THE RIGHT TO SURVIVE SEXUAL VIOLENCE, WOMEN AND HIV/AIDS

Françoise Nduwimana

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PREFACE

In her latest report on violence against women, its causes and consequences,[1] Ms. Yakin Ertürk, UN Special Rapporteur, drew attention to the fact that HIV/AIDS intersects many forms of violence against women. Among them, rape and other acts of violence commonly carried out in the scope of armed conflict considerably increase women's vulnerability to HIV/AIDS.[2]

Rights & Democracy's Women's Rights Programme made the decision to fund and publish this study in response to the Special Rapporteur's appeal for more research on the subject and the need expressed by the Coalition for Women's Human Rights in Conflict Situations to better respond to the unparalleled situation experienced by women who were raped and infected with HIV/AIDS during the Rwandan genocide.

This essay is divided into two parts. The first part discusses the specific case of the Rwandan genocide and the second, the armed conflicts plaguing sub-Saharan Africa. Any analysis of the violence perpetrated against Rwandan women is incomplete without a full comprehension of the very logic underlying the genocide of Tutsis and the massacres of Hutus opposing the genocide. The genocide was the work of the State, its administration, bureaucracy, army, militias and the structures implemented to foment ethnic hatred and to incite the majority of the population to participate in the "final solution". As Jean-Pierre Chrétien[3] points out, the Rwandan genocide is the result of an ideology and a successful and per-

[1] United Nations, Economic and Social Council, *Towards an effective implementation of international norms to end violence against women, Report of the Special Rapporteur on violence against women, its causes and consequences*, E/CN.4/2004/66, December 26, 2003, p. 15.

[2] AIDS, or acquired immunodeficiency syndrome, is a disease caused by a virus that attacks the immune system (the body's natural defence system). Scientists have named the virus HIV (human immuno-deficiency virus).

[3] Jean Pierre Chrétien, *Le défi de l'ethnisme*, Karthala, 1997, pp. 91-99.

sistent propaganda campaign. One million deaths in one hundred days, thousands of rapes and acts of sexual violence, committed without regard to the victims' ages and throughout the country: this constitutes a record of rapid and "efficient" destructiveness that no other African country has ever known. The African regional context, in which many armed conflicts are being played out, requires a different analysis. Unlike the Rwandan genocide, which lasted 100 days, those conflicts are characterized by their long duration of between 10 and 30 years. In addition, while the Rwandan genocide was the work of a State, the crisis in Sierra Leone and the Democratic Republic of Congo (DRC) have demonstrated a regionalization of civil war in terms of the size of military forces, armed groups and the number of countries involved.

The first part of the essay is a monograph written using data, interviews and accounts gathered in Rwanda in February 2004. We met with 30 victims, members of survivor women's associations in Kagugu, Taba, Cyangugu, Butare, Kigali, Ruhengeri and Nyanza, and 18 women gave their personal accounts of events. This section recounts the sexual violence and the high level of HIV/AIDS among these surviving women and its relationship to the genocide, the hate propaganda and the underlying ethnic violence. In addition, the victims' rights to reparation and psychological and physical rehabilitation should clearly be of concern to the International Criminal Tribunal for Rwanda (ICTR), the Rwandan government and international cooperation organizations.

The second part of this paper is based in part on interviews and data gathered in February 2004 in Goma, DRC, and in Bujumbura, Burundi. The historical poverty of Africa, the persistence of armed conflict, the transregional mobility of many armed groups, the non-compliance of peace-keeping forces with the code of conduct, their inability to protect the civilian population, and gender-based inequalities are all elements taken into account to explain the situation of women grappling with political violence and HIV/AIDS. The analysis set forth in this part focuses on sub-Saharan Africa, particularly the Great Lakes region. After demonstrating the link between rapes committed during wartime and the HIV/AIDS infection of victims, it calls upon the African Union, the States concerned and the international community in general to uphold the victims' rights to reparation and psycho-medical rehabilitation.

Jean Louis Roy, President, Rights & Democracy

INTRODUCTION

This year, Rwanda commemorates the tenth anniversary of a tragedy that has marked the collective memory: the genocide of Tutsis and the massacre of Hutus who opposed it. According to the latest statistics published by the Rwandan government on the occasion of this tenth anniversary, 934,000 people lost their lives during the 100 days of the tragedy. Although today we commemorate the dead, and keep their memories alive, one reality is disregarded and it is that despite the official end of the genocide, lives continue to be forfeited. For many of the women who were the victims of rape during the genocide as part of a larger strategy of ethnic extermination; the relationship of rape to the genocide is not solely a matter of history. The challenge for these women is not merely to keep the memory of the tragedy alive but to reclaim their right to leave the nightmare of the genocide behind, the right to survive.

The 30 women who were the subject of this study, including 18 who related their personal stories, have something in common. They were all raped during the genocide and infected with HIV/AIDS. Can we accurately refer to them as survivors, when every day, these women, linked by the miserable three-pronged destiny of genocide, rape and HIV/AIDS, witness their friends, acquaintances, neighbours, and family members dying in anonymity, with the world utterly indifferent to their fate? Can we accurately refer to them as survivors when, in the absence of treatment for HIV/AIDS, those who are still living see only death on the horizon? While these women, victims of rape and HIV/AIDS, did not die during the 100 days that rocked Rwandan history, they have been visited with another form of atrocious, unnameable and insidious death. They are dying slowly, an invisible extermination. They are demanding justice. What was the point of surviving only to die a few years later, completely disfigured and dehumanized? Survival is not an imperative stripped of sub-

stance and meaning. It depends on social justice measures that can help people put their war-torn lives back together and make a new start. In the absence of health or social measures, such as access to HIV/AIDS treatment, women who have been raped and who are living with HIV/AIDS are condemned to death.

This study is a plea for these women's right to survival. They are in this situation because they were victims of genocide. It would be a betrayal of memory to say that they are victims of HIV/AIDS only. The women were infected with HIV/AIDS in the very specific context of the genocide. In such a circumstance, HIV/AIDS cannot be considered uniquely as a disease transmitted during sexual activity. In the context of rape and physical violence, HIV/AIDS infection is criminal in nature and requires a different response. As it is blatantly clear that the high incidence of HIV/AIDS, estimated at between 66.7%[4] and 80%[5] among surviving women, is closely linked to rape and the other physical violence suffered by these women during the genocide, the justice system must include HIV/AIDS as one of the consequences of these crimes and adopt the appropriate legal and reparation measures.

[4] AVEGA-AGAHOZO, *Étude sur les violences faites aux femmes*, 1999, p. 33.

[5] Save the Children, *HIV and conflict: a double emergency*, 2002, p. 5.

RWANDA

For 60 days, my body was used as a thoroughfare by all the hoodlums, militia men and soldiers in the district… Those men completely destroyed me, they caused me so much pain. They raped me in front of my six children… Three years ago, I discovered I had HIV/AIDS. There is no doubt in my mind that I was infected during these rapes… Here in the village, we are 200 Hutu and Tutsi women united by the Rwanda Women's Network. It disgusts us to see the treatment given to prisoners in Arusha while we are left to our own devices. We were killed once and we are now dying because of lack of drugs. What did we do to deserve such a punishment? I speak on behalf of my children because I no longer exist. What will happen to my children?

Statement taken from a survivor at the Polyclinic of Hope in Kagugu, prefecture of Kigali.

Genocide, Sexual Violence and Propagation of HIV/AIDS

On June 28, 1994, after the publication of the enquiry report of the former UN Special Rapporteur on Rwanda, René Degni-Ségui,[6] the UN Commission on Human Rights formally acknowledged the Rwandan genocide. In points 43 and 48 of his analysis differentiating categories of massacres, the Special Rapporteur confirmed that it was judicious to refer to the massacres in Rwanda as the genocide of the Tutsis as a social group.

[6] United Nations, Economic and Social Council, *Report on the situation of human rights in Rwanda submitted by Mr. R. Degni-Séqui, Special Rapporteur of the Commission on Human Rights, under paragraph 20 of Commission resolution E/CN.4/S-3/1 of 25 May 1994*, E/CN.4/1995/7, 28 June 1994.

The Commission of Experts created on July 1, 1994 by the UN Security Council confirmed in its report,[7] in accordance with Article II of the *Convention on the Prevention and Punishment of the Crime of Genocide,* that genocide had been committed against the Tutsis and strongly recommended the creation of the International Criminal Tribunal for Rwanda. With respect to women, a later report by Degni-Ségui,[8] submitted on January 29, 1996, revealed the magnitude of the sexual violence during the genocide. The report stated that rape was used as a weapon of war against women aged 13 to 65 and that neither pregnant women nor women who had just given birth were spared, that it was systematic and constituted the rule and its absence, the exception. In the absence of exhaustive investigations, the Special Rapporteur estimated that the figure of 15,700 rapes recorded by the Rwandan Ministry for the Family and the Promotion of Women underestimated the real number because it did not take into account women who had been raped in refugee camps and outside Rwanda's borders.

He added that the absence of data was related to the fact that most of the women who had been raped were reluctant to talk about it. Using the number of women who became pregnant after the rapes (2000-5000) and based on the hypothesis that one hundred cases of rape give rise to one pregnancy, he estimated that between 250,000 and 500,000 women were raped during the genocide. According to many observers, this method of estimating is questionable, although there is consensus that during the Rwandan genocide rapes were committed on a large scale.

We will probably never know the exact number of rapes committed during the Rwandan genocide, just as we will never know the exact number of women who were infected with HIV/AIDS through sexual violence. In any case, the challenge we now face is to respond to the known consequences it has had on its victims.

Point 20 of the above-mentioned report, on the consequences of rape, underscores the extremely troubling situation of victims who contracted sexually transmitted diseases, particularly HIV/AIDS. The Special Rapporteur stated that "the militiamen carrying the virus used it as a

[7] United Nations, Security Council, *Letter dated 1 October 1994 from the Secretary General addressed to the President of the Security Council*, S/1994/1125, 4 October 1994, points 124 and 133.

[8] United Nations, Economic and Social Council, *Report on the situation of human rights in Rwanda submitted by Mr. René Degni-Ségui, Special Rapporteur of the Commission on Human Rights, under paragraph 20 of resolution S-3/1 of 25 May 1994* , E/CN.4/1996/68, 29 January 1996, points 16-20.

'weapon,' thus intending to cause delayed death."[9] In addition, the international organization African Rights, the first to publish a detailed analysis of the genocide,[10] presents HIV/AIDS and other sexually transmitted diseases as the legacy left to women raped during the genocide. Later work focused exclusively on violence against women has shone a clearer light on the nature, breadth, consequences and authors of rape and other physical atrocities inflicted on women. The first large-scale study, written in 1996 by Binaifer Nowrojee,[11] is a joint publication of Human Rights Watch (HRW) and the International Federation of Human Rights (FIDH). The second study is the report by the former UN Special Rapporteur on violence against women, Radhika Coomaraswamy.[12]

It is striking to see how, barely two years after the genocide, HIV infection had officially been noted as one of the consequences related to rape. In addition to the concerns expressed in this matter by Degni-Ségui, the HRW/FIDH report, while admitting the difficulty of proving with certainty that transmission of HIV/AIDS occurred during the rapes, states "Nonetheless, it is certain that some women were infected with the virus as a result of being raped." In addition, based on statements of victims such as Jeanne[13], whose rapist did not hide his ultimate intention when he told her "I have AIDS and I want to give it to you," Radhika Coomaraswamy affirms that "[t]here are many women like Jeanne who survived the genocide only to be left with AIDS."[14] The Special Rapporteur stated that she was "deeply concerned at the lack of medication available for persons with HIV/AIDS, and especially for women survivors who were infected through rape and sexual violence during the conflict."[15]

Pretending HIV/AIDS Doesn't Exist: Reasons for Silence

The burning question is why, when the existence of HIV/AIDS was known, and that without a doubt, it would predispose the victims to cer-

[9] Ibid.

[10] African Rights, *Rwanda, Death, Despair and Defiance*, September 1994, p. 448.

[11] Human Rights Watch/FIDH, *Shattered Lives: Sexual Violence during the Rwandan Genocide and its Aftermath*, 1996.

[12] United Nations, Economic and Social Council, *Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy , Addendum, Report of the mission to Rwanda on the issues of violence against women in situations of armed conflict*, E/CN.4/1998/54/Add.1, 4 February 1998.

[13] Ibid., point 31.

[14] Ibid., point 32.

[15] Ibid., point 84.

tain death, were measures not taken to find out more and care for those who survived the genocide? The statements of the victims interviewed for this study provide part of the answer.[16] Only a small number of rapists told the victims while raping them that they were also transmitting a slow death, in the form of HIV/AIDS.

Several years went by without women suspecting that they had HIV/AIDS. Many women began presenting with signs of the disease between 1999 and 2002. This corresponds to the incubation period for HIV/AIDS, which is estimated to be between three and ten years. It is also important to stress the urgent problems these women were confronted with at the end of the genocide. Physical and psychological injuries had to be tended to, they had to find food to eat, and a place to live, find lost children, etc. The extreme poverty in which women found themselves did not allow them to think further than their immediate situation.

Consolée Mukanyiligira,[17] president of the Association of Genocide Widows (Association de Veuves du Génocide d'Avril – AVEGA-AGAHOZO) sums up the situation this way [translation]: "These women are very vulnerable. They have lost everything, their husbands, their material support. Most of them depended on their husbands, they have no diplomas, nor activities that can generate income. From 1995 to 1997, AVEGA mainly sought emergency assistance: clothing, food, etc. The International Committee of the Red Cross (ICRC) was our main benefactor. Thirty percent of AVEGA's members still do not have a fixed domicile despite efforts to build homes. The need for housing is desperate as are all other primary needs."

However, responsibility for women's health was not solely that of victims and women's groups. It was, above all, the responsibility of the government and of international cooperation organizations. While it is true that Rwanda was dealing with several emergencies at once, it is also true that the health of the women should have been one of its priorities, as they were becoming sick following the rapes, in other words, because of the genocide. They were also caring for thousands of orphans.

It is estimated that in Rwanda, 400,000 children are orphans. Among them, 95,000 are AIDS orphans. Thirty six percent of Rwandan households are headed by women and 60% of them have no income and no

[16] See Appendix: Testimony of women who were victims or rape and HIV/AIDS during the Rwandan genocide

[17] Interviews, Kigali, February 11, 2004.

support. Despite this, it is the women who are building the future of Rwanda. All the women we met in connection with this study are, on average, responsible for five children. The death of one woman can therefore mean that five children will become homeless or be uprooted.

This debate should be situated within the larger context of the right to health, and especially access to HIV/AIDS treatment[18] in poor countries. To understand the silence surrounding the women who were raped and who are living with HIV, we should remember that in January 2004, out of the 500,000 people with HIV in Rwanda, only 2000[19] were receiving triple therapy, which consists of a "cocktail" of three different drugs that block replication of the virus and restore the immune system.

The same situation prevails throughout all of sub-Saharan Africa. Out of 30 million Africans living with HIV/AIDS, UNAIDS estimated that in June 2002, only 30,000 people (0.1%) were receiving treatment. It is also important to remember that on August 31, 2003, after the 21 months of negotiation that followed the Doha Declaration in November 2001, the World Trade Organization finally ratified the agreement on trade related aspects of intellectual property rights (TRIPs) allowing the manufacture, importation and exportation of generic drugs. Before ratification of this agreement, copyright law prohibited poor countries from importing or manufacturing generic drugs. Despite the agreement taking effect and the reduction in the price of antiretroviral drugs, the majority of women do not have the means to access them. In Rwanda, even though the price of antiretroviral treatment was reduced by 200%, i.e., from US$6000 per month in 1999, to US$30 in 2004, treatment remains inaccessible to persons with little or no income.[20]

It should also be noted that voluntary screening centres were basically nonexistent at the time of the genocide and afterwards. In 1998, four years after the genocide, there was only one voluntary screening centre in the entire country.[21] There are now over twenty. However, it should be noted that even though the screening test is free, one still must pay over US$50[22] for laboratory examinations, which excludes many women who have no

[18] Also referred to as antiretroviral treatment.

[19] Amnesty International, *Rwanda: "Marked for Death", rape survivors living with HIV/AIDS in Rwanda*, 2004.

[20] National AIDS Control Commission (NACC), 2002-2006 Rwandan National Strategic Framework for HIV/AIDS Control, November 1, 2002, p. 55.

[21] Ibid.

[22] This estimate was established by Godelième Mukasarasi, president of SEVOTA.

income and those living in the countryside, where the income level is between 2000 and 5000 FRw, or less than US$10.[23]

It was only at the end of 1999, almost five years after the genocide, that the first estimates were made of the number of women infected with HIV after being raped. The study carried out by the Association for Genocide Widows, AVEGA-AGAHOZO, was in fact, at the time, the only reference available and has since been frequently cited, including by the National AIDS Control Policy.[24] Carried out over three prefectures selected on the grounds that the surviving women are representational of the other survivors in the country (Kigali, Butare and Kibungo), the study established that 66.7% of the 491 cases of trauma, illness and other consequences of the rapes were HIV/AIDS-related. Out of the 491 women who had serious sequelae, 327 were HIV-positive. The study concludes that sexual violence was a primary tool of "ethnic cleansing."[25] Since the AVEGA-AGAHOZO study, interest in the subject has continued to mount, as can be seen by recent publications by Save the Children,[26] Amnesty International[27] and African Rights.[28]

Women and Hate Propaganda

Like many other African societies, Rwandan culture is more oral than written. In the context of genocide, ethnic hatred was nurtured without leaving many written traces. This poses two challenges: how to collect evidence and how to interpret a language that uses figures of speech difficult for Western culture to decipher. The ethnic and sexist preconceptions that led to the deaths of Tutsis and moderate Hutus described by the genocide machine as traitors were not set forth in a Rwandan version of *Mein Kampf*.

In the absence of a genocidal plan written by the regime that orchestrated it, the two main scientific texts that contributed to uncovering the ideological basis of the Rwandan genocide were a study of the media[29] and a

[23] Interviews with Godelième Mukasarasi, Taba, February 16, 2004.

[24] AVEGA-AGAHOZO, op. cit., note 4.

[25] Ibid, p. 33.

[26] Save the Children, op. cit., note 5.

[27] Amnesty International, op. cit., note 19.

[28] African Rights, *Broken bodies, torn spirits: living with genocide, rape and HIV/AIDS*, 2004.

[29] Jean-Pierre Chrétien, op. cit., note 3.

structural analysis of the genocide.[30] In Rwanda, the media constituted [translation] "the transductive vector through which the terrible venom of racist ideology was injected."[31]

The only evidence in print, which was used to analyze hatred against Tutsi women, is the *Ten Commandments of the Bahutus* (No. 6, December 1990), published in the infamous newspaper *Kangura*.[32] *Kangura's* role in the genocide was well described during the media trial,[33] which the ICTR qualified as "hate media." At the end of that trial, Hassan Ngeze, editor-in-chief of *Kangura*, and his co-accused were found guilty of conspiracy to commit genocide, of genocide, and of direct and public incitement to commit genocide, and extermination and persecution, all of which constitute crimes against humanity.

In fact, during the period preceding the genocide, and during the genocide itself, certain media, such as *Kangura* and Radio Television Libre des Milles Collines proved to be powerful vehicles of hate and ethnic violence. In his indictment against Hassan Ngeze, the ICTR prosecutor presented the "Ten Commandments of the Bahutus" as "not only an outright call to show contempt and hatred for the Tutsi minority but also to slander and persecute Tutsi women."[34] Stereotyped and stigmatized through the prism of sexuality, Tutsi women, to whom the extremist press attributed sexual prowess, were portrayed as constituting a threat to the homogeneity of Hutu blood. Described as objects of temptation for Hutu men, Tutsi women were thus used as the preamble for a call to ethnic unity of Hutus.

Such a fixation on sexuality set the foundation for ethnic hatred against those women, who were reduced in this case to their sexuality. This raises two conflicting issues according to Rwandan culture. The first is the explicit recognition of the biological reality that women have the power to bring life into the world. The second concerns the term "Nyampinga"

[30] HRW/FIDH, *Leave None to Tell the Story: Genocide in Rwanda*, March 1999.

[31] Jean-Pierre Chrétien, (under the direction of), *Rwanda. Les medias du genocide*, 1995, p. 7.

[32] The HRW report, that of the Special Rapporteur on Violence Against Women, Its Causes and Consequences and the AVEGA-AGAHOZO study all referred to these commandments, particularly the first three related to Tutsi women. For a detailed analysis of the Ten Commandments, see J.P. Chrétien, *Les medias du genocide*.

[33] ICTR, *Judgement and Sentence: The Prosecutor of the ICTR v. Ferdinand Nahimana, Jean-Bosco Barayagwiza, Hassan Ngeze*, ICTR-99-52-T, 3 December 2003.

[34] ICTR, *The Prosecutor of the ICTR v. Hassan Ngeze, Amended Indictment*, ICTR-97-27-I, para. 5.6.

which defines women as citizens without ethnic affiliation because in Rwanda, affiliation is patrilineal.

Although in the case of Rwanda, the term "ethnic group" is not the most appropriate, it is true that a pre-colonization sociological construct has become a political reality. The challenge that today faces leaders and the Rwandan population in general is not to deny this established fact, but to stop using ethnicity to exclude and discriminate.

With respect to women, the fundamental issue consists of questioning the limits of the notion of *Nyampinga*. If women do not belong to any ethnic group, they should not have been subject to so much hate. How can this fear of seeing Hutu men marry Tutsi women be explained? How can it be explained that Hutu women who had married Tutsi men were accused by the *genocidaires* of treason to the Hutu cause, to the point of being subjected to the same torture and horrors as their Tutsi sisters?

Without attempting to vindicate women's right to an ethnic identity, because the problem is not so much one of identity as one of political manipulation, with women as the subject, it must be recognized that in Rwanda one is born Tutsi, Hutu or Twa, according to the ethnicity of the father. Paradoxically, in the context of genocide, women acquired an ethnic identity.

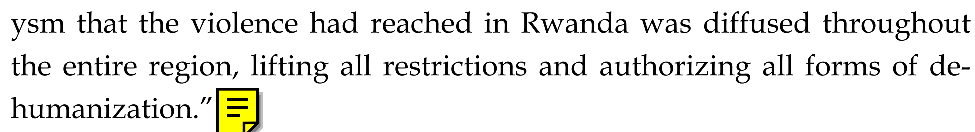
The transmission of HIV/AIDS was a triply effective weapon in the eyes of the *genocidaires*. A woman who had been raped and infected would be a potential source of contamination to her future partners, supposedly Tutsi; she would give birth to children who would have very limited chances of survival; and she would finally die, bringing several others with her.

From Hatred Towards Women to Sexual Violence and HIV/AIDS

Rwanda provides an historic regional precedent respecting violence committed against women in the context of war because of the extent and forms of the sexual violence committed during the genocide. It was also an historic precedent judging from the exportation of the Rwandan model to the rest of the Great Lakes Region and considering how commonplace those practices have become. Colette Braeckman[35] sums up the situation in these words [our translation]: "Everything happened as if the parox-

[35] Colette Braeckman, *Les nouveaux prédateurs. Politique des puissances en Afrique centrale*, Fayard, 2003, p. 163.

ysm that the violence had reached in Rwanda was diffused throughout the entire region, lifting all restrictions and authorizing all forms of dehumanization.”



To understand what this paroxysm consisted of, one must remember that the rapes were often gang rapes and occurred over a long period. Among the women we interviewed, some endured 60 days of rape. The rapes were also accompanied by mutilation and ablation of genital organs. The introduction of sharp and damaging objects or liquids, such as bayonets, knives, tree trunks, boiling water, acid, etc., into the genital organs expressed a hatred and a furious determination to destroy women, to a degree never seen before in that society.

Sexual violence was integrated into a strategy aimed at destroying an ethnic group. As noted by Alison Des Forges,[36] in several localities such as Taba[37] and Kabyayi, political and military authorities organized and supervised the rapes.

Everyone was aware that HIV prevalence was high in urban centres (18%). It was in these centres that the majority of women from the hills gathered, hoping to find protection, and where they were raped. It is clear that the rape would have the murderous consequence of infecting its victims with HIV/AIDS.

Of the 18 interviews conducted as part of the study, only one proves that the rapist had the intention of slowly killing his victim by giving her HIV/AIDS [translation]: “I was raped by two gendarmes …one of the gendarmes was seriously ill, you could see that he had AIDS, his face was covered with spots, his lips were red, almost burned, he had abscesses on his neck. Then he told me ‘take a good look at me and remember what I look like. I could kill you right now but I don't feel like wasting my bullet. I want you to die slowly like me’…”[38]

Proving that these women were infected during the rapes is far from an easy task, especially given that this study is conducted ten years after the genocide. Some facts, such as the abnormally high incidence of HIV/AIDS among women who were raped during the genocide and that the rapists did not wear condoms, show that these organized rapes were, for the majority of victims, vectors of HIV/AIDS. The similar testimony

[36] HRW/FIDH, op. cit., note 30, p. 215.

[37] The October 1998 ICTR judgment (ICTR-1996-4) of Jean-Paul Akayesu former prefect of Taba, is an eloquent example.

[38] Telephone interview carried out on March 17 in Nyanza.

of victims interviewed in Kigali, Taba, Butare and Cyangugu, as well as that taken by telephone in Ruhengeri and Nyanza, led us to conclude that they were infected with HIV/AIDS during these rapes.

Indicators of HIV/AIDS Transmission Through Rapes Carried Out During the Genocide

The abnormally high incidence of HIV/AIDS infection among women raped during the genocide

The official rate of HIV/AIDS prevalence in Rwanda is 13.5%. UNAIDS estimates that out of 500,000 people living with HIV/AIDS in Rwanda, 250,000 are women.[39] With regard to the statistics that demonstrate an equal distribution of HIV/AIDS prevalence among men and women, we must conclude that there is a particular explanation for the fact that women raped during the genocide have a rate of HIV/AIDS infection of between. 66.7%[40] and 80%[41]

According to the Rwandan National AIDS Control Commission, tests performed on 100,000 prisoners linked to the genocide indicate that 13,000 of them, or 13%, are HIV-positive. That rate is identical to the national rate of HIV/AIDS prevalence cited above. The disproportionate level of infection in women who were raped compared with the rest of Rwanda's population can only be explained by the sexual violence inflicted on them.

The Rwandan National AIDS Control Policy states that, through population movement, the war has considerably changed the repartition of HIV/AIDS in the regions.[42] At first, it was an urban phenomenon with around 18% HIV/AIDS prevalence in 1986, while it was 1.3% in the countryside. HIV/AIDS has now become a homogeneous phenomenon affecting urban and rural areas proportionally. In 1997, three years after the genocide, when HIV/AIDS was showing a downward trend in urban areas (at 11.6%), it had climbed in rural regions to 10.8% of the population. The same document recognized that the socio-political crises[43] in Rwanda

[39] UNAIDS/UNICEF/WHO, *Rwanda. Epidemiological Fact Sheets on HIV/AIDS and SexuallyTtransmitted Infections*, 2002.

[40] AVEGA-AGOHOZO, op. cit., note 4.

[41] Save the Children, op. cit., note 5.

[42] National AIDS Control Commission (NACC), op. cit., pp 25 and 37.

[43] Ibid., p. 22.

were often accompanied by violence against women, of whom some were infected with sexually transmitted infections and HIV/AIDS.

If we consider the barbaric manner in which the rapes were committed, barbarism that lasted weeks and even months and that included mutilations and ablation of female genitalia, and if we admit that sexually transmitted infections and other injuries to women's genital organs increases the risk of HIV/AIDS by more than five to ten times,[44] it is understandable why the women who were raped have such a high rate of HIV/AIDS.

The Incubation Period

Out of 18 women interviewed,[45] only four showed signs of the disease between 1995 and 1998. The 14 other women took screening tests between 1999 and 2003 when certain signs of HIV/AIDS began to appear.

These facts reveal two things. Firstly, women underwent screening when they began to notice the first signs of AIDS. In Cyangugu, women who were raped during the genocide and who are living with HIV/AIDS have created a subgroup of AVEGA, called Duhozanye.[46] Of 75 women who were raped, voluntary screening performed between 2001 and 2003 has revealed that, to date, 30 of them are HIV-positive. According to the group’s President, not all of the 75 women have undergone screening and, if the association had the means to reach more women, the number of HIV-positive women could still increase.[47] In fact, only rape survivors living in areas close to the urban centre have been reached. This situation is similar to that of a group of HIV-positive women in Kagagu, coordinated by the Rwanda Women's Network, and a group of HIV-positive women in the district of Save, coordinated by the Duhozanye Association of Butare.

Secondly, 1998 marked the end of the period of doubt and the beginning of knowledge of HIV/AIDS status. The first four years after the genocide, during which the women did not experience HIV/AIDS-related health problems, corresponds to the incubation period of three to ten years es-

[44] Martine David, *Gender Relations and AIDS*, International Cooperation Center for Health and Development, June 1997.

[45] See Appendix: Testimony of women who were victims or rape and HIV/AIDS during the Rwandan genocide

[46] Not to be confused with the Duhozanye Association of Butare, which also brings together genocide survivors.

[47] Interviews, February 17, 2004, Cyangugu.

tablished by the WHO and UNAIDS, and also explains the exponential increase in signs of HIV/AIDS in rape survivors as of 1998.

Rape-Related Health Complications

Injuries and trauma related to the rapes committed during the genocide are indescribable because of the unparalleled levels of violence. Ten years after, women are unable to speak about it without screaming out in pain and disgust. All the victims have talked about the fact that the severity of the injuries, ablations and other mutilations were such that they would never have lived if at that time they did not have healthy immune systems. Therefore, they could not have had HIV/AIDS before the rapes, as their immune systems would already have been compromised.

Many women died during the period of the genocide, victims of rape and other physical violence committed against them. We will never know their exact number. Others died from the same causes after the genocide. According to AVEGA, at least 200[48] members of the association have died of AIDS since 2001.

Children Born Before the Rapes

Of the 18 interviews conducted, 13 women were with mothers who had children before the genocide, one had just given birth, two were young single women and two were minors at the time of the genocide.

All the women who were mothers before being raped and who are living with HIV/AIDS today, state that before the genocide they had given birth to healthy babies. They also state that if they had been affected with HIV/AIDS before the genocide, their babies would not have been healthy. In fact, before the introduction of PMTCT (Preventing Mother-to-Child HIV Transmission) treatment, the risk of infection from mother to child was very high.

It is true that the data compiled by UNAIDS, UNICEF and WHO indicate that in Kigali in 1988, 32% of pregnant women aged between 20 and 24 were HIV-positive, while outside of Kigali the level was assessed at between 8% and 10%.[49] Those statistics lead us to believe that it is more

[48] Amnesty International, op. cit., note 19.

[49] UNAIDS/UNICEF/WHO, op. cit., note 39.

probable that women who were pregnant before the genocide and living outside of Kigali contracted HIV/AIDS through the sexual violence committed during the genocide.

Age at Which Some Women Were Raped

Four of the women interviewed were very young at the time of the genocide. They were virgins, and the brutal rapes committed during the genocide were their first "sexual experiences." Two of them went further in their testimony, stating that after the trauma of the rapes they have never been with another man. They wonder how they could have been infected with HIV/AIDS if it wasn't through rape.

To this category we could add that of women who were relatively older, and who are not generally considered to be at risk, according to the criteria of sexual activity. In Cyangugu,[50] the cases of Immaculée and Thérésie, who died of AIDS last year, aged respectively 57 and 67, who became HIV-positive after having been raped, indicate that rape was the origin of their disease.

Why Did the Rapists Not Use Condoms?

With the exception of one case, all the victims that we spoke with told us they were raped by several men at a time and over several days. None of the men used condoms. The women's testimony is much the same as that of witness J.J. in the Akayesu trial. In the ICTR ruling against Akayesu, the court recognized that rape and sexual violence constitute a crime of genocide. The witness J.J., testified that out of four rapists, only one used a condom. Foregoing condom use was not a common practice. It is highly probable that the average Rwandan, whether peasant, businessperson or soldier, was aware of HIV/AIDS, how it is contracted, transmitted and how to prevent it.

Education and prevention programs were regularly aired on the national radio station, so much so that according to Braeckman,[51] Rwanda was even considered as a "posterchild" in the struggle against HIV/AIDS. In

[50] AVEGA-AGAHOZO, *Rapport d'utilisation du fonds de soutien aux femmes victims des violences*, Sepember 21, 2002 to June 21, 2003.

[51] Colette Braekman, *Rwanda. Histoire d'un genocide*, Fayard , 1994, p. 97.

this African country, having a radio and listening to it almost religiously is part of popular culture.

Unless one wanted to die, how could one participate in a gang rape and even individual rape without protecting oneself? A woman who was violated for 60 days by a horde of bandits, soldiers and militia men, asked how a man who had no doubts about his health could participate in such an ignoble act.[52]

Statistics Don't Tell the Whole Story

The indicators described in the previous paragraph, establishing a link of cause and effect between the rapes committed during the genocide and the infection of rape victims with HIV/AIDS, are not exhaustive. The intention is not to scientifically prove this link but to demonstrate by a balance of probabilities that the link exists and that it is the responsibility of an institution such as the ICTR to assist these women victims.

During a meeting on HIV/AIDS and its gender-based implications, the former gender advisor to the ICTR Registrar, Françoise Ngendahayo,[53] noted that many victims had died before testifying and others were too sick to participate in trials at the ICTR. The advisor also noted that in offloading its function vis-à-vis witnesses and victims, the ICTR has found itself in a situation in which victims and survivors have been, in fact, left to their own devices. She therefore pleaded for a perspective of justice, which, without getting involved in humanitarian assistance, would extend into the five areas,[54] including medical and psychological assistance. Such a vision has the goal of ensuring physical, psychological and social rehabilitation for witnesses, particularly victims of sexual violence and HIV/AIDS.

It is from this perspective that a "programme of assistance for witnesses and potential witnesses" was launched in Taba in 2000, by the former Registrar of the ICTR, Agwu U. Okali. In his inaugural speech, the Registrar stated that, in the future, international criminal justice would have to move towards restitutive justice, with the objective of re-establishing the

[52] Interviews, Polyclinic of Hope, Kagugu, February 13, 2004.

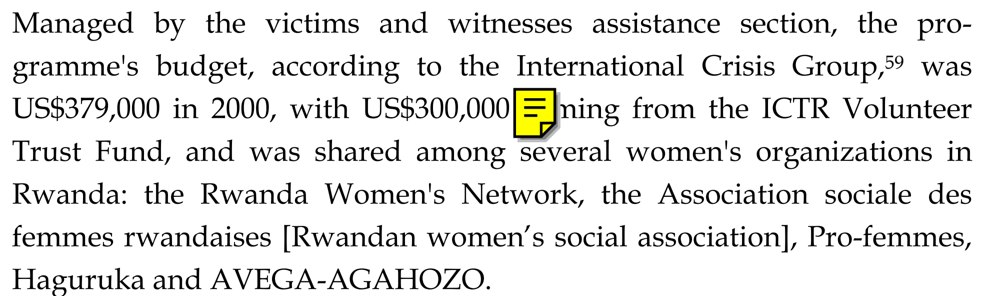
[53] Françoise Ngendahayo, "Gender and HIV/AIDS challenges," Paper presented at the Expert Group Meeting on the HIV/AIDS Pandemic and its Gender Implications, 13-17 November 2000.

[54] *Ubutabera*, No. 29, December 9, 1997.

victim in her situation before the violation took place, based more on the needs of the victim than on the guilt or innocence of the accused.[55]

Despite the nuance established by Agwu Okali, that this programme would not be a programme of economic and social assistance for all Rwandan people, any more than it would be a compensation programme,[56] Jean-Paul Akayesu's lawyers decided to contest its rationale for existence. In a letter dated October 2, 2000, addressed to Agwu Okali, John Philpot and André Tremblay,[57] Akayesu's lawyers, severely criticized the Registrar for several aspects of the initiative, notably the fact that the ICTR did not have the legal mandate to carry out a programme of restitutive justice and that the neutrality of the Registrar was compromised.

The response of the Registrar, speaking of the programme of assistance for witnesses, was based on article 21 of the *ICTR Statute* and rule 34 of the *Rules of Procedure and Evidence*, which, as we will see later, authorizes the provision of support to victims and witnesses for their physical and psychological rehabilitation. With respect to neutrality, the Registrar stressed that neutrality does not mean passivity or the absence of action, any more than impartial services "means no services to anyone."[58]



Managed by the victims and witnesses assistance section, the programme's budget, according to the International Crisis Group,[59] was US$379,000 in 2000, with US$300,000 coming from the ICTR Volunteer Trust Fund, and was shared among several women's organizations in Rwanda: the Rwanda Women's Network, the Association sociale des femmes rwandaises [Rwandan women's social association], Pro-femmes, Haguruka and AVEGA-AGAHOZO.

Nevertheless, although it is innovative, and part of it is dedicated to medical assistance, the programme has not responded to the fundamental need of women witnesses and victims for access to HIV/AIDS treatment. The amounts received were so meagre that they did not even provide access to antibiotics to heal opportunistic infections.[60] The issue of

[55] ICTR, *Press Release: ICTR Launches Victim Support Initiative In Rwanda*, ICTR/INFO-9-2-242, 26 September 2000.

[56] International Crisis Group, "International Criminal Tribunal for Rwanda: Justice Delayed," *Africa Report*, no. 30, June 7, 2001, p. 37.

[57] Letter appended to ICTR/INFO-9-12-017, October 9, 2000.

[58] Ibid.

[59] International Crisis Group, op. cit., note 58.

[60] These infections arise when the body's immune system is weak.

HIV/AIDS treatment remains completely unresolved. One of the principal tests for justice is its ability to adopt reparation measures that, without limiting their scope, guarantee the right to HIV/AIDS treatment for victims of sexual violence.

The need for justice and reparation

The addition of HIV/AIDS to the consequences of the rapes committed during genocide reconfigures the perception of justice and requires entitlement to physical rehabilitation, because, in the absence of antiretroviral treatment and other consequential care, the survivor-victims are virtually sentenced to death.

Enter the right of victims to a remedy for reparation, which is a well-established principle of international law that is recognized in the provisions of many treaties as well as by the courts. In traditional law, the State is liable for reparation of damages caused by a violation of international law.[61] Thus, where a State violates its international obligations and where that violation causes damages to a third party, that State is liable for reparation of the damage caused. The International Court of Justice, created under the Charter of the United Nations, has recognized that the principles of State liability allow the courts to grant compensation to a State on behalf of its nationals who sustain damages caused by another State.[62]

The Sub-Commission on Prevention of Discrimination and the Protection of Minorities, the principal subsidiary organ of the United Nations Commission on Human Rights, is currently formulating the rights of victims to institute actions for reparation for violations of international law. *Basic Principles and Guidelines on the Right to Remedy and Reparation for Victims of Violations of International Human Rights and Humanitarian Law* are in the process of being drafted. This document defines the mechanisms, terms and conditions, procedures and methods for performance of legal obligations currently in force under international human rights and humanitarian law. These principles and guidelines are based not only on notions of State liability but also on the relatively recent concept of "human solidarity with victims, survivors and future human generations." Thus, the

[61] Jean-Maurice Arbour, *Droit international public*, 4th edition, Cowansville, QC, Yvon Blais, 2002, p. 507.

[62] *Case Concerning the Factory at Chorzow* (Claim for Indemnity), P.C.I.J., Series A, No. 17, Sept. 13, 1928.

right of victims to reparation has been broadened in relation to the concept of State liability. A government could be called upon to directly assist the victims of such violations even if it has no liability with respect to those particular violations.

Developments in international law in favour of victims' rights are also confirmed by article 75 (2) of the *Rome Statute*, which allows the International Criminal Court to make an order against a convicted person specifying an appropriate amount of monetary compensation, appropriate reparations and rehabilitation.

Like the *Statute of the International Criminal Tribunal for the Former Yugoslavia* (ICTY), the Statute of the ICTR allows for only one form of reparation, namely material restitution. If the Tribunal "…finds the accused guilty of a crime and concludes from the evidence that unlawful taking of property by the accused was associated with it, it shall make a specific finding to that effect in its judgement" and can order the restitution of that property.[63] However, the material restitution is only one form of the right to restitution and the Statute of the ICTR is limited in that respect.[64] Wherever possible, restitution should restore the victim to her original situation before the violation took place.[65] For a victim of sexual assault, especially those who have contracted HIV/AIDS, restoration to her pre-violation situation is impossible. It is therefore important to note that there are other forms of reparation and that in international law, victims of gross violations of human rights and serious violations of humanitarian law should, as appropriate, and in proportion to the seriousness of the violation and the circumstances of each case, be assured full and effective reparation in all its forms namely, restitution, compensation for all financially quantifiable damages, rehabilitation, satisfaction[66] and assurance of non-repetition, and prevention of recurrence.[67]

[63] See rule 88 B) and rule 105 of the *Rules of Procedure and Evidence*.

[64] See revised *Basic Principles and Guidelines on the Right to Remedy and Reparation for Victims of Violations of International Human Rights and Humanitarian Law* dated 5 August 2004. According to According to point 20, restitution should, as appropriate, include restoration of liberty, legal rights, social status, identity, family life and citizenship, return to one's place of residence and restoration of employment and return of property.

[65] Ibid.

[66] Ibid, point 25. Satisfaction should include, for example, cessation of continuing violations and/or legal or administrative sanctions against the persons responsible for the violations and/or apologies, specifically, public acknowledgement of the facts and acceptance of responsibility and/or commemoration and tributes to the victims.

[67] Ibid, point 26. These are measures taken by national legal systems aimed at preventing a recurrence of violations. For example, measures aimed at ensuring and strengthening, as a priority and on a continuing basis, training in human rights and interna-

In the context of extreme poverty, as is the case in Rwanda, and in the face of crimes which, like sexual assault causing HIV/AIDS, have caused physical and psychological damage resulting in death, victims should be entitled to avail themselves of the clearly stated principle that "rehabilitation should include medical and psychological care as well as legal and social services." [68] The December 2002 report on the consultations organized on this subject concluded as follows: "The need for victims, many of whom come from the least-resourced sectors and groups of society, to be afforded medical, psychological, legal and social services… was seen to be crucial."[69]

The majority of women living with HIV/AIDS are indigent. For those among them who make their living from agriculture, their monthly income is estimated at less than US$10. Faced with a national triple therapy access program, the treatment capacity of which will not exceed 7000 by 2006, these women's chances for eligibility are very poor. It is therefore a matter or urgency to find mechanisms for justice and social rehabilitation that take account of this specific feature.

Therefore, for women living with HIV/AIDS, entitlement to rehabilitation should include not only access to psychological services and triple therapy, among other medical treatments, but also access to a social worker who could counsel them and help them manage the consequences of sexual violence and genocide, such as depression and loss of autonomy. On the other hand, their entitlement to compensation should provide a means for dealing with the socio-economic consequences of violence, such as loss of family income and reduced productivity, thereby enabling them to pay for such things as their children's school fees and rent.

The right of the victims to obtain satisfaction includes legal sanctions for the crimes of sexual violence committed in connection with the genocide, for example the decision rendered by the ICTR in the *Jean Paul Akayesu*

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tional humanitarian law to all sectors of society, including training of the staff responsible for applying the relevant legislation, as well as military and security forces.

[68] United Nations, Economic and Social Council, *The right to restitution, compensation and rehabilitation for victims of gross violations of human rights and fundamental freedoms, Final report of the Special Rapporteur, Mr. M. Cherif Bassiouni, submitted in accordance with Commission resolution 1999/33*,

E/CN.4/2000/62, 18 January 2000, point 24.

[69] United Nations, Economic and Social Council, *The right to a remedy and reparation for victims of violations of international human rights and humanitarian law, Note by the High Commissioner for Human Rights*, E/CN.4/2003/63, 27 December 2002, point 57.

case, or proceedings before Rwandan courts under the *Genocide Act*. As regards the ICTR, it is crucial that the Prosecutor's Office ensure that ICTR decisions reflect the range of sexual violence committed in Rwanda, but also that they broaden the definition of crimes of sexual violence so that the many forms of sexual violence inflicted on Rwandan women are taken into account, for example by categorizing sexual slavery (individual or collective) and rape as forms of torture. The Prosecutor's Office should also attempt to develop a body of case law on the transmission of HIV/AIDS as an element of the crime of rape and a tool of genocide. AVEGA recommends considering the possibility of a class action aimed at managing the care of women who were victims of violence during the genocide and primarily those who are now infected with HIV/AIDS. Entitlement to satisfaction would be connected to entitlement to rehabilitation, because in order to initiate a class action before the Rwandan courts or elsewhere, the women must be ensured of having legal advisors assigned to them. Lastly, in order to provide assurances of non-recurrence and prevention, the Rwandan government should train the staff responsible for the administration of justice and public security (law enforcement, the military) on the rights of women and on crimes of sexual violence in order to put an end to impunity for such crimes and provide justice to women.

The women who testified in connection with this study were unanimous in their condemnation that justice has ignored them. They question the morality of the ICTR feeding and caring for their assailants, while they are left to die in total indifference.

These women are living in the corridors of death. Through their testimonies they pay homage to the high numbers of women who were living in the same conditions and who have already died from HIV/AIDS. In Cyangugu, eight of the 30 members of Duhozanye (an AVEGA-affiliated association of women raped during the genocide and living with HIV/AIDS) died in 2003. At this pace, none of the others will be alive in three years.

Regardless of where they live, Butare, Taba or Kagugu, the testimony of the members of ABASA, SEVOTA and the Rwanda Women's Network reveals the extent to which raped and infected women are dying of HIV/AIDS. The mortality rate among those women is so high that the little funds they can raise must be divided between the costs of hospitalization and the purchase of coffins.

With the realization that they have been forgotten, many of them readily say that they no longer consider themselves part of this world and that they did not testify for themselves, but for their children so that one day they will know that many women were killed and that humanity turned its back. In such a context of denial of justice, it is of the utmost urgency that the ICTR, the Rwandan Government and international cooperation agencies work together to find sustainable solutions if they are to be truly regarded as survivors.

Medical Assistance for Witnesses and Victims Provided by the International Criminal Tribunal for Rwanda

The ICTR is governed by a statute and regulations that allows the Registrar's Office to grant the assistance necessary for the physical and psychological rehabilitation of witnesses and victims. On one hand, article 21 of the Statute of the ICTR, pertaining to the protection of witnesses states "the International Tribunal for Rwanda provides in its rules of procedure and evidence measures for the protection of victims and witnesses. The protection measures include, *without limitation,*[70] the holding of closed hearings and the protection of victims' identities." However, rule 34 of the *Rules of Procedure and Evidence* explicitly states as follows:

A) There shall be set up under the authority of the Registrar a Victims and Witnesses Support Unit consisting of qualified staff to:

    (i) recommend the adoption of protective measures for victims and witnesses in accordance with Article 21 of the Statute;

    (ii) *ensure that they receive relevant support, including physical and psychological rehabilitation,*[71] especially counselling in cases of rape and sexual assault; and

    (iii) develop short term and long term plans for the protection of witnesses who have testified before the Tribunal and who fear a threat to their life, property or family.

Thus, the entitlement of victims and witnesses to the support necessary for their physical rehabilitation is granted by the Registrar's Office without regard to the criminal liability of an accused.

[70] Our emphasis.

[71] Our emphasis.

So that rule 34 can be applied, the ICTR produced and provided the VWSU (Victims and Witnesses Support Unit) with a Manual of Operational Guidance. Based on the challenges specific to the Rwandan genocide, the manual recommends several alternatives that could help to alleviate the life-long consequences of rape and sexual assault.[72] In the paragraph pertaining to physical assistance and psychological rehabilitation of victims of rape and sexual assault, the Manual of Operational Guidance states that it is crucial for a special program to be created within the VWSU to respond appropriately to the needs of survivors and witnesses.[73] The document further stipulates that the VWSU must provide medical and psychological services in strict confidence to the victims and the witnesses who, because of the genocide, are seriously traumatized or have contracted illnesses that they were unable to recover from before testifying.[74]

As seen earlier, the ICTR has all the legal tools to ensure that triple therapy is provided to those witnesses and victims in need of it. Nowhere in the ICTR's own documents is there a stated hierarchy of medical needs for the witnesses and victims. At issue are illnesses and traumas that are the result of rape and other forms of sexual assault, without any distinction.

However, six of the 18 women interviewed individually for this study, 6 testified before the ICTR or provided information in an investigation conducted by the Prosecutor's Office in Rwanda, but only three of them received triple therapy from the ICTR. Two of the other six had their requests refused and one said it was not worth the trouble to ask for triple therapy from the ICTR, because it had already refused to provide the treatment to other women with HIV/AIDS who testified.

It is astounding that the ICTR agrees to defray the costs related to all other illnesses from which these women suffer, but vacillates when it comes to HIV/AIDS. The women who testify in court are treated for things such as opportunistic infections, gynaecological complications and psychological trauma. HIV/AIDS intersects all these ills.

According to unofficial explanations by ICTR representatives, refusal to provide triple therapy to the victims would be based on three main rea-

[72] ICTR, Victims and Witnesses Support Unit, *Manual of Operational Guidance*.

[73] Ibid.

[74] Ibid., p. 51.

sons, namely the ICTR's mandate, its credibility vis-à-vis the defence and the lack of evidence linking sexual violence to the HIV/AIDS status of the victims.

Respecting ICTR Medical Care of Witnesses, Including Access to Triple Therapy

The ICTR has the power to use Rule 34 of its *Rules of Procedure and Evidence* to ensure that witnesses and victims receive HIV/AIDS treatment. In September 2000, in a public announcement[75] concerning implementation of its restitutional justice project, the ICTR stated that this new way of approaching justice included medical assistance for victims and witnesses, the majority of whom were sexually assaulted during the genocide. In response to the comments of the attorneys for Jean-Paul Akayesu to the effect that the Statute of the ICTR did not sanction such a programme and that the neutrality of the Registrar was compromised in such circumstances, the former Registrar, Agwu Okali, justified the assistance programme for witnesses and potential witnesses by invoking Rule 34.

In 2002, on the advice of the United Nations Office of Legal Affairs in New York, the programme was the subject of reorientation: The Court "… will now provide legal, psychological and medical assistance to *witnesses* testifying before the Tribunal."[76] This interpretation of Rule 34 ensured that the Court would no longer provide assistance to victims who were not called to testify. However, the testimony obtained in connection with this study, reveals the tendency of the Court to back-peddle when it comes to the right of witnesses to have access to triple therapy. According to the Court, the medical assistance provided to witnesses does not include access to triple therapy because HIV/AIDS in an incurable disease and when the Tribunal's mandate ends in 2010,[77] the ICTR would not be able to continue to provide HIV/AIDS treatment.

[75] ICTR, *Press Briefing by the Spokesman for the* ICTR, ICTR/INFO-9-13-016, 19 September 2000.

[76] Our emphasis. United Nations, General Assembly, Security Council, *Report of the International Criminal Tribunal for the Prosecution of Persons Responsible for Genocide and Other Serious Violations of International Humanitarian Law Committed in the Territory of Rwanda and Rwandan Citizens Accused of Genocide and Other Such Violations Committed in the Territory of Neighbouring States between 1 January and 31 December 1994*, A/57/163-S/2002/733, 2 July 2002, point 89.

[77] In its Resolution 1503 (2003), the Security Council requested the ICTR to complete its investigations by the end of 2004, hold all trials at first instance by the end of 2008, and terminate its work in 2010.

The creation of the Victims and Witnesses Support Unit(VWSU) constitutes a precedent[78] in the history of the United Nations, because the UN realized that it was necessary to meet the particular needs inherent in the issues involved in the Rwandan and Yugoslavian situations. Furthermore, the operations of the ICTR's VWSU differ from those of the ICTY because of the specific problems posed by the Rwandan genocide.[79] Thus, as HIV/AIDS is a pandemic and Rwandan genocide accelerated the spread of HIV the disease, it is all the more crucial that the VWSU address this issue so as to provide justice to Rwandan victims of rape and other sexual assaults. In light of the serious consequences such as failing health, loss of autonomy and depression caused by rape and HIV/AIDS, it is essential for the women who testify before the ICTR to have access to antiretroviral treatment.

Further, only a handful of women raped during the Rwandan genocide testified before the ICTR. The argument to the effect that there would have been a rush of witnesses seeking HIV/AIDS drugs were the ICTR to grant the victims and witnesses access to HIV/AIDS treatment, is unfounded. Not all women who were raped contracted HIV/AIDS and not all women living with HIV/AIDS meet the criteria for being witnesses. Moreover, the fact that the women persisted in testifying, despite the refusal of the ICTR to grant antiretroviral treatment to the majority of them, implies that their primary motivation for cooperating with the Tribunal was not access to treatment, but the search for the justice. If the ICTR provided care and services other than triple therapy to the witnesses and victims and if the defence were amenable, the defence's objection to witnesses and victims receiving triple therapy no longer has any basis. It is a fact that the ICTR provides alleged *genocidaires* with access to antiretroviral treatment. The experts formulating the right to reparation observed that victims were "…often treated by legal systems with less dignity and compassion than perpetrators."[80] The ICTR should therefore not use the excuse that it will attract criticism from the defence as grounds for denying the same right to the victims, i.e., access to antiretroviral treatment, that it grants to the accused. It is the ICTR's responsibility to decide the issue of access to HIV/AIDS treatment because even in restricting its mission to simply trying the accused, accomplishment of that mission is in-

[78] ICTR, Manual of Operational Guidance, op cit., note 72.

[79] Ibid.

[80] United Nations, Economic and Social Council, op. cit., note 69, p. 9.

conceivable without witnesses. It is therefore in the interests of the Prosecutor's Office of the Tribunal to preserve the health of witnesses.

In its last annual report, the ICTR announced that the Registrar had "recently recruited three medical experts for ICTR in Kigali, comprising a gynaecologist, a psychologist and a nurse-psychologist, to improve access to and monitoring of medical support for victims and witnesses, including in relation to the management of HIV/AIDS." [81] This recent initiative is positive and we trust that it presages a policy change regarding the Court's medical management of witnesses and victims of sexual violence who have HIV/AIDS.

The Court cannot hide behind the terms of its mandate to explain its refusal to allow access to HIV/AIDS treatment. The Voluntary Trust Fund created by Resolution 49/251 of July 20, 1995 of the UN General Assembly, is a fund with an unlimited term. Supplementing the regular budget of the ICTR, the fund is oriented towards financing the activities of several key sectors, including the Victims and Witnesses Support Unit. If it were to be better endowed, it would guarantee the long-term needs of witnesses *and victims*[82], including for HIV/AIDS treatment. It is therefore of paramount importance that the Fund's budget be applied, on a priority basis, to achieving that objective, and that the Registrar's Office adopt a strategy to convince States to increase their monetary contributions.

Compensation of Victims of the Rwandan Genocide by the ICTR

The Tribunal stated its position regarding the broader principle of compensation of victims as follows: "The Tribunal agrees with the principle of compensation for victims, but […] under the terms of its Statute, it cannot meet this expectation and that the subject of compensation to victims can be more appropriately addressed by the international community in general and by the Security Council in particular." [83]

This interpretation of the ICTR's mandate is a restrictive vision of the concept of justice and indicates a lack of commitment to the question of

[81] United Nations, General Assembly, Security Council, *Report of the International Criminal Tribunal for the Prosecution of Persons Responsible for Genocide and Other Serious Violations of International Humanitarian Law Committed in the Territory of Rwanda and Rwandan Citizens Responsible for Genocide and Other Such Violations Committed in the Territory of Neighbouring States between 1 January and 31 December 1994*, A/59/183-S/2004/601, June 2004, point 60.

[82] Our emphasis.

[83] United Nations, General Assembly, Security Council, op. cit., note 64, points 90-91.

the reparation of Rwandan victims. Although the *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of Humanitarian Law* are still in the process of formulation, the ICTR nevertheless had the latitude to use the *Basic Principles and Guidelines* to interpret its mandate regarding the compensation of victims. Intended on a priority basis for States and non-State participants, the principles could be applied by any other institution responsible for administering justice. In raising the right of victims to a remedy and reparation based on social and human solidarity,[84] the principles allow for innovation by extending the notion of reparation beyond the determination of criminal liability. Thus, as an international institution, whose mandate is to obtain justice for the victims of Rwandan genocide, the Court should develop a strategy for compensating victims and their dependants, in collaboration with the United Nations, the Rwandan government and members of the international community.

As the 8th Annual Report of the ICTR states, creation of a special Trust Fund for the victims of genocide in Rwanda would be desirable as would be the creation of an advisory group responsible for finding the ways and means to ensure that sustainable rehabilitation of witnesses and victims survives termination of the Court's mandate.[85] The idea of creating such a fund is supported by many NGOs and prominent people. It has been defended by Ms. Najat Al Hajjaji,[86] President of the 59th Session of the UN Commission on Human Rights, as well as by the International Crisis Group.[87] It is essential that the Fund take into account the needs of witnesses and victims of sexual violence who have contracted HIV/AIDS as a result of such acts. There is an urgent need to create this fund to benefit the women survivors of genocide who are living with HIV/AIDS, before they die.

Creation of the fund is all the more important given that Rwanda is one of the ten poorest countries in the world and that 60% of its citizens live

[84] Op. cit., note 64, see Preamble.

[85] United Nations, General Assembly, Security Council, *Report of the International Criminal Tribunal for the Prosecution of Persons Responsible for Genocide and Other Serious Violations of International Humanitarian Law Committed in the Territory of Rwanda and Rwandan Citizens Responsible for Genocide and Other Such Violations Committed in the Territory of Neighbouring States between 1 January and 31 December 1994*, A/58/140-S/2003/707, 11 July 2003, point 71-72.

[86] ICTR, Press Release, *The President of the UN Human Rights Commission to Lead a Campaign to Support Victims*, ICTR/INFO-9-2-363, October 7, 2003.

[87] ICG, op. cit., note 56, pp. 37 to 41.

on less than one dollar a day. There is very little likelihood that the victims and witnesses living with HIV/AIDS will be cared for by the Rwandan health care system. The only procedure created by the Rwandan government to help the survivors of genocide is the Fonds d'aide aux rescapés du génocide (FARG) [genocide survivors' assistance fund]. Victim support provided by the Rwandan government is estimated at 5%[88] of its national annual budget. Inspired by the right to reparation, specifically by the need for States to create national victims' compensation funds, as recommended by the United Nations Commission on Human Rights,[89] the FARG covers several basic needs, including providing schooling for orphans and lodging for widows. It does not ensure universal access to health care, never mind access to HIV/AIDS treatment.

The issue of material compensation of victims by the Rwandan courts is not related to a mandate but rather to financial means. In 2001, the International Crisis Group estimated that after only 4000 persons were prosecuted and judged, the Rwandan courts granted close to US$100 million in damages to victims. However, not one cent has been paid out, the principal reason being the indigence of the accused. [90]

If the ICTR adhered to Rule 106[91] of its *Rules of Procedure and Evidence,* which recognizes the entitlement of victims to compensation but at the same time discharges it from performing this responsibility by referring the victims to a forum of national jurisdiction or any other institution of competent jurisdiction for reparation, the cases where victims requiring psycho-medical care would have their rights respected in connection with compensation are rare, even non-existent. Where the persons found guilty by the ICTR are not indigent, it is the responsibility of the Victims and Witnesses Support Unit, according to Rule 34 of the *Rules of Procedure and Evidence*, to provide advisory services, which in this case could result

[88] ICTR, Press Release, *ICTR Registrar Seeks Support of the African Community*, ICTR/INFO-9-2-343.EN, 9 May 2003.

[89] United Nations, Economic and Social Council, op. cit., note 68.

[90] Ibid, p. 39.

[91] Rule 106 of the *Rules of Procedure and Evidence* reads as follows:
(A) The Registrar shall transmit to the competent authorities of the States concerned the judgement finding the accused guilty of a crime which has caused injury to a victim.
(B) Pursuant to the relevant national legislation, a victim or persons claiming through him may bring an action in a national court or other competent body to obtain compensation.
(C) For the purposes of a claim made under Sub-Rule (B) the judgement of the Tribunal shall be final and binding as to the criminal responsibility of the convicted person for such injury.

in initiating legal proceedings to obtain compensation in Rwanda or elsewhere should the possibility arise.

Recommendations to the ICTR

- The ICTR should, as a matter of urgency, adopt a policy on access of victims and witnesses to antiretroviral treatment and related care. To do this, it should comply with the following:
  - the recommendations set forth in the Manual of Operational Guidance, especially as regard to interpreting the mandate of the Victims and Witnesses Support Unit, which explicitly addresses support to rape victims and sexual assault in terms of physical and psychological rehabilitation;[92]
  - the main features of the assistance program for witnesses and victims, as targeted by the Manual of Operational Guidance, which specifically include medical services;
  - Rule 34 of the ICTR's *Rules of Procedure and Evidence,* which recommends that victims and witnesses be provided with the assistance necessary for their physical and psychological rehabilitation, in particular through advice and counselling in the case of rape and sexual assault;
  - the UN's draft *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Laws and Serious Violations of Humanitarian Law*. These principles concern the reparation of physical or moral damage and call for medical and psychological care of victims as well as access to legal and social services.
- The investigation team of the ICTR Prosecutor's Office, specifically the gender crimes unit, should conduct a detailed investigation into the relationship between HIV/AIDS and the sexual violence and use the results of the investigation to develop a body of case law on the transmission of HIV/AIDS as a weapon of genocide.
- The ICTR should adopt measures so that on termination of its mandate, some other umbrella organization that includes international, bilateral or multilateral organizations like WHO, UNAIDS, the UNDP,

[92] ICTR, Witnesses and Victims Unit, op. cit., note 72, p. 41.

the European Union or the African Union, take over the medical care of victims and witnesses, as well as persons approached by the prosecution in the investigation phase who were called to testify. To do this, the Registrar's Office should adopt a strategy of asking States to increase their voluntary monetary contributions to the Fund.

- Compensation of the victims of Rwandan genocide and their dependents can be assured by a Trust Fund for assistance to victims. It is important and urgent that the ICTR approach all UN member countries and financial donors, in order to create such a fund.

The Role of the Rwandan Government

To replace old structures designed to battle HIV/AIDS, a National AIDS Control Commission was created in November 2000, with its principal task being to provide the country with a national HIV/AIDS policy. The 2002-2006 National Strategic Framework for HIV/AIDS Control as well as the 2002-2004 Multisectoral National Plan created by this Commission are the government's main policy tools.

The national HIV/AIDS control policy was conceived from a gender-based perspective.[93] It is based on five values and guiding principles including equity and respect for gender specificity. Out of five strategic intervention axes of the National Strategic Framework for HIV/AIDS Control, the fourth is "to strengthen measures for poverty reduction and integrate poverty/gender/HIV dimensions in HIV/AIDS control." The policy also acknowledges that there are substantial differences in the way the pandemic affects male and female populations and that the national response, in its strategies for education, medical care and reduction of the impact of HIV/AIDS, must take gender issues into consideration.[94] In a paragraph on the social impact of HIV/AIDS, the policy clearly states: [translation] "Given that 70% of the women raped during the genocide are HIV-positive, it can be concluded that there is need for the social management of these families and their orphans."[95]

[93] National AIDS Control Policy, op. cit., note 20, pp. 68-69.

[94] Ibid., pp. 22-24.

[95] Ibid., p. 53.

Lastly, the Rwandan government has agreed to take into account special conditions, including those related to the effects of war and genocide, on women, orphans and other groups considered as being vulnerable.[96]

Inadequacy of Resources

However, the national policy contrasts with the reality of the women encountered in connection with this study, just as it contrasts with the right to health of 13.5% of the Rwandan population living with HIV/AIDS. It should be noted that out of 500,000 people living with HIV/AIDS and requiring triple therapy, only 7000[97] of them will have access to the therapy by 2006.

Foreign aid accounts for 96% of the Rwandan national budget. In 2000, the net total of public development assistance received by Rwanda was US$322 million.[98] According to the UNDP, 84% of the Rwandan population lives on US$2 a day, with a life expectancy at birth of 40 years.

Such a picture illustrates the operational limits of the government with respect to public spending, including health spending. It also contributes to an understanding of why only an infinitesimal minority of persons with HIV/AIDS benefit from triple therapy. Out of 30 women interviewed for this study, and apart from three whose medication is taken care of by the ICTR, only one has been on antiretroviral treatment for a year, and she pays for it herself. [99]

Rose Mukamusana,[100] the person in charge of the Programme d'appui aux personnes infectées (PAPI) [Support programme for infected persons] managed by AVEGA- AGAHOZO, states that only one out of 30 members of AVEGA have access to triple therapy. Twenty have access through funding by two international NGOs, one British (Surf), and the other Dutch (the Hildegarde Von Bingen Foundation). The ten others have access under a government program. However, at least 800 women who frequent AVEGA- AGAHOZO need access to treatment.

[96] Ibid., pp. 69-70.

[97] Interviews with Jean Gatana, National AIDS Control Commission, Kigali, February 13, 2004.

[98] UNDP Human Development Report 2002, p. 205.

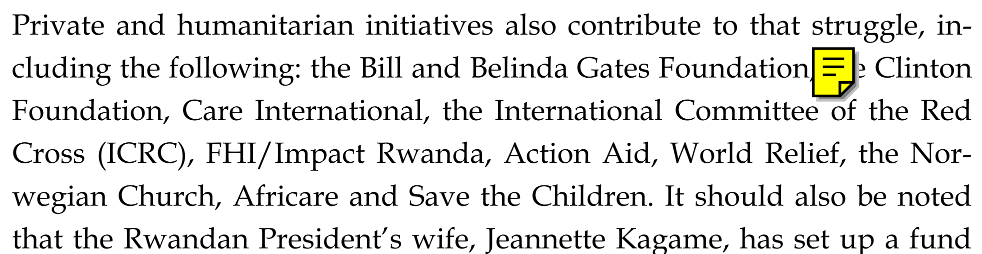
[99] Interviews conducted in Taba on February 16, 2004.

[100] Interviews conducted in Kigali on February 12, 2004.

At the Polyclinic of Hope, coordinated by the Rwanda Women's Network, none of the women have access to antiretroviral treatment. Mary Balikungeri,[101] Executive Director, commented on the difficulty of convincing donors to provide antiretroviral treatment. Because of lack of funding, the Polyclinic of Hope can only provide drugs to counter opportunistic infections. Women die because the Polyclinic is powerless. Mary Balikungeri bitterly recounted the frequency with which groups of investigators came to question victims but left without doing anything for them. She emphasized that the greatest danger is to ignore the victims for whom all these investigations were supposedly conducted.

This feeling of discontent has also been expressed by the spokesperson for Duhozanye: [translation] "We are tired of always saying the same thing. We have testified, but no-one has answered our call for help. We have been dropping like flies without anyone coming to our rescue, neither the government, nor the international aid organizations. Many of us have died. We need help now, tomorrow is too late."[102]

According to the Rwandan policy document on the fight against HIV/AIDS, there is working capital of FRw82 million to make antiretroviral treatment available.[103] Bilaterally, the American, Belgian, Luxembourger, Swiss, French, German, Canadian, British, Italian and European Union cooperation agencies contribute financially to the Rwandan national policy. Multilaterally, UN agencies like UNAIDS, the UNDP, UNICEF, the United Nations Population Fund (UNPF), WHO, United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Bank (WB), the Office of the United Nations High Commissioner for Refugees (UNHCR), the World Food Program (WFP) and the Economic Commission for Africa specifically participate in the Rwandan fight against HIV/AIDS in the form of donations and loans.



Private and humanitarian initiatives also contribute to that struggle, including the following: the Bill and Belinda Gates Foundation, the Clinton Foundation, Care International, the International Committee of the Red Cross (ICRC), FHI/Impact Rwanda, Action Aid, World Relief, the Norwegian Church, Africare and Save the Children. It should also be noted that the Rwandan President's wife, Jeannette Kagame, has set up a fund

[101] Interviews conducted in Kigali, February 12, 2004.

[102] Interviews conducted in Cyangugu on February 17, 2004.

[103] National AIDS Control Policy, op. cit., note 20, p. 55.

devoted to the fight against HIV/AIDS. According to UNAIDS, the fund managed by the Rwandan First Lady has a budget of $US750,000 over three years.

These partnerships, while impressive at first glance, must however be analyzed in light of vast HIV/AIDS-related needs. The funds raised are not allocated solely to the purchase of drugs. In a context of post-conflict poverty, HIV/AIDS has many social and economic consequences, including a negative impact on the active population and on productivity, an increase in the number of orphans and a nursing crisis. For this reason, the Rwandan policy, like all policies of African countries dealing with a high incidence of HIV/AIDS, is a global and therefore costly policy, which takes into account the multiple medical, social and economic consequences of the HIV/AIDS pandemic.

All partners, regardless of whether they are private, bilateral, multilateral or humanitarian, choose an intervention sector on the basis of their particular expertise or vocation. Thus, USAID, UNESCO and Swiss cooperation agencies finance HIV/AIDS awareness and prevention activities, particularly among the young. Some, like UNICEF, finance the prevention of mother to child transmission (PMTCT). Others, like the UNDP, fund micro-projects with a view to reducing the socio-economic impact of HIV/AIDS. Lastly, others, like the Office of Rwanda's First Lady, provide assistance to widows and orphans.

Problem of coordination

The increase in donors undoubtedly reflects international HIV/AIDS awareness, but the mobilization of funds is still inadequate to meet needs. It is also important to note that this increase in donors also raises problems of coordination regarding the management of a national fund devoted to the fight against HIV/AIDS.

Even if the National AIDS Control Commission (NACC) has instruments of operationalization, namely the 2002-2006 National Strategic Framework for HIV/AIDS Control as well as the 2002-2006 Multisectoral National Plan, it recognizes that [translation] "the financing of activities focused on controlling HIV/AIDS is operated without transparency and in an unsatisfactory manner." [104]

[104] Ibid., p.104.

Among its weaknesses, the NACC noted the absence of reliable data on the level of contributions and in the choice of strategic orientations and fields of intervention of the many donors even though they have been involved in battling HIV/AIDS for more than a decade. [105]

Regarding the allocation of funds, the NACC notes that the procedure was not harmonized and was poorly documented until 2002, the year it was created.[106] It specifically notes a significant administrative burden and argues in favour of fast-tracking procedures to facilitate access of stakeholders to financing for HIV/AIDS-related projects and the implementation of a review process covering the terms and conditions for funds allocation[107] as well as the creation of the Central Funds Management Unit,[108] an independently managed para-governmental body.

High Costs of Triple Therapy and the Exclusion of Women

Although lack of coordination impedes carrying out the Rwandan plan to fight HIV/AIDS, it is far from being the primary cause of antiretroviral treatment being inaccessible to patients. This inaccessibility is basically related to an inadequacy of resources and to the excessively high cost of triple therapy.

In a document on the use of antiretroviral treatment, Rwanda's Ministry of Health[109] stated that the social constraints and the high costs of the treatment forced it to tighten the eligibility conditions for antiretroviral treatment. Patients whose stage of illness is considered advanced or who present with serious symptoms are considered high priority. It should also be noted that prescriptions for antiretroviral treatment are given solely in the following certified hospitals: the University Hospital in Kigali, the Military Hospital in Kanombe, the King Faycal Hospital in Kigali, the TRAC Referral Clinic and the University Hospital in Butare.[110] Getting to major hospitals is an obstacle for the majority of women with

[105] Ibid..

[106] Ibid., p. 105.

[107] Ibid., p. 106.

[108] Ibid., pp. 108-109.

[109] *Guide d'utilisation des médicaments antirétroviraux chez l'adulte and l'enfant* [antiretroviral drug use guide for adults and children], Ministry of Health, Treatment and Research on AIDS Centre, 2003.

[110] Ibid.

HIV/AIDS, who live in remote areas far from them and who find the costs of medical consultation too high.

A degree of healthy scepticism is in order with respect to the criteria of the Ministry of Health when it explains that [translation] "… socio-economic criteria are key and are positive discrimination criteria and not criteria of exclusion, because the patients' financial participation in the monthly costs of their treatment is mandatory for any patient who does not have a *certificate of indigence*…"[111]

None of the women interviewed receives antiretroviral treatment from the government. However, with the exception of three witnesses, all are indigent and are cared for by government-recognized women's associations. Out of three women with an income, only one pays for her antiretroviral treatment. In her case, it is at the expense of other basic needs, specifically caring for the ten orphans in her charge. The two other women have paid employment but their incomes are insufficient to defray the costs of antiretroviral treatment.

Recommendations to the Rwandan Government

- The Government should comply with its national HIV/AIDS policy, which recognizes that the women who were raped and who are living with HIV are victims twice over and should receive special attention. To do this, the government should, in collaboration with associations of genocide victims and survivors and bilateral and multilateral partners, formulate a plan of action aimed at providing antiretroviral treatment to women who were raped and are living with HIV/AIDS.
- The government should ensure that women who have a certificate of indigence are eligible for access to the antiretroviral treatment program.
- The Fonds de lutte contre le sida [HIV/AIDS control fund] managed by the First Lady's Office, should, in accordance with national policy principles and orientations and in collaboration with women's associations, ensure that medical care and treatment is provided to the women who were raped and who are living with HIV/AIDS.

[111] Ibid., emphasis ours.

- The government should ensure that women living in regions far from urban centres benefit from all services, including HIV/AIDS treatment and access to antiretroviral treatment.

Humanitarian Organizations and International Cooperation

Doctors without Borders

In a context where the majority of the population and 82%[112]of the women are faced with problems of accessibility to health centres and health care, it becomes urgent to increase cooperation initiatives like those initiated by Doctors without Borders. Moreover, this incidence (82%) is concordant with the AVEGA- AGAHOZO study on violence against women, which indicates that in 1999, only 6% of the women questioned had consulted a doctor since the genocide and 71% of the victims desired medical assistance.[113]

Médecins sans Frontières [Doctors Without Borders]-Belgium conducted two projects in Rwanda, providing HIV/AIDS treatment without the need for sophisticated infrastructures. Two public health centres in Kinyinya and Kimironko are currently operational, and another one in Kagugu is on the verge of being operational. These three health centres cover 22%[114] of the total population of Kigali, namely 132,812 residents out of a total of 609,000.

Pursuant to an agreement signed with the Ministry of Health, MSF-Belgium has undertaken to provide antiretroviral treatment and medical care to 500 persons over five years. In an interview we had with Ms. Helena Hellqwist,[115] attending physician at the Kimironko Centre, she stated that the frequently cited problem of lack of infrastructures and equipment is not a genuine problem. She adds that pilot projects like that in Kimirinko, show that with a little more commitment, accessibility to antiretroviral treatment can be increased. The experience of these pilot projects show that the local paramedical staff working in public health centres are fully equipped to meet the challenge. The major problem is the funding of such projects.

[112] National AIDS Control Policy, op. cit., note 20, p. 27.

[113] AVEGA-AGAHOZO, op cit., note 4, pp. 41-42.

[114] Médecins sans Frontières, Belgium, Rwanda Activity Report 2003, p. 6.

[115] Interviews granted on February 12, 2004, in the Kimironko health centre.

Recommendations to Humanitarian and International Cooperation Agencies[116]

- Finance more projects devoted to strengthening the operational capacities of health centres. The more the health centres develop a program of medical care for persons with HIV/AIDS, the better will be the chances for women to receive care.
- Throughout the entire country, carry out initiatives like those of Doctors Without Borders, which work in cooperation with certified health centres. The more numerous the health centres that dispense the triple therapy, the higher the numbers of women that will be reached.
- Increase and/or start HIV/AIDS treatment funding projects. The women encountered are members of groups of genocide widows or survivors. For SEVOTA, the Rwanda Women's Network, AVEGA, ABASA or Duhozanye, the lack of funding for HIV/AIDS treatment considerably handicaps survival of the victims.
- Integrate access to antiretroviral treatment in development or anti-poverty projects. It is important that international solidarity NGOs incorporate the problem of HIV/AIDS in their work.

Coalition for Women's Human Rights in Conflict Situations[117]

- The Coalition should encourage its members and the NGOs working in related fields to conduct more research with a view to building a body of case law on the issue of reparations in relation to wartime rape and HIV infection.

[116] The international NGOs working in Rwanda and humanitarian organizations such as the International Committee of the Red Cross (ICRC), Doctors Without Borders and Médecins du Monde should be added to the list of donors mentioned in earlier.

[117] The mandate of the Coalition for Women's Human Rights in Conflict Situations, coordinated by Rights & Democracy, is to ensure that crimes committed against women in conflict situations are adequately examined and prosecuted. The Coalition seeks solutions to the invisibility of women's human rights abuses in conflict situations, to condemn the practice of sexual violence and other inhumane treatment of women as deliberate instruments of war, and to ensure that these are prosecuted as war crimes, torture, crimes against humanity, and crimes of genocide, where appropriate. Working at the local and international levels, Coalition members act as a resource for consultation and debate on substantive issues related to the integration of a gender perspective in post-conflict transitional justice systems. Coalition efforts also seek to strengthen international and regional capacity to monitor the respect of women's human rights in conflict and post-war situations through the creation of appropriate mechanisms of accountability and the assessment of their transferability to other contexts. The main focus of the Coalition's work is to promote the adequate prosecution of perpetrators of crimes of gender violence in transitional justice systems based in Africa, in order to create precedents that recognise violence against women in conflict situations and help find ways to obtain justice for women survivors of sexual violence.

- The Coalition, in collaboration with Rwandan women survivors groups and other associations concerned with the rights of women who testify before the ICTR, should ensure that the ICTR *fully respects* the rights of victims and witnesses to physical and psychosocial rehabilitation.
- The Coalition should form a committee to follow up the recommendations put forward in this study. Such a committee should be comprised of persons from the international movement for access to triple therapy, international organizations like Amnesty International and Human Rights Watch, which are focused on the Rwandan situation, and Rwandan women's associations concerned with the issue of rape and HIV/AIDS.
- The Coalition should develop an advocacy strategy and contact multilateral and bilateral agencies for a response to the issues raised in this study.

Rwandan Women's Rights Associations

- As AVEGA-AGAHOZO suggested in its study on violence against women, a class action lawsuit to ensure [our translation] "medical care of women who were victims of violence committed against them during the genocide and especially the care of women infected with HIV/AIDS[118] is an idea that merits consideration by the Rwandan courts and the ICTR. Using that study and recent reports written on this topic by Save the Children, Amnesty International, and African Rights provide the momentum to apply to the Rwandan courts.
- The women raped during the genocide and living with HIV/AIDS and supported by Rwandan women's rights associations should organize into a National Committee and demand that, in accordance with its national policy, the Rwandan government ensure their access to medical care, specifically access to antiretroviral treatment.
- Associations of genocide survivors and widows should provide information to indigent women members so that they can benefit from the national program for access to antiretroviral treatment.

[118] AVEGA-AGAHOZO, op. cit., note 4, p. 56.

THE REGIONAL CONTEXT IN AFRICA

"I've been in the UN Envoy role now for three years. To visit Africa repeatedly, and to observe the unravelling of so much of the continent, is heartbreaking…There are simply no words, in the lexicon of non-fiction, to describe the human carnage. I have heard, from African leaders and social commentators alike, language that startles and terrifies: 'holocaust', 'genocide', 'extermination', 'annihilation', and I want to say that on the ground, at community level, watching the agony, the language is not hyperbolic… The disproportionate numbers of women infected in Africa, requires a similarly disproportionate access to treatment. It is matter of bewildering shame that even an insatiable pandemic, malevolently targeting women, has failed to demonstrate, once and for all, the size of the gender gap, and the deadly risk we run by failing to close it." Stephen Lewis, in a speech he made after receiving the Health and Human Rights Award from the International Council of Nurses, July 12, 2004, in Geneva.

Armed Conflict and the Spread of HIV/AIDS

Armed conflict has dominated the African political landscape since decolonization, with the continent experiencing 80 coups d'états, 75 armed conflicts and about 40 civil wars.[119]

In 2001, the President of the ICRC[120] estimated that of the most serious armed conflicts in the world, 11 were taking place in Africa, the only region that has experienced a significant increase in numbers of armed conflicts since 1995. This trend continued in 2004. Almost 20 countries are

[119] "Instabilité en Afrique", *Fraternité Matin*, Abidjan, Côte d'Ivoire, January 16, 2004.

[120] Jacob Kellenberger, *L'action humanitaire dans les conflits armés actuels: contexte et besoins*, Speech presented in Zurich on January 25, 2001, at the Dolder-Meeting.

still involved in bloody confrontations. During the Special Session on HIV/AIDS in June 2001, the UN admitted that armed conflict and natural disasters have contributed to the propagation of HIV/AIDS, and that refugee and displaced populations, especially women and children, are more exposed to the risk of infection.[121]

Economic and social infrastructure such as schools, water conveyance systems, health centres, dispensaries, hospitals and communication networks, without which a government cannot provide social services, are commonly the targets of attacks. In Sierra Leone, 62%[122] of health centres were not operational after the war. Judging from the portion of the international assistance budgets devoted to the reconstruction of socio-economic infrastructures, the situation is similar in Burundi, Angola and the Democratic Republic of Congo. The collapse of political and socio-economic regulatory institutions engenders the collapse of government intervention, undermining the ability of the public to take care of itself. But battling HIV/AIDS requires a good organizational and operational capacity, above all. It is the responsibility of the State to run prevention programs, to target risk groups and to take care of people living with HIV/AIDS. This requires the existence of a government that has the means to act and is responsible, both difficult to guarantee in the context of war.

The situation in Burundi is an example of the very close link between war, impoverishment of the population and the difficulty of asserting the right to health. A report by MSF Belgium,[123] made public on May 6, 2004, demonstrates that ten years of civil war in the country has not affected the population through political violence alone. Although the erosion in the government's ability to ensure primary health needs is related to the war, it is also the result of the World Bank and the International Monetary Fund's imposition of a cost-recovery policy for health services, at a time when 99% of the population lives below the poverty line, with an average income of US$1 per day. The policy has had the consequence of denying most Burundians the right to health.

[121] United Nations, General Assembly, Declaration of Commitment on HIV/AIDS, A/RES/S-26/2, June 2001.

[122] René Bennett, *The correlation between conflict and spread of HIV/AIDS to women: a case study of the Rwandan genocide*, 2003, p. 17.

[123] MSF-Belgium, *Burundi, Deprived of access to healthcare*, April 2004.

Violence, a Vector of HIV/AIDS

The crimes that are commonly committed during civil war are extremely violent and contribute to the spread of HIV/AIDS.[124] Civil war provides a pretext for massacres, assassinations, mutilation, rape, sexual slavery, torture, forced movement, etc.

These are bloody crimes that expose the civilian population to HIV/AIDS infection. The forced movement of people, mixing of blood among the injured, use of unsterilized instruments when caring for the sick and injured, the cruel treatment commonly carried out during conflicts such as mutilation, physical torture, rape, forced prostitution, are all practices that increase the risk of transmission of HIV/AIDS from one person to another.

A civil war in which bloody crimes are committed has impacts that are difficult to heal and has serious consequences. As a result of living in a culture of total alienation, people end up losing their moral footing. Violence enters the subconscious and transforms the culture. It is therefore not rare to witness a situation in which a population that was the victim of aggression at the outset internalizes the violence and starts to turn on itself. This is particularly true in Africa, where civil wars have beaten all records of longevity. In fact, rare are the cases in which a civil war lasts less than 10 years. In Chad, the civil war lasted 40 years, in Angola, 27, and in the Sudan, civil war has dragged on for 37 years.[125]

Apart from the Democratic Republic of Congo (DRC), countries such as Mozambique, Uganda, Rwanda, Burundi, Sudan, Somalia, Liberia, and Sierra Leone all have over ten years of civil war in common. In addition to these wars, a multitude of recurring political crises constitute time bombs. Such is the case for Cote d'Ivoire, the Central African Republic, Congo-Brazzaville and the conflict between Ethiopia and Eritrea. The fact that HIV prevalence is high in most of these countries is part and parcel of situations of armed conflict. When war drags on to the point that it finally begins to be quasi-normal, the population ends up by assimilating its violence.

The danger for a people living in a situation of permanent war is that it restricts its vision of life. A war that drags on in one form or another will finally provoke human behaviour that demonstrates a degree of disillu-

[124] Pilar Estebanez, "Le facteur guerre," *Le Monde Diplomatique*, December 2000.

[125] Op. cit., note 119.

sion fraught with serious consequences. Living becomes an act of immediacy, because the future is completely blocked by the shadow of death. It is in this type of context, when people are living only for themselves and for the present, that life and death become meaningless. Fatalism dictates daily life. Talking about prevention of HIV/AIDS becomes a difficult task.

The similarity of comments made by the victims of the war in Rwanda,[126] the DRC,[127] and Burundi,[128] show how much fatalism has transformed time into a aleatoric concept. It is common for prostitution to become a survival activity for some women in the context of war. Without any power to negotiate, those women are often obliged to consent to unprotected sex. Many say without hesitation that their only choice was between dying of hunger now or of HIV/AIDS later.

Women in the Crossfire

There are several reasons why sub-Saharan Africa is by far the region most affected by the HIV/AIDS pandemic, with 30 million Africans living with HIV, out of the total of 42 million throughout the world. One is the endemic poverty of the subcontinent, and another, its political and democratic deficit.

While there has been an "Africanization of HIV/AIDS," today we can also talk about its "feminization." HIV/AIDS affects more women than men. In their 2002 annual report,[129] UNAIDS and WHO noted that women constitute 58% of all people affected in Africa. That trend continued in 2003, as can be seen from the chapter on Africa in the latest joint UNAIDS/WHO report,[130] which stated that in Africa, comparatively and contrary to other regions of the world, women are at least 1.2 times more likely to be infected than men.

That difference takes on even more alarming proportions in young African women aged 15 to 24. A study carried out by the Canadian government's Standing Committee on Foreign Affairs and International Trade

[126] Human Rights Watch/FIDH, op. cit., note 11.

[127] Human Rights Watch, *The War within the War, Sexual Violence against Women and Girls in Eastern Congo*, June 2002.

[128] Interview, Bujumbura, February 23, 2003.

[129] UNAIDS/WHO, *AIDS Epidemic Update*, December 2002.

[130] UNAIDS/WHO, *AIDS Epidemic Update*, December 2003.

sounded the alarm when it stated that, in this age group, 67% of people infected are women.[131]

Socio-economic factors such as extreme poverty and ignorance, in addition to cultural factors, nullify any effort to exercise control over sexuality or to advocate responsible sexuality, explaining why HIV/AIDS takes more victims in Africa, as well as testifying to a gender-based relationship unfavourable to women. In fact, HIV/AIDS in Africa is a phenomenon of social breakdown; it considerably undermines the social fabric, which is mainly held together by women.[132] This breakdown manifests itself notably in declining life expectancy, which is today 47 years, while in the absence of HIV/AIDS it would be 62. It is also manifested in how the notions of childhood and old age have been put into question by the reversal of roles and tasks caused by the disappearance of young adults (who are the productive force of society, but also the principal victims of HIV/AIDS), and their abrupt replacement by children and the elderly, two groups that are normally considered to be the responsibility of the State and the community.

In a context in which health and social services are mainly the responsibility of families and communities, the care of millions of sick people and orphans falls mainly on women, who are considered to be natural caregivers. In order to recognize the social support role played by women, the UN Special Session of the General Assembly on HIV/AIDS called for a "review [of] the social and economic impact of HIV/AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers."[133]

In such a situation, which attests to the precariousness, or outright absence of a public health system, invalidating the universality of many socio-economic rights, it would be inadequate to reduce the vulnerability of women confronted with HIV/AIDS and armed conflict to a question of human security. Developed to ensure the protection of people, including civilians, human security constitutes a significant advance in the matter of protection of individuals.

[131] Government of Canada, Report of the Permanent Committee of the Department of Foreign Affairs and International Trade, *HIV/AIDS and the Humanitarian Catastrophe in Sub-Saharan Africa*, June 2003.

[132] Françoise Nduwimana, "Terreur en la demeure. L'Afrique noire dans l'éteau de la guerre civile et du VIH/SIDA", *Revue Frontières*, Vol. 15, No. 2, Spring 2003, p. 26-31.

[133] United Nations, General Assembly, op. cit., note 121, pp. 30-31.

Based on international humanitarian law, this new paradigm takes into account the impact of conflicts on the civilian population. Human security is a response to the realities of armed conflict and HIV/AIDS, but is only an empty shell when it is disconnected from socio-economic rights and an entire series of socio-political conditions and measures to reinforce the status and power of women.

Women and Poverty

The analyses[134] establishing a link between armed conflict, HIV/AIDS and women, have all focused on the status of women. A declaration from the UN Commission on the Status of Women has recognized that women's vulnerability to HIV/AIDS was related to the lack of power they have over their own bodies and sexuality, and that this absence of power is the result of social, economic and political inequalities between men and women.[135]

In the areas of education, literacy, health, property, and access to clean water, key areas without which it would be difficult to realize emancipation, the women of Africa continue to be victims of a patriarchal system, accentuated by the absence of social justice or political will.

According to Amina Lemrini,[136] two thirds of the 100 million African children with no schooling are girls, mainly from rural areas. Only 47% of girls have a primary-level education, 33% have a secondary-level education and 5% have a university-level education. Overall, only 32% of girls have access to education compared to 48% of boys.

In the health field, the social collapse caused by structural adjustment programs has had the effect of reducing women's access to health care even further. In considering the experience of southern Africa, Bookie Monica Kethusegile[137] notes that, although during the post-independence period significant resources were allocated to health, achieving the Beijing objectives related to health for most of the countries of the Southern

[134] See Human Rights Watch, *Gender Inequality Fuels Aids Crisis*, December 2003, pp. 58-77. UNIFEM, *Women, War and Peace*, 2002. p. 51. Human Rights Watch, op. cit., note 127, pp. 20-21.

[135] United Nations Commission on the Status of Women, *Report on the forty-fifth session* (6-16 March and 9-11 May 2001) Economic and Social Council Official Records, Supplement No. 7 (E/2001/27-E/CN.6/2001/14), 2001, p. 49.

[136] Amina Lemrini "L'éducation des filles : constats, enjeux et perspectives" in *Femmes bâtisseurs d'Afrique*, Musée de la Civilisation, Québec, 2000, pp. 46-49.

[137] Ibid, Bookie Monica Kethusegile, « La santé des femmes: un impératif de développement », pp. 46-49.

African Development Community (SADC) has proven difficult to accomplish because of the imposition of budgetary constraints.

The difficulty of achieving women's rights to health while budgetary constraints continue was recognized at the 1995 Beijing Conference on Women. "In many countries […] a decrease in public health spending and, in some cases, structural adjustment, contribute to the deterioration of public health systems. In addition, privatization of health-care systems without appropriate guarantees of universal access to affordable health care further reduces health-care availability. This situation not only directly affects the health of girls and women, but also places disproportionate responsibilities on women, whose multiple roles, including their roles within the family and the community, are often not acknowledged […]"[138]

With respect to drinking water, the statistics are even more alarming for sub-Saharan Africa. In 2003, the International Year of Freshwater, UNESCO stated that one African in two (or over 300 million people), has no access to drinking water and 66% (or 400 million), have no access to water purification systems. In urban areas and slums, the lack of water has led to its commodification, resulting in it becoming inaccessible to women. Very often, women must spend a minimum of three hours a day fetching water at public wells or streams, without counting the time required to boil it. This inaccessibility also explains why women bear the consequences of lack of food and epidemics caused by poverty of diseases such as cholera, malaria and dysentery.

The issue of women's inheritance and land ownership rights provides, however, the best illustration of the combined effects of patriarchal hegemony in Africa and the impact of economic restructuring on women. The agricultural sector provides a living for most people in Africa and it is women who constitute between 70% and 80% of agricultural labour. However, is estimated that only 7% of African women own land.[139] This situation is a direct consequence of the relationship of land as property, structured by patrilineal rules of succession that limit the title of head of the family to men.[140]

[138] United Nations, Beijing Declaration and Platform for Action, 1994, point 91.

[139] The North-South Institute and Third World Network Africa, *Demanding Dignity: Women Confronting Economic Reforms in Africa*, 2000.

[140] Sara C. Mvududu, "En quête de justice et d'équité: les femmes et la loi en Afrique australe," in *Femmes bâtisseurs d'Afrique*, op. cit, note 136, p. 84.

With respect to access to land, the first level of discrimination that women experience from endogenous factors, such as customary law, is also compounded by other exogenous causes, such as agricultural sector cutbacks brought about by the drop in agricultural subsidies. According to New Partnership for Africa's Development (NEPAD), agriculture in industrialized countries receives US$361 billion in subsidies compared to $7.4 million in Africa, where 70% of the poor depend directly on the agricultural sector.

The drastic reduction in funding for African agriculture, which, according to NEPAD, fell from 39% of the World Bank's budget in 1978 to only 7% in 2000,[141] has accentuated the misery of 80% of African women, who constitute the agricultural labour force and who depend on it to survive, making them even more vulnerable to poverty and systemic violence.

The vulnerability of women confronted with the violence of armed conflict is thus a continuation of the poverty and systematic violence that they are subject to in peacetime. Two situations in particular eloquently illustrate this vulnerability: (1) crimes of a sexual nature committed against women in the context of armed conflict, (2) the lives of women in refugee and displaced persons camps.

Women and Gender-Based Crimes

The physical and sexual violence that women endure during wartime constitutes a war in itself. Human Rights Watch best summed up the situation when it referred to the war within the war.[142] In fact, in Rwanda, Sierra Leone, Liberia, the DRC, Burundi, and many other countries, a true war against women has been and is still being fought.

Sexual violence directed against women raises a fundamental question with respect to the HIV/AIDS pandemic. How do we respond to the death sentence of victims who have been infected with HIV/AIDS? This new dimension of sexual aggression does not mean that categories of sexual violence can be hierarchized. Whether or not they are vectors of HIV/AIDS, sexual and physical violence committed in the scope of armed conflict constitute war crimes and/or crimes against humanity and may, as in the case of the Rwandan genocide, constitute crimes of geno-

[141] New Economic Partnership for the Development of Africa Policy Document, October 2001, point. 134.

[142] HRW, op. cit., note 127.

cide. What must be stressed, however, is that after being infected with HIV/AIDS through rape, the victims live in a situation of "death foretold." Survival in that context depends on reconstruction, and justice must take into account the many challenges posed by HIV/AIDS, such as medical and social care of victims.

The Beijing Declaration and Platform for Action formally defined rape as a cause of HIV/AIDS. It announced that "HIV/AIDS and other sexually transmitted diseases, the transmission of which is sometimes a consequence of sexual violence, are having a devastating effect on women's health […] The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective."[143]

Admitting that there is a relationship of cause and effect between rape, infection with HIV/AIDS and a death sentence for victims is the first step that must, however, lead to not only the reinforcement of protection measures for women but also to the adoption of measures for justice and reparation. These measures enlist the responsibility of the African States concerned and of the international community. It is interesting to note that after having established Iraq's responsibility in the invasion and occupation of Kuwait,[144] the Security Council mobilized in 1991 to create the United Nations Compensation Commission. It evaluates requests for benefits and grants financial compensation to claimants for damages suffered during Iraq's invasion and occupation of Kuwait. The amounts granted come from a special fund that receives a percentage of Iraq's oil sales. The Commission evaluates claims and compensates women and girls for gender-based violations that they suffered, such as sexual violence and the negative consequences of the conflict on their health.[145] In this case, the principle of compensation for serious violations of international law was recognized by the Security Council and mechanisms were implemented to make this law effective, through the international community's demonstration of its political will to find a solution to the consequences of the invasion of Kuwait. The same will and innovative ideas are necessary to respond to the HIV/AIDS pandemic. A comprehensive response involves an analysis of the origins and causes of conflicts that

[143] United Nations, Beijing Declaration and Platform for Action, 1994, point 98.

[144] United Nations, *Security Council Resolution 687*, 1991.

[145] United Nations, *Women, Peace and Security*, Study submitted to the Secretary-General pursuant to Security Council Resolution 1325 (2000), p. 46.

have the consequence of the spread of HIV/AIDS in order to determine responsibility (of governments, leaders, corporations) in compensating victims.

HIV Prevalence in the Armed Forces

The high incidence of HIV in sub-Saharan Africa is even higher within the armed forces, both regular and irregular. The war in the DRC is qualified, because of the number of military forces and countries involved, as the "First African World War" and is an example of the consequences of violence against women. The situation of the DRC is so worrying that in a press conference, Peter Piot, Executive Director of UNAIDS, declared on August 31, 2001, that after the war in the DRC, the country should fight another war, a war against HIV/AIDS. The DRC is thus facing two other conflicts in the same war: one of violence against women and the other, the spread of HIV/AIDS.[146]

Although it is difficult to obtain official statistics, several sources corroborate the estimate that soldiers in the DRC have an HIV/AIDS rate of 60%.[147] This figure is corroborated by the UNIFEM study,[148] which established the HIV/AIDS prevalence of the Angolan and Congolese military as between 40% and 60%, and at 70% for the Zimbabwean military. *Afriquesoir*, a Catholic magazine, states that 80% of Ugandan soldiers are HIV positive.[149] These statistics are similar to figures used by John Harker,[150] citing US National Intelligence's estimates of HIV infection within the Congolese Army as between 40% and 60%. Congolese armed forces health officials admit that, between 1989 and 1993, 60% of army deaths were the result of HIV/AIDS, and not of war. Harker then goes on to cite an article from the *Financial Mail,* a South African magazine, entitled "Africa's Military Time Bomb," which cites calculations from 1998 that an estimated 40% of soldiers in the South African National Defence Force (SANDF) were HIV positive. At the time, South Africa had the largest

[146] The reference for this declaration is found in L.B. Mbombo and Bayolo, *Violations of Women's Rights in the Democratic Republc of the Congo*, Rights & Democracy, 2002, note 27.

[147] Estimate made in 2001 by the US Institute for Peace, repeated by HRW, op. cit., note 127, p. 70.

[148] Ibid., p. 53.

[149] Lisette Banza Mbombo and Christian Hemedi Bayalo, op. cit., note 146.

[150] John Harker, *HIV/AIDS and the Security Sector in Africa: A Threat to Canada*, Canadian Security Intelligence Service Publication, Comment no. 80, September 26, 2001.

military contingent of the African Mission in Burundi (AMIB) before it was transformed into the UN Mission in Burundi, known as ONUB.

The Military Code of Conduct

The statistics are revealing and especially disturbing because crimes of sexual violence, prostitution and sex trafficking are likely to increase the transmission of HIV/AIDS. UN peace-keeping forces are governed by a code of conduct that prohibits them from engaging in sexual relations with the local population. The principal challenge is to ensure compliance with the code. The UN Security Council adopted Resolution 1308[151] on HIV/AIDS and international peace-keeping operations specifically to meet that challenge.

Dictated by the impact of HIV/AIDS on peace and security in Africa, the Resolution acknowledges that HIV/AIDS is exacerbated by violence and instability. As regards peace-keeping and security, the Resolution encourages States to improve how they prepare their troops for participation in peace-keeping operations by developing strategies for training, prevention, screening, advice and treatment related to HIV/AIDS.

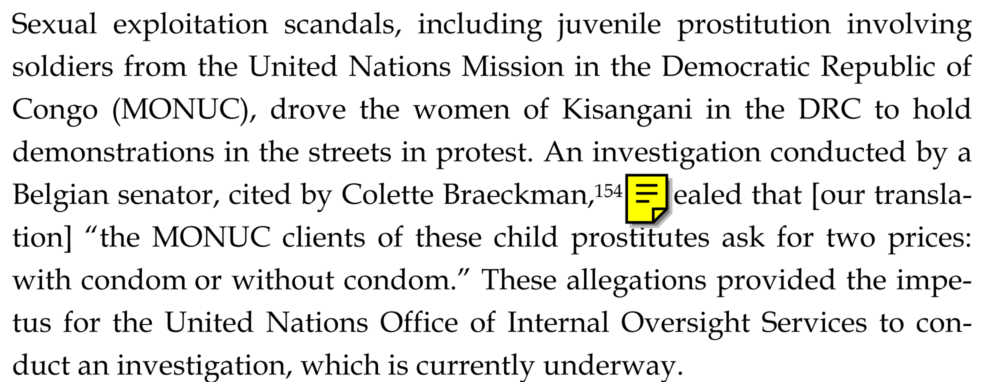
Formulated the same year as Resolution 1308, Resolution 1325 pertaining to women, peace and security also deals with the HIV/AIDS issue to a lesser extent. Resolution 1325 recommends that: "[…] the Secretary-General […] provide to Member States training guidelines and materials on the protection, rights and the particular needs of women, as well as on the importance of involving women in all peace-keeping and peace-building measures, *invites* Member States to incorporate these elements as well as HIV/AIDS awareness training into their national training programmes for military and civilian police personnel in preparation for deployment, and *further requests* the Secretary-General to ensure that civilian personnel of peace-keeping operations receive similar training."[152]

Despite the above resolutions, the West and Central African experience raises questions regarding the conduct of peace-keeping troops. The deployment in Liberia and Sierra Leone of the Economic Community of West African States Monitoring Group (ECOMOG), a military force, has had serious consequences for the women of those two countries. Consid-

[151] United Nations, Security Council, *Resolution 1308 on the Security Council's responsibility to maintain international peace and security: HIV/AIDS and international peace-keeping operations*, S/RES/1308, 2000.

[152] United Nations, Security Council, Resolution 1325 on Women, Peace and Security, S/RES/1325, 2000, point 6.

ering the high number of children born[153] of unions between ECOMOG soldiers and women of Liberia and Sierra Leone, births that are the result of unprotected sex, one can only imagine the extent of the risk of exposure to HIV/AIDS.



Sexual exploitation scandals, including juvenile prostitution involving soldiers from the United Nations Mission in the Democratic Republic of Congo (MONUC), drove the women of Kisangani in the DRC to hold demonstrations in the streets in protest. An investigation conducted by a Belgian senator, cited by Colette Braeckman,[154] revealed that [our translation] “the MONUC clients of these child prostitutes ask for two prices: with condom or without condom.” These allegations provided the impetus for the United Nations Office of Internal Oversight Services to conduct an investigation, which is currently underway.

The Secretary General of the United Nations, called upon the UN Department of Peace Keeping Operations to implement the recommendations regarding “the need to re-examine and improve its disciplinary procedures, the need for the missions, together with local community organizations, to implement monitoring mechanisms and appoint ombudspersons in mission offices.” [155]

In addition, the Secretary General requested “[…] troop-contributing States to enhance their own efforts to ensure that such violations do not occur, to investigate and prosecute effectively cases of alleged misconduct and to set up adequate accountability mechanisms and disciplinary measures.” [156] It is also crucial for the Security Council to ensure “[…] the necessary financial and human resources for gender mainstreaming, including the establishment of gender advisers/units in multidimensional peace-keeping operations and capacity-building activities, as well as targeted projects for women and girls as part of approved mission budgets.”[157]

It is clear that application of Resolution 1308 is far from being a reality. Again, insofar as the Resolution concerns UN peace-keeping forces only, the issue arises regarding the occupying armies and all factions of armed

[153] UNIFEM, op cit., note 134, p. 54.

[154] Colette Braeckman, op. cit., note 35, pp.164-165.

[155] United Nations, op. cit., note 145, point 270.

[156] United Nations, Report of the Secretary General on *Women, Peace and Security*, S/2002/1154, 16 October 2002, point 45.

[157] Ibid., Action 12, p. 9.

forces personnel deployed in armed conflict who are required to apply international humanitarian law, as is the case in the Great Lakes region.

The war in the DRC, and to a lesser extent the war in Burundi, highlights the practices of the region's military allies, which is fraught with consequences for the civilian population, women in particular. It is not simply a matter of foreign military presence, but of their predatory and criminal behaviour, which totally ignores international humanitarian law. As in the Democratic Republic of Congo, although the civil war in Burundi primarily involves Burundians, the actors were not always Burundians. It is common knowledge that the various factions had Rwandan and Congolese soldiers in their ranks. Like the DRC, the relocation of armed forces personnel to Burundi, linked with an already high incidence of HIV/AIDS in the regular army and in the opposing armed forces, does not augur well for women rape victims. An Amnesty International report made the same observation.[158] Stating that rape is a weapon of war used by all belligerents, regular army and armed opposition movements alike, the report also stressed that the number of persons who tested HIV-positive or who have HIV/AIDS is particularly high among women rape victims.

The high incidence of sexually transmitted infections among victims of rape and sexual slavery has also been well documented by Susan McKay and Dyan Mazurana in a recent publication.[159] On the basis of the data on girls who were conscripted to fight in the wars in Sierra Leone, Mozambique and Northern Uganda, the two researchers demonstrated the relationship between sexual violence, sexually transmitted infections and HIV/AIDS. In Sierra Leone, out of 17 victims voluntarily tested, 10 were HIV-positive.[160] In Northern Uganda, a screening exercise conducted among 83 children forcefully conscripted determined that 15.66% of them were HIV-positive.[161] Although the official statistics are silent regarding HIV/AIDS infection among victims of rape and sexual violence, the abnormally high incidence of sexually transmitted infections among Ugan-

[158] Amnesty International, *Burundi: Rape - the hidden human rights abuse*, February 2004.

[159] Susan McKay and Dyan Mazurana, *Where are the Girls? Girls in Fighting Forces in Northern Uganda, Sierra Leone and Mozambique: their Lives During and After War*, Rights & Democracy, 2004.

[160] Ibid., p. 74.

[161] Ibid.

dan and Sierra Leonean victims, which ranges between 70% and 90%,[162] foreshadows a high incidence of HIV/AIDS among those victims.

In addition to measures aimed at putting an end to impunity for violations of international humanitarian law by armed forces personnel, governments must ensure that their armed forces receive training on their responsibilities under international humanitarian law regarding civilians, especially women and children. Training must deal with the HIV/AIDS problem from a gender perspective.

Women Refugees and Displaced Persons

The United Nations High Commissioner for Refugees (UNHCR) estimates that women and children make up between 75% and 80% of war refugees and displaced persons.[163] The concentration of women in refugee and displaced persons camps is a two-pronged issue. In the beginning, the need for security was the impetus for the women to group together. But in the absence of a peace-keeping force with a firm mandate regarding protection of civilians,[164] as is usually the case in Africa, protection is transformed into insecurity.

Even though the majority of people in refugee and displaced persons camps are women, a patriarchal model is replicated in them and has become radicalized. In such a situation, the women are completely defenceless and deprived of all decision-making power. The social, economic and cultural bases that structure negotiations with a modicum of balance of power between men and women are totally destroyed by war. Most often, the camps reflect the disintegration of familial and social structures. The erosion of normalcy, the disappearance of the notion of parental authority, specifically maternal authority, all explain how socio-ethical codes are replaced with the only law that prevails in the camps: might makes right.

[162] Ibid., p. 73.

[163] UNHCR, “Women seeking a better deal”, *Refugees*, Volume 1. No 126, 2002, p. 7.

[164] Only recently has the MONUC mandate been broadened to include protection of civilians. The mandate of the African Peace-keeping Mission in Burundi (AMIB) which, since May 21, 2004, has become ONUB (UN Mission in Burundi) is limited to disarmament, demobilization and the training of a national defence force. It has only about 5650 armed forces personnel.

A patriarchal hegemony[165] thrives much more easily in refugee and displaced persons camps, so that women, primarily single women (who are also referred to as "unaccompanied women" as if they were minors), are like welfare recipients in many respects. No longer producers of food, they depend on food aid, the distribution and control of which they know is based on formal and informal authority structures managed by men. Having no control of their physical safety, they must accept the conditions of those who control the camp.

The conditions of negotiation, as commonly imposed by those who control the camps (armed forces personnel, militiamen, child soldiers, UNHCR field staff and camp administrators), all contribute to the sexual exploitation of women and girls and thus to an increased risk of HIV/AIDS transmission.

The local staff of humanitarian agencies and peace-keeping forces are not innocent of this kind of abuse, as attested to by the investigation conducted by the UNHCR and Save the Children UK in the refugee camps in Liberia, Guinea and Sierra Leone.[166] According to that investigation, which specifically pointed the finger at local male staff, the UNHCR and Save the Children denounced the widespread practice of bartering aid and humanitarian services intended for the refugees in exchange for sexual relations with girls under 18 years of age.

The poverty, promiscuity and insecurity in the camps promote prostitution[167] and pose several challenges, namely, the extent of the women's awareness of the risks they run in having unprotected sex with several sexual partners, the very high risk of contracting sexually transmitted infections, which are also vectors of HIV/AIDS, and lastly, the need for the humanitarian agencies in the camps to view the fight against HIV/AIDS as a humanitarian response.

One study[168] conducted in the Rwandan refugee camps in Tanzania, established that the presence of sexually transmitted infections (STI) during

[165] Judy A. Benjamin, *Women, war and HIV/AIDS: West Africa and the Great Lakes*, paper presented to the World Bank as part of International Women's Day, March 8, 2001.

[166] UNHCR and Save the Children-UK, *Note for Implementing and Operational Partners by UNHCR and Save the Children-UK on Sexual Violence & Exploitation: The Experience of Refugee Children in Guinea, Liberia and Sierra Leone based on Initial Findings and Recommendations from Assessment Mission 22 October - 30 November 2001*, February 2002.

[167] UNIFEM, op. cit., note 134, pp. 47-51.

[168] UNAIDS/UNHCR, *HIV/AIDS, STI prevention and care in Rwanda refugee camps in the United Republic of Tanzania*, March 2003, p. 7.

unprotected sex increased the risk of HIV/AIDS infection from 6 to 10 times. Only 16%[169] of men admitted having used condoms during casual sex, which would explain the presence of STIs in 60% of pregnant women covered in the study.

To curtail the spread of HIV/AIDS in the camps it was recommended that the UNHCR and its partners identify the gender-based causes of crimes of violence against women and girls committed in the camps so that prevention strategies can be developed.[170] According to the UNHCR, the strategies should have as a common objective the adjustment or implementation of local practices and traditions to international standards of protection of the rights of women and girls, reconstruction of family and community support networks, the building of infrastructures and development of appropriate services as well as the documentation of incidents of sexual violence.[171] To ensure that these objectives are achieved, camp personnel must receive gender-based training that emphasizes the relationship between HIV/AIDS, women's rights and rights of refugees and displaced persons. The training would allow for the development of appropriate strategies in the given context. To be able to ensure that women with HIV/AIDS receive medical care, it is essential to ensure that women's health workers provide services in the camps and are equipped with antiretroviral drugs.

Challenges for the Sub-Saharan Region

Since the creation of the Organization of African Unity (OAU) in 1963, which became the African Union in July 2002, the continent has adopted instruments and mechanisms devoted to the protection of human rights. In an effort aimed at creating synergy between African values and international treaties, several innovative initiatives have been developed.

We specifically note the *Protocol to the African Charter on Human and People's Rights on Women's Rights in Africa*, adopted on July 11, 2003. The Protocol further bolsters women's rights and requires political and socio-economic measures, and completes article 18 of the African Charter by

[169] Ibid., p. 15.

[170] See *UNHCR Policy on Refugee Women and Guidelines on Their Protection: An Assessment of Ten Years of Implementation, An independent assessment by the Women's Commission for Refugee Women and Children*, May 2002, p. 30.

[171] UNHCR, *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response*, May 2003.

providing in the third paragraph of the Preamble that States have the duty "[…] to eliminate every discrimination against women and to ensure the protection of the rights of women as stipulated in international declarations and conventions." Regarding the right to health, article 14 of the Protocol requires States to ensure the right of women to be protected against HIV/AIDS and other sexually transmitted infections, as well as their right to have access to adequate health services.

On the subject of violence against women, the Protocol deals with three main aspects of this phenomenon, namely prevention, suppression and taking care of victims. Whereas paragraph 4 of article 3 requires States to adopt and apply measures aimed at ensuring the protection of women against all forms of violence, especially sexual violence; article 4 of the Protocol deals with the right of women to life, integrity and security of person. As regards actions aimed at ensuring social reintegration, the Protocol states at article 4 that "States Parties shall take appropriate and effective measures to: […] (e) punish the perpetrators of violence against women and implement programmes for the rehabilitation of women victims; (f) establish mechanisms and accessible services for effective information, rehabilitation and reparation for victims of violence against women."

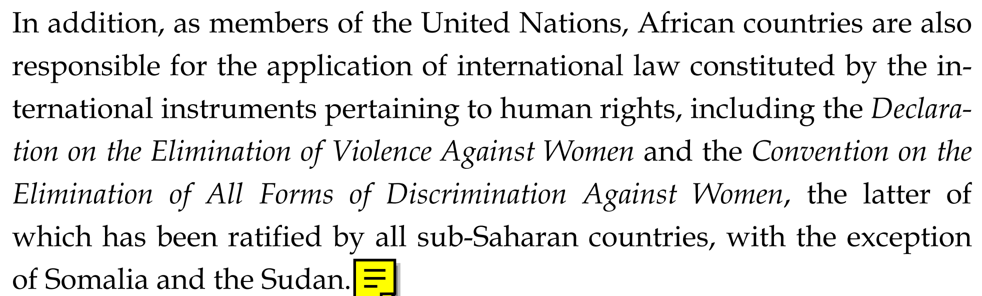
The *Protocol to the African Charter on Human and People's Rights on Women's Rights in Africa* is thus a powerful and appropriate instrument for female victims of armed conflict, because it was developed on the basis of two interconnected precepts: the protection of civilians and the right of victims to reparation. The Protocol is inspired not only by rules of international humanitarian law, but also, and this is its unique feature, by the principles and guidelines governing the right to reparation, compensation and rehabilitation of victims of violations of international humanitarian law.

Paragraphs 1 and 2 of article 11 of the Protocol require that States comply with the rules of international humanitarian law governing the protection of civilians against armed conflict, specifically women. Paragraph 3 of that article insists on the protection of women refugees, returnees, displaced and interned persons etc., against all forms of violence, rape and other forms of sexual exploitation. Furthermore, it requires that these types of violence be considered war crimes, acts of genocide and/or crimes against humanity. Even if the Protocol does not list the consequences of rape and sexual violence committed during armed conflict, it

is important to note that it addresses the issue of reparation at article 25, which reads as follows:

> *States Parties shall undertake to:*
>
> *a) provide for appropriate remedies to any woman whose rights or freedoms, as herein recognised, have been violated;*
>
> *b) ensure that such remedies are determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by law.*

Articles 4 and 25 of the Protocol, respectively pertaining to rehabilitation and reparation of victims, are tools that female victims of violence and HIV/AIDS can use to demand justice. For that reason, women's groups should campaign for widespread ratification of the Protocol and its rapid enforcement.



In addition, as members of the United Nations, African countries are also responsible for the application of international law constituted by the international instruments pertaining to human rights, including the *Declaration on the Elimination of Violence Against Women* and the *Convention on the Elimination of All Forms of Discrimination Against Women*, the latter of which has been ratified by all sub-Saharan countries, with the exception of Somalia and the Sudan.

Lastly, as seen earlier, armed conflict waged in African countries is governed by international humanitarian law constituted by the four *Geneva Conventions* and their two additional *Protocols*.[172] Even if *a priori* they were conceived to regulate the practices of international armed conflict, the four Conventions have a common provision that applies to armed conflict that is not international in nature. Article 3 is common to the four *Geneva Conventions*. That article proscribes "violence to life and person, the taking of hostages and outrages upon personal dignity, specifically humiliat-

[172] The *Geneva Conventions* and their additional Protocols are part of international humanitarian law, a set of legal guarantees that relate to the waging of war and that assure the protection of persons: *Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, August 12, 1949. *Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea*, August 12, 1949. *Geneva Convention (III) Relative to the Treatment of Prisoners of War*, August 12, 1949. *Geneva Convention (IV) Relative to the Protection of Civilian Persons in Time of War*, August 12, 1949. *Protocol I Additional to the Geneva Conventions of 12 August 1949 Relating to the protection of Victims of International Armed Conflict*), June 8, 1977. *Additional Protocol II to the Geneva Conventions of August 12, 1949 Relating to the Protection of Victims of Non-International Armed Conflict*, June 8, 1977.

In particular, the Conventions and their Protocols protect persons who do not participate in hostilities (civilians, health care staff and members of religious orders and humanitarian organizations) as well as those who no longer take part in combat (the wounded, the sick and the shipwrecked, prisoners of war).

ing and degrading treatment."[173] The *Additional Protocol II to the Geneva Conventions* applies to civil war and internal conflict. In symbiosis with article 3 common to the four Conventions, that Protocol also proscribes in its article 4 cruel and degrading treatment, including rape.

Victims Rights to Justice and Reparation

By integrating criminal justice in its peace and reconciliation process, Sierra Leone has promoted the denunciation and punishment of serious crimes, including crimes of sexual violence. From a criminal prosecution perspective, women would otherwise not have been confident that justice would be done and would not have testified before the Truth and Reconciliation Commission. The Special Prosecutor for Sierra Leone set the tone from the outset of his mandate during the investigation phase by paying much attention to crimes of violence and sexual slavery, which ensured that the majority of the indictments included charges of sexual violence.

The DRC and Burundi are different cases. Both countries are not yet categorized as post-conflict countries. They are going through a pivotal transition period with war as the backdrop. Midway between peace and war, this period should lead to the democratization of political institutions. Both countries are now at a stage where enemies are sharing power. In such a circumstance of impunity regulated by an implied agreement for amnesty and self-declared amnesty, the hope for justice for the civilian population is very slim. In both cases, rape was, and still is, common currency. Although the crime of rape is proscribed by the criminal codes of both countries, it has received little political and legal attention. Government and judicial inertia has led many to call for action and for the adoption of a genuine policy of criminalizing rape.

In Goma, in the DRC, Immaculée Birhaeka, director of PAIF (Promotion of and Support for Women's Initiatives) identified as the principal challenge the recognition that rape is a war crime [translation:]:

"The greatest challenge is to recognize that rape is a war crime committed against defenceless persons. Our first task is to work for political recognition of that fact and attempt to demystify the problem. Ninety percent of the women who were raped have not received any treatment. Most of the hostilities took place in the villages, where there are no health centres and

[173] Amnesty International-Rights and Democracy, *Investigating Women's Rights in Armed Conflicts*, 2001, p. 29.

where it is difficult for the women to state publicly that they were raped. They don't want to talk about it because they find it too humiliating. In any event, they know that they will not obtain justice. We know of many cases where women were repudiated by their husbands after they said they were raped. As society still trivializes this kind of violence, the women prefer to keep quiet. But that doesn't solve the problem. The survival of these women depends on social and familial reintegration. There are many degrees of vulnerability after a rape and HIV/AIDS is one of the worst consequences. We have to confront this situation by putting pressure on the authorities and the public to eliminate rape and all forms of violence that adversely affect human life." [174]

This concern to force the authorities to recognize and punish the commission of rape is also stated in the HRW report[175] devoted to sexual violence against women and girls in the Eastern Congo, and is part of the recommendations set forth in the study conducted by Mbombo and Bayolo.[176] Given that the DRC has signed the *Rome Statute* which regards rape, sexual slavery, forced prostitution, sexual persecution and other kinds of sexual violence as war crimes and/or crimes against humanity, the Congolese government should reform its laws so that the criminalization of rape and other sexual violence in the DRC corresponds to the *Rome Statute*.

In Burundi, the same need to wage a vast education campaign on sexual violence was expressed by Chantal Mutamuriza, representative of the Association pour la promotion de la fille Burundian [association for the advancement of Burundian girls] and of the Collectif des associations Burundians des droits de la personne [Collective of Burundian human rights associations] as follows: [translation:] "The Iteka league recently published an investigation that covered 2003. It reported 964 cases of rape, but the figure is probably much too low. For reasons of security, many provinces could not be visited. The case of a woman from Kirundo (in the North), who was over 60, and who was raped and infected with HIV/AIDS was reported on the radio. This indicates the extent of public notoriety of these incidents. However, the authorities are not overly concerned with the issue. For example, a woman bravely filed a complaint

[174] Statements taken in Goma, February 19, 2004.

[175] Human Rights Watch, op. cit., note 12, pp. 4-6.

[176] Lisette Banza Mbombo and Christian Hemedi Bayolo, op. cit., note 146, p. 22.

but the trial ended with a sentence of one year in prison, notwithstanding that the Burundian Criminal Code stipulates that rape is punishable by 5 to 20 years in prison. Therefore, the women don't want to testify for a variety of reasons: the risk of ostracism, the insensitivity with which the trials are conducted (they are conducted by men). If the women were supported and accompanied, they would agree to testify. There are two further challenges. Burundian law on genocide punishes wartime rape but the legislation has yet to be incorporated into that country's criminal code. It would be very worthwhile to wage a campaign aimed at such harmonization. Lastly, in the environs of Bujumbura, 90% of the people in the displaced persons camps are women and children. These women are at the mercy of military misconduct. They are sometimes obliged to engage in prostitution with armed forces personnel who, theoretically, should be ensuring their protection. The women say that they prefer to die of HIV/AIDS later than die of hunger now."[177]

Impunity for the crime of rape, secured by the lack of political will, is also denounced in a HRW report on Burundi. The organization questions the political will of senior armed forces personnel at every level to control wartime rape. Citing the army Chief of Staff of the Burundian National Army, General Germain Niyoyankana, HRW recounted "[He] did not believe that government soldiers committed rapes. He said that had there been such cases, women would not have reported them because of a cultural reticence against discussing such matters. He suggested instead that women who accused soldiers of rape had probably engaged voluntarily in sex with them with the expectation of receiving some form of payment to alleviate their dire poverty. When the payment was not forthcoming, the women accused the soldiers of rape."[178] According to this head of the national army, there is therefore no rape; it is merely free and consensual sexual commerce between the women and armed forces personnel.

The Forces for the Defence of Democracy (FDD) movement, the former armed faction of the opposition, today a participant in the transitional government in Burundi, has displayed the same attitude. HRW noted behaviour aimed at stifling any official revelation of this phenomenon: "[…] a FDD leader in Mubimbi commune told residents that his movement dealt with cases of rape in its own way and that they should not forward

[177] Statements taken in Bujumbura, February 23, 2004.

[178] Human Rights Watch, *Everyday Victims: Civilians in the Burundian War*, 2003, pp. 42-43.

information about such cases to authorities or others. He also told them that women who were raped should not seek medical attention in Bujumbura, an order that could result in these women not receiving necessary care for their injuries."[179]

Since September 21, 2004, Burundi is a state party to the *Rome Statute*. It should also, in compliance with its law on genocide, incorporate suppression of wartime rape into its criminal code. The authorities of both the DRC and Burundi must also confront the consequences of rape, one of which is HIV/AIDS, and take into account the medico-social assistance requirements of victims.

Recommendations

Sexual violence: assurances of non-repetition and prevention

- All African States should ratify and apply the *Protocol to the African Charter on Human and People's Rights on Women's Rights in Africa*. Furthermore, articles 3, 4, 11, 14 and 25 of the Protocol respectively concern the protection of women against any form of violence, specifically sexual violence; the protection of right to life, to integrity and security of the person; the protection of women in armed conflict; the right to health and protection against HIV/AIDS; the right of women to reparation where their fundamental rights have been abused.
- Burundi and the Congo are signatories of the *Protocol to the African Charter on Human and People's Rights on Women's Rights in Africa*, Pursuant to the Protocol, the civilian authorities and armed forces personnel of both countries, but also the heads of all African countries, must take measures to suppress rape and sexual violence and ensure the right of victims to rehabilitation.
- Civil society, specifically women's groups, should develop initiatives so that the Protocol pertaining to women's rights will be ratified.
- The media should play a more active role in denouncing wartime rape and other sexual violence and try to show the link between sexual violence and HIV/AIDS.
- Women victims must be encouraged to file complaints. To achieve that, the women must be entitled to protection and legal and psycho-

[179] Ibid., p. 43.

social support. Such services must be implemented by local authorities and human rights associations. The administrators of justice (prosecutors, lawyers, court clerks, judges) must be trained to deal with similar situations.

- More campaigns are necessary to urge African States to ratify the *Rome Statute* thereby making future prosecutions of sexual violence committed in situations of conflict possible.
- The Democratic Republic of Congo has a Truth and Reconciliation Commission and one is also planned for Burundi. It is important to ensure the presence of women at the decision-making level of these Commissions and ensure that the initiatives do not eliminate the crime of rape, because it is truly a war crime. The formal request to women for forgiveness made on March 8, 2004 by one of the Vice-Presidents of the DRC, Azarias Ruberwa,[180] must be used as a springboard for a crackdown on rape, accompanied and strengthened by such a profession of faith.
- Justice must incorporate access to antiretroviral treatment as part of reparation for women rape victims and the army corps concerned must be called to account.
- Networking among women's associations in the Great Lakes region must be encouraged to ensure that sexual violence and HIV/AIDS infection are taken into consideration by the African regional authorities. Such a network would also facilitate an exchange of information and strategies.

HIV/AIDS prevention and providing care to victims: towards the right to rehabilitation

Women who have been raped should have access to health care and HIV/AIDS prevention measures immediately after being raped. Between December 2003 and January 2004, Dominique Proteau of Médecins sans frontières (MSF) - Belgium identified 110 cases of rape committed in the town of Bujumbura and in rural Bujumbura.[181] In the 72 hours following a rape, MSF provides women who have been raped with prophylactic treatment against HIV/AIDS.

[180] DRC: Vice-President Ruberwa asks forgiveness of rape victims, *IRIN*, March 2004.

[181] Interview granted in Bujumbura, February 23, 2004.

Unfortunately, even where it is provided, few women are aware of the existence of such a service, and many choose to not avail themselves of it for fear of having to recount what happened to them. This has been reported by the Association communautaire pour la promotion et la protection des droits de l'homme (ACPDH) [community association for the promotion and protection of human rights], which states that very few victims seek help of any kind whatsoever and most do not dare discuss it. Out of 20 cases of rape that were investigated, only four women reported it to health centres and the judicial police.[182]

In southern Kivu, Doctors Without Borders - Holland also provides prophylaxis in the guise of preventive treatment against HIV/AIDS as well as psychological and social care to female rape victims. This kind of service should be available in all Congolese health centres, but this is far from being the case. Seventy percent of the population does not have access to health care.[183]

Despite the fact that South Africa is not a country at war, rape occurs every 26 seconds[184] and over one million rapes are committed every year.[185] In light of this situation, the South African parliament has enacted legislation that enables rape victims to immediately receive preventive treatment. The South Africa model of making prophylaxis available to all the country's medical centres and providing universal access should be followed by all countries dealing with the same phenomenon.

- Governments must make prophylactic treatment available throughout their territories and must ensure that health centres have on hand, and provide, prophylactic treatment to all women who have been raped.
- Government services, humanitarian NGOs and women's groups must carry out an information and awareness campaign on HIV/AIDS and prophylactic treatment and tell women where they can go for help in the event of rape.

[182] Association communautaire pour la promotion et la protection des droits de l'homme (ACPDH), *Brochure d'information sur les violences physiques et sexuelles faites à l'égard des femmes et des enfants: cas de la province de Bujumbura rural. Les violences physiques et sexuelles sont elles une réalité banales?*, p. 14.

[183] Human Rights Watch, op. cit., note 127, p. 13.

[184] Jean-Claude Gerez, "Viol, le nouveau fléau sud africain", *Témoignage chrétien*, March 7, 2002, pp. 4 to 7.

[185] Ibid.

- Medical staff must be properly trained to better respond to this kind of situation.
- Campaigns aimed at encouraging women to be tested for HIV/AIDS after a rape should be undertaken without delay.
- Women must be encouraged to file complaints in cases of rape and local awareness campaigns must be conducted to neutralize taboos and educate the public on the links between sexual violence, HIV and destruction of the social fabric.
- Women must be present in decision-making bodies, both in the spheres of health services and justice.
- Networks of women NGOs must be created in the Great Lakes region to exchange information and discuss strategies, and in order to formulate a common vision on the issue of rape, sexual violence, HIV/AIDS and the right to justice.
- Associations of women jurists of the region must create discussion groups on the issue of justice and reparation for victims of rape and HIV/AIDS.
- Civil society should request that the decision-making bodies concerned, specifically in this case health ministries, status of women ministries and national commissions on HIV/AIDS control, conduct studies and collect statistics on female victims of rape and HIV/AIDS, and make these records available to women's groups and other stakeholders concerned with this issue.
- Committees must be created to liaise with women's groups of wartime victims of rape and HIV/AIDS and the various national UNAIDS, UNDP, WHO delegations and peace missions, to raise international awareness of the importance of including physical, psychological and social rehabilitation of women in the justice process.

CONCLUSION

We must commend African women for their mobilization around the issues of HIV/AIDS and peace and deplore the many obstacles to the recognition of their contributions. If African women were able to exercise their civil, political, social, economic and cultural rights without hindrance they would be able to more fully participate in the stability and security of the continent. Victims' rights to justice and reparation are all the more important because they are closely related to social reconstruction. Women survivors of sexual violence are asking for only one thing: respect for their rights in order to better contribute in the social reconstruction of their countries, to move from merely surviving to being active participants in their communities.

Respect for the rights of women to justice and reparation involves not only ending impunity for crimes of sexual violence committed in conflict situations but also taking into account the consequences of such violations, such as HIV/AIDS, by implementing a range of gender-based measures to guarantee these rights. As described in this paper, the right to reparation implies that justice be conceived and conducted through a holistic lense. Beyond traditional criminal justice processes, the responsibility for reparation must be shared by a range of concerned actors. Thus, the recommendations in this paper are aimed at governments, the international community, and international organizations, including international tribunals, humanitarian and cooperation organizations as well as human rights organizations.

The implementation of the right to reparation, in all its forms, for victims of gender crimes, means ensuring the full and complete enjoyment of women's rights. The HIV/AIDS pandemic requires innovative, coordinated actions, and, above all, measures must be fuelled by a sense of ur-

gency regarding the lives of women with HIV/AIDS. Time is ticking away.

APPENDIX TESTIMONY OF WOMEN WHO WERE VICTIMS OR RAPE AND HIV/AIDS DURING THE RWANDAN GENOCIDE[186]

Testimony gathered on February 13, 2003 at the Polyclinic of Hope in Kagugu, prefecture of Kigali.

"I was born in 1959 in Cyahafi. On April 9, my house was invaded by a gang of rapists. I was raped constantly for 60 days straight. For 60 days, my body used as a thoroughfare for all the hoodlums, militia men and soldiers in the district. A soldier named Mugenzi gave the orders. He told the militia men to kill everything that looked Tutsi so that one day Hutu children would ask what a Tutsi looked like. Those men completely destroyed me, they caused me so much pain. They raped me in front of my six children. My genitals were completely mutilated… They came, they raped me like animals, none of them used protection. And tell me this: how could someone take such a risk – take part in a gang rape or rape a woman who has been completely mutilated, without using a condom? They knew that they were already condemned by HIV/AIDS and they wanted to pass it on to me through rape. Three years ago, I discovered I

[186] Translations.

had HIV/AIDS. There is no doubt in my mind that I was infected during these rapes. One thing is certain: if I had had HIV/AIDS before the genocide, I would not have survived all the barbarism they made me experience. Look at me closely: yes, my uterus has been completely destroyed and I still have vaginal discharge, but you see, I am still solid, I could still live a long time if I had HIV/AIDS treatment. Here in the village, we are 200 Hutu and Tutsi women united by the Rwanda Women's Network. It disgusts us to see the treatment given to prisoners in Arusha while we are left to our own devices. We were killed once and we are now dying because of lack of drugs. What did we do to deserve such a punishment? I speak on behalf of my children because I no longer exist. What will happen to my children?"

"I was 48 at the time of the genocide. The Interahamwe killed seven of my children and my husband. My three remaining children and I went to hide at the Red Cross but the militia killed Ntare, who tried to protect us. It was utter chaos. The Interahamwe and the soldiers began raping me, many of them raped me. They raped me for the two weeks that we spent at the Red Cross. I was not the only one to go through this nightmare. Several women were even killed outright. They cut off one of my ears. We managed to escape and to reach the RPF front. In 1997, I started to have health problems; I took an HIV/AIDS test and it was positive. At 48 years old, I had never had any health problems. The militia men knew what they were doing, they knew that I would die in another way, by an invisible death. They took everything from me, my husband, my children, my health. They dared to rape a 48-year-old woman, they killed my pregnant daughter – she was in labour. I have only three children left. My oldest daughter, who was nine at the time the genocide and who is now 19 often says, 'Mama, I lost my brothers, my sisters and my father. I'm still alive because God wanted to save you. If you ever die, I will not be able to survive your passing.' Unfortunately, I am between life and death."

"I was born in 1973. I was in the fourth year of high school at the time of the genocide. I was raped by several men. They made me their sexual slave for the entire war. When the RPF took the city of Kigali, they told me, 'if you do not run away with us to Zaire we will kill you.' Then they took me by force, I was their war trophy. They took me to the Congo and I came back with the wave of refugees who returned in 1997. I was a virgin when they raped me. I was young and I had never known a man.

Since the end of that sexual slavery, I have never been with another man. I know that I have had HIV/AIDS for the past three years, so where do you think it came from? I was a student, I had a future before me; they took everything, they killed my family and they gave me death."

"I was born in 1955 in Kibuye. At the time of the genocide, my two children and I lived with my parents. My entire family was killed by the militia. They tortured and mutilated me. They cut off one of my arms. Laying in the middle of the cadavers, my body was bathed in blood. They thought I was dead, but I was able to hide until the end of the war. Six years ago, I began to have health problems. I learned that I had HIV/AIDS in 2000. If I had caught that disease before the genocide I would not have survived my wounds. I was several days without any care, without any water or food, but my wounds healed. Now I have become sick. I live in fear of dying. My children, aged 17 and 13, have no one to take care of them after I die. It is terrible to live in such anguish, you can't understand."

Taba, February 16, 2004

"I was born in 1960. I'm responsible for eight children. I was raped by three civilians and three soldiers. Among the soldiers, there was one high-ranking officer. It was April 18. We were three women and were running away from the killing. They made me suffer a lot, even now I suffer, I have vaginal discharge and I have nightmares. Every night I have a nightmare, I see an enormous elephant crushing my genitals, I scream as if I was reliving the rapes of 1994. After raping me, one of the soldiers started kicking me furiously in the vagina. I could no longer walk. The two other women and I stayed under the rain for two days. We were completely naked. One of the women died before our eyes. After two days under the rain, we were able to escape and we arrived in Nyamabuye during the night. A Hutu woman took care of us, she gave us something to eat and oil to cover our wounds. I began to show signs of HIV/AIDS in 1998. Many women who were raped have gotten HIV/AIDS. Several have died of AIDS. I'm afraid of dying and I am outraged that I have to die so unjustly. I gave birth to five children before the genocide. They are all in good health. But one of the two children I had after the genocide is sick, and I'm afraid to have the other one tested. When I am sick, I take antibiotics; that is all they give me. I'm a farmer, I still have a small piece of land. But farming requires a lot of strength and I don't have it. I have no income. My main desire is to expose the rapists.

The officer was responsible for the military roadblock in Cyakabiri. He was the one who gave the orders to rape us. We have lost so much, we are dying. We need emergency assistance or it will be too late. Half of our sisters are already dead. Help us to survive."

Cyangugu, February 17, 2004

"I was born in 1957, I am the mother of two children and responsible for two orphans. My husband was killed during the genocide. I was raped by 15 men in front of my children. They thought I was dead. My children went to ask for help from a Hutu neighbour. She came to help and cared for me. In 1999, for the first time in my life, I started to get sick. In 2000, my HIV/AIDS test was positive. My brothers paid for the antiretroviral treatment until March 2003. One of them died, and it was impossible for the other one to pay the monthly cost of the triple therapy by himself. I then stopped taking the antiretroviral drugs and my health has considerably deteriorated. Since November 2003, I have had chronic diarrhoea. I also have tuberculosis. If I had a bit of strength, I would be able to make a living, but I'm an invalid. I ask for HIV/AIDS treatment and some assistance so that I can make a new start."

"I'm 40. I found out that I had HIV/AIDS three years ago. Before 2001, I never had any health problems, despite the torture I was subjected to during the genocide. I was tortured and cut up with machetes that been used on other people, my body is covered in scars. I was raped by several men for three days. They said they wanted to 'taste a Tutsi woman.' They left me for dead in a trench with several bodies. I escaped. They killed my husband and my two children. That happened in Kigali; that is where I was married. After the genocide, I returned to Cyangugu, the province where I was born. I live alone because all my family was killed. I am surrounded by the people who killed my family. Three months ago, I came down with shingles. AVEGA helped me to get into a hospital. I live in anxiety about dying, and I have difficulty accepting people saying that I am a genocide survivor, the very genocide that I experience every day."

"I am 24, I was 15 at the time the genocide, I was a child. At that time I was living with my sister in Gikongoro. When the attacks began, 14 other people came to join me at the house. My sister had gone to Butare. Militia men, armed with machetes, came to attack the house. Several of the people with me escaped, but they caught me. I was raped for the entire week by several people. After, they left me alone. When my sister found me, I was unrecognizable, my mouth had been split open, I had been sexually

mutilated. In 2001, I was engaged to be married, but because I had become sickly, I took the precaution of getting an HIV/AIDS test and the doctor told me that I was HIV-positive. I then broke off my engagement; I did not want to expose the man I love to danger. I have constant back pain. The scar on my mouth swells regularly. I have no more energy to farm. My older sister takes care of me. I was raped by strangers; I will never be able to identify them. I was a child, they took my virginity, they hurt me and they transmitted death. I need treatment to survive because my life has been shattered.

Butare, February 18, 2004

I was born in 1955. I was raped from May 1994 until the end of June after having lost my husband, who was killed by the militia. That happened in Butare. Some of our neighbours were among my rapists. All those people ran away to the Congo when the RPF liberated the country. I never saw them again. I managed to get one of the rapists arrested, but he has always denied his crime. He is in jail in the Butare prison. All those men found me at home; I was alone with two of my children, the youngest ones, including my little girl who I was still breast-feeding. She is now 11 years old. In 2003, during the commemoration of the ninth anniversary of the genocide, they began exhuming the bodies buried in common graves to rebury them with dignity. The exhumation work was carried out by prisoners. That was when I saw one of my rapists. He was in terrible condition, completely disfigured by the signs of AIDS. I then began to fear for my own health. And because, in 2000, I had come down with shingles, I went to get tested. It was then that I discovered that I had AIDS. I am the mother of six children. I'm disgusted with justice, what has it done for me? But I will go to testify anyway. When the ICTR investigators came to ask me to testify, I asked if the ICTR would give me antiretroviral drugs. They told me that the ICTR provided care for all diseases except HIV/AIDS. I find that incredible, but I will still go to testify despite their refusal. It causes me a great deal of pain to see the alleged *genocidaires* receiving treatment when they have refused it to the victims. I beg the ICTR to change their attitude towards us, we have the right to survive."

Kigali, February 19, 2004

"I want to remain anonymous to spare my aunt, who is the only close relative that I have left. For her, I represent hope. I have never revealed the fact that I am HIV-positive. I was in primary school at the time the genocide. I was 14. I lost my entire family, my parents, my eight brothers

and sisters. During the genocide, they stabbed me in the back, my chest was pierced, they burnt my legs with gas. They thought I was dead. When my attackers left, I went to hide the cemetery. I stayed there three days. As I could see that I would die there, I went to a family to ask for help. That family refused to hide me and told me to go away. It was then that three men caught me. They took me to a little house far from the village. There, they raped me for two days. I was able to get away when they went out to kill other Tutsis. I got back to the town and I stayed for two weeks with other survivors. I was finally welcomed into a family and during that time, which lasted until July, the people who were sheltering me told me that the guy who worked for the Red Cross was a criminal, because he had raped several women even though he knew that he had HIV/AIDS. That family did not know that the guy from the Red Cross was one of my rapists. I lived constantly with the fear of HIV/AIDS but I had many other challenges to meet. Despite my young age, I became responsible for four children who were left by a close relative. In 1999, I became sick and I was hospitalized. In 2000, I testified in Arusha. I asked them if the HIV/AIDS test was positive, would the ICTR give me antiretroviral drugs. They told me that it was impossible. I agreed to testify anyway. In 2001, I had other health problems and I asked the doctor not to hide the truth from me. It was then that I learned I had HIV/AIDS. I was very distressed even though I had suspected it all along. I then decided to speak openly of my case at the ICTR. I told them that I had agreed to testify to help justice be served, but in return, that same justice that I wanted to help was renouncing me as a human being who is suffering unjustly and asking for help. The people at the ICTR told me that antiretrovirals were not in the list of the medication offered. During that time my health became worse and I was disgusted that I was being refused access to triple therapy. I then decided to confront the ICTR in its own contradictions. I wanted that institution to consider me as a human being who is struggling to survive."[187]

Telephone interview carried out on March 15, 2004 in Ruhengeri

"I was born in 1962, I was 32 years old at the time. I had five children and I was awaiting the birth of the sixth, who came into the world on the night of April 7, 1994. I was traumatized and I had to cut my baby's umbilical cord with my teeth. I could not leave, I had no other choice. I was

[187] At the time this essay went to press, we learned from the anonymous witness that the ICTR has recently guaranteed her triple therapy for three months.

taken to the brigade with my children, and there I was raped several times by several gendarmes. I remember wondering at one point whether I still had genitals because they had become a plaything for the gendarmes. I had just given birth, I had received no care, I smelled bad, but that didn't stop them from mounting me. And all that happened in front of my children. One gendarme had given the order not to give my children anything to eat. All my life, I had never had any health problems. At the hospital, my medical chart was only used to fill in maternity information. But in 2000, I got shingles and a short time later, several infections. At the end of 2000, I took a test and was told that I had HIV/AIDS. I became terribly depressed. I went from door to door begging people to take care of my children because I could only see death in my future. I thank heaven to have found good people who pay my children's school fees. For me, the word justice means nothing. They killed my husband and I now have to beg, when before we had a normal life. Where is justice? Those who gave me HIV/AIDS have disappeared, others are well treated in Arusha; they receive good food and treatment, while most of us don't even have anything to eat.

ACKNOWLEDGEMENTS

Saying thank you after having described the horror and absence of assistance to victims of rape and HIV/AIDS seems inadequate. So to those women, who have been stripped of everything, but who agreed to open the horrific pages of their history to me, I will not say thank you. Instead, I wish to pay homage to you. I pay homage to your faith in humanity, the same humanity that seems so indifferent to your fate. I pay homage to you for your courage and strength, which, despite everything, carries you through your days fraught with uncertainties. I also humbly acknowledge all the tears, smiles and hope you shared with me. My greatest hope is that your appeal for the right to survive will be heard and supported.

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