DRAFT: DO NOT CITE WITHOUT AUTHOR'S PERMISSION

"Children Born from Rape: Overlooked Victims of Human Rights Violations in Conflict Settings"

Kathleen T. Mitchell, MD
Johns Hopkins University
School of Public Health

Introduction

While rape has occurred in conflict settings for centuries, and while countless children have been born as a result, sexual and gender-based violence (SGBV) has, until recently, been considered an inevitable consequence of war. The children born of rape have not been considered at all. It is only in the past decade that war-related rape and other forms of SGBV have been successfully prosecuted as war crimes, crimes against humanity, and genocide under international humanitarian law. A similar recognition of human rights violations against children born of rape as crimes under international humanitarian law has yet to occur.

To date, the specific rights of children who are born as a result of SGBV have not been adequately addressed under international humanitarian law. There are, however, several arguments that can be made on behalf of the rights of this vulnerable group of children under international human rights law. This is particularly true in relation to violations of right to health and the various determinants of this right.

Children born as a result of SGBV in conflict are at risk of infanticide, abuse, abandonment, rejection, and marginalization[1-3] and, as such, are also at risk for severe human rights violations. Because human rights are universal, interrelated, and indivisible, the violation of any one of them necessarily violates the right to health. Public health practitioners, human rights advocates, and providers of humanitarian assistance have the obligation to ensure that states respect, protect, and fulfill the human rights and, in particular, the right to health for this vulnerable population.

> *I really don't hate him but I feel this child is not mine…I could not imagine how I would nurse this child. I wanted to kill this child. I looked at him and I wanted to kill him. I beat him even when I was still nursing him. I beat him even now.*[4]
>
> Rwandan woman, speaking of her child born as a result of rape.

Problem Definition

Over the course of the 20th and 21st centuries, civilians, and particularly women and children, have become increasingly vulnerable to victimization in times of complex humanitarian emergencies. "Civilians, particularly women and children, account for the vast majority of those adversely affected by complex humanitarian emergencies, including as refugees, internally displaced persons, and increasingly are targeted by combatants and armed elements for murder, abduction, forced military conscription, involuntary servitude, displacement, sexual abuse and slavery, mutilation, and loss of freedom."[5]

Sexual and gender-based violence (SGBV) in time of war is not a new phenomenon; conquering forces that "rape and pillage" their enemies have been both feared and romanticized throughout history. This violence was largely considered to be an inevitable consequence of war, or a "normal" release of energy on the part of the soldiers. In the late 20th and early 21st centuries, however, SGBV against women and girls has become increasingly recognized as a weapon of war and, as such, has been widely condemned. The publicity surrounding the atrocities committed by Serbian forces against Muslim women in Kosovo and the systematic rape of women and girls during the civil wars in Sierra Leone, the Democratic Republic of Congo (DRC), Rwanda, and Darfur,

have caused international outrage and inspired the development of programs aimed at the prevention of SGBV in complex humanitarian emergencies and at responding to the physical and psychological needs of the women and girls who are victims of such violence.

Despite the international attention placed on prevention of SGBV and programs directed toward the victims, there appears to have been very little attention paid to invisible victims of this violence: the children born as a result of rape. While literature from the United Nations High Commissioner for Refugees, the International Committee of the Red Cross, and international human rights organizations recognize the existence of these children,[1, 6, 7] little more than a brief mention of them and their needs is made in the documents published by these agencies. There is very little in the published literature regarding how many children have been born as a result of rape in complex humanitarian emergencies, and, to date, no investigation specifically directed toward identifying the outcomes of these children has been published.

Why do children born as result of SGBV in conflict settings deserve special attention? What makes them unique from other children in similar situations? Because of the circumstances surrounding their conception, and because of social and cultural norms that contribute to their marginalization, children who are born as a result of rape in conflict settings are at risk of systematic human rights violations, in particular, violations of their right to health.

Magnitude of the Problem

In order to comprehend the problem of children born as a result of rape in conflict settings, it is important to understand the phenomenon of SGBV. While SGBV can be directed at men and boys, the most frequent victims are women and girls. The United Nations General Assembly, in the *Declaration on the Elimination of Violence against Women*, defines violence against women as "physical, sexual, and psychological violence" occurring in the family, within the general community, or when "perpetrated or condoned by the State," including, but not limited to: "battering, sexual abuse of female children…marital rape, female genital mutilation…sexual abuse, sexual harassment and intimidation…trafficking in women and forced prostitution."[8] SGBV directed at women has its roots in those social, economic, and cultural structures that promote gender inequality and which place women in positions that are subordinate to men. In times of conflict or in refugee settings, these pre-existing problems are exacerbated by the disruption of social and family structures, indignity, insecurity and the disruption of traditional male roles.[9] Gender-based violence violates such basic human rights as the rights to life, health, dignity, freedom from torture, freedom from slavery, non-discrimination, and equal protection under the law.

SGBV in War. During World War II, the Japanese military forced some 200,000 Asian and Dutch women to serve as "comfort women" for their troops, holding them as sex slaves and subjecting them to rape, torture, and death.[10] During the conflict in Bosnia-Herzegovina from 1992-95, an estimated 20,000 to 50,000 Muslim women were raped by Serb soldiers as part of an ethnic-cleansing campaign.[11] An estimated 500,000 women were raped during the Rwandan genocide of 1994,[12] and massive systematic sexual

violence has been reported in conflicts in Bangladesh, East Timor, Sierra Leone, Liberia, the Democratic Republic of Congo, Uganda, and Sudan, to name only a few.

Violence on the basis of gender is used as a weapon that dominates and degrades not only women but societies as well. The violation of women disrupts family and social structures and symbolizes the rape of the community by the enemy force.[13] Women may be raped in front of their husbands, fathers, or sons in order to demonstrate the powerlessness of men to protect them. Sexual violence is used as a tool in campaigns of ethnic cleansing or genocide: victimized women may be forced to bear their enemy's children, thus diluting bloodlines; they may have their fetuses violently aborted; or they may be rendered sterile as a result of violence or mutilation. In countries where abortion is legal, women who become pregnant as a result of SGBV during times of conflict may not be able access abortion services because of discrimination, disruption of the medical system, lack of security, fear, or shame; these women often have no choice but to carry their pregnancies to term.

Gender-based violence in refugee settings. Women who seek refuge in camps do not escape the threat of SGBV. Women and girls, particularly those who have been separated from male family members, risk rape, abduction, trafficking, and exploitation at the hands of combatants, military personnel, bandits, male refugees, or border guards as they flee from their countries of origin.[14] Once in refugee camps, women are at risk of attack as they travel to collect firewood, or as they walk to peripherally-located latrines or washing sites.[14] In March 2004, the UNHCR reported that up to 16 women were being raped per day as they collected water in a camp for internally displaced persons in western Darfur.[15]

Women and girls are subject to exploitation by local camp personnel, international NGO workers, humanitarian aid workers, and peacekeepers who demand sexual favors in exchange for documents, food rations, or assistance.[16] Single women may be sexually exploited when they are housed with families other than their own,[16] and young girls may be forced into early marriage in similar situations. Women living in camps with their husbands or partners may be victims of domestic violence; while some of these women were likely victims of domestic violence prior to fleeing their homes, the problem may be worsened in the stressful refugee setting.

Of particular concern is the fact that women in refugee settings often do not seek medical attention, and their situation goes unrecognized and unreported. This is, in part, due to a lack of women doctors and health professionals in the camps. Amnesty International reports that in Ethiopia and Zambia, women and girl refugees told investigators that they would not seek medical attention from male healthcare workers.[15] They may also fail to seek medical attention or report SGBV for fear of reprisals by the perpetrators or because they do not want to draw attention to their situation. Victims of SGBV and women who have borne children as a result of rape may be rejected by their husbands or their families and may not be allowed to return to their communities of origin, being seen as "dirty" or "ruined" and bearing the blame for the violence that they have suffered.[10]

Children born as a result of SGBV. It is uncertain how many children have been born as a result of SGBV in conflicts in recent years, but the numbers could range in the tens of

thousands. Women may be hesitant to report rape and associated pregnancy for fear of stigma or ostracism, and many will seek abortion services (when they are available) or will attempt to abort using traditional or unsafe methods. Numbers reported in the literature are often inaccurate, and are likely to be under-estimates.

While it is not crucial to have precise data in terms of the number of women who have been raped, the number of rapes that resulted in pregnancy, or the number of children born as a consequence, it is useful to have a general idea of the magnitude of the problem of children born of rape in conflict for purposes of investigation, programming and resource allocation.

Risk of pregnancy as a result of rape. In order to estimate the magnitude of the problem of children born as a result of SGBV in conflict, it would seem plausible that an estimate should first be made of the numbers of pregnancies that result from rape. This could be calculated by multiplying the rape-related pregnancy rate by the estimated number of rapes that have occurred. A conservative estimate of the number of children born as a result of rape would be 50% of the calculated number of pregnancies resulting from rape. This factor would take into account those pregnancies not resulting in live birth, as in cases of spontaneous or induced abortion, stillbirth, or maternal death resulting in fetal death. This formula would be of use in formulating rough conservative estimates of the numbers of children born in conflict settings in which rapes have been reported and could be used for initial program planning and resource allocation.

A longitudinal survey of 4,000 adult women in the United States found a rape-related pregnancy rate of 5% among women aged 12 to 45 years;[17] the International Planned Parenthood Foundation has associated an 8% risk of pregnancy with unprotected sexual intercourse;[18] and Medecins Sans Frontieres (MSF) reports that 7% of women who present at their clinics in Darfur for medical attention after rape know that they are pregnant as a result of their trauma.[19] (MSF notes that 40% of women present within the first month after rape, before they are aware of their pregnancy status, suggesting that the actual percentage of pregnancies resulting from rape may be higher.[19])

In light of this information, it would seem reasonable to use a risk factor of 5% to 8% as the basis for estimating the number of pregnancies that would occur as a result of rape in conflict settings where estimated data is not already available. Using the more conservative number of 5% could take into account the women and girls of non-reproductive age who are victims of SGBV (the numbers of which may be higher in conflict settings than in non-conflict settings) and who, by definition, cannot become pregnant.

In Rwanda, an estimated 800,000 people were killed between April and July 1994.[20] Up to 500,000 women were raped,[9] giving birth to between 10,000 and 25,000 "children of bad memories," *les enfants de mauvais souvenir*.[4, 21] In Rwanda, abortion is illegal, but many women used traditional methods to abort their pregnancies or traveled to neighboring Zaire in order to obtain abortion services.[22] These figures indicate that an estimated 2% to 4% of Rwandan women who were raped gave birth to children and is consistent with a rape-related pregnancy risk of 5% to 8%.

In the example of Bangladesh, however, the percentages of 5% to 8% are less predictive. In 1971, between 200,000 and 400,000 Bengali women were raped by Pakistani solders during Bangladesh's nine-month war for independence,[3] and 25,000

pregnancies were reported as a result.[3] This would mean that between 6% and 12% of raped women gave birth as a result of SGBV. These percentages are high in light of the fact that many raped women aborted their pregnancies, either through medical services provided in clinics in Bangladesh or India or through the use of traditional methods.[3] If the rape-related pregnancy rate of 5% to 8% is accurate, rape was likely under-reported in the Bengali conflict.

A conservative application of 50% of the rape-related pregnancy rate, therefore, is of limited use in predicting the number of children who are born as a result of SGBV and is likely most useful in those situations in which information regarding the magnitude of the problem is not available. The primary limitation of the use of this formula is that the estimates of SGBV are often inaccurate due to under-reporting of rape. In addition, such factors as accessibility of healthcare services, access to reproductive health services (including emergency contraception and abortion services), traditional abortion practices, as well as cultural beliefs and local laws regarding emergency contraception and abortion will influence the number of pregnancies carried to term and will vary from one context to another. In conflict situations in which rape is prevalent and the numbers of children born as a result have not been determined, the use of this formula could be used to establish a conservative estimate of the magnitude of the problem that could be used as a guide for initial program planning and resource allocation.

Country profiles

Former Yugoslavia. The use of rape as a weapon of war in the conflicts in the former Yugoslavia during the early and mid-1990s was widely publicized and caused international outrage. Systematic rape was part of an ethnic cleansing campaign carried out by Serbian forces against Muslim populations in Bosnia-Herzegovina and Kosovo. Massive rapes were carried out in villages, and thousands of women were kidnapped and raped repeatedly in detention camps. Women who were raped were told by Serbian soldiers that they were producing "little Chetniks."[23] It has been estimated that between 20,000 and 50,000 women were raped during the violence in Bosnia,[24] and while the number of women raped during the conflict in Kosovo is not known, it is estimated at around 20,000.[25]

In Kosovo, information regarding the number and fates of these children born of rape is not easily found. During the month of January 2000 alone, international humanitarian organizations reported that at least 100 babies were born in Kosovo as a result of rape.[26] Many more were likely born but not reported because of cultural stigma surrounding sexual violence. For Albanian women, rape is a fate worse than death, and it is likely that many women who became pregnant as a result sought abortion. A gynecologist at the University Hospital in Pristina reported that during the conflict, physicians "were conducting abortions around the clock."[26] For many women in both Bosnia and Kosovo, however, abortion was not an option, either because they presented for medical attention too late, or because they were purposefully held in captivity until late in their pregnancies, so that they would be forced to carry the pregnancies to term.[25, 27] A UNFPA consultant reported that for "[m]any Kosovar families…it was impossible for them to keep a baby that was the result of a rape even if the woman did not necessarily want to have an abortion."[28] One Kosovar husband told a journalist that if his

wife were raped, he would consider her "dirty, evil, the castle of the enemy."[26] He went on to say that women who become pregnant as a result of rape should give birth in secret and "if they are even more sensible…they kill their scum-babies." [26] Those children who survived have been referred to as "children of shame." [26]

Sierra Leone. The decade-long civil war in Sierra Leone was characterized by murder, mutilation, rape, and massive displacement of the population. Upon cessation of fighting in January 2002, an estimated 50,000 people had been killed, 100,000 mutilated, and over half of the population had been displaced.[9, 29] Physicians for Human Rights (PHR) estimates that between 50,000 and 64,000 IDP women in Sierra Leone were victims of war-related SGBV.[30] (If the non-IDP female population and non-war-related cases of SGBV are considered, PHR estimates that up to 257,000 women and girls were victims of rape during the years of the civil war.[30]) 9% of Sierra Leonenan IDP women included in the PHR study self-reported pregnancy as a result of war-related SGBV,[30] which is equivalent to between 4,500 and 5,760 pregnancies. Given the unwillingness of women to self-report rape-related pregnancy, it is likely that 9% is an under-estimate of the actual number of pregnancies that occurred as a result of rape in Sierra Leone. The number of pregnancies that were carried to term is also unknown. Human Rights Watch reported that some women were denied access to abortion services: "[M]edical personnel were instructed by a rebel doctor…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."[31]

Darfur. In 2003, the long-standing conflict over resources and access to land[2] in the Darfur region of Sudan escalated. Government and militia forces (called *Janjaweed*, or "devils on horseback") have carried out a scorched-earth campaign against the non-Arab population of Darfur, which has resulted in the deaths of approximately 400,000 people, at a rate of 500 persons per day.[32] At least 1.2 million Darfurians are internally displaced and over 200,000 more have sought refuge in neighboring Chad.[33] The United Status government has formally declared that genocide is being carried out in Sudan, but this declaration has not been supported by the United Nations thus far.

Sexual violence, including rape and mutilation, has been a prominent part of the conflict in Darfur. A report released in October, 2004 by the Francois-Xavier Bagnoud Center for Health and Human Rights stated that since April 2003, "the military forces attacking the non-Arab population, the *Janjaweed* in collaboration with forces of the Government of Sudan (GOS), have inflicted a massive campaign of rape as a deliberate aspect of their military assault against the lives, livelihoods, and the land of this population."[2] The prevalence of rape has not been accurately determined, but in a recent report by the Coalition for International Justice, 16% of people in Darfur reported having witnessed or experienced rape.[33]

Like the prevalence of rape, the number of children born as a result of SGBV in Darfur has not yet been determined. Abortion is not a common practice in the region, so it is likely that many pregnancies resulting from rape will be carried to term.[2] Because family identity is traditionally passed on to a child through the father,[34] the light-complexioned children who are born from rape in Darfur are often referred to as little "Janjaweed."[34] Abandonment of children has been reported, but the outcomes for

children who are born as a result of SGBV in the Darfur conflict have yet to be determined.

Key Determinants

Outcomes of Children born of rape. What are the outcomes for children born of rape? Like so many aspects of this issue, the answer is not clear. In relation to children born of rape in Bosnia, Carpenter has said that "[t]here is no way of knowing precisely how many pregnancies resulted in live births or, of these, how many children were killed, abandoned, kept by their mothers, institutionalized, or adopted by Muslims, Serbs, or foreigners. These facts have not been established because these questions have not been asked."[35]

Some children meet an early and violent end: infanticide was reported during the conflicts in Bangladesh,[36] the Balkans,[37] and Rwanda,[38] and it has recently been reported in Darfur.[39] According to the declaration of the *Amsterdam Conference on the Rights of Children in Armed Conflict* of June 1994, children who are born as a result of rape should not be marginalized.[28] Nevertheless, they are at risk of marginalization and rejection. Children are abandoned at hospitals and in orphanages. Gingerich and Leaning have reported that in Darfur, "there are reports of unattended children in many camps but interlocutors state that it is not clear whether these children are 1) orphans from the conflict, 2) separated from families who are scattered elsewhere, or 3) abandoned as products of rape."[2] These children, particularly those who are abandoned in refugee settings, take on the status of unaccompanied minors, and are vulnerable to the same risks as other unaccompanied children, including sexual and physical abuse and trafficking.

Referred to as "devils on horseback," "children of bad memories," and "the dust of life," children who escape death or abandonment are at risk of abuse and neglect. Because the identities of their fathers are unknown or undocumented, they may be denied the right of citizenship.[40] Cultural beliefs and customs surrounding rape may affect the child's health. In the DRC, for example, the breast milk of a woman who has been raped is considered to be contaminated, and so she may not breastfeed her newborn child.[41] Women who are victims of rape and forced pregnancy may not seek prenatal attention due to shame or fear of abandonment or ostracism,[2] which may contribute to poor health status of the newborn. Children who are born with or develop physical characteristics of the rapist may be associated with the enemy and be particularly vulnerable to mistreatment. In Darfur, the grandfather of an unborn child of rape stated, "If the color [of the child] is like the mother, fine….If it is like the father, then we will have problems. People will think the child is an Arab."[21] One Rwandan woman told reporters:

> "I really don't hate him but I feel this child is not mine…I could not imagine how I would nurse this child. I wanted to kill this child. I looked at him and I wanted to kill him. I beat him even when I was still nursing him. I beat him even now."[4]

The fate of the mother within the family and within the community is critical to the well-being of the child. In Darfur, it is believed that a woman can only become pregnant through consensual sex;[7] thus, women who are victims of SGBV risk rejection by their husbands and by their communities. In Darfur, women who have been raped

have been "forced to build their own straw hut outside the family compound,"[19] and women who become pregnant as a result have been arrested by the Sudanese police for "illegal pregnancy."[19]

Women who have sexual intercourse before they are married, even under conditions of rape, are often considered to be ruined and are unlikely to marry in the future. Without the security and economic support provided by her husband and her community, a woman is more likely to be marginalized or excluded, which will have a negative impact on her ability to sustain herself and her children. The marginalization of women who have been raped during conflict and of the children born as a result may have long-term implications for the future potential for resettlement, for health, and for development. Female heads of households are more likely to experience further sexual violence or to be exploited.[42] In addition, their children are at greater risk of malnutrition, are less likely to receive an education, and risk exploitation themselves.[7]

Human Rights Implications for Children born of SGBV

While rape has occurred in conflict settings for centuries, and while countless children have been born as a result, SGBV has, until recently, been considered an inevitable consequence of war. The children born from rape have not been considered at all. It is only in the past decade that war-related rape and other forms of SGBV have been successfully prosecuted as war crimes, crimes against humanity, and genocide under international humanitarian law. A similar recognition of human rights violations against children born of rape as crimes under international humanitarian law has yet to occur.

The Fourth Geneva Convention of 1949, "Relative to the Protection of Civilian Persons in Time of War," calls for the protection of women "against any attack on their honor, including rape, enforced prostitution, or any form of indecent assault."[43] The first and second additional Protocols to the Geneva Conventions call for protection of women against "[o]utrages upon personal dignity, in particular humiliating and degrading treatment, enforced prostitution and any form of indecent assault…whether committed by civilians or military personnel," in international and internal conflicts, respectively.[44, 45]

The Rome Statute of the International Criminal Court was adopted in July 1998 and classified the crimes of "[r]ape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity" as crimes against humanity.[46] Later that same year, the Akayesu decision was passed by the International Criminal Tribunal for Rwanda (ICTR), which set precedent by finding the defendant guilty of crimes against humanity and torture on the grounds of rape.[47] The Court also recognized forced impregnation as a potential form of genocide.[48] In the Celebici decision of November 1998, the International Criminal Tribunal for Yugoslavia (ICTY) recognized rape as a form of torture.[48]

Carpenter has argued that until now, the crime of forced impregnation has been considered to be primarily a violation of the rights of the women victims and that the children who are born as a result of forced impregnation and enforced pregnancy have not been recognized as victims of crime. By focusing solely on the rights of women who have been victimized, the legal discourse surrounding the criminalization of forced impregnation has ignored the rights of the children born as a consequence because "the legal discourse that articulated forced impregnation as a distinct crime was framed in such a way as to: 1) marginalize the children as subjects of human rights law and 2)

identify them with the perpetrators, rather than the victims, of genocide."[35] She notes "the general inadequacy of international law to address children's rights in general"[35] and raises the question of whether any specific rights of a child are violated when she is "forcibly and intentionally conceived in a context that precludes her from acceptance by her family, identity with a community, or access to resources." [35]

To date, the specific rights of children who are born as a result of SGBV have not been adequately addressed under international humanitarian law. There are, however, several arguments that can be made on behalf of the rights of this vulnerable group of children under international human rights law. This is particularly true in relation to violations of right to health and the various determinants of this right (which are specific rights in and of themselves).

The Right to Health

Health is defined in the preamble to the Constitution of the World Health Organization (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[49] Although the violation of the right to health and its determinants may not be justiciable in all cases under current international law, an argument should be made for the need to respect, protect, and fulfill the right to health of children who are born as a result of SGBV in conflict settings.

The Universal Declaration of Human Rights (UDHR), adopted in 1948, is not a treaty and, as such, is not legally binding; nevertheless, it set the standards for international human rights law as it is applied today. Article 25.1 of the UDHR addresses the right to health and some of the key determinants of health: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services."[50] Article 25.2 more specifically addresses the rights of children, and can be applied to the rights of children born as a result of SGBV: "Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."[50]

Under the UDHR, "all human beings are born free and equal in dignity and rights;"[50] and all people have the right to "life, liberty and security of person."[50] The UDHR guarantees the "right to a nationality," the right to "equal access to public service in his country," and the right to education.[50] According to the WHO definition of health, all of these rights can be considered determinants of health, and the denial of any these rights would also lead to a denial of the right to health.

Article 12 of the ICESCR specifically refers to the right to health and outlines the general responsibilities of the states in regards to guaranteeing that right.[51] Article 10.3 places further responsibility for the protection of vulnerable children in the hands of the states by declaring that "[s]pecial measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions."[51] While allowance is made for the "progressive realization"[52] of the rights guaranteed in the ICESCR on the basis of the resources available to the states, children who are born as a result of rape must not be discriminated against and must be afforded the same rights and protections as children who are born under more socially, culturally, or politically "acceptable" circumstances. For the case of refugees, the ICESR states that host countries "may determine to what extent they would

guarantee the economic rights recognized in the present Covenant to non-nationals,"[51] but again, the guarantee of rights cannot made on a discriminatory basis. In situations in which the host country is unable to guarantee the rights and protection of refugee children living within its territories, it should be the responsibility of UNHCR or international aid organizations to guarantee their protection.

General Comment 14 of the ICESCR on the right to the highest attainable standard of health provides examples of circumstances in which states would be held responsible of violating their obligations to respect, protect, or fulfill the right to health.[53] Specific examples which are applicable to the violation of the right to health among children born as a result of rape in conflict settings would include "State actions, policies or laws that…are likely to result in bodily harm, unnecessary morbidity and preventable mortality;"[53] and "failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties."[53]

The UN Convention on the Rights of the Child (CRC) was adopted in 1989 and has been ratified by every country in the world, with the exceptions of the United States and Somalia.[54] This document sets forth the basic rights which should be guaranteed to all children, "without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status."[55] Because of the conflict, hatred, and shame surrounding their births, children who are born as a result of rape or forced pregnancy during times of conflict may be particularly vulnerable to violations of these "guaranteed" rights. Carpenter has noted, however, that the CRC does not go far enough in guaranteeing the rights of this group of children, because it does not explicitly state that they should be equally guaranteed to children who are born out of wedlock.[35] This is a criticism that can also be applied to the ICESCR.

The CRC guarantees all children such rights as "the inherent right to life;[55] the right to a nationality; to "the highest attainable standard of health;"[55] to an adequate standard of living; and to protection against violence, abuse, and neglect or maltreatment at the hands of caregivers.[55] The CRC also calls on states to establish "social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment"[55] and to "take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of: neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts."[55]

It is clear that children born as a result of SGBV in conflict are at risk of infanticide, abuse, rejection, abandonment, and marginalization[1-3] and, as such, are also at risk for severe human rights violations. Because human rights are universal, interrelated, and indivisible,[56] the violation of any one right necessarily violates the right to health. Public health practitioners, human rights advocates, and providers of humanitarian assistance have the obligation to ensure that states respect, protect, and fulfill the right to health and its determinants for this vulnerable population.

Intervention Strategy

International humanitarian agencies as well as local governments should be made aware of the vulnerability of children who are born as a result of rape and should prioritize the incorporation of measures to protect the human rights of these children into pre-existing reproductive health, SGBV, and child protection programs.

International humanitarian agencies, such as UNHCR, UNICEF, and ICRC, should collaborate in the development of a framework which will serve as a tool for information-gathering, risk assessment, and which should contain core minimum intervention strategies that aim to protect the human rights of children born as result of rape. This framework should serve as a guideline and should allow for individualization, in order to adapt to the cultural, ethnic, and political conditions specific to a particular conflict. Situation-specific intervention strategies should be developed based on information gained through the implementation of the framework and should also be aimed at preventing human rights violations against children born of rape.

In gathering information and assessing risk, the framework should attempt to determine the magnitude of SGBV and of pregnancy as a result of rape and should include screening of all women seeking reproductive health services, prenatal attention, or treatment related to SGBV. Pregnant adolescents, in particular, should be screened for SGBV. All women who are pregnant as result of SGBV should be offered culturally-appropriate counseling in an attempt to minimize risks to the mother and to the child. Every attempt should be made to obtain safe abortion services for women who want to terminate their pregnancies. Women who carry their pregnancies to term should be evaluated for risk of infanticide or of child abandonment. Risk factors for marginalization of the mother, which would lead to human rights violations of the child, such as unmarried civil status, abandonment by spouse, domestic violence, ostracism by community, and HIV/AIDS, should determined and addressed.

Information should be obtained regarding the numbers of children abandoned at hospitals or at orphanages, and programs to promote local adoption of abandoned children should be promoted.

Health workers carrying out nutritional surveys or immunization programs, primary care providers, and teachers should be sensitized to the issues surrounding children born of rape and should provide referral for intervention or counseling in cases where neglect or abuse are suspected.

Intervention strategies should be designed and implemented in a participatory fashion and should be customized to adapt to the particular risks and needs identified in the assessment. When possible, men and women community leaders, traditional birth attendants, teachers, health care providers, local health authorities, and representatives from international humanitarian agencies should participate in the development of intervention strategies. Interventions should be carried out by local personnel, with oversight by international humanitarian agencies whenever possible. Intervention strategies should incorporate community sensitization with an aim of preventing ostracism or maltreatment of both rape victims and their children and of encouraging local adoption of abandoned children, when appropriate.

Factors which must be considered in the development of the framework include:

- Ethical considerations surrounding the identification of women who are pregnant because of rape and of children who are born as a result
- Protection of the child and the mother

- Cultural context and variability
- Availability and legality of abortion services
- Confidentiality and appropriate use of information obtained.
- Availability of counseling
- Resource (financial and human) availability

Simultaneous assessment of long-term outcomes of children born from rape in conflict settings should be carried out, and information regarding risks and outcomes should be incorporated into the development and revisions of the framework mentioned above. Study of children born of rape with sibling or neighborhood controls using indicators such as mortality rates, nutritional status, history of abuse or neglect, academic achievement, socio-economic status, and social class may help to identify the impact of human rights violations against this group of children. Adoption rates of children born of rape as compared to other orphans may also be useful. Further discussion regarding the design and implementation of long-term outcome studies is beyond the scope of this paper.

Implementation and Evaluation

Because of the widespread use of rape as a weapon of war, and particularly in light of the brutal ongoing crisis in Darfur, it is essential that the development of this framework be prioritized and that field-testing be initiated as soon as possible. In ongoing conflict situations for which the magnitude of the problem has not been determined, a conservative estimate of the numbers of children born as a result of rape should be calculated using the formula of 50% of the estimated rape-related pregnancies, as previously outlined. This number should be used for initial program planning and resource allocation until more accurate numbers can be determined.

Monitoring and evaluation should be ongoing; community participation should be an integral component of the evaluation process, and revisions to the framework should be made in response to strengths and weaknesses identified. Information regarding numbers and outcomes of children born as a result of SGBV should be maintained in a confidential manner, but in such a way as to allow for follow-up of these children to assess for long-term effects of human rights violations as well as for violations which may occur in the future.

References

1. United Nations High Commissioner for Refugees, *Sexual and gender-based violence against refugees, returnees and internally displaced persons: guidelines for prevention and response.* 2003. Retrieved Dec. 9,2004 from http://www.unhcr.ch/cgi-bin/texis/vtx/home/+zwwBmeMUiECwwwwnwwwwwwwhFqA72ZR0gRfZNtFqrpGdBnqBAFqA72ZR0gRfZNcFqG5nL1wcawDmatnDmnGDzmxwwwwwww1FqmRbZ/opendoc.pdf

2. Gingerich T and Leaning J, *The use of rape as a weapon of war in the conflict in Darfur, Sudan*. 2004, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health: Boston.

3. Brownmiller S, *Against our will: men, women and rape.* 1975. Retrieved April 18,2005 from http://www.drishtipat.org/1971/war-susan.html

4. Olojede D, *Day 1: Genocide's child - a mother struggles to love her child of rape.* 2004. Retrieved April 17,2005 from http://www.newsday.com/news/nationworld/nation/ny-rwanda-day1,0,4498404,print.story?coll=ny-top-headlines

5. *Women and Children in Conflict Protection Act of 2003*. 2003.

6. Lindsey C, *Women facing war: ICRC study on the impact of armed conflict on women*. 2001, Geneva: International Committee of the Red Cross.

7. Amnesty International, *Sudan, Darfur - rape as a weapon of war: sexual violence and its consequences*. 2004, Amnesty International: London.

8. United Nations General Assembly, *Declaration on the elimination of violence against women.* 1993. Retrieved Dec. 12,2004 from http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En?Opendocument

9. Human Rights Watch, *Seeking protection: addressing sexual and domestic violence in Tanzania's refugee camps.* 2000. Retrieved Dec. 13,2004 from http://www.hrw.org/reports/2000/tanzania/Duhweb-06.htm#P333_55294

10. Durham, H. and B. Loff, *Japan's "comfort women"*. The Lancet, 2001. 357: p. 302.

11. Watts C and Zimmerman C, *Violence against women: global scope and magnitude.* The Lancet, 2002. 359: p. 1232-1237.

12. UN Office for the Coordination of Humanitarian Affairs, *Our bodies - their battle ground: gender-based violence in conflict zones.* 2004. Retrieved Dec. 9,2004 from http://www.irinnews.org/webspecials/GBV/print/p-default.asp

13. Seifert R, *The second front: the logic of sexual violence in wars.* Women's Studies International Forum, 1996. 19(1/2): p. 35-43.

14. UNHCR, *Guidelines on the protection of refugee women.* 1991. Retrieved Dec. 12,2004 from http://www.unhcr.ch/cgi-bin/texis/vtx/home/+kwwBme0h6B8wwwwnwwwwwwwhFqhT0yfEtFqnp1xcAFqhT0yfEcFqB7GdBnqBodDadhaidMnDDzmxwwwwwww1FqmRbZ/opendoc.pdf

15. Amnesty International, *Lives blown apart: Crimes against women in times of conflict. Stop violence against women.* 2004. Retrieved Dec.12,2004 from http://web.amnesty.org/library/pdf/ACT770752004ENGLISH/$File/ACT7707504.pdf

16. United Nations Secretary-General, *Investigation into sexual exploitation of refugees by aid workers in West Africa: report of the Secretary-General on the activities of the Office of International Oversight Services*. 2002.

17. Holmes MM, et al., *Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women.* American Journal of Obstetrics and Gynecology, 1996. 175(2): p. 320-24.

18. Terki F and Malhotra U, *Emergency contraception*, in *Medical and Service Delivery Guide for Sexual and Reproductive Health Services*, M. Powlson, Editor. 2004, International Planned Parenthood Foundation: London. p. 252-65.

19. Medecins Sans Frontieres (Holland), *The crushing burden of rape: sexual violence in Darfur.* 2005. Retrieved April 17,2005 from http://www.msf.ca/press/images/070305_darfur_sexualviolence.pdf

20. United Nations High Commissioner for Refugees, *Chapter 10: The Rwandan genocide and its aftermath*, in *The State of the World 2000: Fifty Years of Humanitarian Action*. 2000, UNHCR. p. 245-75.

21. Wax E, *Rwandans are struggling to love children of hate*, in *The Washington Post*. 2004: Washington, DC. p. 1.

22. Nowrojee B, *Shattered lives: sexual violence in the Rwandan genocide and its aftermath.* 1996. Retrieved May 4,2005 from http://hrw.org/reports/1996/Rwanda.htm

23. Neier A, *Rape*, in *War Crimes: Brutality, Genocide, Terror, and the Struggle for Justice*. 1998, Random House: New York. p. 172-91.

24. Rechel B, Schwalbe N, and McKee M, *Health in south-eastern Europe: a troubled past, and uncertain future.* Bulletin of the World Health Organization, 2004. 82(7): p. 539-46.

25. Rehn E and Sirleaf EJ, *Women war and peace: the independent experts' assessment on the impact of armed conflict on women and women's role in peace-building*. 2002, United Nations Development Fund for Women.

26. Smith H, *Rape victims' babies pay the price of war.* 2000. Retrieved April 18,2005 from http://observer.guardian.co.uk/print/0,3858,3986888-102275,00.html

27. Toomey C, *A cradle of inhumanity.* 2003. Retrieved April 17,2005 from http://www.bosnia.org.uk/bosrep/report_format.cfm?articleid=1053&reportid=163

28. Fitamant DS, *Assessment report on sexual violence in Kosovo (report of consultancy for UNFPA).* 1999. Retrieved February 27,2005 from http://www.ess.uwe.ac.uk/Kosovo/Kosovo-Current%20News196.htm

29. United Nations Development Fund for Women, *Gender profile of the conflict in Sierra Leone.* 2005. Retrieved April 5,2005 from http://www.womenwarpeace.org/sierra_leone/docs/sierraleone_pfv.pdf

30. Physicians for Human Rights, *War-related sexual violence in Sierra Leone: a population-based assessment*. 2002: Boston.

31. Human Rights Watch, *"We'll kill you if you cry:" sexual violence in the Sierra Leone conflict*. 2003, Human Rights Watch: Washington, DC.

32. Coalition for International Justice, *New analysis claims Darfur deaths near 400,000*. April 21, 2005, Coalition for International Justice: New York.

33. Coalition for International Justice, *Documenting atrocities in Darfur.* 2004. Retrieved April 22,2005 from http://www.state.gov/g/drl/rls/36028.htm

34. Polgreen L, *Painful legacy of Darfur's horrors: children born of rape.* 2005. Retrieved February 15,2005 from http://www.iht.com/bin/print_ipub.php?file=/articles/2005/02/11/news/sudan.html

35. Carpenter RC, *Surfacing children: limitations of genocidal rape discourse.* Human Rights Quarterly, 2000. 22: p. 428-77.

36. Grieg K, *The war children of the world.* 2001. Retrieved March 25,2005 from http://www.warandchildren.org/report1.pdf

37. Becirbasic B and Secic D, *Invisible casualties of war.* Balkan Crisis Report, 2002(383).

38. Shanks L and Schull MJ, *Rape in war: the humanitarian response.* Canadian Medical Association Journal, 2000. 163(9): p. 1152-56.

39. United Nations Development Fund for Women, *Crisis in the Darfurs: report on West Darfur and South Darfur*. 2004, UNIFEM.

40. Pokhrel D, *Camouflaging crime: women victims of the war are weeping silently.* 2004. Retrieved May 4,2005 from http://www.nepalitimes.com/issue183/guest_column.htm

41. Medecins Sans Frontieres (Holland), *"I have no joy, no peace of mind:" medical psycho-social and socio-economic consequences of sexual violence in eastern DRC.* 2004. Retrieved April 17,2005 from http://www.msf.org/source/countries/africa/drc/2004/drcreport-nojoy.pdf

42. United Nations High Commissioner for Refugees, *Reproductive health in refugee situations: an interagency field manual*. 1999, Geneva: UNHCR.

43. *IV Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949.* 1949. Retrieved April 18,2005 from http://www.genevaconventions.org/

44. *Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 8 June 1977.* 1977. Retrieved April 18,2005 from http://www.genevaconventions.org/

45. *Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 8 June 1977.* 1977. Retrieved April 18,2005 from http://www.genevaconventions.org/

46. United Nations, *Rome statute of the International Criminal Court.* 1998. Retrieved Dec. 13,2004 from http://www.un.org/law/icc/statute/romefra.htm

47. International Criminal Tribunal for Rwanda, *The prosecutor versus John Paul Akayesu.* 1998. Retrieved April 17,2005 from http://www.ictr.org/ENGLISH/cases/Akayesu/judgement/akay001.htm

48. Human Rights Watch, *Kosovo backgrounder: sexual violence as international crime.* 1999. Retrieved April 17,2005 from http://www.hrw.org/backgrounder/eca/kos0510.htm

49. World Health Organization, *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.* 1948. Retrieved Dec. 11,2004 from http://www.who.int/about/definition/en/print.html

50. United Nations General Assembly, *Universal Declaration of Human Rights.* 1948. Retrieved September 28,2004 from http://www.un.org/Overview/rights.html

51. United Nations General Assembly, *International Covenant on Economic, Social and Cultural Rights.* 1966. Retrieved October 18,2004 from http://www.unhchr.ch/html/menu3/b/a_cescr.htm

52. United Nations Economic and Social Council, *The nature of States parties obligations (Art. 2, par.1). 14/12/90. CESCR General comment 3. (General Comments).* 1990. Retrieved April 17,2005 from http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CESCR+General+comment+3.En?OpenDocument

53. United Nations Economic and Social Council, *The right to the highest attainable standard of health E/C.12/2000/4.(General Comments).* 2000. Retrieved Dec. 23,2004 from http://www.unhchr.ch/tbs/doc.nsf/(symbol)E.C.12.2000.4.En?OpenDocument

54. UNHCHR, *Status of the ratifications of the principal human rights treaties as of 09 June 2004.* 2004. Retrieved April 12,2005 from http://www.unhchr.ch/pdf/report.pdf

55. United Nations General Assembly, *Convention on the Rights of the Child (A/RES/44/25).* 1989. Retrieved April 12,2005 from http://www.hrweb.org/legal/child.html

56. United Nations General Assembly, *Vienna Declaration and Programme of Action (A/CONF.157/23).* 1993. Retrieved April 20,2005 from http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En?OpenDocument