Advancing Women’s Agency in Conflict Settings through Health Work

A Comparative Evaluation of the Dr. Hawa Abdi Foundation and the Panzi Foundation

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Executive Summary

The work of Dr. Hawa Abdi and Dr. Denis Mukwege present an interesting set of approaches to connecting international resolutions with practical, tangible change. Their work -- leveraging their organizations’ success in providing medical care, especially to women, in conflict settings -- to institute larger programming efforts aimed at increasing women’s empowerment and agency is innovative, holistic and - with appropriate adaptation - replicable. While there has been a growing recognition of the ability of health professionals to play an important role in conflict resolution processes and peacebuilding efforts by a small set of theorists and practitioners in the conflict resolution field, its connection with the field of women, peace and security has yet to be made. The medical success of these two organizations, the international recognition accorded to their founders and their large repertoire of programming relating to women beyond the purely medical realm warrants a consideration of their work and unique approach.

There are many similarities between the various projects implemented by Dr. Abdi through the Dr. Hawa Abdi Foundation in Afgoye, Somalia and by Dr. Mukwege through the Panzi Foundation and Hospital in Bukavu, Democratic Republic of Congo. First and foremost, they both function from a common base of providing quality medical care that is accessible, affordable, and tailored to the needs of the population they serve, in large part women. Additionally, both organizations have emphasized the provision of educational opportunities for women and girls in order to address deficiencies they often suffer in terms of literacy and access to schooling. These basic educational opportunities are built upon with more specific programming tailored to address either specific educational needs for women entering into certain business environments or skills development related to income generating opportunities. Model social environments are also created providing the women these organizations serve with examples of social structures in which they have greater levels of safety and agency than they experience in their home communities. Additionally, both Dr. Abdi and Dr. Mukwege have leveraged their, and their organizations’, social capital in order to speak out about the impact of conflict on women, using this platform to encourage greater engagement and interaction between the international community and civilian women in conflict settings.
Despite the many similarities, there exist important differences between the two organizations as well. One such difference is the overt provision of mental health care, which is a core component of Dr. Mukwege’s Panzi Hospital, but relatively lacking in Dr. Abdi’s Foundation. Additionally, the size of model communities created by both organizations differ. The Dr. Abdi Foundation’s communities are large and multi-gendered, with those facilitated by Dr. Mukwege’s being predominately female and much smaller. The setting of each conflict is a factor in each organization’s actions as well as their key strengths. Attending to the similarities and differences between these two organizations reveals many of the positive aspects of their programming. However, there still remain key areas for growth in order to improve their capacity to influence women’s ability to positively impact conflict in their respective communities. Foremost among these areas of growth is a need to explicitly state the connection that can be made between their health, educational, and skills programming and the resultant individual and communal changes that allow women greater access and agency in decision making processes related to conflict. Currently these connections are predominately drawn by rational observation, and not an explicit thought process articulated by Dr. Abdi or Dr. Mukwege. Changing this could have a significant impact on partnership and funding opportunities available to their respective organizations. Additionally, both of these organizations could benefit from a greater development of monitoring and evaluation mechanisms related to their non-medically related programming. Though difficult to measure, moving beyond outputs to measurement of indicators tied to desired individual or social changes would strengthen their programming and its connection to women’s ability to address conflict as equal and competent actors in their own communities.
Introduction

Since the watershed passage of UNSCR 1325 in October 2000, the role of women as active agents in conflict settings has taken a more prominent role on the international stage. In the last fifteen years, there has been considerable international attention focused on increasing women’s involvement in, and access to, the myriad of processes involved in addressing and resolving conflict. From early conflict warning mechanisms utilizing gender-based indicators to conflict resolution training for women community leaders, all female peacekeeping units to transitional justice approaches recognizing the importance of addressing sexual violence in conflict, national action plans to governmental quotas for female involvement in post-conflict national legislative bodies, women have played an important part in these efforts pertaining to conflict. However, there still remains much work to do in effectively translating the desire to increase women’s involvement and agency in conflict resolution processes into a reality on the ground.

The work of Dr. Hawa Abdi and Dr. Denis Mukwege present an interesting set of approaches to connecting international resolutions with practical, tangible change. Their work -- leveraging their organization’s success in providing medical care, especially to women, in conflict settings -- to institute larger programming efforts aimed at increasing women’s empowerment and agency is innovative, holistic and - with appropriate adaptation - replicable. While there has been a growing recognition of the ability of health professionals to play an important role in conflict resolution processes and peacebuilding efforts by a small set of theorists and practitioners in the conflict resolution field, its connection with the field of women, peace and security has yet to be made. The medical success of these two organizations, the international recognition accorded to their founders and their large repertoire of programming relating to women beyond the purely medical realm warrants a consideration of their work and unique approach.1

This study begins with a consideration of Dr. Hawa Abdi’s Dr. Hawa Abdi Foundation and Dr. Denis Mukwege’s Panzi Foundation. The Dr. Hawa Abdi Foundation is treated first, beginning with a discussion of the history of conflict in Somalia and specifically its impact on

1 Both Dr. Abdi and Dr. Mukwege have been nominated for the Nobel Peace Prize. Dr. Abdi was nominated in 2012 and Dr. Mukwege was nominated in 2009.
the role women play in Somali society. The history of her organization and a description of the medical and non-medical services offered, especially as they relate to improving women’s agency in conflict settings, are then provided. A discussion of Dr. Mukwege’s Panzi Hospital follows in a similar manner, placing the services and programming offered by the hospital in the setting of the history of conflict the Eastern DRC has experienced, noting the especially strong role sexual violence has played in the conflict. The programming related to women’s agency and empowerment to address conflict offered by these two organizations is then compared, looking at how the different conflict factors, positions of women in society, and organizational strengths have influenced their different programming approaches. These programs and activities are then tied to the theoretical articulations of Peace through Health, a growing academic field falling under the larger umbrella of Conflict Resolution. Finally, key recommendations are made regarding the primacy of medical efforts, international involvement, the role of men in these efforts, and leveraging female physicians’ social capital for conflict work.

Conflict in Somalia: A Historical Backdrop of Insecurity, Instability and Inequality

Since the fall of Siad Barre’s regime in 1991, Somalia has experienced extensive protracted conflict characterized by violence and social disruption. From 1991 to the Arta Process in 2000, Somalia lacked any central government and warlords asserted their power through clan identity and a strong willingness to use violence. After 2000, and the creation of largely ineffective transitional government bodies, conflict and violence still continued. In addition to clan-based identities, groups organized based upon fundamentalist interpretations of the Islamic faith joined as belligerents in the conflict. Intense periods of fighting in 1991-1992, 1993-1994, and again in 2006-2008, have led to large movements of civilians from their places of residence to tribal “safe areas,” or locations where one could expect protection based on clan

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2 For the context of this paper the term “women’s agency” refers to the ability of women to be active and informed contributors and decision makers within their community. Thus promoting women’s agency entails efforts that situate women within a social setting that respects, and expects, their active participation as contributors and decision makers on all matters, not just those related to the “home”. As a prerequisite for this, promoting women’s agency also pertains to healing processes, skills training, and social services that provide women the necessary health and skills to be competent actors in the above mentioned social situations.

In addition to the breakdown of society based upon clan identities, the prolonged experience of conflict has led to the collapse of traditional economic roles and a restructuring of traditional gender roles. While a more detailed discussion of the history of this conflict is beyond the scope of this paper, the two factors of large numbers of displaced peoples and the changing role of women in society warrant further elaboration in light of Dr. Abdi’s work in Somalia.

One of the defining factors of the Somali conflict has been its profound numbers of refugees and internally displaced peoples. In 2012 Somalia had over 1.1 million internally displaced peoples. Furthermore, another 1.1 million individuals were listed as refugees who had fled Somali and were residing outside of the country. Out of a country of an estimated 10.2 million individuals, slightly more than 1 out of every 5 Somalis has been displaced because of the conflict over the past 20 years. These numbers reveal the widespread nature of displacement among Somali people; understanding the impact of this displacement on Somali society is essential.

Large population movements have a lasting impact on societies and this is especially true in terms of the impact on women and the roles they play within a society. Conflict and population movements tend to exacerbate already unequal social structures, and women, along with other disadvantaged groups, suffer disproportionately. Specifically, women often face increased risk of sexual, gender based, and domestic violence, exclusion from decision making processes regarding family movements, increased economic and social demands as men are forced to flee or join armed forces and traditional sources of income are no longer viable.

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6 Ibid.
Due to these large population movements and the changes they force upon a society, it is no surprise that Somali women have assumed new economic roles, often time supplanting the traditionally male role of providing for the family’s financial needs.\textsuperscript{13} Furthermore, women have been able to expand their traditionally informal involvement in conflict resolution process and governing bodies to be included, albeit in a limited manner, in national dialogues and governmental institutions.\textsuperscript{14}

A Visionary’s Vision: Dr. Hawa Abdi and the Dr. Hawa Abdi Foundation\textsuperscript{15}

In the context of prolonged conflict – mired by clan divisions, large numbers of internally displaced individuals, and changing roles for women in society – Dr. Abdi has developed her organization. Dr. Abdi opened her first one-room clinic in 1983 just outside of Mogadishu in the small town of Afgoye. Originally designed to meet the medical needs of women and expectant mothers in this rural community, with the onset of civil war in 1991 she soon expanded her clinic to provide housing and medical support for the growing number of IDPs in the region. To provide for the growing number of IDPs taking refuge with her organization, Dr. Abdi purchased additional land around her clinic and expanded its medical capacities to include a surgical unit and employed a variety of specialists. She also set up agricultural programs to help feed the growing population depending upon her organization, developed schools to provided education for their children, and instituted connections with international organizations to provide for additional supplies and food. To date, her organization has expanded to encompass a 400-bed hospital, implemented programming increasing women’s agency, and now serves an estimated 90,000 people through its different programming efforts.

Medically, the Dr. Hawa Abdi Foundation is based out of the above-mentioned 400-bed hospital. In addition to 400 inpatients served, on an average day the hospital treats over 300 hundred outpatients, delivers 20 babies, and hosts a myriad of surgeries in its two operating theaters. It also provides emergency feeding care for malnourished children, runs a cholera treatment center, and continues to offer the maternity and obstetric care it was initially founded to provide. During the beginning of the civil war, and again from 2007 to 2010, the hospital

\textsuperscript{13} Gardner & Bushra, 2004, p.117.
\textsuperscript{15} Unless stated otherwise, the information in this section comes from an interview conducted with Dr. Abdi on April 1, 2013.
partnered with Médecins Sans Frontières to provide needed physicians and supplies. Dr. Abdi currently partners with her two daughters, Deqo and Amina, who are also physicians, in order to lead the foundation and hospital.

Beyond medical care, in 2010 the Dr. Hawa Abdi Foundation began providing educational classes, income generating skills training, and civic opportunities designed to address the needs of internally displaced peoples and, in particular, promote women’s agency. The organization provides primary education for young Somali girls through the Waqaf-Dhiblawe Primary School, which educates nearly 800 children a year and teaches foundational lessons in Math, English, Science, Arabic, and Somali. For Somali women, educational and income-generating skills training are provided through the Women’s Education Center. The Center houses classes focused on literacy, sewing, handicrafts, nutrition, and basic medical care. These programs are much effort in response to the estimated 26% literacy rate for Somali women.  

To foster civic engagement, the Dr. Hawa Abdi Foundation has organized community councils to assist the governance of the seven sections of its camp. These councils are comprised of men and women and male and female youths. These councils provide women of all ages the opportunity to be active decision makers in the governance of their own community and an equal public platform to make their voice heard. In addition to providing a strong example of female leadership and agency in conflict settings, Dr. Abdi also advocates to the international community regarding the impact of the Somali conflict on the women and IDPs served by her organization.

**Conflict in the Eastern Democratic Republic of the Congo: The Devastating Impact of Sexual Violence**

Much like Somalia, the Democratic Republic of the Congo (DRC), has experienced sustained levels of conflict, violence and population displacement since the mid-1990’s. Since the Rwandan-Ugandan led invasion of the DRC in 1996 and the eventual overthrow of Mobutu, the Eastern DRC has been a hotbed for violence, instability and gross human rights violations. In

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17 The numerous awards Dr. Abdi has received by such organizations as the John Jay College of Criminal Justice, Vital Voices, and Glamour, as well as her nomination for the Nobel Peace Prize in 2012, have afforded many opportunities to address international leaders and organizations on these matters.
light of a weak and ineffective central government, presence of loot-able mineral wealth\textsuperscript{18}, pre-existing regional conflicts, and the propensity of violence to beget more violence\textsuperscript{19}, many different conflicts have played themselves out on the soil of the Eastern DRC.\textsuperscript{20} Though the Lusaka Agreement and Sun City Agreement have attempted to address the drivers of conflict by including a broad collection of stakeholders, at times including civil society leaders, heightened levels of violence continue to this day. Again, like the treatment of Somalia, an in depth discussion of the history of conflict in the eastern DRC is beyond the scope of this paper. However the key factor of widespread sexual violence and its attendant effects on society are important to consider in light of Dr. Mukwege’s work.

Rape and sexual violence have emerged as one of the most recognizable, and pervasive, aspects of the conflict in the Eastern DRC. Though it is difficult to ascertain the true extent of this phenomenon because of under-reporting and lack of access to all of the populations affected, it is apparent that Congolese women have suffered from sexual violence at an, arguably, unprecedented level in modern history.\textsuperscript{21} From 2003-2007, the International Rescue Committee assisted over 40,000 rape survivors in South Kivu and the UN reported 27,000 sexual assaults in 2006.\textsuperscript{22} In June 2008, 2,200 rapes were reported in North Kivu in that month alone.\textsuperscript{23} The widespread nature of sexual and gender-based violence in the DRC is indisputable; it is a physically, emotionally, socially, economically and even politically devastating phenomenon.\textsuperscript{24}

The widespread use of sexual violence has had a profound impact on both the female and general population in the Eastern DRC. On an individual level, sexual violence can have a devastating mental and physical impact on its victims.\textsuperscript{25} Not only does undergoing sexual violence often lead to depression, anxiety, and post-traumatic stress, but given the extremely violent manner of rape and sexual violence often perpetrated in the region, it can lead to adverse

\textsuperscript{23} Ibid.
physical outcomes such as fistula and chronic incontinence as well. The social consequences of such violence can be equally devastating. Women who suffer from sexual violence are often shunned by their husbands and communities, being held responsible by society for the violence that they have suffered. Due to this ostracism, families are broken apart and already marginalized women are forced even further to the edges of society. Women in these situations often resort to prostitution to make ends meet, making them increasingly vulnerable to suffering from further sexual violence and social ostracism. Moreover, armed groups in the conflict often utilize sexual violence as a deliberate tactic in order to humiliate and tear apart the social fabric of the communities with which they are in conflict because of the multiple levels of pain, terror and suffering that results.

A Man Set Apart: Dr. Mukwege’s Panzi Foundation and Hospital

Dr. Mukwege established the Panzi Hospital in Bukavu in 1999 in order to provide comprehensive and affordable medical, psychological, and social services to the large number of women victims of sexual violence in the Eastern DRC. Originally designed to accommodate 120 beds, the hospital and its services have grown considerably since its inception. In 2008, Dr. Mukwege helped transform the Panzi Hospital into the Panzi Foundation and expanded its repertoire of medical and non-medical programming to reach a broader population and emphasize the promotion of women’s rights and gender equality. The Panzi Foundation now boasts international connections with respected humanitarian organizations, research partnerships with European hospitals, and programming designed to increase women’s agency in the educational, economic, social, and legal spheres.

Medically, the Panzi Hospital is a 450-bed hospital comprised of four departments: obstetrics and gynecology, internal medicine, pediatrics, and surgery. Over 200 of these beds are dedicated to survivors of sexual violence. Additionally, the hospital provides laboratory,
radiology, ophthalmology, and dentistry services to its patients. It augments its onsite services with mobile clinics and programs aimed at addressing malnutrition, sexual violence, and health literacy among the rural population in South Kivu. As of 2012, the hospital employed 342 personnel and had provided care to over 28,000 patients throughout the last calendar year.

Beyond its medical programming, the Panzi Foundation and Hospital seeks to build skills and capacity for the women it serves through a variety of programs that include educational support, income generating training, trauma healing, and legal advice. The first among these programs is the Survivors of Sexual Violence (SSV) program. SSV compliments the provision of medical to women who have survived sexual violence by providing group therapy sessions, literacy classes, and mediation sessions with family members. Given the propensity of husbands to abandon their wives after an incidence of sexual violence, and the positive impact spousal support plays in recovering from sexual violence, the mediation sessions are an important aspect of this programming. The SSV program aims to effect mental, emotional, and social healing to compliment the physical healing provided by the medical team, and in doing so return the survivors as whole, and hopefully empowered, members of their community.

In addition to the SSV program, the Panzi Foundation runs Maison Dorcas. Maison Dorcas is a community for survivors of sexual violence and their children, where the women continue to receive group counseling sessions and medical treatment, but a greater emphasis is placed on income generating skills development. In this community, women receive training in mathematical skills, small business development, and other areas concerning the generation of an economic livelihood. This community also serves as a safe home and transition point for women unable to return to their former communities because of spousal abandonment. The goal of this program is to provide additional time and space for survivors to heal and develop skills that will allow them to play a positive and self-reliant role in the community they next enter.

In addition to these two key programs, the Panzi Foundation also provides legal support to survivors of sexual violence and engages with outside agencies to promote international engagement and awareness with the issue of sexual violence in the Eastern DRC. The most notable of these partnerships on an engagement level is through the City of Joy. The City of Joy program was initiated in 2011 by Eve Ensler after consultations with Dr. Mukwege and provides

a larger scale version of the Panzi Foundation’s Maison Dorcas program.\textsuperscript{32} The City of Joy provides a community for survivors of sexual violence in which to develop leadership skills, business skills, and heal together before returning to their communities. Raising awareness, Dr. Mukwege has spoken through the United Nations and other international platforms to address the international community regarding sexual violence and impunity of perpetrators in the Eastern DRC.\textsuperscript{33}

**Analysis and Comparison of Dr. Abdi’s and Dr. Mukwege’s efforts**

There are many important similarities between the various projects of Dr. Abdi and Dr. Mukwege. First and foremost, they both function from a common base of providing quality medical care that is accessible, affordable, and tailored to the needs of the population they serve, in large part women. Additionally, both organizations have emphasized the provision of educational opportunities for women and girls in order to address deficiencies they often suffer in terms of literacy and access to schooling. These basic educational opportunities are also built upon with more specific programming tailored to address either specific educational needs for women entering into certain business environments or skills development related to income generating opportunities. Model social environments are also created providing the women these organizations serve with examples of social structures in which they have greater levels of safety and agency than they experience in their home communities. Finally, both Dr. Abdi and Dr. Mukwege have leveraged their, and their organizations’, social capital in order to speak out about the impact of conflict on women, using this platform to encourage greater engagement and interaction between the international community and civilian women in conflict settings.

Noting the pervasive, broad level, similarities between these two organizations reveals much about the identified needs of women in conflict settings and how health professionals can address them. However, much can also be revealed by looking to the distinct features of each model. One such difference is the prominent role mental health services play at the Panzi Hospital and lack of emphasis on such services at the Dr. Hawa Abdi Foundation. Providing mental health services and psychosocial healing programs has been noted as an extension of


appropriate medical care in cases of sexual violence.\textsuperscript{34} Furthermore, while rape and sexual violence have been a factor in the conflict in Somali\textsuperscript{35}, it has not occurred at the same levels as in the Eastern DRC. As such, the emphasis of mental health programming at the Panzi hospital can be seen in light of the specific needs of the population served by the hospital. Dr. Mukwege and the Panzi Hospital responded to the specific conflict dynamics of the Eastern DRC and widespread use of sexual violence and institute programming to meet the needs of the women they served. In Somalia, Dr. Abdi and the Dr. Hawa Abdi Foundation have responded to the needs of their populations, which to date have not required the same type of mental health or psychosocial programming. This is not to suggest that severe trauma is not an issue amongst displaced populations under the care of the Dr. Hawa Abdi Foundation. It may be a need that is inadequately met or served. Considering this contrast between the models, future programming – especially attempts to replicate the work of Dr. Abdi and Dr. Mukwege in other contexts – can learn from these distinctions and the potential added value of alloying the best of both cases.

Another important difference between the work of these two organizations is the scale on which they have created model communities for the women they serve. The Dr. Hawa Abdi foundation, in response to large numbers of IDPs and Dr. Abdi’s possession of a large tract of land, has come to be the de facto community for over 90,000 people. The Panzi Hospital operates on a completely different scale, operating in a facility originally designed for 120 beds. Given the large number of people served by Dr. Abdi’s foundation, the civic structures she has helped create to manage a camp that include both men and women, have of necessity been quite large. While with Dr. Mukwege’s work, the model communities mirrored in the City of Joy, Maison Dorcas, and other projects have been much smaller, on the level of 40-100 women. Again, this can be seen in the light of the different conflict dynamics and needs presented influencing the way in which these two organizations have gone about providing services. Dr. Mukwege’s more specific focus has led to working with a more targeted number of female individuals, while Dr. Abdi’s broad ranging services leads to work with larger numbers of men and women together.

Taken together, the similarities and differences between these two organizations shed light on the connections that can be drawn from their work and how these examples can serve as


\textsuperscript{35} Gardner & Bushra, 2004.
a vehicle for promoting both protection and participation of women in humanitarian care in other conflict settings. From their similarities, it is evident that programming originating from medical based efforts must provide competent and accessible health care. Furthermore, they demonstrate that non-medical programming related to educational or income-generating opportunities and the utilization of model communities is appealing to women across different conflict and geographical settings. From their differences, it is shown that this general type of approach, leveraging the provision of medical care to address other issues related to women’s agency in conflict settings, can be accomplished across different conflicts and cultures. The different emphasizes of Dr. Abdi’s and Dr. Mukwege’s organizations makes the argument that with appropriate attention to the needs of a populations, this type of programming can successfully respond to the needs of a specific conflict or setting.

However, one of the largest areas of growth for the programming employed by Dr. Abdi and Dr. Mukwege is the understated connection from the provision of medical care to potential gains in women’s agency impacting conflict. One can easily comprehend how providing women needed medical care, educational programming, a model community, and specific skills can lead to a female population that is more capable and active in addressing the conflicts their communities’ face. The link between programming that provides the aforementioned skills and opportunities is rarely explicitly made to the potential positive impact it could have on the conflict these women face. Understandably, Dr. Abdi and Dr. Mukwege draw attention to how the impetus for their programming comes from an imperative to serve women who are uniquely impacted by conflict and often have no other recourse for aid, as well as the positive impacts of healthy and educated women for their families and communities. However, without an equal emphasis on how these same programs can potentially provide women with a better ability to address conflict, they miss out on possible partnerships that could help improve, expand, and fund their programming.

Following in this vein, as Dr. Abdi and Dr. Mukwege’s efforts can be considered through a Peace through Health lens (to be discussed in detail in the next section) and the women, peace, and security lens mentioned above, it is no surprise that an area of needed growth is

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36 Peace through Health refers to an academic field that studies the way in which health work, and health professionals, can positively influence conflict through their unique social standing, skills, and access to a population. Please see the following section for a more in depth discussion of the term and how it applies to the work of Dr. Abdi and Dr. Mukwege.
effective monitoring and evaluation. Both fields, as well as the larger more encompassing field of conflict resolution, have acknowledged the need for more robust monitoring and evaluation of their respective programming efforts. In terms of medical efforts, these two organizations’ monitoring and evaluation efforts are on solid footing, given the well-defined and accepted methods of determining the efficacy of medical interventions. Recording the number of patients treated, outcomes of surgical interventions, infection rates, mortality rates, etc. are based upon empirical methods and well accepted within the international medical field. However, evaluation of the impact of the programming that extends beyond the medical sphere is less rigorous and less easily defined. Counting of outputs (i.e. number of women enrolled in programming) and anecdotes, as well as qualitative assessments, do provide some insight into the impact of programming. However, this form of analysis lacks the weight of more in depth evaluative measures that carry with international donors and can more fully determine causality. Lack of ability to quantitatively or explicitly measure the impact of their efforts in these areas does not by any means negate the potential positive impacts these programs have had, or will have. Instead, it underscores the necessity of further developments in monitoring and evaluation of conflict resolution efforts, both by their organizations, as well as the field in general, in order to more firmly determine the true impact of these efforts.

**Theoretical Support: Peace through Health**

The field of Peace through Health provides academic support for why the efforts initiated by Dr. Abdi and Dr. Mukwege have been able to successfully engage issues beyond the medical field related to conflict. There is a long connection between the field of health and mitigating the effects of conflict. Institutions such as the International Committee for the Red Cross or

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Médecins Sans Frontières have been established to provide essential medical care for victims of conflict and other disasters in an attempt to mitigate the impact of large-scale political violence on civilian populations. Indeed, many of the reasons people in these populations seek health care services are due to the effects of conflict. Whether it is because of physical trauma due to direct violence, the psychological wounds of interpersonal or intergroup conflict, or malnutrition and disease as a result of structural violence, conflict often necessitates action in the field of health. However, it was not until the 1980’s that the idea of using health as a springboard to resolve conflict, instead of solely mitigating its consequences, came about.

The first efforts in this regard were undertaken by the Pan American Health Organization (PAHO) to address conflict between guerilla groups and the governments in El Salvador and Peru. Beginning in 1985, PAHO implemented a campaign of “days of tranquility” or temporary cease-fires in order to immunize children from both groups against preventable disease. The idea of using immunization campaigns as a way to temporarily halt hostilities, and bring opposing groups to the table, while at the same time providing for the basic health needs of their respective populations soon took hold. Primarily through the vehicle of the WHO, these campaigns sought to positively influence both health and peace in many conflicts throughout the late 1980’s and 1990’s. Afghanistan, Lebanon, and Sri Lanka are just a few of the many countries in which WHO and others utilized this approach.

Building upon the perceived successes of the immunization campaigns, other programs incorporating health and peacebuilding began to emerge. Psychosocial healing programs gained acceptance in the Balkans and other actors in Sri Lanka and the North Caucasus. So too did training efforts related to conflict management, negotiation, and facilitation through workshops and networks for health care professionals in conflict zones. This focus on conflict management skills for health care professionals has grown and now has many advocates calling for its further adoption and development. A final area of development during this period was the use of

medical information, and social capital of physicians, as a way to restrict or ban the use of certain weapons such as landmines, cluster bombs, or light arms.\textsuperscript{43}

The core theory behinds these efforts is outlined in the ten ways that health can be mobilized to include peacebuilding goals: 1) health-related superordinate goals, 2) evocation and extension of altruism, 3) discovery and dissemination of facts, 4) redefinition of the situation, 5) healing of trauma, 6) contributions to civic identity, 7) contribution to human security, 8) diplomacy, mediation, and conflict transformation, 9) solidarity and support, 10) dissent and non-cooperation.\textsuperscript{44} All ten of these arenas dictate, in a theoretical sense, what physicians and medical organizations can draw upon to positively impact conflict in addition to health. The founders of the field rest upon the large number and moral weight of these arenas to support their claims that peacebuilding can be successfully implemented by health practitioners.

Tying the theory to the efforts of Dr. Abdi and Dr. Mukwege, the theoretical articulations of the Peace through Health field line up with the actions undertaken by these physicians’ respective organizations. Dr. Abdi’s has capitalized on her access to a population and the high level and unique trust accorded to her and her organization, and her effectiveness is propelled by her ability to define her work in terms of superordinate goals in order provide multifaceted economic, educational, and civic programming for women served by her organization. In a similar vein, Dr. Mukwege has capitalized on these same factors in order to provide trauma healing, economic, and educational programming to the women his organization serves. Furthermore, both Dr. Abdi and Dr. Mukwege have spoken out to the international community using their locally and internationally respected position to make their voice heard. They have called attention to the violence being perpetrated in their communities and emphasized the need for international engagement and support of their efforts through appeals to human security\textsuperscript{45} and a redefinition of the situation in terms of human suffering and health problems, rather than political or ideological differences.

The strong correlation between the theoretical foundations of Peace through Health and the practice of Dr. Abdi and Dr. Mukwege’s organizations not only lends credibility to the notion

\textsuperscript{43} Arya & Santa Barbara, 2008, p. 182.
\textsuperscript{44} Santa Barbara, J. & MacQueen, G. (2004). Peace through health: Key concepts.\textsuperscript{45} The Lancet, 364(9431), p. 384.
\textsuperscript{45} The term human security refers to an understanding of security that takes into account the human experience in addition to its traditional military, political, and international dimensions. Human security emphasizes concerns about access to food, water, shelter, healthcare and livelihood, considering them on the same level as other factors such as the distribution and strength of military forces and political control.
that medicine can be an opening for conflict resolution and peacebuilding but, more importantly, provides legitimacy to the efforts of these two physicians. These two cases support the notion that humanitarian assistance programming can also be an opportunity to promote women’s agency in conflict-ridden settings. In other words, despite the terrible suffering that is endured by the women beneficiaries of both Dr. Abdi and Dr. Mukwege’s hospitals, a new opportunity for empowerment is created and, with adequate resources and guidance, can be seized to further stability and security not only for women but also their families and communities writ large.

Looking to the Future/Recommendations

I: Looking at these case studies, and the impact of organizations leveraging their medical care to institute programming promoting women’s agency in conflict settings, certain lessons can be drawn from their analysis. First and foremost among these is the primacy of providing quality medical care. The extortion that “health must always be the primary concern” even though programs desire to expand their influence and programming beyond solely the sphere of health, rings true. The legitimacy of the efforts of Dr. Abdi and Dr. Mukwege, both in the eyes of local population and international actors, hinges upon their ability to provide quality medical services in a time of great need. Looking to both of these physicians, their success in this arena is apparent. Dr. Mukwege has many respected publications regarding fistula surgical techniques, holds a reputation as one of the preeminent fistula surgeons, and has developed strong international medical connections with his Panzi Hospital. Dr. Abdi, as well, has achieved recognition as the first Somali-born female gynecologist and has worked alongside Médecins Sans Frontières, a preeminent medical association in conflict settings, during many periods of violence in Somalia.

Programming that moves beyond purely medical services must be built upon a solid foundation. If health needs are not met, then improvements in terms of economic abilities, greater influence in conflict resolution processes, and political empowerment are impaired.

Those to whom these skills and opportunities are being afforded or taught must still concentrate their attention on basic health needs, drawing important resources, time, and effort away from their efforts to address these new skills and opportunities. Commitment to providing the best possible care in the current circumstances of the situation provides a base from which trust is built with the local population, increasing access for later programming. It also increases trust with the international community and opportunities for collaboration and funding. If this additional programming is divorced from an ability to meet the basic health needs of a population these opportunities are lost, and efforts will most likely falter.

The importance of building successful, and locally conscious, international partnerships is also apparent. The efforts of both Dr. Abdi and Dr. Mukwege have benefited from strong international partnerships and support. For example, Dr. Abdi’s collaboration with Médicins Sans Frontières provided needed medical staff, expertise, and equipment unavailable at the scale required during certain periods of conflict.\textsuperscript{48} Similarly, Dr. Mukwege has developed extensive international connections and funding sources for the Panzi Foundation and Hospital, and governmental and non-governmental international organizations have served as platforms through which to raise awareness about his work.\textsuperscript{49}

II: Physician-founded humanitarian initiatives stand at an important nexus between the health and security fields given their ability to address health issues as well as large social and cultural issues impacting women’s agency. In the light of the recent G8 declaration in April 2013 on sexual violence in conflict, the issues of maternal/child health, sexual violence in conflict, and the broader women, peace and security agenda continue to be important issues on the international agenda. Dr. Abdi’s and Dr. Mukwege’s work are deeply relevant to the key points articulated in the G8 declaration such as promoting the full human rights of women and children, providing comprehensive support to survivors of sexual violence, documenting its occurrence, and providing broad-based essential services (e.g. health, psychosocial, legal, economic, etc.). Dr. Abdi’s and Dr. Mukwege’s initiatives have much to offer in terms of effective programming, and much to gain through building and sustaining strong international connections. However, it is also important to remember the medical dictate “do no harm,” and consider all the implications

\textsuperscript{48} Abdi, 2013.
of international involvement. As Dr. Abdi’s experience with inflated wages and inability to retain staff during critical periods of need because of the arrival of international organizations demonstrates, not all international involvement is beneficial. It can and should augment local efforts, but it must be well planned and locally driven.

III: Dr. Mukwege’s work highlights the importance of engaging men in the promotion of greater women’s involvement in peace and security efforts. This is a fundamental aspect of his strategy and one that is context-appropriate. Men and boys, like women and girls, are important in increasing women’s involvement in conflict prevention, conflict resolution, negotiations, peace agreements, and other efforts surrounding peace and security. Just as the argument goes that one cannot create peace with only 50% of the population (men), efforts to increase women’s agency cannot rely on only 50% of the population (women). Dr. Mukwege’s dedication to providing medical services to women in need, as well as his consistent denunciation of sexual violence and the impunity accorded to its perpetrators, anchor him as a strong advocate of women and women’s rights in conflict. His actions have had a recognizable impact on the health and rights of women in Bukavu and demonstrate that the involvement of men in the support of women in conflict settings can have important consequences not only for the security and rights of women but for societies writ large. Indeed, while the effort to engage men and boys on issues regarding gender and women’s rights develops, male physicians seem uniquely positioned to address women’s health needs and speak out as respected members of society in support of women. Respected healthcare professionals are first hand witnesses of the horrific impact of conflict on women and their ability to frame their support for women through a “health lens” helps to avoid potential negative consequences or stigma that may be present in societies that have less respect for women’s rights.

Interestingly, Mary Anderson has also expanded this dictate to the field of conflict resolution, see Anderson, M. (1999). Do no harm: How aid can support peace—or war. Boulder, CO: Lynne Reinner.

IV: Looking closely at the case of Dr. Abdi and her team underscores the importance of partnering with successful female professionals and helping expand their professional respect and influence to address larger issues of peace and security. In contexts where women are not accorded a large role in the public sphere, working with women in professions that are almost universally respected, such as the medical field, can be a creative avenue through which to increase the visibility and influence of women improving conditions ridden by conflict. Much like providing quality medical care provides organizations a foundation from which to undertake broader level efforts, women’s medical professional capabilities provides them a foundation from which to speak about other important issues facing their society. Dr. Abdi’s personal development, including her professional training as a lawyer subsequent to receiving her medical degree, buttressed her ability to advocate for the thousands of people in her care. It also informed her understanding of how to maneuver the circumstances in which she built her hospital to better serve those in need, reduce suffering and contribute to creating more peaceful community. This idea is not uncommon although it can be difficult to replicate. Targeting the development of leadership and political communication skills sets in female medical professionals in conflict or post-conflict settings could capitalize on their unique standing in society and provide support to the women most likely to be able to translate these opportunities into benefits for their larger society, and especially its women.

Conclusion

A close examination of the operations of the Dr. Hawa Abdi Foundation and the Panzi Hospital reveals that both organizations have been able to leverage the provision of quality medical services to institute a growing number of programs aimed at increasing women’s agency in conflict settings. Tailored to the unique needs of the female population in each context, their programming has taken similar, but slightly different forms. In the Eastern DRC and in response to the high prevalence of sexual violence, Dr. Mukwege’s Panzi Foundation and Hospital combines surgical expertise related to fistula repair with a set of programs aimed to help women and their communities heal from the trauma of sexual assault. This is accomplished primarily through providing training opportunities to ensure women’s economic independence, psychosocial healing programs, and mirroring a community where women are active participants.
and decision makers. In Somalia, in the face of drought, clan-based conflict, and the collapse of civic institutions, the Dr. Hawa Abdi Foundation provides for the comprehensive health needs of women and their families, in addition to strengthening women’s leadership roles inside their own communities. Programming related to educational, economic, and civic engagement for the women they serve is the primary means of accomplishing these endeavors.

Through attending to and meeting the specific health needs of women in conflict settings, Dr. Abdi’s and Dr. Mukwege’s respective organizations help the women they serve to return to health, then move from health to agency through a set of conflict and context specific programming. Though these programming efforts can be logically connected to increased agency in addressing conflict – healthy, educated, women who are part of a community that respects their input and provides a forum for it to be publically heard would surely be a positive asset in helping their community address one of its most pressing concerns, deep-rooted and violent conflict – there has yet to be an emphasis on how their programming can positively impact conflict resolution or security concerns. Indeed their work could benefit greatly from an explicit emphasis on the connection between their programs and women’s engagement as competent, accepted, and skillful actors in conflict resolution processes within their communities and societies. Yet, just because this connection has not been specifically made does not negate its potential impact. As with the field of Peace through Health, their approach is not a panacea. It cannot, and will not, provide the singular way to attend to the needs of women in conflict settings and provide them with the necessary skills to engage in conflict resolution processes. However, their work does provide two powerful examples of possible, and potentially effective, avenues to connect the provision of health care in conflict settings with increasing women’s ability to positively and effectively engage with the conflict their communities and societies face.
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