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Rape as a Crime of War

A Medical Perspective

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Although widespread, rape of women has been an underreported aspect of military conflict until recently. The current war in the former Yugoslavia has focused attention on the use of rape as a deliberate strategy to undermine community bonds and weaken resistance to aggression. In addition to providing treatment for individual survivors, the medical community has an important role to play in investigating and documenting incidents of rape. Such documentation can help to establish the magnitude of rape in war and hold perpetrators accountable. Since rape in war affects not only the individual but also the family and community to which the survivor belongs, the restoration of social and community bonds is central to the process of healing and must be addressed within the specific cultural setting.

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WRITTEN accounts of rape of women during war date back to ancient Greece.[1] The abduction of Helen of Troy and the rape of the Sabine women are archetypal in Western culture, so much so that their human tragedy is obscured. Despite the fact that rape has always been part of war, little is known about its scale, the circumstances that provoke or aggravate it, or how to prevent it. We know even less about how women heal after the trauma of rape in war and how rape affects the communities in which they live.

Only recently, with the media focus on allegations of widespread rape in the former Yugoslavia, has there been a significant increase in public awareness and support for measures that respond to the trauma and crime of rape in war. A number of agencies, including the United Nations (UN), have begun to develop methods to document the scale of rape in the former Yugoslavia, collect individual testimonies, and provide humanitarian assistance to the survivors of rape in war.

Health care professionals can support individual and community healing from rape and other war-related trauma. We examine herein some of the medical sequelae and human rights issues that surround the crime of rape in war and the role that health care professionals can play in treating individual survivors as well as in collecting and analyzing evidence of these violations.

THE SCALE OF RAPE DURING WAR

Compared with the estimated 5% civilian casualty rate in World War I, an estimated 90% of war casualties in 1990 were civilians,[2] many of whom were women and children. This dramatic change is in part the result of deliberate and systematic violence against whole populations in wars increasingly waged between ethnic groups, as in the former Yugoslavia.

Many hundreds of thousands of women have been raped in wars in this century alone.[1] The following examples give some indication of the scope of the problem:

1. In Korea, recent reports estimate that in World War II, Japanese soldiers abducted between 100 000 and 200 000 Asian women, mostly Korean, and sent them to the front lines, where they were forced into sexual slavery.[3]

2. In Bangladesh, estimates of the number of women raped during the country's 9-month war for independence in 1971 range from 250 000 to 400 000, and these rapes led to an estimated 25 000 pregnancies, according to International Planned Parenthood.[1]

3. In Liberia, health care personnel estimate that large numbers of women and girls have been survivors of sexual coercion and rape during the country's ongoing civil war.[4-6]

4. In Southeast Asia, the UN High Commissioner for Refugees reported that 39% of Vietnamese boat women between the ages of 11 and 40 years were abducted and/or raped at sea in 1985.[7]

5. In Uganda, a village health worker reported that approximately 70% of the women in her community in the Luwero triangle had been raped by soldiers in the early 1980s.[8] Many of the survivors were assaulted by as many as 10 soldiers in a single episode of gang rape.[9]

RAPE AS A STRATEGY OF WAR

The common occurrence of sexual violence and rape of women and girls during detention, torture, and war has previously been documented.[10] In war, rape is an assault on both the individual and her family and community. As well as an attempt to dominate, humiliate, and control behavior,[11] rape in war can also be

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intended to disable an enemy by destroying the bonds of family and society. For example, the rape of women and girls in front of family members has been frequently reported during war.[10] The terrorism of rape sometimes forces entire communities into flight, further disintegrating community safeguards against rape.

In situations of ethnic conflict, rape can be both a military strategy and a nationalistic policy. As an expression of ethnic group hatred, rape of "enemy" women can be explicitly ordered or tacitly condoned by military authorities. In the former Yugoslavia, refugees described how public raping of women by military forces was used systematically to force families to flee their villages, achieving the goal of "ethnic cleansing."[12] In Burma, it has been reported that entire village populations fled into Bangladesh after Rohingya women were raped by the Burmese military.[13] A randomly chosen sample of 20 Ethiopian refugees who had fled forced relocation and ethnic persecution in Ethiopia were interviewed in a refugee camp in Somalia in 1986; 17 knew someone in their village, and 13 knew someone in their family, who had been raped by the Ethiopian militia.[14]

HUMAN RIGHTS ISSUES OF RAPE IN WAR

Treaties and other international agreements provide the legal basis for establishing prosecutions in cases of rape committed in wartime.[15-17] Evidence of rape by soldiers was first introduced in the Nuremberg War Crimes Trials, although it was not mentioned in any of the final judgments.[18,19] Rape was specifically identified as a war crime for the first time in the Tokyo War Crimes Trials after World War II, when commanders were held responsible for rapes committed by soldiers under their command.[20]

In January 1993, the UN sent a medical team to investigate rape in the former Yugoslavia. In light of evidence of rape perpetrated on a massive scale, the UN Commission on Human Rights passed a resolution placing rape, for the first time, clearly within the framework of war crimes and called for an international tribunal to prosecute these crimes.[21] In such a tribunal, individual soldiers and officers could be held accountable at several levels: those who committed rape, those who ordered it, and those in positions of authority who failed to prevent it.

The following sections examine some of the ways the medical community can support this process of accountability as well as perform its more usual role of treating individuals.

THE ROLE OF THE MEDICAL COMMUNITY

Documenting Incidents of Rape in War

Because the use of rape statistics for propaganda purposes is common during war, documenting rape—already difficult during peacetime—is even more challenging in the midst of war. While rape is known to be underreported in peacetime[22] (unpublished data, crime rate statistics on rape, Federal Agency of Statistics, Socialist Federal Republic of Yugoslavia, 1979 through 1988) because of the profound emotional pain and stigma attached to it, fear for the safety of family left behind and lack of ordinary support systems militate even further against disclosure during wartime. In a study of 107 Ugandan women who had been raped by soldiers, only half had told anyone about the rape incident as many as 7 years after the rape, despite the fact that all still had problems related to the rape when they finally spoke of it.[8]

Health care workers are in a unique position to recognize and document individual incidents of rape in war and to treat survivors. Women who have been raped often seek medical assistance, even when they fail to disclose the fact that they have been raped. It is important for health workers to be aware of common physical findings following rape, such as signs of violence to the genitalia (bruising, lacerations, or sometimes more severe mutilation and damage to surrounding pelvic structures such as the bladder or rectum), bruising on the arms and chest,[8] and other evidence of the use of force such as patches of hair missing from the back of the head or bruising on the forehead (oral communication, Marian Chatfield-Taylor, MA, Connecticut Sexual Assault Crisis Services, February 1993). Because rape is often accompanied by beatings or other acts of torture, there may also be signs of violence to other parts of the body.[5,8,10,23,24] At the Cambodian refugee camp Site II in Thailand, special examination forms were created to document physical signs of sexual violence.[25]

Using Medical Data to Verify Widespread Rape

When the media first focused attention on the rapes in Bosnia, published estimates of the number of rape survivors fluctuated widely from 10 000 to 60 000. In most instances there appeared to be no method for arriving at the stated figures. While the true numbers may be very high, unsubstantiated claims risk creating questions about the credibility of the numbers themselves and the scale of human rights violations against women in general.[26]

Using a public health approach, medical personnel can help provide evidence of the scale of these abuses. An illustration of this kind of documentation is provided by the international team of four physicians (which included one of us [S.S.]) sent by the UN to investigate reports of rape in the former Yugoslavia in January 1993. The medical team collected data on abortions, deliveries, known pregnancies due to rape, and sexually transmitted diseases. The team identified 119 pregnancies that resulted from rape from a small sample of six hospitals in Bosnia, Croatia, and Serbia.[11] According to estimates established in medical studies, a single act of unprotected intercourse will result in pregnancy between 1% and 4% of the time.[27,28] Based on the assumption that 1% of acts of unprotected intercourse result in pregnancy, the identification of 119 pregnancies, therefore, represents some 11 900 rapes. These numbers, however, must be interpreted carefully. Underreporting, along with the reluctance of many physicians to ask women seeking abortions or perinatal care whether they had been raped during the war, would lead to an underestimate of the number of women raped. On the other hand, multiple and repeated rapes of the same women were frequently reported and could lead to an overestimate of the number of women (as opposed to the number of incidents of rape) involved.[12] The goal is not to come up with an exact number, which is impossible, but rather to use medical data to suggest a scale of violations that cannot be determined from individual testimonies alone.

Using Techniques of Medical Science to Validate Testimony of Individual Rape

In most wars, soldiers are strangers to the women they rape, as both international and civil conflicts often take place between ethnic groups that were geographically separated before the war. In the case of the former Yugoslavia, however, dozens of testimonies have revealed that many women knew the names of, and often knew personally, the men who raped them.[12] While political events have led many to doubt whether war criminals will in fact be brought to justice in the former Yugoslavia, the UN Security Council has authorized the establishment of a war crimes tribunal. The following procedures, some of which are currently being used in criminal cases in the United States, could, in the future, help establish the identities of these perpetrators.

In countries at war, for women who

are able to seek gynecologic help within a day or two of being raped[29] (although most do not or are not able to), sperm collected from the genital tract could be dried on a microscope slide and stored for later analysis. For those women who become pregnant as a result of rape, placental tissue (following abortions or delivery) could be frozen and preserved for future testing. Alternatively, blood samples taken from the mother and child at any time could also be used. Matching of DNA or human lymphocyte antigen protein markers from such specimens can help determine paternity even many years later, using blood samples or hair follicles from the alleged perpetrator.[30] Medical services that are sufficiently organized to collect and safeguard the evidence would be able to help call alleged rapists to account.

Treatment of Individual Trauma

Medical services will frequently be the first recourse for women who have been raped because of injuries sustained or the fear of or actual symptoms of sexually transmitted diseases, including infection with the human immunodeficiency virus, or pregnancy.[4-6,8] It is important to address these medical needs by providing screening for sexually transmitted diseases, access to abortion, and obstetric and gynecologic services.

Having already suffered the trauma of rape, women who then become pregnant face further emotional and psychological trauma. Health care professionals in the former Yugoslavia have described responses of women including denial, severe depression, and neglect or rejection of the child after its birth.[12] While some women have been able to choose abortion, others, who lived in rural areas, were held captive, or lived in communities with religious prohibitions or laws limiting or denying access to abortion, may have had no choice but to bear an unwanted child.

Rape commonly results in severe and long-lasting psychological sequelae that are complex and shaped by the particular social and cultural context in which the rape occurs. Most of the data on the psychological effects of rape come from studies of adult Western women in peacetime who have suffered a single episode of rape. They describe both short-term and long-term effects. Commonly reported feelings at the time of the rape include shock, a fear of injury or death that can be paralyzing, and a sense of profound loss of control over one's life.[31-33] Longer-term effects can include persistent fears, avoidance of situations that trigger memories of the violation, profound feelings of shame, difficulty remembering events, intrusive thoughts of the abuse, decreased ability to respond to life generally, and difficulty reestablishing intimate relationships.[11,34-36]

To understand the effects of rape in wartime, one must consider the additional trauma that women may have experienced: death of loved ones, loss of home and community, dislocation, untreated illness, and war-related injury. In addition, the common sequelae of rape described above may or may not be present in various cultural settings, and their relative importance may vary widely. It is critical to describe and address any psychological sequelae within the woman's cultural context. In any culture women may not voice their distress in "psychological" terms. For example, in the study of 107 Ugandan women raped during war,[8] only two presented with what could be termed psychological symptoms (nightmares and loss of libido). Fifty-three percent described their distress in physical complaints (headaches, chest pain, and rashes), and 57% in gynecologic symptoms, mainly vaginal discharge or pelvic pain, dating from the time of the rape. The persistence of perceived infection in this group, often despite multiple treatment for symptoms (approximately two thirds had no clinical findings of infection), reflects a common sequel to rape of feeling dirty and infected.[8] Similarly, Cambodian women who were raped during the Pol Pot period complained of vaginal discharge many years after the rape occurred.[37] Understanding the ways in which distress is expressed in particular cultural settings will shape responses to trauma. For Ugandan women, for example, it was important that their physical complaints were all treated as such. Once trust had been established between the health care workers and the women, it was then possible for the women to develop their own responses to rape trauma.

COMMENT

Certain tensions emerge in the roles of the medical community: (1) between the demand for adequate human rights documentation and the needs of the individual survivors of rape, (2) between the focus on individual healing and the emphasis on restoring bonds within the family and community, and (3) between the role of international medical assistance and the local medical community.

First, the very process of human rights documentation may conflict with the needs of individual survivors. Recounting the details of a traumatic experience may trigger an intense reliving of the event and, along with it, feelings of extreme vulnerability, humiliation, and despair.[11] Health professionals in the former Yugoslavia have reported a number of harmful outcomes after survivors of rape have been interviewed by journalists, human rights workers, and even medical personnel. These include attempted or actual suicides, severe clinical depressions, and acute psychotic episodes.[12] Survivors require an environment that feels safe and contains adequate social support systems. They need to maintain control over when and where they talk about their experiences of abuse. Health care professionals can help ensure these safeguards by contributing to the development of guidelines that would limit further traumatization of rape survivors by assessing social and professional supports, ensuring voluntary consent and appropriate confidentiality, and structuring adequate collection of evidence.

Second, rape in war disrupts not only individuals but also social and community bonds (unpublished data, J.E.G., September 1992).[4,11,38,39] The restoration of these bonds, within a cultural framework that is free from the continuing effects of trauma, is fundamental to healing. For Ugandan women, the experience of rape disrupted their sense of community; keeping this aspect of their lives secret alienated them from other people. These women often expressed the fear that they would be rejected by their partners and the rest of the community.[8] The mending of social relationships was an important aspect of healing for them. Their response, once they felt that it was legitimate to talk about their experiences and to acknowledge that other women shared their own distress, was to organize themselves into meeting groups that focused on development projects and not specifically on their experiences of rape.[8]

In many cultures, interpersonal relationships rather than intrapsychic experiences are paramount, and the healing of social relationships will be an important starting point of therapy, before focusing on the individual. This is at the center of much traditional healing. Community-based interventions that are sensitive to the local context and methods of healing may be the best approach to treating the wounds of rape in many situations. This is not to ignore or minimize the medical and psychological sequelae of rape, which may be severe, but rather to situate them in a cultural, social, and political framework that expands the therapeutic potential for overcoming the suffering engendered by rape.

Third, while the international medical community can share skills, for ex-

ample, in field-research techniques, which may enhance the community's resources and strengthen its responses to individual and community-wide trauma, its role must remain peripheral to that of the local community. Interventions are likely to succeed only if they do not create excessive dependence on imported expertise and solutions. Local personnel must be supported and encouraged in documenting rape, applying methods to aid accountability, and developing strategies for healing that are appropriate to the local community.

CONCLUSION

Health care professionals have a unique role to play in the investigation and documentation of rape in war as well as in the treatment of survivors. Collecting and presenting solid evidence will help hold perpetrators accountable, restore the rule of law, and limit future violations. Furthermore, increasing medical and social knowledge about rape in war will facilitate the development of strategies that foster the recovery of survivors of rape and their communities.

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