and involuntary sterilizations of Romani women.

The Roma have been found to be the most disliked ethnic minority in Europe. Over the last ten to fifteen years, the European Roma Information Office (ERIO) conducted surveys in countries of Western and Eastern Europe and found “an alarmingly high level of rejection of Roma in all European countries” (See www.erionet.org). In many countries, health care providers openly display negative attitudes towards Roma. A doctor, cited in a report from the Center for Reproductive Rights on forced sterilization of Roma in Slovakia, explained that Romani women “have several partners, are promiscuous, travel a lot, and bring diseases with them from other countries”. As this report shows, doctors and other health care providers throughout Europe often believe that Romani women have several children in order to take advantage of health care benefits. One hospital administrator in Slovakia stated: “Many Roma abuse the practice of intermarrying to purposefully create imbecile children in order to get more money from the state.” Such blatantly racist sentiments are used to justify coerced sterilization.

Sounding eerily similar to racist eugenics propaganda supporting the concept of a “pure race”, the Czechoslovak government repeatedly sterilized Romani women from the 1970s until the 1990s, with a view of reducing the “high, unhealthy” birth rate of the Roma, as documented in a 1992 Helsinki Watch report (now Human Rights Watch). During that period, women were often offered financial incentives to agree to sterilization. While

criminal complaints were filed in 1992-1993 with the Czech and Slovak governments on behalf of Romani women who had been sterilized under the Communist regime, both governments dismissed them. In fact, there were indications that a resurgence of racist sentiments after the collapse of Communism allowed the practice of coerced sterilization to go on.

In 2003-2004, the European Roma Rights Center (ERRC) undertook several field missions to the Czech Republic and Slovakia to determine whether or not coercive sterilization procedures continued to occur. In both countries, the ERRC documented numerous cases of Romani women who underwent surgery, without informed consent, which resulted in their sterility. In the Czech Republic city of Ostrava, the ERRC found that of 35 sterilization cases of Romani women documented, 25 appeared to have involved inadequate levels of information as to possible consequences to the procedure. In both countries, the ERRC reported several cases of pressure, misinformation and outright trickery. (See www.errc.org for further details.)

Uninformed and involuntary sterilizations are contrary to international human rights instruments that the Czech and Slovak Republic are party to. According to the Universal Declaration of Human Rights, “no one shall be subjected to cruel, inhuman or degrading treatment or punishment” (art.5). Article 7 of the International Covenant on Civil and Political Rights (ICCPR) further adds that: “No one shall be subjected without his [or her] free consent to medical or scientific experimentation.” Moreover, the UN Committee on the Elimination of Discrimination Against Women has affirmed that “women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives” (General Recommendation 24(20)). As signatories to these human rights instruments, the Czech Republic and Slovakia have the obligation to investigate and to put an end to coerced sterilization without delay, and have a responsibility to offer redress to those who have been subjected to coerced sterilization.

The Slovak government has been responding to pressure from intergovernmental and non-governmental organizations to draft new legislation in conformity with international law and put a stop to coercive sterilization. After the Commissioner for Human Rights of the Council of Europe issued several recommendations concerning aspects of the law and practices relating to the sterilization of women in the Slovak Republic in October 2003, the government recognized that “a thorough investigation of some sterilizations of women, indeed, [had] confirmed procedural shortcomings” and undertook criminal investigations as well as a review of the medical legislation. On October 21st 2004, the Slovak Parliament finally adopted amendments to the Health Care Act which better reflect international law. The amendments, which came into force on January 1st, 2005, will hopefully provide patients with adequate safeguards against further uninformed or involuntary sterilizations. However, this new legislation does not mention providing

redress to those who have already suffered.

In the Czech Republic, a campaign is also under way to end coerced sterilization, but it has not yet resulted in changes to legislation or in official acknowledgement that forced sterilizations occurred. According to the ERRC, more than fifty persons – the vast majority of them being women – who have undergone coercive sterilization procedures have come forward in the Czech Republic within the last year in an attempt to press charges and to receive recognition of the injustice they have suffered. The Czech Public Defender of Rights, who has been receiving individual complaints, has begun to consult with the Czech Ministry of Health to review each person's files. However, no concrete action has been taken by the Czech government thus far. As noted by the ERRC, although a commission was established to review these files, the body had not convened a single meeting as of December 2004.

Coerced sterilization is an outright violation of human rights and is banned under international law. The practice of sterilizing individuals is an extremely invasive procedure which often results in misplaced feelings of shame and embarrassment; it is a direct attack on the dignity of the person. While the Slovak government, under international pressure, is changing its legislation, the impact of the revised Health Care Act has yet to be determined in practice. The Czech Republic will continue to be subjected to pressure by organizations, such as the ERRC, to amend its legislation, to provide remedy to those who suffered human rights violations, and to adequately prosecute those who carried out such grave violations.

Michele Vernet is currently working with the European Roma Rights Center in Budapest, Hungary, on a range of activities aimed at combating anti-Romani racism and human rights violations against Roma.

[HRI](#) [Table of](#) [Previous](#) [Next](#)
[Home](#) [contents](#) [Article](#) [Article](#)

The Denial of Sexual Rights in Botswana: A Threat to the Health of Sexual Minorities

By Natalie Doyle

South Africa made history when it became the first country in the world to explicitly provide constitutional protection and civil rights to individuals of all sexual orientations. Nonetheless, South Africa's progressive sexual orientation clause does not reflect the policies of neighboring South African Development Community (SADC) countries. Botswana, a country that has been a model for peace and development in the region has not embraced South Africa's stance on lesbian, gay, bisexual and transgendered (LGBT) rights.

In a letter sent to *The Botswana Guardian* on August 7, 2004, Bonani Kopi pleaded "There are naturally born homosexuals across the world. This is not a Western concept adopted. Not all men were meant for women and not all women were meant for men. Don't judge us." Unfortunately discrimination against lesbian, gay, bisexual and transgendered populations is all too common in Botswana, where same-sex sexual activities are essentially illegal. At the moment, the Botswana Penal Code (Section 164) provides that same-sex sexual relations, or rather "carnal knowledge of any person against the order of nature", are illegal. This being said, LGBT cannot be arrested because of their sexual identities or for the simple fact of having feelings for a person of the opposite sex. Two people of the same sex who engage in sexual activities or a relationship can only be arrested if they are caught in the act; this act is punishable by up to seven years in prison.

The erroneous argument that homosexuality is not an 'African' concept is unfortunately still used to justify and guide discriminatory policies against LGBT in most African countries. But, while few would dare to acknowledge it, there is evidence that homosexuality has existed in Africa, well before the coming of colonial powers. An example that refutes the argument that homosexuality is an un-African concept is that of Shona culture in Zimbabwe, which has long accepted the existence of homosexuality. In Shona culture, when a person did not want to marry nor had no sexual interest in a person of the opposite sex, it was said that the spirit of the opposite sex had taken over his or her body. It was thought that when a male spirit possessed a woman, she had to have sex with a woman to fulfill the needs of the male spirit, and vice-versa.

Contrary to the association of gay men to HIV/AIDS that regrettably still sometimes occurs in Western countries and helps fuel unwarranted stigma and discrimination against sexual minorities, in the African context, gay men are rarely associated with the virus because the very existence of gay men is denied by many. At the same time, in African countries, as in most places, the most common mode of transmission of HIV is through sexual intercourse. In fact, 70% of all HIV infections worldwide are transmitted through vaginal intercourse between men and women, as reported by Helen Jackson in *AIDS Africa: Continent in Crisis*. Nevertheless, in the heightened context of HIV/AIDS in Botswana, which has one of the world's highest HIV rates in the world, it is critical that LGBT be included in the national strategy against the spread of the disease and be protected by the law.

Due to the lack of acceptance and understanding of LGBT, these individuals receive little if any attention in Botswana's HIV/AIDS prevention strategies, programming and service delivery, nor are they represented in mainstream media. Because there is so little information, and no condoms or dental dams are provided specifically to LGBT, many individuals may be unaware of the dangers of having unprotected anal sex or oral sex. In fact, since there is no risk of becoming pregnant through same sex sexual activities, many individuals – both heterosexuals and LGBT – practice unprotected anal sex as an alternative to vaginal intercourse, thus failing to protect themselves from HIV/AIDS and other Sexually Transmitted Diseases (STD).

The spread of HIV is amplified by the taboo nature of same-sex relations and of HIV/AIDS itself. Same-sex sexual relations are frequent in certain social settings in Botswana, settings which may also provide fertile ground for the transmission of HIV, like prisons or predominantly male or female working environments. Such activities are not discussed and are widely denied. A former inmate shared with *The Botswana Guardian*: “there is a lot of sexual activity in prison... I have seen people dying of AIDS in prisons when they had come into prison without the virus.” (“Prison Sex Cover-Up Revealed”, *The Botswana Guardian*, February 28, 2003). While there is evidence that HIV is spreading in Botswana prisons, Government authorities still refuse to hand out condoms in prisons alleging that same-sex activities are “unnatural”. Prisoners should have the right to health, including the right to remain HIV-negative.

Mining villages and border villages have been particularly touched by the scourge of HIV/AIDS in Botswana, as in many other countries. This is in part due to migrant mine workers practicing unprotected same-sex activities amongst each other and often seeking sex from young boys and girls from neighboring villages. Mine workers put themselves and their families at risk of contracting HIV when they practice unprotected sex while away from their home villages and then return to their wives. Addressing these social realities would be an essential component of the fight against HIV/AIDS in Botswana. Nonetheless, to do so would involve acknowledging same-sex relations.

As is true for all areas of the world, legal protection of LGBT would allow for these individuals to have their rights respected, form support groups and associations and feel at ease with their identities. At the moment in Botswana, there are no formal associations, networks, or support groups for sexual minorities to gather, support each other and share experiences. The Botswana Network on Ethics Law and HIV/AIDS (BONELA) and Ditshwanelo (or ‘human rights’ in Setswana), two local human rights NGOs, have been researching and advocating for the rights of sexual minorities in the country. Under the auspices of BONELA, some individuals have even been able to gather informally, almost clandestinely, every month. Last year, BONELA also held a public discussion seminar titled “Facing Sexual Orientation in the midst of the AIDS epidemic” which was the first of its kind. An individual, who attended the discussion stressed that as members of the underground gay community, “we can no longer deal with these issues as individuals [...] we need a structure”.

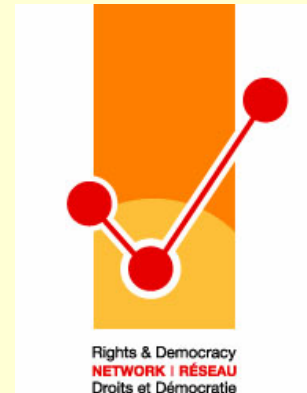
The hostile legal and cultural environment sexual minorities are subjected to increase their risk of contracting HIV and curtails their enjoyment of basic civil rights and liberties. Decriminalizing same sex sexual activities is an essential step in the fight against HIV/AIDS since it would allow for LGBT to be incorporated into the nation’s mainstream fight against the spread of HIV/AIDS and for condoms to be provided in prison. Legally protecting sexual minorities’ rights will not only allow them to enjoy the right to health but also the rights to found a family and to be free from discrimination.

Natalie Doyle is currently working with BONELA on media relations. She is writing a chapter on sexual minorities for a human rights training manual.

[HRI](#) [Table of](#) [Previous](#) [Next](#)
[Home](#) [contents](#) [Article](#) [Article](#)

Le Réseau Droits et Démocratie au sein des universités canadiennes: la prochaine génération à l'oeuvre pour « Mettre le monde à l'enDROITS »

Par Cynthia Gervais et Lloyd Lipsett



Le Réseau Droits et Démocratie (le « Réseau ») est une initiative à travers laquelle Droits et Démocratie encourage, au sein des universités canadiennes, la création d'espaces de réflexion où les étudiants se rencontrent pour discuter et proposer des activités concrètes qui font la promotion des droits humains. D'un bout à l'autre du Canada, et au-delà, les étudiants ont spontanément répondu à cette proposition et ont animé ces espaces : sur les lieux de leurs cités universitaires; au sein de leurs communautés; à l'échelle de leur monde. Depuis le lancement du Réseau en septembre 2003, nos efforts, avec l'appui financier du ministère des Affaires étrangères Canada (FAC), ont initié la création d'associations étudiantes – des « Délégations Droits et Démocratie » – au sein de plus de 35 universités canadiennes, rassemblant de futurs politologues, ingénieurs, éducateurs, statisticiens, journalistes, biologistes, avocats, musiciens.

Le Réseau Droits et Démocratie croit que tenter de «mettre le monde à l'endroits » nécessite une large coalition de citoyens informés et engagés provenant de tous les horizons. Ainsi, nous allons à la rencontre d'étudiants et de professeurs de toutes les disciplines et facultés et nous les incitons à travailler ensemble à développer une culture commune des droits humains. À titre d'exemple :

- les étudiants des facultés de médecine de la McMaster University, de l'University of British Columbia et de l'Université de Montréal se sont penchés, avec d'autres de leurs collègues du Canada, sur les besoins en matière de formation relative aux droits humains au sein des programmes de sciences de la santé ;
- à l' Ontario College of Art and Design, la Délégation a créé un vidéo interactif fait d'interviews ayant pour thème les droits humains ;
- à l'Université Laval, les étudiants ont élaboré un jeu de société au sujet des enjeux sociaux et de droits humains liés à la mondialisation ;
- à la Mount Allison University, la Délégation prépare un concert au bénéfice des filles ayant été impliquées dans les conflits armés.

Le Réseau Droits et Démocratie apporte un appui intellectuel, financier et administratif aux initiatives menées par les étudiants. Chacune de nos Délégations reçoit une trousse de documents et d'outils de recherche multimédia qui comprend, à titre d'exemple, la collection CD-ROM de [Bilan : Le système des droits humains à l'ONU](#), un outil de référence produit par Internet des Droits Humains (IDH). Nous aidons également les étudiants à trouver des stages et des emplois. Plusieurs stagiaires appuient l'équipe de coordination du Réseau et dès janvier 2005, une finissante à la maîtrise en éducation et développement effectuera un stage dans le domaine des droits de l'enfant auprès de l'UNESCO, à Paris.

Le Réseau est en développement constant et voici quelques uns de nos événements récents et à venir:

- **De Moncton à Ouagadougou : l'internationalisation du Réseau**

Le 25 novembre 2004, dans le cadre du Xe Sommet de la Francophonie, le Réseau a inauguré son premier jumelage international soit celui de ses Délégations Droits et Démocratie de l'Université de Ouagadougou et de l'Université de Moncton au Nouveau-Brunswick, au cours d'événements simultanés, au Burkina Faso et au Canada. Le ministre canadien responsable de la Francophonie, l'honorable Jacques Saada, le ministre des Relations intergouvernementales et internationales du Nouveau-Brunswick, l'honorable Percy Mockler, de même que Son Excellence Monsieur Denis Briand, ambassadeur du Canada au Burkina Faso ont participé à cette célébration. La ministre de la promotion des droits humains du Burkina Faso, Madame Monique Ilboudo, à qui nous devons de nous avoir mis en lien avec les étudiants et les professeurs de l'Université de Ouagadougou, nous a aussi fait l'honneur de sa présence. De concert avec les professeurs et les administrateurs des universités qui accompagnent les étudiants dans leur démarche, tous et toutes ont témoigné de leur soutien à cette initiative favorisant la solidarité entre les jeunes générations dans le domaine de la promotion des droits humains et de la démocratie.

- **Le Réseau dialogue sur la politique étrangère**

Les étudiants membres du Réseau contribuent au dialogue en ligne organisé par le ministère des Affaires étrangères Canada : à l'Est, à l'Ouest et dans la région centrale du Canada nos Délégations tiendront un forum régional où elles discuteront avec des étudiants provenant d'autres universités, des experts en politique étrangère canadienne et internationale ainsi qu'avec le grand public de questions inhérentes à la politique étrangère du Canada relativement aux droits de la personne et au développement démocratique.

- **Rendez-vous national**

Au mois de mars prochain aura lieu à Montréal notre deuxième rendez-vous annuel : le « Mingler » national du Réseau auquel participent des représentants de nos Délégations de toutes les régions du Canada. Ils auront l'occasion de rencontrer les membres du Conseil d'administration et le personnel de Droits et Démocratie ainsi que nos partenaires et se réuniront en conseil afin de discuter avec nous de leur vision du Réseau.

Il ressort clairement de notre rencontre avec les étudiants et les étudiantes universitaires - à travers le Canada et à l'étranger - qu'ils ne doutent pas, pour citer Margaret Mead « qu'un petit groupe d'individus conscients et engagés puisse changer le monde ».

Droits et Démocratie est un organisme non partisan investi d'un mandat international et qui a été créé en 1988 par le Nous travaillons en partenariat avec des groupes et associations de défense des droits humains et avec des gouvernements afin de promouvoir le respect des droits de la personne et la démocratie. www.dd-rd.ca

Pour plus d'information, n'hésitez pas à visiter notre site Internet www.droitsdemocratie.net à communiquer avec Cynthia Gervais, coordonnatrice, Réseau Droits et Démocratie, reseau@dd-rd.ca, Tél. : (+1 514) 283-6073.

Cynthia Gervais est coordonnatrice du Réseau Droits et Démocratie. Lloyd Lipsett est adjoint principal au Président à Droits et Démocratie

[HRI Home](#) [Table of contents](#) [Next Article](#)

Les jeunes s'organisent contre la peine de mort

Par Maude Hébert et Julie Rivest

***L'article ci-dessous a été soumis par les coordonnatrices de la Délégation Droits et Démocratie de l'Université de Sherbrooke (Québec, Canada). Cet article fait état d'activités organisées dans le cadre du Réseau Droits et Démocratie, tout en exposant les motivations animant les étudiants qui y ont pris part.*

Lorsque l'on vit au Canada, il peut parfois être facile de prendre les droits humains pour acquis. Bien que ces droits semblent mieux respectés que dans d'autres régions du monde, l'implication et l'engagement restent primordiaux pour faire évoluer la situation qui reste imparfaite. La lutte pour les droits humains se manifeste à travers plusieurs faits et gestes, et c'est pourquoi l'organisme Droits et Démocratie offre l'opportunité aux étudiants de s'impliquer au sein de ses Délégations afin de faire la promotion des droits de la personne et du développement démocratique.

Dans le cadre des initiatives du Réseau Droits et Démocratie, des étudiants des programmes de politique appliquée et de droit de l'Université de Sherbrooke, sous la direction de leur professeur, M. Pierre Binette, ont eu la chance d'organiser le Forum étudiant contre la peine de mort, un événement qui a permis à des étudiants venus de différentes régions du monde de prendre position contre la peine de mort .

Ce Forum étudiant a eu lieu dans le cadre du 2^e Congrès mondial contre la peine de mort, qui s'est tenu à Montréal du 6 au 9 octobre 2004. Le Congrès, à l'initiative d'Ensemble contre la peine de mort (ECPM) et de Penal Reform International (PRI), avait pour objectif principal de faire connaître la lutte contre la peine de mort tant au niveau international, national que régional. Il a été l'occasion pour les abolitionnistes du monde de faire valoir leurs points de vue.

La tenue du Forum étudiant a donné aux étudiants la chance de s'exprimer, tout comme les politiciens, les juristes, les artistes et les familles de condamnés. En plus d'offrir une tribune pour les étudiants, le Comité organisateur de l'Université de Sherbrooke avait mis sur pied un forum de discussion sur Internet, qui permettait de proposer des amendements

au projet de Déclaration finale directement en ligne. De plus, le Comité avait organisé un concours de plaidoiries dans le cadre duquel cinq étudiants, provenant d'Europe, d'Amérique du Sud et d'Amérique du nord, ont été sélectionnés pour venir faire une présentation lors du Forum, sous forme de plaidoirie d'ordre juridique ou de texte argumentatif contre la peine de mort. Grâce au travail accompli par le Comité organisateur de l'Université de Sherbrooke et à la participation de nombreux étudiants venus des quatre coins de la planète, le Forum s'est conclu par l'adoption unanime d'une déclaration solennelle qui rassemble les opinions, les arguments, les constats et les propositions des étudiants. (Consultez la Déclaration solennelle au www.montrealforum2004.org)

Lors du Forum étudiant, plusieurs arguments ont été mentionnés afin d'expliquer en quoi la lutte contre la peine de mort est nécessaire, et notamment le fait que la peine de mort constitue une violation des droits humains et une atteinte à la dignité humaine. C'est pourquoi dans leur Déclaration les étudiants ont enjoint la « communauté internationale d'agir solidairement contre la peine de mort afin que le caractère sacré de la vie humaine soit respecté comme il se doit. »

Tout au long de l'organisation du Forum étudiant contre la peine de mort, les étudiants de l'Université de Sherbrooke ont été soutenus par l'équipe de coordination du Réseau Droits et Démocratie. Reconnaissant que l'engagement des étudiants est nécessaire et primordial pour faire avancer la lutte pour les droits humains, les étudiants du Comité organisateur ont décidé de poursuivre leur participation au sein du Réseau et de contribuer activement à la mise sur pied officielle et au développement des activités de la Délégation Droits et Démocratie au sein de l'Université de Sherbrooke.

Depuis le printemps 2004, l'initiative de Droits et Démocratie a permis à de nombreux étudiants, appuyés par leurs professeurs, de mettre sur pied des projets se rapportant à divers thèmes, tels que les droits humains, l'éducation et la démocratie. Les avantages de faire partie de la Délégation de notre université sont nombreux. Tout d'abord, les projets sont libres et proviennent de l'initiative des étudiants. De plus, Droits et Démocratie favorise l'autonomie et la discussion entre étudiants puisque le Réseau leur offre la chance d'établir des contacts entre les différentes universités du Québec et du Canada. Les échanges d'idées se font donc à une plus grande échelle et sont bénéfiques pour tous.

Le Réseau Droits et Démocratie soutient, encadre et conseille les étudiants afin qu'ils mènent à terme leurs projets. À titre d'exemple, bien que la création de la Délégation de l'Université de Sherbrooke soit récente, celle-ci a déjà six projets à son actif, y compris un jeu portant sur la question de la peine de mort. Ce jeu a d'ailleurs pu être testé lors du Congrès mondial contre la peine de mort de Montréal où il a connu un grand succès.

La Délégation de Droits et Démocratie de l'Université de Sherbrooke estime que l'implication étudiante est primordiale, et ce à plusieurs niveaux. Les étudiants étant les

décideurs de demain, leur engagement a un impact direct sur les processus décisionnels actuels et futurs. Lors de congrès d'envergure comme le Congrès mondial contre la peine de mort, la présence d'étudiants est non seulement remarquée, mais leur voix est également entendue. Il ne fait aucun doute que l'engagement des étudiants peut faire évoluer les causes telles que la lutte pour les droits humains.

[HRI](#) [Table of](#) [Previous](#) [Next](#)
[Home](#) [contents](#) [Article](#) [Article](#)

Turning the Tide: Preventing Natural and Man-Made Threats in Southeast Asia

By Erik Friberg

The tsunami that hit Southeast Asia on December 26, 2004, and the ensuing disaster and human suffering amount to a tragedy beyond words. The increasingly resolute worldwide action of support extended to the surrounding states of the Indian Ocean will hopefully enable effective and sustained relief and reconstruction efforts for the years to come.

Importantly, public and policy attention has also been immediately directed towards *preventive* thinking: how can a regional early warning system prevent future natural disasters? UNESCO reports that a **tsunami early warning system for the Indian Ocean could be operational by the middle of 2006, and a world-wide system in place the year after**. While the recent tsunami originated from the earthquake off the coast of Sumatra, the waves that followed affected the shores of at least 12 states, and caused casualties among citizens of many more – including tourists and families from literally the other side of the world. The effects of various human security threats pay no respect to national borders, proving the necessity for effective inter-state cooperation in preventing and addressing them. This is certainly no less true for man-made disasters. For example, while the origin of trafficking, illegal migration, environmental haze and violent inter-communal conflicts may stem from one country, the effects can be felt in the wider region and beyond.

The human and economic costs of leaving root causes threatening human security unattended are well documented. While “an ounce of prevention is worth a pound of cure”, the focus and resources dedicated to prevention remain minute in comparison to post-disaster and post-conflict efforts. The “culture of prevention” as labeled and envisioned by UN Secretary-General Kofi Annan remains unattained; while many talk about “preventive action” and “conflict prevention”, very few international mechanisms have been developed with such a mandate. However, there are examples of how regional cooperative (as opposed to coercive) mechanisms have been able to successfully address the root causes of human misery at an early stage.

The early warning system in the Pacific Rim has been increasingly reported as a system which could provide some inspiration for the states surrounding the Indian Ocean.

Similarly, regional early warning systems for man-made threats exist in other regions, including Africa and Europe. Whether the data to be collected stem from indicators of natural causes or human behavior, there must be a capacity to promptly analyze the information with timely suggestions for effective policy responses. This function is best performed by impartial, professional expertise, mandated to warn about potential threats – whether natural or man-made – and to assist governments, in a cooperative manner, in responding to them. It would be desirable if such a mechanism could take effective action, even if the measures might be discomforting to some in the short-run. The actual risk must triumph over other considerations. For example, it might be necessary to issue a travel warning due to infectious diseases, even if this could temporarily hamper local tourism. Direct access to the highest levels of governments could be granted for such an early warning mechanism, in return for applying an assistance-oriented, non-confrontational and problem-solving approach.

In the past, there has been limited inter-governmental cooperation beyond the economic sphere in the region. However, both South Asia and Southeast Asia have sub-regional inter-governmental organizations that could be further developed to address a variety of human security threats regionally. The South Asian Association for Regional Cooperation (SAARC) and the Association of Southeast Asian Nations (ASEAN) have indeed taken cautious steps towards deepened political cooperation ^(a). Indeed, in November 2004, a Plan of Action towards an ASEAN Security Community (ASC) was adopted, which specifically envisions the development of preventive and diplomatic conflict prevention mechanisms, including an early warning system. With an expanded ASEAN Regional Forum (ARF) ^(b) – which brings together countries like India and Pakistan at a same table – the time could be ripe to build on the confidence-building measures that the ARF has developed over the past decade, and establish envisioned ARF preventive diplomacy mechanisms. While the UN should stand ready to coordinate and cooperate more systematically with sub-regional cooperation such as SAARC, ASC and ARF, it is apparent that in-regional solutions are often better suited to effectively deal with in-regional threats and problems – and more likely to be accepted and implemented.

The challenge is to reconcile the approach of prospective mechanisms with the principle of non-interference and respect for state sovereignty in the region. The principle of non-interference should not equal a policy of non-cooperation and non-involvement. If mechanisms applied a cooperative, quiet diplomatic, problem-solving approach, thereby effectively assisting governments in responding to emerging threats, this methodology would ensure warranted inter-governmental cooperation and engagement. And since mechanisms would function on the basis of state consent, sovereignty would be fully respected. One concrete and immediate response could be to revisit the idea and create a comprehensive regional risk reduction centre within the ASEAN Secretariat, possibly under the recently established ARF Unit. A Regional Risk Reduction Desk, staffed with seconded government officials from ASEAN states, could assist the ASEAN Secretary-

General, the ASEAN/ARF Chair and the ARF Group of Eminent and Expert Persons by providing ongoing analysis. This capacity at the regional level, with direct access to the region's capitals, would enhance, rather than threaten, the role of the participating states in addressing both natural and man-made threats, which risk harming human and state security alike. Which government in the region could possibly not have wanted the friendly, timely advice and effective assistance in advance of the deadly tsunami?

(a) The South Asian Association for Regional Cooperation (SAARC) was founded in 1985. SAARC has seven member states: Bangladesh , Bhutan , India , Maldives , Nepal , Pakistan and Sri Lanka . See <http://www.saarc-sec.org>. The Association of Southeast Asian Nations (ASEAN) was founded in 1967. ASEAN has ten member countries: Brunei Darussalam, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, Vietnam. See <http://www.aseansec.org>.

(b) The ASEAN Regional Forum (ARF) was created in 1994 with the objective to 'foster constructive dialogue and consultation on political and security issues of common interest and concern; and to make significant contributions to efforts towards confidence-building and preventive diplomacy in the Asia-Pacific region'. The current participants in the ARF are: Australia, Brunei Darussalam, Cambodia, Canada, China, European Union, India, Indonesia, Japan, Democratic Peoples' Republic of Korea, Republic of Korea, Laos, Malaysia, Myanmar, Mongolia, New Zealand, Pakistan, Papua New Guinea, Philippines, Russian Federation, Singapore, Thailand, United States, Vietnam. See <http://www.aseansec.org/arf>

Part of this article was published in the [Jakarta Post](#) on January 31, 2005.

***Erik Friberg**, a Swedish national, is Research Fellow at the Centre for Strategic and International Studies in Jakarta, Indonesia. He is part of an HRI project to encourage the development of in-regional capacity to prevent conflict through quiet diplomacy. He can be reached at erik.friberg@csis.or.id.*

[HRI Home](#) [Table of contents](#)

[Previous Article](#)