

III. Challenges and progress in implementing the women, peace and security agenda: two case studies

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This section describes two case studies that highlight the challenges and progress in implementing the women, peace and security (WPS) agenda: women's participation in security sector reform (SSR) and the work to prevent gender based violence in conflict and post-conflict reconstruction of health systems.

Resolution 1325 and security sector reform¹

The WPS agenda and the concept of SSR both stem from the notion of human security and the idea that security institutions should be representative of and responsive to the needs of the whole population. In recent years, SSR has become an increasingly significant component of peacebuilding efforts, recognizing the need for effective and accountable security sector institutions in order to achieve sustainable peace and security.² This is reflected in the WPS agenda and United Nations Security Council Resolution 2122, which proposes women's full participation in and protection by the security sector.³ When the Security Council adopted its first resolution on SSR—UN Security Council Resolution 2151 in 2014—it emphasized the importance of gender mainstreaming as well as 'the importance of women's equal and effective participation and full involvement in all stages of the security sector reform process'.⁴ When UN member states and the international community fail to promote Resolution 1325 and gender equality within SSR, such programmes are unlikely to create security and justice institutions that meet the needs of both men and women. They also risk perpetuating structural inequalities and tensions that reduce the chances that SSR and the broader peacebuilding process will be successful.⁵

Interest in incorporating Resolution 1325 into SSR programmes has increased in the past 15 years, as more governments and peacebuilding prac-

¹ This section is written by Emmicki Roos.

² United Nations, *Securing States and societies: Strengthening the United Nations comprehensive support to security sector reform*, Report of the Secretary-General, A/67/970-S/2013/480 (United Nations: New York, 2013); and United Nations, *Securing peace and development: The role of the United Nations in supporting security sector reform*, Report of the Secretary-General, A/62/659-S/2008/39 (United Nations: New York, 2008).

³ UN Security Council Resolution 2122, 18 Oct. 2013.

⁴ UN Security Council Resolution 2151, 28 Apr. 2014.

⁵ Gordon, E., Welch, A. and Roos, E., 'Security sector reform and the paradoxical tension between local ownership and gender equality', *International Journal of Security and Development*, vol.4, no.1 (2015), p. 1.

tioners have been made aware of the WPS agenda and the obligations to implement it. However, much remains to be done to ensure that SSR programmes are gender sensitive and involve local ownership, including the direct and meaningful participation of women.

Local ownership in the context of SSR is often restricted to members of the male-dominated security and political structures at the state level, which means that international actors involved in SSR might not be exposed to wider society and may therefore rely on the perceptions of male-dominated elites.⁶ Research based on public surveys in some post-conflict contexts suggest that local populations may be more open to women's inclusion and gender mainstreaming in SSR than is perceived by policymakers. For example a public survey carried out in Nepal in 2011 disclosed that 77 per cent of respondents thought that there was a need for greater participation of women in the Nepal Police.⁷ Similarly, a survey in Afghanistan in 2013 showed 53 per cent support for women police officers.⁸ To ensure that the SSR discourse is not dominated by external actors and male elites at the state level there is a need for consultations and dialogues with wider society, including women, minorities, conflict-affected communities, youth and civil society.

An example of how the engagement of women can build consensus and legitimacy around security reform processes is the 1996–98 South African Defence Review. During the review, woman's organizations played a crucial role in highlighting issues that had previously been ignored. These included the consequences of military activities on the environment, the situation for communities whose land had been seized by the military, and cases of sexual harassment by military personnel. Two new subcommittees were established within the South African Defence Secretariat to address these issues. The inclusive nature of the review contributed to national agreement around security-related issues and increased the ownership and public support for the new security apparatus.⁹

Resolution 1325 in health systems reconstruction¹⁰

Resolution 1325 recognizes that violent conflict and insurgency have different impacts on men and women. Sexual violence against girls and women, as

⁶ Gordon, Welch and Roos (note 5), p. 2–4.

⁷ Gordon, E., Sharma, S., Forbes, A. and Cave, R., *A Safer Future: Tracking security improvements in an uncertain context* (Saferworld and Interdisciplinary Analysts: London and Kathmandu, 2011), p. iv.

⁸ UNDP, *Afghan police force recruits women to fight crime and stigma* (UNDP: New York, 2013). Also see Gordon, Welch and Roos (note 5), p. 12.

⁹ Bastick, M. and Whitman, T., *A women's guide to security sector reform* (Institute for Inclusive Security and DCAF: Washington, DC, 2013), p. 9.

¹⁰ This section is written by Valerie Percival and Sally Theobald.

well as boys and men, is a frequent consequence of conflict, both as a deliberate tactic of insurgency and war, and as a by-product of the breakdown of law and order.¹¹ Women are also deeply affected by disruptions to the health sector, as their reproductive role makes them more exposed to ill-health and heightens their dependence on health services.¹² Despite its devastating impact on human rights and health, conflict can also present an opportunity—social and political norms are in flux, and the opportunity may exist to transform gender norms and undertake peaceful development by evading channels that are normally resistant to change.

Although Resolution 1325 has been a critical instrument to galvanize action to address sexual and gender-based violence (SGBV), as well as the health impacts of war, its focus has been on taking action in the security sector and political spheres to promote change. The focus on SGBV, rather than the health sector as a whole, has led to missed opportunities.

Both women and men interface with the health sector throughout their lives, and health professionals provide important guidance on health and lifestyle issues. In addition, the health system is a significant employer in society, and could galvanize change through its own practices in conflict and post-conflict settings. However, Resolution 1325 and follow-up resolutions view the health sector as an institution that provides a ‘service’ for women, and not as an institution that should be engaged in broad societal efforts to promote human security and gender equality in conflict and post-conflict settings. It fails to explore the potentially transformative role of the health sector.

Health services for women

Resolution 1325 and follow-up resolutions have raised awareness of SGBV and propose adequate health services for survivors of such violence. Security Council Resolution 1889, which was adopted in 2009, went further and urged member states ‘to specify in detail women and girls’ needs and priorities and design concrete strategies . . . to address those needs and priorities . . . through . . . access to basic services, in particular health services including sexual and reproductive health and reproductive rights and mental health’.¹³ In addition, the resolution called on the UN to develop specific indicators to measure the implementation of Resolution 1325 and the follow-up resolutions.¹⁴ UN Security Council Resolution 2122 (2013) also called for ‘the

¹¹ Percival, V., Richards, E., Maclean, T. and Theobald, S., ‘Health systems and gender in post-conflict contexts: Building back better?’, *Conflict and Health*, vol. 8, no. 19, (Oct. 2014); and United Nations, Security Council, *Report of the Secretary-General on conflict-related sexual violence*, S/2015/203 (United Nations: New York, 23 Mar. 2015).

¹² Percival, Richards, Maclean and Theobald (note 11).

¹³ United Nations, Security Council, *Report of the Secretary-General on Women, Peace and Security*, S/2010/498 (United Nations: New York, 28 Sep. 2010).

¹⁴ United Nations (note 13).

development and strengthening of the capacities of national institutions, in particular of judicial and health systems'.¹⁵

Partly as a consequence of the WPS agenda, specific action has been taken to integrate a gender perspective into humanitarian action. Gender advisers are included in each UN-led humanitarian operation and a Minimal Initial Services Package for Reproductive Health in Crisis Situations (MISP)—a distant learning module—has been established, resulting in heightened, although not comprehensive, access to reproductive health services in emergency situations.¹⁶ Concerns remain that the implementation of reproductive health standards in conflicts lags behind for internally displaced persons, as well as in conflicts in the Middle East—particularly treatment for survivors of sexual violence and access to reproductive and sexual health services more generally.¹⁷

The WPS agenda's engagement in the health sector remains vague, lacking the precision that characterized recommendations on promoting the involvement of women in peace processes, security and political engagement. The indicators developed by the UN Secretariat to measure progress toward the goals articulated in Resolution 1325 and subsequent resolutions include only one indicator related to health services: maternal mortality.¹⁸ While the UN argues that this is a proxy indicator for women's access to reproductive health, it is clearly inadequate in its analysis or assessment of the factors that limit gender equity in health in crisis situations.

In the implementation of Resolution 1325 and its follow-up resolutions, UN member states also have a narrowly defined focus on the health sector, concentrating their efforts primarily on the provision of 'health services' to women, and mostly to survivors of sexual violence. Rather than seeing the health system as no more than a 'service' to 'fix' women who suffer SGBV, the health system should be seen as a key part of post-conflict reconstruction and one that can be mobilized as a tool to address the underlying inequalities that cause SGBV in the first instance.

¹⁵ UN Security Council Resolution 2122 (note 3).

¹⁶ Inter-Agency Standing Committee, 'IASC Gender Marker: Frequently Asked Questions', Inter-Agency Standing Committee, Geneva, 2011; and Tran, N-T., Dawson, A., Meyers, J., Krause, S. and Hickling, C., 'Developing Institutional Capacity for Reproductive Health in Humanitarian Settings: A Descriptive Study', PLoS One, vol. 10, no. 9 (2015), p. 18.

¹⁷ Krause, S. et al., 'Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: An evaluation of the Minimum Initial Services Package', *Conflict and Health*, no. 9 (2015) (Suppl 1), p. 10.

¹⁸ United Nations, *UN Strategic Results Framework on Women, Peace and Security: 2011–2020*, (United Nations: New York, 2011).