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Sierra Leone's 'Rebel' Babies: International Invisibility v. Program Responses at Country Level

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215,000 - 257,000 women and girls may have been affected by sexual violence over the last 10 years of conflict in Sierra Leone, according to the Physicians for Human Rights Report on "War-related sexual violence in Sierra Leone". Among them, an estimated 9% (more than 20,000 newborn) resulted in pregnancy. One might argue that the immediate human rights issue regards these raped girls and women, not the children born out of the horrific experience of rape, often seen as unfortunate "products" of the war. This is especially the case when these women are children themselves, maybe twelve, thirteen; abducted from their home by rebel forces, as in Sierra Leone, repeatedly raped by several men, sometimes child soldiers of their same age, sometimes forced to become "wives" of one of the rebels. The urgent humanitarian concern (even in terms of time pressure) regarding the thousands of young girls and women who were victims of sexual assaults during the conflict is to provide them with medical care, psychological and legal support, to facilitate the reintegration in their community after returning from "the bush", helping them to avoid the stigma which is often attached to rape.

Although the first concern for young mothers is more than justifiable, these babies born from rape still exist, and their presence is massive in Sierra Leone and in other conflict areas, even in numerical terms. These children are going to be a part of the generation growing up right after the war, of which they are an uncomfortable reminder, and yet they deserve the same right to a life with dignity as the rest of the population, the right to survive and thrive, to receive an adequate education, to have access to medical treatment, to have a family who loves them and takes care of them.

An endless number of questions and issues could be raised around this complex topic. However, this paper will just address the issue from a limited perspective: that of emergency response Though, the physical and mental status of these children has implications beyond the emergency relief and post-conflict effort, even in the immediate aftermath of the conflict their specific needs must be taken seriously. Below, the case study of Sierra Leone will be evaluated below. In the first section of the paper, I summarize what is known about this category of child in the Sierra Leone case, extrapolating from existing source documents. In the third section, I provide an overview of the existing humanitarian response, and consider whether these children's particular needs are adequately served by current humanitarian programming in Sierra Leone.

The findings below are based on a multi-method analysis of existing literature on sexual and gender-based violence in Sierra Leone, supplemented where possible with interviews with humanitarian practitioners in the region. that there is hardly any literature focusing on children born from rape either as specific study population, or as direct right-holders under international law. This is another indication that these children are still left in the shadow, and they are hidden behind the statistics of pregnancies as result of rape. In order to find some qualitative/quantitative data, I had to look at epidemiological evidence and gray literature concerning sexual violence in conflict situations, and to look for specific paragraphs in which the issues of forced pregnancies and/or impact of violence against women were addressed. The annotated literature at the end of the paper provides an overview of the result of my "treasure-hunting" for relevant documentation.

Sierra Leone as my focus country was the availability of a comprehensive population-based study on war-related sexual violence (Physicians for Human Rights 2002), which provided reliable data, both quantitative and qualitative. Also, the special focus given to girl soldiers in two recent

reports by Susan McKay and Dyan Mazurana was a good opportunity to explore the issue of forced pregnancies within this study population, trying to shift the perspective of the analysis from the girls to their babies. Some of the most useful information, however, was provided by the type of specific international response for pregnant girls as result of rape in terms of programs put in place at country level. Such response allowed to deductively identify some of the main issues related to children born from rape, even in the absence of data to exactly quantify the dimension of the problem. For example, an American NGO called Leonet works with unwanted street children in Sierra Leone, many of whom are sexual violence/abduction survivors (PHR 2002) . Leonet has been assisting a number of young girl abductees who have been rejected by their families due to resulting pregnancies. The presence of this NGO which responds to these "hopeless" cases is evidence of a demand of a service because a problem exists: the problem of stigmatization of children of rape and their young mothers by some of their families.

The most useful sources of information about the programmatic response to children born from rape in the Sierra Leone conflict were Annex C in the PHR Study, which is a recompilation of programmatic experiences within Sierra Leone by different organizations, and also a few interviews to programme managers to provide more details of a specific example of intervention at country level. For example, Philip Kamara, the former coordinator of the Conforti Welcome Home, Interim Care Center for pregnant abductee girls and their children was interviewed to provide insights on the program managed by COOPI, an Italian NGO (Cooperazione Internazionale).

This process of "reading through the lines" of several documents did not allow me to obtain comprehensive answers to my research questions, but it certainly made me reach the conclusion that more targeted studies towards this specific study population are urgently needed, and that some of the answers are already in the field, given the presence of services to respond to specific needs within the population, even though they are not well documented yet. In short, despite the invisibility of this category of child in existing human rights discourse, humanitarian practitioners are taking some steps to alleviate the worst harms to which these children are suspect. These responses should be evaluated, strengthened, and replicated as appropriate in other country contexts where wartime sexual violence is prevalent.

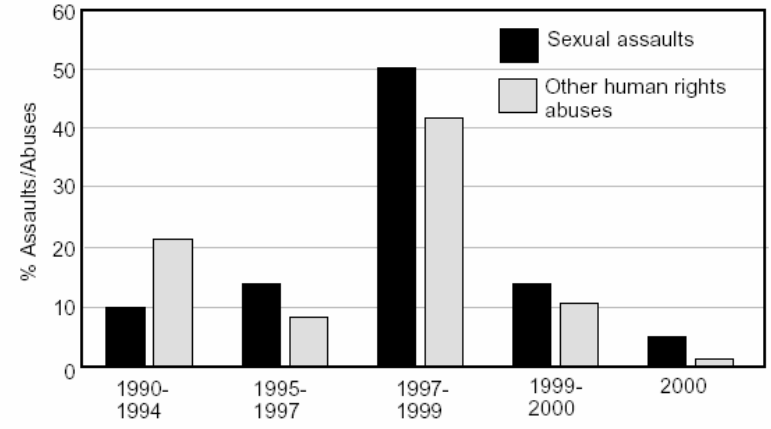
Children Born of Sexual Violence in Sierra Leone

Two studies helped me find some quantitative and qualitative information about children born of rape and their mothers in Sierra Leone. One study is the 2002 Physicians for Human Rights (PHR) report, the other is a policy paper called "Girls in fighting forces in Northern Uganda, Sierra Leone, and Mozambique: policy and program recommendations". Other qualitative and anecdotal information was available through the 2003 Human Rights Watch Report on Sierra Leone and another Amnesty International Report from 2000.

PHR sampled 1,048 households in three IDP camps (near Freetown, Port Loko, and Kenema) and one community with a large number of IDPs, Mile 91 Township. The camps/locales included in this study represented the 91% of the registered IDP population in Sierra Leone. All participants were selected using systematic random sampling or a combination of systematic random sampling and cluster sampling. A total of 991 female heads of household participated in the study (response rate 95%). The 991 household representatives reported on the experiences of 9,166 household members, which included themselves and those who lived with them prior to the displacement. The PHR survey contained 49 questions pertaining to demographics, physical and mental health perception, experiences of human rights abuses among household members and experiences of sexual violence. It also inquired about assistance needs, opinions regarding punishment and justice for perpetrators, and attitudes on women's human rights and roles in society. In order to gain additional insight into individual experiences of human rights abuses of Sierra Leonean women and their families, the PHR study included qualitative assessments of abuses as well, with seven open-ended questions included in the questionnaire, and longer semi-structured interviews conducted with survivors.

The most interesting findings to my research concern the reported human rights abuses among household members. Regarding sexual violence, 9% (94) of the 991 respondents reported one or more war-related sexual violence experiences. Study participants also reported sexual violence among 396 (8%) females and 6 (0.1%) male household members. The prevalence of war-related sexual violence among female households may be as high as 11% (554/5001) if 158 women, who did not report sexual violence, but either became pregnant, or experienced vaginal bleeding, pain, swelling, uterin pain, vaginal discharge, or sexually transmitted diseases, are also included. For all abuses reported, the RUF was identified most often (1,490, 40%) as the perpetrator. Respondents reported that 36 (9%) female household members became pregnant as the result of the attack. Respondents also reported that the majority of the abuses occurred in the past three years, with most of these occurring between 1997 and 1999. Therefore, it can be estimated that the majority of the children born of rape in Sierra Leone are in the age range 4 - 6.

FIGURE 2:
Occurance of Sexual Assaults Among Respondents and Other Human Rights Abuses Among Household Members



Source: PHR Survey Sierra Leone, 2002

One first consideration is that there might be a natural underestimation of the reported pregnancies, as a result of fear of stigmatization or refusal from the community. Even the interviewed heads of household might have contributed to such an underestimation, maybe in the attempt to protect some of the pregnant girls within the household.

Very little is known about the level of care given to the children born of rape by their mothers or primary caregivers. A recent mortality survey conducted between 2000 and 2001 by the International Rescue Committee (IRC) in Kenema District showed a dramatic increase in child mortality, especially neonatal and infant mortality, if compared to 1999 data.. The survey recorded 197 deaths of children under 5 over the year covered by the survey, which corresponds to a crude mortality rate (CMR) of 3.7/1000/mo, or 440/10,000/yr (almost twice the rate estimated by UNICEF in 1999). Neonatal mortality rose to 53/1000 live births, while infant mortality was 330/1000 live births (95% CI 241-365). In regards to the 21% of child deaths which did not receive any treatment by a health provider, it would be interesting to know the reasons for such a lack of care-seeking, and how many of these children were born from an unknown father during the war. This information could provide a possible proxy for health care seeking patterns for children born of rape by their mothers, at least within the district covered by the survey. Unfortunately, the survey report did not reach such level of detail. Among the 77% of these child deaths which reached some government health facilities, it would be important to know whether the deaths were mostly attributable to poor health care or to delay in seeking health care by the mothers. Lack of knowledge to recognize signs of illness among very young mothers (who are often younger than 18) could be

an important factor behind these increased deaths. This hypothesis seems to be confirmed by some of the services provided within the interim care centers established by NGOs for pregnant women and their babies, which include training to improve young mothers' skills to take care of their children. The Conforti Welcome Home established by the Italian NGO COOPI provides a good example of such programs.

Additional to the increased rate of neonatal mortality, the trend rate of abortions would also be useful to know, in order to have a better idea of the destiny of the children of rape. Anecdotal reports included in the 2003 Human Rights Watch Report on Sierra Leone "We'll kill you if you cry" suggest an increased trend. As described by M.W., an abducted nurse who was interviewed, "Many women and girls became pregnant as the result of the rape(s) they were subjected to. Although some women were reportedly able to abort without the knowledge of the rebels using traditional herbal treatments, the majority had no choice but to carry the child to full term[1]". M.W., the abducted nurse, also mentioned that "Medical personnel were instructed by a rebel doctor, Dr. Lahai, not to perform abortions, give birth control, or advise that traditional herbal treatments be taken, as the rebels felt that too many people had died and they needed to increase the population. Many women did have miscarriages because of the brutal rapes and trauma they were subjected to by the rebels, as well as the difficult conditions in the bush" (Human Rights Watch 2003).

Dangerous childbirth practices were also reported, especially for pregnant girls who participated in fighting, such as pushing on the pregnant girl's abdomen when labor contractions are strong and beating the mother when she is giving birth. Maternal and infant deaths in the bush were reported (Mazurana, McKay 2003, page 15). In Sierra Leone, babies were left behind (for example, at a clinic or with captor husbands in the bush), died in the bush, or were killed by rebels, sometimes by cutting them out of the pregnant girl's body. Many girls died in the bush from abortions induced by girls themselves, by nurses and doctors in rebel forces, and by traditional birth attendants. Finally, being pregnant or the mother of children could have either highly adverse or relatively favorable consequences, depending upon the context and the girl's roles and status within a fighting force.

Some additional pieces to the scattered puzzle which attempts to portrait the conditions of children born of rape in Sierra Leone is provided by the recent report by Mazurana and McKay on girls in military and paramilitary groups. Among the estimated total force of child soldiers (48,216: 22,500 estimated to be part of the RUF), 7,500 are estimated to be girls. According to Mazurana and Carlson's study population (N=50), most girls and young women reported that their primary roles were as cooks and fighters, followed by porters, "wives" and food producers. All respondents who reported their primary role as fighters also reported that they were forced to be "wives", with "wives" of commanders holding considerable power and influence within rebel compounds (Mazurana 2003).

Within Mazurana's and Carlson's study, 49% of respondents said participation in skills training was the most important factor in helping to mitigate the hardest aspects of reintegration. While 68% of respondents participated in skills training, 90% reported that the training was important for them and rated it as excellent or good. However, a number of girl mothers are unable to attend skills training classes because of the lack of adequate care for their children, which, in their cases, related to stigmatization and rejection by their families who might welcome the girl back but not her children (Mazurana, McKay 2003, page 15-16).

As a result, a number of policy recommendations are provided in the paper to tackle the challenges faced by girl mothers and their babies within the reintegration, such as: the development of income-generating skills training and educational programs for this target group; ensuring that

[1] For example, I.S., a twenty-seven-year-old student who was abducted by the AFRC during the January 1999 invasion, tried to abort, but was unsuccessful: "When I got pregnant I didn't tell my rebel husband for months. I asked a woman who knows about medicine to give me herbs to abort the baby, but it never worked and after my belly started to swell, he found out. He warned me that if I tried to flush the baby out, he'd kill me. He said he wanted the baby and that he hoped it would be a boy".

skills training includes basic literacy and numerical skills to help girls manage future accounting. Skills training programs should also consider the rights and needs of girl mothers, in particular providing space and food for mother and child during the day. Similar conditions should be taken into account for girl mothers wishing to return to school. The report stresses the fact that, because of stigma and rejection, relying on family members to take care of the children of girl mothers during the day does not appear to be realistic, and other means should be developed (Mazurana, McKay 2003, page 25).

Some traditional and religious rituals can also be used to impose community normative behaviors- such as forbidding girls and their babies to be called "rebel wives" or "rebel babies", and laying the groundwork for not talking about what happened in the fighting forces. When they are contextually appropriate and safe, produce no further trauma, and do not contravene international human rights standards, rituals can be an important part of the healing process when children return to their communities (Mazurana, McKay 2003, page 29). The report stresses that returnee girl mothers and their babies/children are a highly vulnerable group within Sierra Leone. Even if the girl mother is welcomed back by her family and community, the babies are often poorly accepted. If the father is unknown, the stigma is greater. Cultural factors, such as whether a society is matrilinear or patrilinear, affect whether babies are accepted, although this is complex because of complicated notions of whether the baby belongs to the father or mother's family.

Both mothers and babies face major health threats, HIV/AIDS in particular (vertical transmission and AIDS orphans issue), but also lack of access to basic health care, food, shelter and clothing. Furthermore, attachment disorders between mothers and babies can affect the ability of these babies to thrive. In relation to HIV and other STDs, it is reported that the majority of the girls returning from fighting forces have STDs, including syphilis, gonorrhea, chlamydia, and HIV/AIDS. STDs are sometimes treated, especially when demobilization is conducted through a rehabilitation or interim care center or if an NGO has established primary health care services. For returning girls, HIV/AIDS is a significant threat to themselves and their communities. Testing is seldom available or may not be offered unless requested. If the girl is HIV-positive, no treatment exists at this time (until anti-retroviral therapy is available) other than supportive counseling. This has also major implications on the risk of mother to child transmission of HIV (Mazurana, McKay 2003, page 27).

Another possible problem is related to the relation between the girl mother and the rebel captor within the reintegration process after the war. It is quite common that a girl with a baby and a rebel-captor husband who might potentially marry her according to community customs of marriage can find herself in a more advantageous social position than a girl reintegrating with a baby and no "husband". If her bush captor-husband is accepted by her family and community, she avoids the great cultural fear that she is not wanted by a man or that she might not have a husband. In some cases, girls need help getting away from their rebel captor-husbands. Due to economic and social factors (such as whether she will be accepted if she returns to her community with a baby or children), girls may face the difficult choice of staying with their bush captor-husbands or becoming sex workers (Mazurana, McKay, page 27).

The Humanitarian Reponse

With scarce resources and constant emergency situations, both the government of Sierra Leone and the UN agencies face a number of difficulties in providing coordination, continuity and leadership for the myriad of humanitarian and development needs in the country. Therefore, services addressing the various aspects of sexual/gender violence are fragmented and coordination is a continuing problem. In spite of these challenges, there are a plethora of international NGOs and UN agencies efficiently operating in Freetown and other areas.

Below, I briefly overview the major international actors whose response, during and in the aftermath of conflict, is relevant to the needs and challenges of babies born of rape and their mothers. I then provide a more in depth analysis of the work of a specific organization the Italian NGO COOPI and its "Conforti Welcome Home." This case study serves as a critical example of programme response at country level.

Overview of International Response

International agencies operating in Sierra Leone around the issue of SGBV response included several of the major internationals, including UNICEF, IRC and Caritas; issue-specific international NGOs such as Marie Stopes Society; and local or regional NGOs, including the Forum for African Women's Educationalists (FAWE).

Of these, UNICEF played a major coordinating role among the various agencies (PHR 2003). It chaired a sexual violence committee in Freetown comprised of international, local and government agencies working on the needs of girls. The committee met regularly and its members included: COOPI, MSF-Holland, Marie Stopes, CARITAS, GOAL, FAWE, Planned Parenthood Association of Sierra Leone (PPASL), the Ministry of Social Welfare, and the Council of Churches of Sierra Leone with their Child Rights Monitoring Network. During and in the aftermath of the conflict, the Committee has acted as a referral system for girls who were abducted and raped. While UNICEF's efforts are focused on those under 18, the needs of women are also being addressed through their education efforts, which are aimed at the population as a whole. UNICEF has been providing training on sexual violence for lawyers and police, as well as in schools. They have found that more women and girls are coming forward, but that the judicial process is slow and frustrating.

Other major international humanitarian NGOs include the International Rescue Committee (IRC) and Caritas. IRC is providing comprehensive maternal-child health services, sexual violence services and operating an interim care center for former child soldiers in Kenema District. The IRC was the first international NGO to focus on sexual violence beginning in November 1999 in Kenema. It has been providing sexual violence services under the umbrella of a safe motherhood program which addresses basic reproductive health. CARITAS is an NGO working as UNICEF child protection partner and operates interim care centers in Lunsar and Makemi.

Some NGOs based in donor countries focus on particular issues. Maries Stopes Society (MSSSL) is an international NGO headquartered in the UK, focusing in reproductive health matters. Similarly, Leonet is an American NGO, which works with street/unwanted children, many of whom are sexual violence/abduction survivors. Many sexual violence survivors are seen among the 7,000 women treated every month in the three MSSSL outpatient clinics in west, central, and east Freetown. The organization accepts referrals for abandoned children and rape survivors in need of delivery services through the Child Protection Committee on Sexual Violence, which MSSSL fully subsidizes. Like other members of the Sexual Violence Committee, Marie Stopes does not test patients for HIV partly because of concerns over the lack of an official national policy on confidentiality of test results. Although MSSSL's concerns are valid, hundreds of pregnant women are passing the disease to their babies or to their partners when transmission could be prevented through medication. Leonet has been assessing a number of young girl abductees who have been rejected by their families due to resulting pregnancies. UN agencies, government ministries, and NGOs refer the "most hopeless" cases to Leonet. In 2000, the organization was operating a day care and skills training centers in Kissy, the eastern part of Freetown, which was hardest hit by the January incursion of 1999, and was operating in Port Loko. The building was given by the community and was open to other single mothers and their babies, but the program was at a standstill because of lack of funds. Leonet uses Marie Stopes for referrals.

The Forum for African Women's Educationalists (FAWE) is a pan-African NGO which has been successful in promoting education for girls. FAWE expanded their mandate to respond to the needs of rape victims after the January 1999 incursion by rebels in Freetown and, because there was a vacuum, became the primary organization providing medical and counseling services to rape survivors. Their ultimate goal, in service of their mandate, is to get these girls back to school and as of March 2000 they had been 100% effective in negotiating with parents of girls who had babies as a result of rape, to keep them in school. FAWE has been working to sensitize the community at large to accept girls who have become pregnant as result of rape. Many of these girls have been gang-raped and do not know who their father is. There is often a stage of rejection of these babies both by the mother and their communities. FAWE created two training centers in the Eastern area

of Freetown, which provide comprehensive services to young women/girls and their babies including: skills training, education, parenting skills and medical care for their children. They do not provide human rights training specifically, but do sensitize the adolescents about what is appropriate treatment. Young women participating in the program who were interviewed by the PHR team expressed a keen interest in learning marketable skills so they could take care of their children (PHR 2003). In 1999, FAWE served over 2,000 women and girls in the Western area alone. In 2000, it expanded its programs to Kenema in the Eastern area, where sexual violence has been particularly widespread, and immediately enrolled 700 victims.

Case Study: The Italian NGO COOPI and the "Conforti Welcome Home"

The Italian NGO COOPI is an example of a programme response to children born of sexual violence survivors at country level. COOPI (Cooperazione Internazionale) is an Italian NGO which has been working in Sierra Leone since 1967. In 1998, when the rebels invaded Freetown and the invasion increased the suffering of children as they were recruited, abducted, raped, sexually abused, conscripted, amputated and a range of atrocities were committed on them, COOPI was spurred into Child Protection activities such as the provision of humanitarian assistance for them.

In collaboration with UNICEF, ECHO and the MSWGCA, COOPI started working with sexually abused girls released by the fighting forces as its beneficiaries. Subsequently the focus extended to de-traumatised Internally Displaced Persons (IDP's) in their various camps and communities. As the warring factions continued to release children, the issue of separated children and child ex-combatants came in the limelight, and they were incorporated as another set of beneficiaries of COOPI Social Reintegration programmes.

In the accomplishment of this expanded mandate, COOPI started operating several interim care centers, that provide family tracing services, medical care, counseling and skills training. One of the three Interim Care Centers (ICCs) created within the social reintegration program, the Conforti Welcome Home is a very interesting example of programme response at country level for girls who became pregnant as a result of rape and their children. It is similar to FAWE's program, except that it also provided housing to the mothers and their children.

Conforti Welcome Home was set up in Freetown as a temporary facility for pregnant girls and child mothers who could not go home for reasons ranging from their area of origin being inaccessible for fear of rejection by their families. Entirely supported by UNICEF, it opened in 1999 and closed in October 2002. It hosted 200 mothers and 193 children (7 were miscarriages). All girl mothers were former child combatants, age 8-15.

The primary objective of the Conforti Welcome Home was to eventually reunite the girls and their babies to their families and communities, overcoming stigma and possible initial rejection. A family tracing and reunification program (FTR program) was run within the center, which accomplished to successfully reunite 75% of the cases. Key tools to overcome stigma and reunite families included: radio massive campaigns; 1-2 TV appearances community involvement, through the creation of Community Child Welfare Committees, composed by local authorities, from the political field, education, health, and police forces.

An array of services were directly provided to the young mothers and children while in the center, such as income generating activities and skills training; those enrolled in the program expressed a desire for skills training before returning to their families so they have something to offer and are not dependent. COOPI was therefore providing them with such training, as well as general education and literacy, and was actively working to sensitize communities and families to be more accepting and supportive of these young mothers with their babies. The center was also providing care for children for mothers who went to school, as a form of support and incentive for them not to drop out of school. Psychosocial support and medical referral to a private clinic funded by COOPI was also part of the services provided by the center; COOPI operates the Holy Mary Clinic in the Eastern part of Freetown where the women and girls at Conforti Welcome Home receive a full range of reproductive health services including deliveries.

After Conforti Welcome Home and the other Interim Care Centers closed, COOPI was able to ensure continuity of its work and moved to work with community children through the community-based reintegration programme and as well as undertaking water and sanitation in Kono and closely working with Progressive Women's Association (PROWA) in aiding women's groups (Kamara 2004).

Information on the experience and achievements of the Conforti Welcome Home was gathered through a phone interview with Phillip Kamara, former coordinator of the Conforti Welcome Home, who last year testified in front of the Truth and Reconciliation Commission (TRC) on behalf of the ex-child combatants that COOPI has worked with from the period December 1999 till October 2003 (Kamara 2004).

This case study helps highlight some of the common gaps which need to be filled within the programme response to the need of children born of rape in conflict and post-conflict situations and their mothers in Sierra Leone. A first gap is the lack of follow-up monitoring of the conditions of those children who were re-united to their families and communities, from a child protection and health perspective. There is an urgent need for longitudinal studies on this target population, especially in the post-conflict situation. The long-term mechanism through which stigma operates should be investigated. There is an ethical issue which should be carefully considered, though: while it would be necessary to collect individual information on the children and their mothers to be able to look at specific outcomes - like morbidity, mortality, any proxy for stigmatization/marginalization of children, adoption, institutionalization, proportion of street children – it would be extremely important not to violate privacy issues and therefore risk to create even more stigma around these children.

Related to this first gap is the more general issue of lack of international funding for post-emergency context: funding often follows the big waves of emergencies, and once a conflict and its immediate aftermath are over, funds tend to disappear. This common trend makes it difficult to raise funding and attention on a possible silent emergency like the issue of stigma in the reintegration process of children born of rape and their mothers within their own communities.

Conclusions

Research on babies born of rape as a result of conflict in Sierra Leone was both intriguing and challenging. Lack of epidemiologic data, lack of an explicit status of these children under international law and under the labels of emergency relief/child protection programs made it extremely difficult to gather information on this population. However, if the estimates of the PHR studies are correct, it is not possible for the international community to ignore 20,000 children under five (only in Sierra Leone!) which are most likely to be a particularly vulnerable segment of the population, given their "history". Longitudinal studies on the health and psychological status of these children and their mothers are urgently needed, and this point has already started to be raised in some studies, such as the Canadian 2003 policy paper on girl soldiers in Sierra Leone, Northern Uganda and Mozambique and the 2000 PHR study. Ongoing programming efforts at country level can provide a key source of information to help fill in the current data gap. Community and families' participation in the reintegration process of girl mothers and their babies is essential within a long-term healing process in the aftermath of the conflict.

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