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On the battlefield of women's bodies: An overview of the harm of war to women

H. Patricia Hynes

Boston University School of Public Health, Department of Environmental Health, 715 Albany St., Boston, MA 02118, USA

Synopsis

By the 1990s, 9 of 10 people who died in war from direct and indirect effects were civilians. Bombs and weapons of modern war kill and maim civilian women in equal numbers to civilian men. A unique harm of war for women is the trauma inflicted in military brothels, rape camps, and the growing sex trafficking for prostitution and by increased domestic violence, all of which is fueled by the culture of war, male aggression, and the social and economic ruin left in the wake of war. Widows of war, women victims of landmines, and women refugees of war are particularly vulnerable to poverty, prostitution, the extortion of sex for food by post-war peacekeepers, and higher illness and death in the post-conflict period. While problems exist with definitions and methods of measurement, a full accounting of the harm of war to civilian women is needed in the debate over whether war is justified.

Bombs and missiles kill men and women indiscriminately, but other aspects of war affect women and girls disproportionately. (Ashford & Huet-Vaughn, 2000, p. 186).

Introduction

The history of war has preoccupied itself with the decisions of elite men to declare war, with mythic generals who command with charismatic virility, and with non-elite war heroes who have done "the noblest of deeds," given or risked their lives for their country. War and militarism, that is, the encroachment of military institutions and ends into politics and society, are normalized by "rites," such as war veterans' parades and "sites," such as monuments to war heroes and the military war dead (Adelman, 2003). Few have noted that the greatest casualties of modern war are non-combatant civilians not soldiers.[1] Fewer still have acknowledged that, among civilian casualties, women and girls are deliberately targeted and disproportionately harmed by war and its aftermath.

New words—*genocide* (1944) and *overkill* (1957)—were devised in the 20th century to name the wholesale and deliberate destruction of specific groups of people and the excessive kill capacity of weapons used against cities and human settlements

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(Renner, 1999). In the late 1980s, *genocidal rape* was coined to describe the new extreme of men's inhumanity to women in war when Serbs intentionally detained and raped Muslim women in camps to destroy them and their people by sexually "contaminating" the women.[2] The 20th century, one in which conventions and covenants on human rights for all flourished, was also the century of record-breaking death and human rights violations perpetrated within war, both declared and undeclared.

All wars, just and unjust alike, and the less conventional wars such as "dirty wars" of repression, low-intensity conflicts within and between countries and political groups, ethnic conflicts and civil wars are largely unexamined public health disasters that leave in their wake humanitarian crises and human rights abuses; aggravated sexual exploitation of women and girls; and extreme environmental degradation (Geiger, 2000; Toole, Galson, & Brady, 1993). In pondering the harm and more specifically the health impacts of war on women, three intrinsic questions arise. What do we mean by war, as we set out to document its impact on women's health in particular? Who defines the harm of war and how do they measure it? What do we mean by health?

The first question is significant because if we define war solely as direct conflict employing weapons (also referred to as armed conflict) and exclude the war-related disruption of economic activity and social services infrastructure; the displacement of people within or outside their country; the increased rates of crime and sexual violence in conflict-ridden, unstable situations; decades of military occupation in strategic areas of the world with the twin impacts of pollution and prostitution in those areas; and the culture of hypermasculinity and male "warrior" narratives in military culture, we will fail to document the more systemic, gender-based, and enduring impacts of war on women.

The U.S.-led coalition in the 1991 Persian Gulf War, for example, bombed urban industrial infrastructure, including all significant electricity-generating plants, chemical industries, and oil refineries. Nearly 75% of the 80,000 tons of explosives dropped on Iraq's urban areas missed their targets; hospitals, health facilities, the Ministry of Health, and sewage and water treatment facilities suffered considerable damage from both deliberate targeting and errant missiles and bombs. An estimated 50–70% of the Iraqis who died as a direct result of the war and civil strife that ensued were civilians (Medact, 2002; Hoskins, 2000). Of these, 13,000 were killed directly by American and Allied firepower and weapons, and 70,000 died from the destruction of medical facilities and supplies and water and electric power plants.[3]

The intensive aerial war and the continuing UN sanctioned embargo together erased the socio-economic gains made in Iraq during the 1980s (despite the repressive regime and Iraq's war with Iran), creating immense setbacks for women. Domestic violence against women and divorce increased; some impoverished single mothers and widows—the most indigent casualties of that war—resorted to prostitution to survive and feed their families. Gains in literacy and education gains among girls and women in Iraqi society have been eroded, and early marriage of preadolescent girls surged in rural regions (Medact, 2002).

The second question, concerning who defines war-related harm and how they measure it, is central to making visible the harm of war for women. Data on wartime morbidity and mortality is collected by the military and includes primarily the direct effects of combat and combat-related exposures on combatants and less frequently on civilians (Garfield & Neugut, 2000). Rape and sexual exploitation in war, on the other hand, have been systematically disregarded (even when documented) as war atrocities and crimes until the recent revelations of the genocidal rape of Muslim women during the conflict in the former Yugoslavia and of Tutsi women in Rwanda.[4] Yet, history reveals that senior officers of war and military occupation have commonly sanctioned and normalized the sexual exploitation of local women by military men. Governments on all sides of war have initiated, accommodated, and tolerated military brothels under the aegis of "rest and recreation" for their soldiers, with the private admission that a regulated system of brothels will contain male sexual aggression, limit sexually transmitted diseases in the military, and boost soldiers' morale for war (Barry, 1995; Brownmiller, 1975; CATW-Asia Pacific, 1996; Enloe, 1990; Moon, 1997). Because military data gatherers have ignored military sexual exploitation and violence against women, a substantial portion of the harm of war to women and girls has been

overlooked and, thus, uncounted within the "official" tally of war casualties.

The third question regarding the meaning of health offers the opportunity to define health (as we will do with war) in as dimensioned and complete a way possible. To die by a bullet in war is a "clean death," said one refugee and survivor of the war in Kosovo. To lose one's family, home and community in conflict; to be raped by enemy soldiers and then made suspect and shunned by one's husband and community—these are a living death marked with acute impoverishment, profound culturally imposed shame and hopelessness (Muska & Olafsdottir, 2002). These consequences of war, so disparately suffered by women, unleash a dreadful morbidity of the soul, psyche and livelihood rarely diagnosed in clinical incidence of morbidity and mortality and missing from conventional health statistics and surveillance.

Definitions and methodology considerations

War: a life cycle definition

Historians frame war with begin and end dates that roughly correspond to the start of armed conflict and a surrender, truce, or cessation of battle. We choose, for the sake of a more thorough accounting of the harm of war to women, to define war in its full life cycle. This approach is modeled on the life cycle analysis of industrial, commercial and consumer products that is conducted to account for their full impact (from mining and manufacturing to consumption and disposal) on the environment (Franklin Associates, 2004). Similarly, we cast the net of war over all aspects of military production that contribute to, sustain and result from armed conflict in order to describe its harm to women. In its full life cycle, war includes military training and military bases and garrisons operating worldwide in a state of training, practice and preparedness for conflict; formal and informal armed conflict; post-war peacekeeping by civilian and military personnel based in countries and refugee camps after armed conflict has ended; the military-industrial sector that researches, tests, manufactures, markets, finances and purchases military weapons and agents intended to maim and kill; and the governing public policy that casts military-based prowess as the cornerstone of national security. Succinctly put, the life cycle of war includes preparing for war, the practice of war, post-war activities, and the public ideology of militarized defense as the guarantor of national security. All of these constituents of the military sector have profound impacts on women.

Measuring the toll of war on women's health: the limits of surveillance

Many factors confound the effort to document the toll of war on women's health. Chief among these is the fact that most research on the casualties of past wars has been done by military agencies and contractors to serve military planning for future wars, the driving interest being how to win in armed conflict with the fewest military casualties. Otherwise, there has been little epidemiologic research on human impacts.[5] Thus, the primary injuries and deaths reported are ones that are caused by military weapons and equipment (Garfield & Neugut, 1991). A broader definition of indirect casualties resulting from war-related shortages of food, potable water and medical supplies or from unexploded ordnance is infrequently used. Further, injured civilians who are not treated in clinics and hospitals are excluded in military statistics on wartime morbidity and mortality. Thus, women who were assaulted and harmed by martial rape and women who died in childbirth from war-related neglect and trauma, whether they sought treatment in clinics or not, have not generally been documented as civilian casualties of war.[6]

Conflict diverts health resources away from health care delivery and disease prevention to treating trauma. In Zenica, Bosnia, for example, the proportion of military and civilian surgical cases due to war-related trauma rose from 22% to 78% in the city's major hospital during the first 6 months of the war in 1992, overwhelming medical services. In the same period, infant and child mortality nearly doubled and newly diagnosed tuberculosis cases quadrupled (Toole et al., 1993). When conflict is extended, public health activities, including immunization and surveillance systems, can be substantially reduced, dismantled and destroyed, as happened during recent conflicts in Rwanda, Sudan, Liberia, Chechnya, and Iraq. Thus, health care resources are diverted from primary care

and civilian health to treating war-related trauma; and the increased injuries, illness, and death among civilians, due to this triage favoring combatants, are not reported in military or public sector statistics as conflict-related casualties (Eban, 2002).[7]

Moreover, even if women casualties from war-related shortages of food, potable water and medicine were documented, the data would understate the impact of war on civilian women. For the greater and more intense the conflict, the more likely it is that public registries and information systems that record civilian deaths and injuries break down. Bosnia and Herzegovina, for example, have ceased reporting data on causes of death from vital registration records to the World Health Organization since the conflict in the Balkans (Murray, King, Lopez, Tomijima, & Krug, 2002).

Another limitation to surveilling war-related harm to women is that women do not always report rape for reasons that include: fear of the rapist, fear of being socially ostracized, and internalized shame induced by traditions which blame women for male sexual exploitation. Even when they seek medical assistance (which would be near impossible in situations of conflict and health resource scarcity), women often do not disclose having been raped (Swiss & Giller, 1993). Thus, precise estimates of women raped in war will be extremely difficult to obtain, unless there is a gender-conscious health care system in place during armed conflict that documents rape in war and gender-sensitive health investigations after a war to interview survivors and key informants in order to gather rape-related data.

Given their reliance on and demand for brothels, how could the military be counted upon to record reliably (and prosecute) rape, abduction, and sexual torture in war? In the "best" of military situations—non-combat bases and elite training schools in the United States, domestic violence and sexual assault of women by military husbands, fellow students and colleagues has been severely underreported, tolerated by responsible authorities, and leniently punished within the military legal system (Elsner, 2002; Herdy & Moffeit, 2003; Schemo, 2003). Because of similar negligence on the part of military authorities, numerous U.S. female service members recently returned from Iraq, Kuwait and other overseas stations have sought counseling and assistance from civilian rape-crisis organizations about being sexually assaulted by fellow military personnel. They reported receiving inadequate medical examinations, counseling and criminal investigations from the military. Some were threatened, after they reported their assault (Moffeit & Herdy, 2004).

In one instance where military record keeping could have provided more accurate data on the magnitude of military sexual exploitation, records remained closed for some 50 years. The sadistic and clinical prescriptions for military brothels that the Japanese kept prior to and during World War II also included records on the women they enslaved. Even so, the abduction and sexual torture of hundreds of thousands of women and girls by Japanese military forces was minimized in the post World War II war crimes tribunal in Tokyo. Those records only came to light in the 1990s due to feminist forums and tribunals on the human rights abuses of women in situations of conflict (Lynch, 2002; United Nations Division for the Advancement of Women, 1998).

Finally, much of the data gathered in conflict and post-conflict situations is not disaggregated by gender, although this is changing with non-governmental organizations (NGOs) conducting independent impact analysis of war and a growing consciousness of documenting violence against women, a result of more than three decades of feminist research, activism and advocacy. War-related impacts on women, then, often have to be extrapolated from other reported conditions, such as from records on war refugees, from what is known about the gender-prescribed status and work of women in particular cultures, and from changes in warfare weaponry and tactics which now target urban areas and, thus, civilian populations.

Health: more than the absence of disease

The World Health Organization (WHO) has defined health as not only the absence of disease but also the presence of physical and mental health and social well-being (Raphael, 2000). Such an enlarged notion of health implies that shelter, food, a dependable livelihood, education, and a sense of safety from sexual and physical violence within one's community, control over one's life, and equality are all elements of health and well-being. Mental well-being presumes a peace of mind, which is only achievable in a state of societal peace. "The law of the gun has devastated the

condition of women," an advisor to UN peacekeeping troops observed about armed conflict (Ms., 2003/2004, p. 21). Social well-being for all is only possible within a socially just society and a healthy ecosystem. Otherwise, inequality—by gender, race, income and other determinants of discrimination—results in the unequal allocation of and access to resources; in loss of health and well-being (Wilkinson & Marmot, 2003); and in greater vulnerability to natural, social-economic and personal crises. This enlarged understanding of health moves beyond the traditional mortality and morbidity rates as the sole evidence of harm and health. It takes us out of the clinic to look for evidence of physical, mental, sexual, spiritual, and social harm within the multiple environments of deprivation and violence that accompany war and that can fester and worsen during post-conflict periods.

The full health impacts of war on women's health, then, must include the harm and trauma during all phases of military activity that disrupt and destroy their shelter, food and health systems, their children's education, their personal life, and their community's cohesiveness. Women are harmed by war indiscriminately with men as civilian casualties of the direct effects of weapons, bombs, and combat. And women are harmed discriminately by the increased domestic violence within the military, as targets of rape and sexual exploitation fueled by armed conflict, and by the increased domestic violence that persists beyond war. Women and girls are uniquely harmed by war-related disintegration of health, education and social services, by the breakdown of civil society and security, and by the loss of basic environmental assets, including potable water, sanitation, land, food, and fuel sources. These resources, still provided by women in the majority of the world's households, are always jeopardized by war.

Overview of the impacts of war on women

If we are to envision a less violent world, we must first understand how violent the world is (Reza, Mercy, & Krug, 2001, p. 104).

In her memoir of early childhood in Bangladesh at the time of the independence movement from Pakistan, Taslima Nasrin pieces together her earliest impressions of war from the cascade of tragedies that beset herself and women and children around her: Fleeing the sound of bullets with her mother and siblings; being obstructed in flight and bullied by young men brandishing rifles; boys leaving to fight and girls being hidden from invading soldiers; the odor of corpses burning in houses afire; the sound and smell of heavy-booted soldiers laughing and joking as they searched her house at night, eyeing every sleeping female child, "their eyes and tongues dripping with lust"; her mother's despair when the life savings of local women, which she safeguarded in a basket, were stolen by soldiers; her grandmother sifting through a heap of bones—"shinbones, ribs, arms, skulls—looking for her son" (Nasrin, 1998, pp. 16 and 19). These fragments, filled out and fit together, contain many of the consequences of war lived by women and girls.

Death and disability of women civilians in war

War has never spared or protected women civilians. The number of people killed from direct and indirect effects in selected wars since 1500, as shown in Table 1, indicates that in nearly half the wars prior to the 20th century, equal and greater numbers of

Table 1
Death toll of selected war, 1500–1945

Conflict	Time period	Number killed (thousand)	Civilian victims (%)
Peasants' War (Germany)	1524–1525	175	57
Dutch Independence War (vs. Spain)	1585–1604	177	32
30-Year War (Europe)	1618–1648	4000	50
Spanish Succession War (Europe)	1701–1714	1251	n.a.
7-Year War (Europe, North America, India)	1755–1763	1358	27
French Revolutionary and Napoleonic wars	1792–1815	4899	41
Crimean War (Russia, France, Britain)	1854–1856	772	66
U.S. Civil War	1861–1865	820	24
Paraguay vs. Brazil and Argentina	1864–1870	1100	73
Franco–Prussian War	1870–1871	250	25
U.S.–Spanish War	1898	200	95
World War I	1914–1918	26,000	50
World War II	1939–1945	53,547	60

Source: Renner, 1999.

civilians than soldiers were killed. The 20th century, however, is the most war-ridden century of recorded history and the most lethal to civilians. The bombing of British, German, and Japanese cities in World War II set the course of war henceforth: The targets of modern warfare are not primarily combatants, they are the enemy's infrastructure, economy, and, thus, civilians. Forty-four of every one thousand people died of direct and indirect war-related causes in the 20th century, almost four times the rate of 19th century conflicts (Garfield & Neugut, 2000). Even with the passage of international conventions that criminalize the deliberate targeting of civilians in war, including the Hague Convention of 1907 and the Geneva Convention of 1949, a growing number and proportion of civilians have died in armed conflict since World War II. Civilian deaths as a percent of all deaths, direct and indirect, from war rose from between 60% and 67% in World War II to 90% in the 1990s (Garfield & Neugut, 2000; Renner, 1999),[8] a trend that makes the enterprise of war increasingly unjust, when those who wage it are a diminishing fraction of those who suffer its consequences.

The few recent studies that have examined the death toll of war on females and males have concluded that equal numbers of civilian women and girls die of war-related injuries as civilian men and boys (Murray et al., 2002; Reza et al., 2001). In 1990, one of the only years for which female civilian deaths were computed, an estimated 211,000 women and girls were killed in war (Reza et al., 2001). Many more, from 2 to 13 times more, are likely to have been injured (Murray et al., 2002). This data does not include the increased suicide and premature death that would directly result from the sexual torture, despair, and destitution of women in conflict-ridden and armed societies.

Since World War II, the world has witnessed an acceleration of conflicts within countries and the intent to eliminate entire peoples. The Nazis "final solution" against the Jews has been replicated in recent internal conflicts against Cambodians during the Pol Pot regime, Muslims in Yugoslavia, Tutsis in Rwanda, and Kurds in Iraq. Men, women, and children equally are victims of genocide; women are sexually exploited and tortured as well as killed for their ethnicity. In the central African country of Rwanda in 1994, nearly 1 million people were killed in ethnic conflict during a 3-month period, the most rapid genocide in recorded history. An estimated 40–45% of those killed were female, and up to 500,000 women and girls were raped and sexually tortured (Amnesty International USA, 1997). After the war, many rape survivors were isolated, suspected, and shunned by their community, consigned, in effect, to a social death.

The rise in the proportion of civilian, and notably women's and children's deaths, in 20th century warfare is attributed to changes in war technology and war tactics. High-tech war from the sky coupled with massive firepower has replaced army combat in the field; modern military strategy employs so-called precision bombing to destroy civilian infrastructure such as power plants, water works, industrial plants, and communications systems, as the U.S. did in Iraq in 1991. A much larger percent of munitions deployed in the 2003 war against Iraq were precision-guided (68% in 2003 vs. 6.5% in 1991); yet in the 2003 war, the rate of civilian to military death was twice that of the 1991 war (Connetta, 2003). It is hypothesized that Connetta (2003) reasons that urban warfare, indiscriminate and mistaken attacks, as well as "more ambitious objectives" with precision-guided weapons led to the greater proportion of civilian dead in the recent Iraq war.

Another reason for such egregious civilian death in recent warfare is that conflicts within countries have "no distinct battlefield," and armed fighters target civilians to kill, rape, terrorize, and expel (Renner, 1999). Medical clinics, hospitals, and personnel have also been deliberate targets of many recent armed conflicts worldwide (in violation of UN Conventions), including in Africa, the Middle East, Nicaragua, and Yugoslavia. Warfare today is increasingly waged against unarmed women, men, and children and their social, medical, and economic structures, such that nothing—no person, social system, or human right—is immune (Geiger, 2000). War technology and tactics, together with improvements in military medicine, account for the rise in civilian deaths per military combatant death in the 20th century, such that an estimated 9 of 10 people who have died from direct and delayed effects of war in the 1990s were civilians (Garfield & Neugut, 2000).

Indirect effects of war

Bombs and weapons kill and maim civilian women equally with civilian men during armed

conflict; however, the indirect and long-term consequences of war, years after the conflict has ended, are disproportionately suffered by women and children. Women and children constitute the majority of refugees and internally displaced persons who flee conflict to camps where mortality and morbidity rates escalate due to poor sanitary conditions, scarce medical supplies, malnutrition, discrimination, and sexual abuse (Ashford & Huet-Vaughn, 2000). Within post-conflict societies whose economies, schools, health services, and security systems are ravaged and over-burdened, women and girls are more vulnerable to discrimination and exploitation with the breakdown of social norms. According to a recent Medact (2003) report on the social costs of the 2003 U.S.-led war in Iraq, school attendance has fallen particularly among girls. Prostitution, rape, abduction, and smuggling of Iraqi women and girls by human traffickers have risen such that since April 2003, when Baghdad fell, millions of women have had to live in "de facto house arrest" (Sandler, 2003, p. 11), a situation that is devastating to women's work, income, education, and role in society. The rise of fundamentalism in that society has also ushered in a rise in "honor" killings of women by relatives and the erosion of women's presence and power in society. When asked about security for women and prosecution of violence against women, American occupying officials asserted "We don't do women" (Sandler, 2003, p. 14).

In a landmark study of the indirect effects of war—a cross-national analysis of 1999 WHO data on death and disability, broken down by age, gender, and disease or disability, researchers found substantial indirect and lasting health effects on largely civilian people who had survived civil wars in the years 1991–1997. Of these, women and children were most affected. The researchers estimate that the continuing health impacts from all civil wars during the years 1991–1997 was nearly equivalent to the amount of death and disability from all wars in 1999. The lingering war-related disease, disability, and death include elevated infectious disease, HIV/AIDS (from rape), cervical cancer (likely from rape), homicide, and transportation accidents. They concluded, "overall women and children were the most common long-term victims of civil war" (Ghobarah, Huth, & Russett, 2001, p. 31).

Rape, sexual torture, and sexual exploitation in war

"Red Army soldiers don't believe in 'individual liaisons' with German women," wrote the playwright Zakhar Agranenko in his diary... "Nine, ten, twelve men at a time—they rape them on a collective basis." (Beevor, 2002, p. 28).

Military aggression and military occupation are predictors of violence against women. The earliest written accounts of men raping women in war derive from ancient Greece. Women were raped by knights and pilgrims in the Crusades; by soldiers in the American Revolutionary war; by Germans marching through Belgium in World War I and through Poland and Russia in World War II and by Russians as they took Berlin in World War II; by Pakistanis in the Bangladesh war of independence; by U.S. soldiers during the occupation of Japan, in the Vietnam War and in military bases in the Philippines and Korea; by Serbs and Rwandans for the intent of "ethnic cleansing"; and by Indonesian pro-militia in retreat from East Timor as that country was voting for independence (Brownmiller, 1975; Rehn & Johnson Sirleaf, 2002).

Military rape and sexual exploitation, however, have generally been ignored or mentioned only anecdotally by chroniclers of war, until recently; until very recently, little has been known about the prevalence and scale of sexual abuse of women by men in war and the health effects of war on women. In the past 30 years, a growing number of women journalists, lawyers, physicians, and human rights activists have uncovered and exposed the war crimes against women, namely rape, abduction, sexual torture, and trafficking for prostitution. Feminist tribunals on sexual violence in war have provided the forums for the so-called "comfort women"—then in their seventies—to make public their wartime enslavement and to claim restitution from the Japanese government. An estimated 200,000 girls and young women were abducted by Japanese soldiers during the 1930s and World War II to serve as sexual slaves to the Japanese Imperial Army in euphemistically named "comfort stations." Records indicate that Japanese military sought girls and young women who were virgins so as not to infect their men. Eighty percent were Korean, and the remaining were Chinese, Philippine, Indonesian, and Dutch girls and

women. Described by the Japanese as "war supplies," they were raped, their breasts were sliced off with swords, and they suffered crude surgery in which sexual organs were cut out to make them continuously available without pregnancy. At the war's end, women were executed or made to commit suicide; some were killed in caves and locked in submarines. Less than 10% survived (Matsui, 1999; Sajor, 1993).

In October 2002, the United Nations Development Fund for Women (UNIFEM) released a commissioned report, written by two independent experts, on the impact of armed conflict on women during and after conflict. The authors, who interviewed women in 14 countries in Europe, Asia, Africa, and the Middle East, found a similar continuum of violence against women in all regions. Domestic violence dramatically increased during and after conflict. Some women were deliberately raped in front of husbands, parents, siblings and children to "pollute," humiliate, and terrorize the enemy; others were deliberately infected with HIV/AIDS. Soldiers punctured pregnant women with sharp weapons and ripped the fetuses from their wombs. Women and girls were raped and sexually enslaved in war zones; others were trafficked from war zones for sexual exploitation. Women were forced through imprisonment to bear children born of military rape. Soldiers sexually assaulted women for their activism in politics, for relationships with activists, and simply because they were home when the soldiers arrived (Rehn & Johnson Sirleaf, 2002).

The women's stories bespeak the sexual aggression unleashed in men by war; and the statistics cited in the UNIFEM report (Rehn & Johnson Sirleaf, 2002) suggest the scale and magnitude of sexual violence in conflict and post-conflict situations. In Sierra Leone, 94% of households surveyed about sexual assault in war reported women experiencing rape, torture, and/or sexual slavery. In household surveys conducted by the government ministry of approximately 59% of Cambodian women in the mid-1990s, many reported being abused by their husbands who have retained weapons and small arms they used during the war. In one study, 75% of Khmer women experienced domestic violence, a rate higher than pre-war (Rehn & Johnson Sirleaf, 2002). Doctors treating rape victims in the Democratic Republic of the Congo recently reported that the victims' vaginas have been punctured and destroyed with weapons and tree branches in systematic and brutal gang rapes. Girls as young as 5 and women as old as 80 have been the targets of what some have said is the most extreme sexual torture they have ever witnessed in war (Washington Post, 2003; Ms., 2003).

An insidious outcome was women and girls in post-conflict areas is the epidemic of sexual exploitation that has been aggravated by UN peacekeeping forces and international police. In Bosnia–Herzegovina, the trafficking of women and girls for prostitution has grown exponentially during the past 8 years since the Western protectorate was established at the end of the war in 1995. The number of women trafficked into the protectorate is estimated to be between 6000 and 10,000. International police serving with the UN mission there have facilitated the trafficking, accepted bribes from traffickers and brothel owners, purchased women from traffickers, frequented brothels and arranged for trafficked women to be delivered to their residences (Robson, 2002).[9]

In February 2002, the United Nations High Commissioner for Refugees (UNHCR) and Save the Children released a report on their investigation into allegations of sexual abuse of West African refugee children in Guinea, Liberia, and Sierra Leone. Their interviews with 1500 men, women, and children refugees revealed that girls between the ages of 13 and 18 were sexually exploited by male aid workers, many of whom were employed by national and international non-governmental agencies (NGOs) and the UN, and also by UN peacekeepers and community leaders. "They say 'a kilo for sex'," reported a woman from Guinea about the rampant extortion of sex for food by aid workers who abused their positions of power over the distributions of goods and services (United Nations High Commissioner for Refugees, 2002, p. 14). A man interviewed stated that without a sister, wife or daughter to "offer the NGO workers," one does not have access to oil, tents, medicines, loans, education and skill training, and ration cards (United Nations High Commissioner for Refugees, 2002, p. 14). The sexual exploitation of girls, fueled by the disparity between the relative wealth and power of the aid workers and peacekeepers and the poverty and dependency of refugees, was most extensive in camps with large, well-established relief programs.

Wars of the late 20th and early 21st centuries are fought with remotely guided weapons, at distances that shield the combatant from witnessing the death and maiming of his victims. Even landmines, the sadistic toy-like objects planted in the path of civilians, are remote from those who seeded them aerially or scattered them manually and thousands of miles more removed from their manufacturers. Military rape and sexual exploitation, on the other hand, are perpetrated face to face on the battlefields of women's bodies. Of all who suffer the trauma of war, women and girls pay the highest price for the military culture and war environment that prepares and inures men to kill and exploit humans—no matter the age, gender, and civilian status—and that cordons off a zone of tolerance for sexual exploitation of women and girls around military bases, during armed conflict and in post-conflict peacekeeping and occupation sites.

Death and injury of women from land mines

More than 100 million antipersonnel landmines and unexploded ordnance lie dispersed and unmarked in fields, roadways, pasturelands, and near borders in 90 countries throughout the world. These indiscriminate weapons harm civilians to a much greater extent than soldiers and impede re-development and recovery from war. From 15,000 to 20,000 people are maimed or killed each year by these "weapons of mass destruction in slow motion," as landmines have been called (Physicians for Human Rights and Human Rights Watch, 1993); and more than 70% of the reported victims are civilians (International Campaign to Ban Landmines, 2002). Women and children are common casualties in agrarian and subsistence-farming societies where landmines were deliberately placed in agricultural fields and along routes to water sources and markets (Geiger, 2000), to starve a people by killing its farmers. In Bajaur, Pakistan, thousands of landmines were scattered on the Pakistan–Afghanistan border by the Soviet military during their war against Afghanistan. Women and girls constitute almost 35% of mine victims there, injured while fetching fodder for animals, crossing agricultural fields, and carrying out their daily activities. Yet mine awareness sessions in the conservative tribal society are provided in mosques and schools to men and boys who are then relied upon to educate women and girls at home (Fayyaz, 2003).

The International Commission to Ban Landmines estimates that 234,000 of the 300,000 landmine survivors need continuous support for healthcare and to regain the capacity for life-sustaining income and participation in their community. A vast network of non-governmental organizations working with affected states has enabled mine clearing to evolve from a military clearance activity to a humanitarian and developmental initiative (International Campaign to Ban Landmines, 2002). Even so, the plight of women amputees is particularly serious. Women are a larger percent of farmers than men in Asia and Africa, responsible for up to 80% of food produced in many parts of Africa. When maimed, they lose the ability to farm and feed their family; and their husbands often abandon them, leaving them to beg on the streets (Ashford & Huet-Vaughn, 2000). Nearly one-half of land in Cambodia, where 1 of every 236 people is an amputee due to landmine injury, is unsafe for cultivation and human use. So as the recovery from war continues, it is likely that an even greater percent of those injured and killed by landmines will be women and children as they return to peacetime sustenance activities, collecting firewood and water, tending animals, and farming (Ashford & Huet-Vaughn, 2000).[10]

While women and girls are extremely vulnerable to landmines in war-torn agrarian societies, little documentation exists on their impact—by injury and death, by loss of income and community, by victim assistance, by participation in the mine action program. The following questions must be answered in order to design programs that educate, support, and assist women and girls at risk. Do injured women and girls receive immediate and equitable medical assistance and prostheses? What are the social and economic supports for landmine-injured women? Are women the primary caretakers of amputees and others injured; do they receive adequate assistance, given their other household responsibilities; and who cares for the caretakers when they are injured? Are women and girls equally educated with men and boys in landmine awareness and equally trained in de-mining methods (United Nations, 2001)?

Widows of war

Women who survive war as widows are the most invisible and undocumented group of war-related casualties. To the heartbreak of losing loved ones is added the daily burden of providing subsistence and health care needs within cultures that have not prepared nor permitted women to be "bread winners," nor trained them in trades to rebuild homes and infrastructure. Post-war unemployment, large price increases, and reductions in real wages affect acutely those who are most economically vulnerable, that is, widows, single mothers with children, and abandoned and divorced wives leading to indigence, homelessness and prostitution to feed themselves and their children (United Nations Division for the Advancement of Women, 2001).

In the recent war-torn countries of Angola, Bosnia and Herzegovina, Kosovo, Mozambique, and Somalia, the majority of adult women are widows. Seventy percent of Rwandan children are supported solely by mothers, grandmothers, or oldest girl children. Girls in Rwanda are heads of household for an estimated 58,500 households (Save the Children US, 2002). Many war widows live as recluses in refugee camps because they have no male relative to assist in repairing their homes. In Kosovo, where an estimated 10,000 men died or disappeared, many widows returning from refugee camps had no social safety nets and no advocacy organizations and became indigent and socially marginalized (United Nations Division for the Advancement of Women, 2001).

Women of all ages are much more likely to be widowed than men for multiple reasons, in addition to the longer life span of women. Widowers are far more likely to remarry; and older men marry younger women and girls, in some cultures. The majority of combatants are male; those who die in war and from HIV/AIDS account for the higher percentage of widows. In some cultures, widows may be forced to marry a male relative in her husband's family; in other cultures, widows are forbidden to remarry. In either case, they are extremely vulnerable to eviction and homelessness, loss of property (particularly if they have no adult male children), discrimination in law and custom, extreme poverty, and violence. Under the Taliban, an estimated 2 million war widows, who were the sole supporters of their families, were forbidden to do paid work outside the home and had no access to international food aid because only a male relative could collect it for the household (United Nations Division for the Advancement of Women, 2001).

In Cambodia, 35% of rural households are headed by women, many of whom are widows. Many young widows raising children have been channeled through the vise of poverty into prostitution. In regions such as Nepal and Bangladesh, where girls are trafficked into Indian brothels, the daughters of widows—who are more likely than sons to be taken out of school to help their mothers—are particularly at risk of being trafficked into prostitution (United Nations Division for the Advancement of Women, 2001). Young destitute widows from the 2003 Iraq war have been recruited to enter temporary marriages called muta'a, an equivalent of prostitution. Hundreds to thousands of impoverished women have resorted to this economic sexual enslavement, a practice condemned by Sunnis but recognized by Shiites (Allam, 2003).

UN studies reveal that the household census in developing countries fails to document the inequality and poverty of widows within intergenerational households and misses completely those who are homeless. Widows who have survived political and personal crises, are uncounted and unidentified; they are the least likely voices heard. The poorest widows, UN studies find, are the young with children and the elderly, those who are displaced and refugees, and those who are widows of war (United Nations Division for the Advancement of Women, 2001).

War refugees

The landscape of contemporary war is neither easily defined battlefields nor naval confrontations at sea where armed men battle each other. Rather it is civilian population centers in cities and villages, easy targets for aerial bombing, ground warfare, and protracted "low intensity" wars. The scale and nature of war in the late 20th century has resulted in unprecedented numbers of people fleeing conflict, such that the displacement of people by war in the 1990s has had more severe public health impact, in

many situations, than the conflict itself (Toole, 2000; Toole & Waldman, 1997). Most of those who have died as a consequence of civil conflicts in Asia and Africa have been those who migrated en masse to escape areas of conflict and suffered contagious and infectious diseases and food shortages. Two million refugees fled from the ethnic conflict in Rwanda into neighboring countries in the first month of the conflict in 1994. An estimated 8% of refugees died, many from cholera, one of the highest mortality rates ever documented (Toole & Waldman, 1997). In addition, refugees are injured or killed by landmines as they flee to and across deliberately mined country borders.

Eighty percent of the world's refugees and internally displaced persons are women and children (Ashford & Huet-Vaughn, 2000). Being responsible for basic household needs, including procuring food, fuel, fodder, and water and for disposal of waste, women and girls in refugee camps are more likely to be exposed to contaminated water supplies and human waste. They are also more at risk of rape and sexual exploitation than men and boys; a risk heightened by the fact that men can more easily prey upon them in the milieu of conflict-related scarcity. Women and girl children are multiply burdened by the perpetuation of discrimination and exploitation in refugee camps. The most commonly used indicator of health status among displaced persons is the crude mortality rate (CMR) (Toole, 2000), that is, the number of people who have died in a total population.[11] Comparisons of crude mortality rates between the host country or local country and displaced persons show that the displaced and refugee populations nearly always die in significantly higher rates than people in their own country and their host country (Toole, 2000).

Crude mortality rate data mask the health impact of displacement on women and girls because (like other social and environmental impact data) they are rarely disaggregated by gender. In one of the few documented cases, a refugee camp in Bangladesh, Burmese girls less than 1 year of age died at twice the rate of boys, and girls over 5 years of age and women died at 3.5 times the rate of males. In another case, Rwandan refugee families headed by women suffered more malnutrition than those headed by men in an eastern Zaire refugee camp (Toole & Waldman, 1997). Even with minimal gender-based data, many conclude that refugee women and girls have a higher mortality rate than men and boys because systems of health services and food provision in refugee camps privilege men and boys over women and girls (Toole & Waldman, 1997). Single women heads of household, widows, and girl children may be last in line for food and medical services in refugee camps unless gender equity is assured. Without protection and equity, they are also prey to sexual exploitation for food and medicine.

Conclusion

War has been exalted as the inevitable path to nation-building and empire-building, justified in the name of national security, and more mundanely dubbed "politics by other means." These clean and clear views from the top, untainted by the haze of blood and body parts, are then fashioned into myths of heroism and patriotism that are "essential to justify the horrible sacrifices required in war" (Hedges, 2003, p. 26). The killing of innocents—civilian casualties—is neutered as "collateral damage" and neither reported nor publicly discussed by those responsible.

From the podium of military headquarters, wars are useful from time to time. Even ragged and messy ones, like those of Afghanistan and Iraq, can be alchemized into opportunities to instill in soldiers "the warrior ethos." For what good is an army that trains but does not fight, asks General Peter Schoomaker, the U.S. Army chief of staff. He sees the 9/11 attack on the New York Trade Center and the Pentagon as providing the opportunity to declare war and the war in Iraq as whetting the "appetite for what the hell we exist for" (BBC, 2004).

On the ground "violence, sex and male camaraderie are the big draw for many adolescents who enlist" in the military (Bowden, 2003, p. 8), as one soldier and war chronicler depicted the raw allure of military and war for young men. He described the Marine recruiter luring him with opportunities to buy sex "in the Philippines and Italy and Sweden and Panama" (Bowden, 2003, p. 8). So interlinked are these three draws for combat soldiers, that an anthropologist who lived among and studied Special

Forces soldiers (Green Berets) in combat training concluded that the glue that binds and unifies for killing in combat is boasting about heterosexual exploits. Discussions of religion and politics, which carry the risk of disagreement and disunity, are avoided. Bragging about scoring women creates friendly competition and male bonding and provides pseudo-individuality without diminishing group identity (Simons, 1997). This observer of traditional combat culture draws a conservative conclusion: Keep women out of combat units so as not to undermine male bonding and, ultimately, national security. Other researchers of military socialization, however, offer more challenging prescriptions: Integrate women thoroughly into basic training and change the paradigm of military culture from masculinist aggressivity to strength with compassion (Morris, 1996).

Embedded between the protected perch of war analysts and planners and the agonies of the dead, dying and disabled are those who report war from the frontlines. Writing of his years as a journalist covering armed conflicts in Latin America, Africa, the Balkans, and the Middle East, Chris Hedges (2003) summarizes the role of the media in mediating war to the world watching and reading from a safe distance: *to entertain* as if war is a sports event, *to manufacture* heroes and sustain the national myths supporting war, and *to ignore* death, blood, destruction, and sexual exploitation. To sanitize war, in a nutshell, of its harm to civilians and culture so as to keep it acceptable.

War has been normative and peace, exceptional throughout history. And the 20th century saw more bloodletting, genocide and sexual exploitation in war than any previous century. Even so, the modern reality and perception of war and peace are oddly reversed, observes Susan Sontag (2003). She notes that the modern world carries "the conviction that war is an aberration, if an unstoppable one. That peace is the norm, if an unattainable one" (Sontag, 2003, p. 74).

I find some hope, paradoxically, in this apparently contradictory and a-historical public conviction. If we were faced with the full harm of war, and not fed the sanitized version mediated by the major networks and press; if we would debate publicly the overkill technologies of war and the tactics of targeting human settlements; if we exposed war's proponents and profiteers, its colossal civilian casualties and destruction of culture, its cultivation of hyper-masculinity and male bonding based on sexual exploitation, and its massive and savage impact on women, then perhaps we—or at least enough of us—could be compelled to make war stoppable and peace attainable. Justifying war as a moral or beneficial response to conflict between parties would grow increasingly difficult, increasingly less palatable.

The global chorus opposing a U.S.-led war on Iraq in 2003, which reached a crescendo on February 15 when 10 million people on five continents marched and demonstrated in solidarity, is unprecedented and unparalleled in history. May this "spectacular display of public morality," as Arundhati Roy described it in her address to the World Social Forum (2004), portend a global quest for non-violent means of conflict resolution and make attainable the modern conviction that peace is the norm.

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Endnotes

[1] More children died in armed conflicts (an estimated 2 million) than soldiers in the 1990s (Foege, 2000; United Nations Children's Fund, 2001).

[2] In fact, women on all sides of that conflict were raped, a human rights violation that is endemic to war. Soldiers raped their own countrywomen in World War II and, more recently, in wars in Bangladesh, Rwanda, and the U.S. war in Iraq.

[3] The U.S. Commerce Department demographer who made these estimates. Beth Osbourne Daponte, was dismissed from her job when her estimates contradicted those of then-Secretary of Defense Richard Cheney. Her report was confiscated and new "official" estimates, which greatly reduced the numbers of civilian casualties, were prepared by her supervisors. Daponte recently stated that postwar fatalities from modern warfare (i.e., intensive bombing of urban infrastructure) are responsible for a large percent of total war-related deaths (Ginsberg, 2003).

[4] This article is not a risk/benefit calculus that weighs the harm to women from armed conflict with the potential benefits of a particular war to women. Even in "just" wars, such as the American Revolution and the World War II (author's opinion), women have

been sexually violated by military on all sides of the war. Sexual violence is always unjust and corrupts so-called "just" military actions, and it deepens the criminal content of unjust wars. All wars, just and unjust alike, warrant prosecution of criminals for sexual crimes against women.

[5] Because body counts and casualties of war are usually reported by parties involved in conflict, bias generally exists in their data. Data collected on the direct and indirect effects of war has, though, become more precise since World War II (Garfield & Neugut, 1991). One reason may lie in the creation of the United Nations and the growth of non-governmental organizations after World War II, organizations which offer more "neutral" aid, basic needs provision, and on-site surveillance in time of conflict and immediately post-war. The Los Angeles Times reported in December 2003 that the head of the statistics department in the Iraqi Health Ministry stated that their count and release of data on civilian war casualties was halted by order of the health minister because the U.S.-led Coalition Provisional Authority disapproved of it. (The health minister denied the charge.) The paper further stated that the U.S. military does not routinely count civilian war casualties.

[6] Military records have cited prevalence of sexually transmitted diseases (STDs) among soldiers, but they have rarely reported (or assessed) STD prevalence, incidence of AIDS, unwanted pregnancy, abortions and death among girls and women in local populations sexually exploited in prostitution by soldiers. When the rates among soldiers have risen, the military response has typically been to institute a regulated brothel system with the military and local health authorities as pimps, screening and controlling the women so as to protect the military users (Pollack Sturdevant & Stoltzfus, 1992).

[7] Similarly, the U.S. war against terrorism is siphoning resources from vital social and health programs. In 2002, reliance on emergency food from soup kitchens/pantries and emergency housing in shelters rose and state and federal programs for dental and health insurance for the uninsured as well as for youth-oriented drug prevention, HIV/AIDS prevention and smoking cessation were radically cut, while homeland defense against bio-terrorism enjoyed windfalls. The 2003 budget for biodefense is $5.9 billion, up more than 300% from 2002, while 41 million Americans lack health insurance and medical and public health infrastructures are overburdened and understaffed from two decades of managed care and government cuts in funding (Eban, 2002). The recently departed head of the Centers for Disease Control and Prevention, Dr. Jeffrey Koplan, likened the surge of funding to create a health system prepared for bioterrorist attacks, while the primary health care system languishes, to ' "building walls in a bog' where they are sure to sink. . ." (Eban, 2002, p.13).

[8] Murray et al. (2002) point out that many factors make war-related mortality and injury difficult to estimate. These included widely ranging definitions of conflict, the breakdown of information systems during war, and lack of standardized data collection for direct and indirect effects during and after war. By their estimates, there was at least one civilian death for every military death as a direct result of military conflict in 2000, with women and men civilians killed in equal numbers and large numbers of children and adolescents killed. These estimates do not include those who died from indirect effects of food and medicine shortages nor post-war deaths, the majority of whom are consistently civilians.

[9] The investigator who exposed the sexual abuse was demoted and then fired from her job. The UN personnel involved have legal immunity for their actions and are subject only to the jurisdiction of their respective countries, a provision of the Dayton Peace Accord signed by Bosnia, Croatia, and Yugoslavia in 1995. None of those repatriated for involvement in trafficking and prostitution has been prosecuted. The UN has suppressed the investigation and the expose of crimes against women and girls has been led by the UN High Commissioner for Human Rights in Bosnia, Marilyn Rees, and NGOs (Robson, 2002).

[10] The 7-year-old Mine Ban Treaty (first signed in December 1997) has been ratified by 131 countries with another 15 signatories, including every member of NATO except the United States. The United States employed antipersonnel landmines in the 1991 Persian Gulf War and in the recent war in Iraq. While policy from the Clinton administration has the U.S. signing on with conditions to the treaty in 2006, current Department of Defense has recommended that the U.S. ignore and abandon the growing global consensus against landmine trade, manufacture and use, an arrogant and morally bankrupt posture it has taken with many international agreements. As for the effect of the treaty to date, the number of countries which make landmines has dropped to 14 from 54, trade in landmines has nearly stopped, many have been destroyed (nearly 34 million), and the number of people maimed and killed has dropped from 26,000 per year to 15,000–20,000 (Coplon-Newfield & Omenn, 2003).

[11] The rates are generally considered underestimates because deaths among refugees are both undercounted and underreported, and the size of refugee populations is often exaggerated (Toole & Waldman, 1997).

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