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Women, Health and Humanitarian Aid in Conflict

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The burden of political conflict on civilian populations has increased significantly over the last few decades. Increasingly, the provision of resources and services to these populations is coming under scrutiny; we highlight here the limited attention to gender in their provision. Women and men have different exposures to situations that affect health and access to health-care and have differential power to influence decisions regarding the provision of health services. We argue that the role of women in planning is central to the provision of effective, efficient and sensitive health-care to conflict-affected populations.

Key words: women and health-care, political conflict and civilians, provision of resources and services to civilians in conflicts, influence of gender.

Introduction

The increased recognition of the burden of political conflict on civilian populations has attracted attention to the position of women as refugees and internally displaced people. Although refugee numbers have traditionally been assessed in order to plan and provide relief, relatively little attention has been devoted to establishing the precise composition of the refugee population whether in terms of age, sex, religion, local geographic origin or ethnicity. This is unhelpful given the different roles of subgroups within populations. Women in particular are often identified as a 'vulnerable group' with specific needs while little recognition is given to the contribution they make to enhancing local capacities and rebuilding communities (Byrne and Baden, 1995).

In this paper we review current knowledge about the influences on gender differentials in health in conflict settings. Gender affects exposure to situations which have an impact on health, dictates who has access to health-care services and influences its planning and provision. The role of women in planning may be the key point at which relevant interventions could make a valuable impact. We present a model that identifies the role of women in planning and providing services as central to the provision of effective and efficient health-care to conflict-affected populations. Many conflicts today are intranational rather than international (Kemppi-Repo, 1994). The targets of these intranational conflicts are increasingly seen not simply as the armed forces of the opposing side but the political, social and economic structures

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which maintain the social cohesion of the opposing group (Meyers, 1991; Bennett and Kayetisi-Blewitt, 1996).

The trend in the civilian involvement in modern conflicts shows massive increases over time which reflects the changing nature of war. Five per cent of war casualties in World War I were reported to be civilians, 52 per cent in World War II and around 90 per cent in ongoing conflicts during 1991 (Sivard, 1989, 1991, 1993, 1996). Violent political conflict is often low intensity and targets social structures and livelihoods. One consequence of the targeting of entire communities and their livelihoods has been the dramatic rise in numbers of refugees, reaching almost 14.5 million as of 31 December 1996 (US Committee for Refugees, 1997). Besides refugees (who have crossed borders into neighbouring states and are officially recognised), an even greater number of people are displaced within countries with little access to material and international support. Some sources suggest that the number of internally displaced people has reached at least 30 million (UNHCR, 1997a). Without crossing an international border, these populations are assumed to be under the protection of the state despite the fact that in many circumstances it is the state itself, whether directly or indirectly, that is responsible for their forced movement.

This huge growth in both refugee and internally displaced populations has placed an increased load and responsibility on agencies charged with assisting them: on 1 January 1997 the United Nations High Commissioner for Refugees (UNHCR) provided protection and assistance to 13.2 million refugees (UNHCR, 1997) compared to 10.5 million in 1985 and 2.4 million in 1975 (UNHCR, 1995). On average half these populations are female: together with their children they account for about three-quarters of conflict-affected groups (UNHCR, 1995). Relatively little is known about their specific needs or coping strategies, or factors which enhance resilience despite adversity.

Some factors affecting women's health are already a problem before the conflict but are exacerbated by hostilities, while others are direct consequences of the conflict. How conflict-related and non-conflict-related factors interact dynamically within emergency settings, however, enables us to explore their separate and combined effects. It also helps highlight where potential interventions may assist in reducing the adverse influences on women's health in conflict-affected populations. Figure 1 conceptualises the influences on women's health and identifies their consequences.[1]

Pre-conflict factors

Most conflicts in the past decade have occurred in Africa and Asia, although since the end of the Cold War there has been a significant geographical redistribution of ongoing conflicts with a rise in Europe and the former Soviet Union (Wallenstein and Sollenberg, 1995). Attitudes to women in many countries are largely based on their traditional roles within marriage and the family.

Life chances for females may often be compromised: in some countries breastfeeding is more prolonged for boys; elsewhere access to food is reduced for girls (Merchant and Kurz, 1993) and a higher prevalence of malnutrition among girls than boys may result (Chen et al., 1981; Chandler, 1985).

When resources are scarce, girls have less chance of getting an education. A recent study of local government areas in Tigray and north Omo, Ethiopia revealed that not

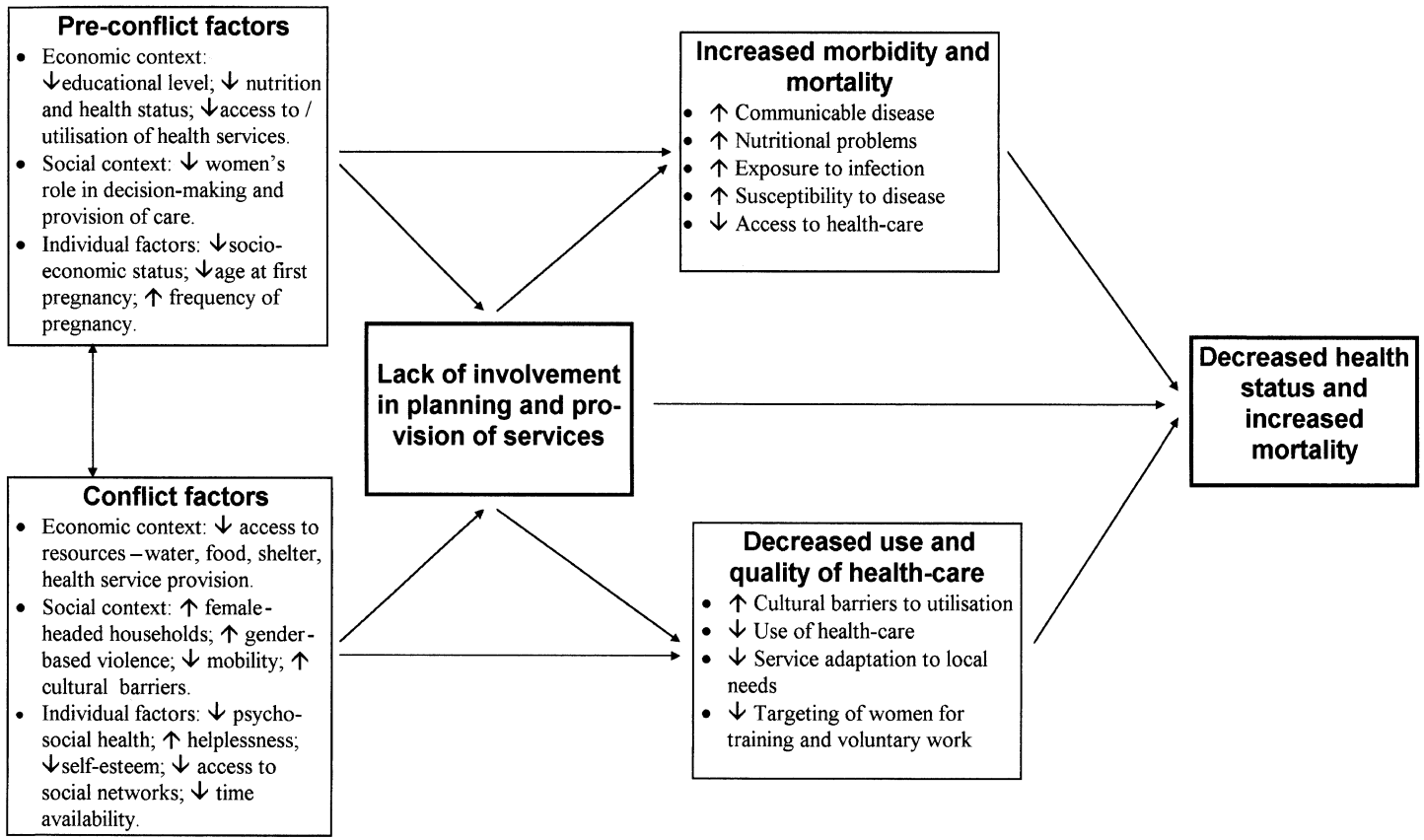

Figure 1 Factors that may reduce the health status of women in conflict

only were secondary-school levels low overall, but that young girls were disproportionately affected (Barnabas, 1997). An estimated 60 per cent of those with no access to primary-school education are women (Ascadi and Johnson-Ascadi, 1993). Female illiteracy has been shown to reduce child survival (Cleland and Van Ginneken, 1988); to have detrimental effects on health and health-seeking behaviour (Bicego, 1993) — for example, a failure to recognise early symptoms of infection and disease (Timyan et al., 1993); and to be correlated with higher fertility levels (Unicef, 1996). In Somalia, despite the existence of literacy campaigns targeting women and men, literacy levels for women remain low. In a focus group discussion men stated that

> daughters should help their mothers both at home and to farm instead of studying. Often we do not let females study, not even the Qur'an. They may attempt to compete with males and divorce their husbands if they disagree for some reason (Persson and Wall, 1994).

There is increasing recognition of the ways in which gender affects health and access to health-care resources (Vlassof, 1994). A woman who requires health-care knows that her productive and reproductive roles cannot be carried out by other family members; this influences her decision of whether to seek or accept health-care (Vlassof, 1993). This hesitation may be compounded by considerations of the social, economic and physical impediments to obtaining care.

Traditional health beliefs and the family decision-making process which other members contribute to or even control are also important (Koblinsky et al., 1993). Explicit rules for women may involve restrictions on both movement and decision-making, with the hierarchy within households arranged by sex and age. Despite the fact that some women may earn substantial incomes, they may not have increased control over resources due to prior claims on this money and male-dominated decisions about expenditure (El-Bushra and Piza-Lopez, 1993a: 23).

Younger women in particular may have very little control over a range of decisions affecting their lives — such as the age at which they marry, the number of children they have and when or whether they make use of health-care services. Genetic and behavioural factors enhance women's survival and decrease vulnerability. Globally women have a lower disease burden than men (World Bank, 1993: 28), although they suffer more from communicable diseases. Iron-deficiency anaemia, protein-energy malnutrition and iodine deficiency all affect women more than men and vitamin-A deficiency is twice as common in girls as boys. These deficiencies all increase the risks of maternal and infant mortality (World Bank, 1993: 76).

Excess female mortality is well documented in deprived communities (Wells, 1975) and from a variety of areas including south Asia (El-Badry, 1969) and the Horn of Africa (MacCormack, 1988). A study in rural Somalia showed women at greater risk of dying during their reproductive life than men (Aden et al., 1997); this was found to be related to female illiteracy, divorced or single status and dependence on commercial rather than farming activities.

This is in spite of the crucial role women play in maintaining the structure and function of families and society as a whole. This role is essential in the nurture and care of other members of the population. In southern Sudan, for example, only women have the knowledge about which wild roots and fruits are edible (Palmer, 1997). Additionally, women's associations have been identified as a way of addressing local

problems through involvement in local government (Barnabas and Zwi, 1997). The way these roles can be built on and developed during conflict are discussed later in this paper.

Conflict factors

Traditional networks that form the foundation of women's social and family roles may be disrupted or destroyed during conflict. Women may be separated from their partners and other family members during periods of forced migration or intense fighting. Their partners may have been war casualties or absent either to fight or to seek income-generating opportunities elsewhere. Women in Cambodia had to travel great distances to return home in time to harvest crops, despite ongoing insecurity and separation from their families (Panhavichetr, 1993).

Women may also leave their communities and husbands for other partners in order to guarantee a source of food for themselves and their families (Payne, 1997). This forced increase in partnerships puts women at higher risk of both earlier and more frequent pregnancies as well as sexually transmitted diseases. During conflict changes may also occur in the division of labour and in the main tasks undertaken by the household. This is illustrated by the words of a displaced Sudanese woman:

> I'm a woman and my husband is not here so women move to do men's activities. Some women have built their own houses. This would never happen in normal circumstances. Women don't normally control anything, now as men are not there, women need to control everything (Palmer, 1997).

Particular emphasis must be given to tasks which ensure survival. Burundi refugees in Tanzania focused most attention on acquiring food, collecting firewood, clearing land and constructing houses. Households with an ample labour supply were most successful. Female-headed households stripped of close relations were least able to command labour where communal support was lacking. Women in these households adopted different survival strategies such as attaching themselves to others who were relatively better off (Daley, 1991). In post-conflict Tigray, women-headed households had least access to oxen for ploughing because of the absence of men to assist them (Barnabas, 1997). These changes all serve to increase the work burden of women. Men may also find themselves in different roles, even in some circumstances taking over cooking and caring for the children. In Uganda male Sudanese refugees who undertook this role were described as becoming demotivated and turning to alcohol or smoking marijuana with an accompanying increased level of domestic violence (Payne, 1997: 10).

Elsewhere women have taken on their new roles, often with increased economic responsibility, despite a lack of a concomitant increase in power over decision-making or access to resources (El-Bushra and Piza-Lopez, 1994). In the words of two Chadian refugees:

> I was one of the last refugees to arrive [in Poli-Faro] and aid was drying up at the camp. We even had to pay for certain foodstuffs. So I took up petty commerce. I made fried doughnuts and peanut cakes which I sold.

> In addition to the assistance we received, I would go into the bush to look for tubers, partly to eat and partly to sell (Watson, 1996).

Unfortunately, in some cases the only available income-generating activities are prostitution or beer brewing (Achta Djibrine Sy, 1993: 10) which place women at increased risk of HIV/AIDS and violence (Zwi and Cabral, 1991). Women may even be penalised for capitalising on these survival strategies (El-Bushra and Piza-Lopez, 1993b; Schoepf, 1988). In some circumstances, despite needing to carry out new roles, women may be reluctant to do so: an elderly woman in Mozambique, for example, was unable to slaughter a goat despite urgent need because such decisions were usually made by the male head of the family (Dolan, pers. comm.).

A Chadian widow and mother of eight remarked on her return from a refugee camp in the Central African Republic, 'Life in the camp was good. ... Then in 1987, I don't know why, my son decided we should return' (Watson, 1996). During the war, some women found that leaving their partners actually improved their prospects. One displaced Sudanese who had left her partner stated that:

> Women with husbands don't have a business. Women without husbands are able to manage. It is usually good to have a husband but at this time during the war, there are no jobs and all he can do is cultivate (Palmer, 1997).

Recent studies (see, for example, Bennett et al., 1995; Lentin, 1997; Turshen and Twagiramruya, 1998) have begun to highlight the particular ways in which women experience and respond to conflict, displacement and complex emergencies, although the specific implications for health have so far received scant attention.

The provision of food assistance to refugees and the displaced has itself actively discriminated against women refugees. In 1991 when providing assistance to Kurdish refugees, UNHCR realised that food was simply not reaching families headed by women. All the distributors were men. The result was described as 'malnutrition, exploitation, suffering' (UNHCR, 1997b). In Ifo camp in Kenya the mortality rates stayed high for as long as six months after the camps opened. Food distribution policies were blamed. It was undertaken through clan leaders who apparently diverted some. As a result the food failed to reach those who most needed it (Gallagher and Forbes Martin, 1992).

Now women's role as income earners, managers and providers of food is more recognised and policies are being developed to ensure more equitable food distribution. In Tanzania, the 'Family Group Distribution System' was used. Families who had been allocated rations of the same size were grouped together. They elected members to collect and distribute the food to their own group of families. In general it was found that men were elected to collect the food but women were then chosen to distribute it. Women were felt to be more honest and fairer (Mirghani and Bhatia, 1998: 18–19). WFP and UNHCR have jointly agreed a Memorandum of Understanding for food distribution which states that women must be involved in all aspects of the management of food aid (WFP/UNHCR, 1997).

Despite this progress, however, there remain challenges to determining how best to respond to:

- the particular needs of women-headed households;
- social and aid structures which require wives to go with their husband's families,

thus separating them from their own traditional support systems of sisters, mothers and grandmothers; and
- the particular problems faced by widows and unaccompanied women.

Recent debates concerning gender in relation to policy and practice in the field of food and nutrition are extensive and will not therefore be discussed further here.[2]

During conflict, cultural norms that may not be strictly enforced in peacetime may become a symbol of cultural identity and social cohesion. Thus, Afghan refugees living in Pakistan found that the imposition of purdah was much stricter in the camps than it had been in their communities before the war (Dupree, 1992). From marriage until the birth of her second child a woman could not attend the dispensary unless accompanied by her husband. In Somalia the *de facto* military authorities implemented new laws calling for the death penalty if a women was suspected of mixing 'too freely' with foreign soldiers (Maier, 1993).

Women affected by conflict have been shown to have lower self-esteem and a greater sense of helplessness than men (Oxfam Health Unit, 1993; Summerfield, 1990), which is partially attributable to the loss of their position within society (Al-Rasheed, 1993; Jacob, 1992). Malnutrition and stress among Khmer women led to cases of amenorrhoea as well as contributing to low quantity and poor quality breast-milk (Sundahagul, 1981). Complications in pregnancy may also increase as a result of violence (Zapata et al., 1992) and pre-natal care may be discontinued. In Mozambique, for example, the percentage of pregnant women vaccinated against tetanus fell from 40 per cent in 1980 to 19 per cent in 1986 (Refugee Policy Group, 1992).

Women on their own may find it more difficult to assure both their own safety and that of their children. They can become targets of violence from three sides: the opposing army, the armed forces in the country to which they have fled and even from members of their own community. They may be forced to provide sex in exchange for food, shelter or other necessities for self and family preservation (see testimonies in Bennett et al., 1995). The experience of Afghan refugees (Amnesty International, 1995) is illustrative:

> In the camps in Pakistan, most of which are controlled by one or other of the warring Afghan factions, women have been attacked, particularly those who are unaccompanied by men. If they refuse sexual favours, they are often denied access to vital rations.

In Somalia fear of rape and shooting prevented women from leaving their homes. Women standing in food queues risked being caught in cross-fire if gunmen attacked the food as it arrived (El-Bushra, 1993). In 1992 security for Somali refugee women in north-east Kenya deteriorated and refugee women and girls were attacked during night raids on the camps and when searching for firewood or herding their livestock on the camp periphery. Fencing the camp with thorn bushes reduced these attacks (Bissland, 1994).

Conflict situations are often characterised by rapid mass migration and subsequent re-location and settlement. Mortality rates during the acute phase of displacement have been extremely high, up to 60 times the usual rates (Toole and Waldman, 1990). Much of this mortality is due to an increase in infectious disease (Shears et al., 1986). The principal causes of mortality among Ethiopian refugees from Sudan were measles, diarrhoea and dysentery, respiratory infections and malaria.

Causal factors in these circumstances normally relate to poor public health conditions and the resulting increased exposure to disease. Glass et al. (1980) in their rapid assessment of the health status of newly arrived Kampuchean refugees in Thailand found that women had a relative risk of death that was 1.7 times that of men. Besides increased exposure to infectious disease, there is often decreased resistance to infection as a result of protein-energy malnutrition and other micro-nutrient disorders. Case fatality rates therefore also rise.

Women's use of health-care facilities may be severely reduced if service provision is dominated by men. Burmese Muslim women, including many rape victims, who fled to Bangladesh had difficulties both in gaining access to health-care due to the predominance of male providers (UNHCR, 1992: 7) and in using washing facilities due to cultural rules forbidding sharing with men (Hilsum, 1992). Lack of appropriate clothing prevented some women in Sudan from leaving their homes (J. Adams, pers. comm.). A report on refugees in Sudan revealed that all inpatients and most outpatients were men despite women and children making up 75 per cent of the population (Scott et al., 1993).

Lack of attention to reproductive health-care continues to result in insufficient information and education about birth spacing, family planning and sexually transmitted disease (Anonymous editorial, 1993). Women refugees in Ghana believed that gonorrhoea was the most important disease that should be addressed in the camp. Sex education was not being provided and free condoms were not being distributed (UNIFEM, 1991).

Involvement in planning

International aid providers often fail to pay enough attention to the role of affected communities and may further undermine women's coping strategies and ability to influence decision-making. When trying to respond rapidly and save as many lives as possible, relief organisations may inadvertently undermine attempts to promote gender and cultural sensitivity within project and programme activities.

In some refugee situations only men were counted and food distribution was often undertaken solely by men. As described earlier, when in 1991 UNHCR assisted Kurdish refugees in northern Iraq, it was only realised later that food was not reaching households headed by women and that all the distributors were men. The UNHCR emergency officer commented that

> had that group stood out in some way — visually or physically, because of their ethnic background or a religious difference, or whatever — we would have made sure they got food but because they were women, it didn't even occur to us. It didn't even occur to me I have to admit it to my shame.

In another camp, women complained about the rain and lack of plastic sheeting; this had been given to the male camp committee to distribute and most of it had been sold (UNHCR, 1997b). In the same way lack of gender sensitivity among service providers may diminish the quality of care received and may reduce the likelihood of attending for follow-up (Vlassof, 1994; Hudelson, 1996).

Too little attention has been paid by service providers to gender differences in either the susceptibility and exposure to disease or its consequences (Rathgeber and

Vlassof, 1993). Schemes offering food in return for work often involve heavy labour that men are expected to perform. Furthermore men continue to be specifically targeted for income-generating activities and have generally not been expected to carry out traditional roles of collecting water and fuel and looking after children (tasks which may become more energy- and time-consuming in a refugee setting (Sundhagel, 1981)).

Daley (1991) describes the attitude of predominantly male administrators in Tanzania who treated Burundi women refugees as passive recipients without public responsibilities. They therefore allocated resources to men assuming they had total control over the household as well as over women's labour; as a result even those women who had the support of kin relations had no access to resources beyond those provided by donors for immediate subsistence. Subsequently nuclear families without adult men were found to have experienced higher-than-average mortality rates.

In 1991 the importance of the lack of attention paid to refugee women was recognised by UNHCR who stated in their document 'Guidelines on the protection of refugee women' (UNHCR, 1991: Section 1, C11) that

> to understand fully and address the protection concerns of refugee women, they themselves must participate in planning protection and assistance activities. Programmes that are not planned in consultation with the beneficiaries, nor implemented with their participation, cannot be effective.

Some programmes, however, persist in excluding women from the planning and provision of services. In southern Sudan fishing nets were distributed to women without involving them in the planning process. As women were not normally engaged in fishing there was little change in the productive activities of either sex except for reported incidents of men violently seizing the nets. The distribution therefore did not address women's real practical needs and may have compromised their strategic needs by alienating men (Smyth, 1997).

In contrast, support of the widows of the genocide in Rwanda who had formed an organisation, Avega-agahoza ('a poem to dry one's tears') in January 1995 to respond to the needs of survivors, has been very successful (Mujawayo, 1995). Avega is run by volunteers and provides a place for women to share their experiences, cry together and express their feelings. It campaigns to raise money for materials so that survivors can build themselves houses. The organisation now has over 8,000 registered members all over the country, run by local associations that are co-ordinated and advised by the head office.

In Peru displaced women support each other through mothers' clubs, communal kitchens and other grass-roots women's organisations. By buying food in bulk and cooking in large quantities, they manage not only to improve the food available to their families but also to start small-scale businesses (Deng, 1996).

Women have different roles and perspectives from those men have. Involvement of women at all stages in a response to a humanitarian disaster and/or complex political emergency is desirable. Through such involvement, benefits could include a reduction in women's exposure to risk situations, an improvement in access to appropriate health services and helping to increase their self-esteem. Finally, there should be progress in building and supporting the coping strategies of refugee and displaced women and ensuring their viewpoints are heard, understood, respected and enacted.

Strategies for involving women

Barriers to the involvement of women are erected by both the providers and beneficiaries of services. In Somalia and Somaliland, for example, the existence of male elders' committees was important in protecting and guaranteeing the survival of communities yet they were often reluctant to accept women as producers and decision-makers. Food aid was expected to be distributed to the community through traditional male structures (El-Bushra and Piza-Lopez, 1994). UNHCR recognises that some relief officials are reluctant to involve women and states that 'their concerns may reflect the cultural biases of the officials and/or inadequate understanding of both the traditional cultures and the new situations in which refugee women find themselves' (1991: paragraphs 13, 14).

A key step, therefore, will be to raise awareness among service providers of both the value and necessity of involving women in order to provide an appropriate, efficient and gender-sensitive service. Field-workers need training to appreciate the gender dimension of their work, as well as other related cultural issues whether from the pre-conflict, intra-conflict or post-conflict period. A recent code of conduct for NGOs (IFRC, 1995) recognises the 'crucial role played by women in disaster-prone communities' and the desire to 'ensure that this role is supported and not diminished, by our aid programmes'.

Assessments of need in emergency settings should include information about the different roles, needs, perceptions and capacities of both women and men. Attention to the social context of a conflict situation will be key in making appropriate decisions as to what and how services should be provided. A number of frameworks — based on rapid assessment techniques — have been proposed to help agencies in planning a gender-appropriate and sensitive response to emergencies (Williams et al., 1994; Byrne and Baden, 1995).

Registration of refugees and the displaced should always specify exactly the number of women. These data, along with other data on the composition of affected communities, can then be used to ensure that the distribution of food and other resources is targeted appropriately. In western Ethiopia many young Sudanese refugees were gathered and assessment revealed very high morbidity and mortality rates. These rates did not fall when food was shipped into the camps and a gender analysis showed that the male refugees were unable to prepare and cook the food. The situation improved when aid workers organised the women (10 per cent of the camp) to teach the men how to cook (Anderson, 1994).

Needs assessments should involve women in the planning, provision and implementation of health-care services. Useful assessments should enable subgroups within the population: women, the poor and minority groups, to articulate their needs and have them taken into account. Assessing and responding to needs is a politically contentious process (Robertson, forthcoming): excluding women reduces their ability to ensure that their needs are met. Existing structures that encourage, support and contribute to the organisation of women within communities should be supported.

Planning groups should be established which either include women or receive input from women less directly where this is more appropriate. Monitoring and evaluation of programmes could routinely include the perspectives of both women and men, in this way ensuring that the appropriateness and sensitivity of the response is continually improved.

Finally further gender-based research into refugees and displaced people is urgently needed (World Vision International, 1996; Muecke, 1991). At present we know too little about the gendered impact of conflict on the roles, attitudes and needs of refugees and displaced people in emergency situations. Lessons learned about problems, solutions and their limitations, need to be more systematically and critically documented and fed back to the organisations concerned: NGOs, donors and academic institutions should commit themselves to supporting such a project in an ongoing way.

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Notes

1. This framework does not attempt to identify the precise mechanisms by which conflict leads to poor health outcomes. Nor does it draw strongly on the nutrition and food security literature which may offer avenues for its further development and refinement.
2. Linking these debates with the framework we present may be a fertile area for further analysis, however, and we invite such debate.

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