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Gender-specific medicine in humanitarian contexts

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Summary. With more than 135 million people in need of humanitarian assistance, with an unprecedented 68.5 million people around the world forced from home, half under the age of 18, nearly 25.4 million refugees, average displacement soaring to 17-25 years, crises have become the 'new standard'. Crises affect women and men differently. Women and girls are indeed the most impacted, first of all in terms of reduced access to basic services, specifically to health services (pregnancy, childbirth). On top of that, women and girls are the most vulnerable to the threat of sexual and gender-based violence. As a matter of fact, when crises hit, the humanitarian response very often does not take the gender-specific medicine perspective into due account. Improving the overall framework of gender-specific medicine in humanitarian responses is crucial. Meanwhile some smaller pilot projects, as in South Sudan the project to address the psychosocial needs of internally displaced persons (mainly women and children) and another one targeted at increasing the availability of basic and emergency healthcare services in the maternal and child environment, have helped probe the way forward and find a new pattern for responding.

Key words. Gender, humanitarian contexts, gender violence.

La medicina genere-specifica nei contesti umanitari

Riassunto. Con oltre 135 milioni di persone bisognose di assistenza umanitaria, 68,5 milioni di persone in tutto il mondo costrette a vivere forzatamente lontano da casa, metà delle quali sotto i 18 anni d età, quasi 25,4 milioni di rifugiati, la cui età media si aggira tra i 17 e i 25 anni, le crisi sono diventate il 'nuovo standard'. Le crisi colpiscono in modo diverso donne e uomini. Le donne e le ragazze sono indubbiamente le più colpite, prima di tutto in termini di accesso ridotto ai servizi di base, in particolare a quelli sanitari (gravidanza, parto). Inoltre, le donne e le ragazze sono le più vulnerabili di fronte alla violenza sessuale e di genere. Di fatto la risposta umanitaria alle crisi molto spesso non tiene conto della prospettiva della medicina di genere. Migliorare il quadro generale della medicina genere-specifica nei contesti umanitari è quindi cruciale. Nel frattempo alcuni piccoli progetti pilota, come quelli avviati con la collaborazione italiana nel Sud Sudan e volti uno ad affrontare i bisogni psicosociali degli sfollati interni (principalmente donne e bambini) e l'altro indirizzato ad ampliare la disponibilità di servizi sanitari di base e di emergenza in ambito materno-infantile, hanno aiutato a sondare la via da seguire e a trovare un nuovo modello per rispondere alle emergenze umanitarie.

Parole chiave. Genere, contesti umanitari, violenza di genere.

Humanitarian response treats women's health 'as an afterthought', says the UN. That was the headline in *The Guardian* three years ago, in 2015. It focused on the precarious position of women and girls in times of crisis, with pregnancy, childbirth and family planning services grossly lacking.

Has anything changed in the past three years? That is the question. Honestly, I don't know. Surely, it is a topic that we're starting to take into serious account in the humanitarian environment, but the main concern is still on the table: how do we translate it into action? Can we claim that we are applying gender-specific medicine's consolidated standards in crisis and emergencies contexts?

After years of hands-on experience with heterogeneous emergencies around the world, I can be both pessimistic and optimistic in this regard. Paraphrasing the motto of the Italian Marxist Antonio Gramsci: pessimistic reality, optimistic will.

A black and white picture

With more than 135 million people in need of humanitarian assistance (Global Humanitarian Overview, OCHA 2018), with an unprecedented 68.5 million people around the world forced from home, half under the age of 18, nearly 25.4 million refugees, average displacement soaring to 17-25 years (UNHCR 2018), how not to be doubtful? Crises have become the 'new standard'. And it goes without saying that in crisis situations the most fragile become even more fragile.

Crises affect women and men differently. Women and girls are indeed the most impacted, first of all in terms of reduced access to basic services, specifically to health services (pregnancy, childbirth). On top of that, women and girls are the most vulnerable to the threat of sexual and gender-based violence. As a matter of fact, when crises hit, the humanitarian response very often does not take the gender-specific medicine perspective into due account.

So, optimism stems from our will, but I am also buoyed by gender health interventions I've directly verified, whose precise focus conveys the impression of a

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new sensitivity, of a strategy tuned into gender-specific medicine. Women and girls have different health needs. They are exposed to all kinds of risks and vulnerabilities. A better understanding of that simple reality allows a better response to different crisis contexts, because knowing how crises particularly affect women is critical to assuring an effective humanitarian response.

Gender equality in humanitarian action is also – I would say 'above all' – about better targeting and implementing health programs. Without such awareness and knowledge, humanitarian health initiatives run the risk of being gender-blind. We want to further underscore that gender-specific medicine in crisis contexts shares many features with prevention and protection.

Social, cultural and biological factors increase the risks faced by women and particularly girls. Any commonly available data suggests that there is gender disparity in terms of exposure to health risk, and that there is greater physical and psychological impact in fragile and unsafe contexts. Women and girls are often at increased risk of violence and may be unable to access health assistance. They are not free to point out their necessities clearly, thus their health needs are often not met. Very often for cultural reasons, women are not generally involved in community consultation and even less so in decision-making processes.

From another viewpoint, women play unique and important roles in responding to health emergencies within their respective communities. A wider gender medicine strategy in humanitarian response thus calls for investment in dedicated emergency-focused female human resources, in building skilled and motivated emergency workforces, including, for example, midwives to increase access to skilled birth assistance. Such advances are finally seeping into humanitarian projects. More and more humanitarian health programs are building in components for medical personnel with a special focus on women. It's just a matter of common sense to specify that in humanitarian crises every health project must include gender at every stage of delivery of health services. Let us add that every initiative must find a way to involve women beneficiaries in the implementation process.

In the standard way of delivering healthcare in crisis situations, first of all, we have to do a needs survey, but immediately thereafter we need to see to it that all categories, say, women, men, girls and boys, children, have free and equal access. This entails collecting health data, breaking it down by sex and age, and applying gender analysis. This in turn requires establishing specific gender health indicators. The situation is improving, but it's still much too slow. The outlook is dark and clouded in this respect.

Very often there is difficulty in putting simple rules into practice. UN agencies, as well as the different national cooperation offices, are working on that. The In-

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terAgency Standing Committee (the primary mechanism for inter-agency coordination of humanitarian assistance) has issued "The IASC gender handbook for humanitarian action", a reference book that provides practical guidance for humanitarian workers to take gender equality mainstream into humanitarian action across sectors, with an entire, extended chapter dedicated to gender and health in emergencies. It clearly states that "The right to health is a fundamental human right indispensable for the exercise of other human rights". But there is still a long way to go.

Improving the overall framework of gender-specific medicine in humanitarian responses is crucial. Meanwhile some smaller pilot projects have helped probe the way forward and find a new pattern for responding.

Rapes and sexual abuses on the one hand, and all issues related to pregnancy, childbirth, family planning and maternal mortality on the other, are two main issues of gender-specific medicine in humanitarian response.

Gender-specific medicine in humanitarian response: sexual rapes and abuses

Medical personnel working in conflict settings must be trained to recognize victims of rape, and to address both the immediate and long-term consequences. Clear protocols for responding to and documenting episodes of sexual violence are particularly important in emergency humanitarian interventions, since the issue may otherwise go lost if there are more immediately pressing needs such as ensuring clean water and providing access to basic healthcare. A comprehensive protocol should be adopted. The first step is to obtain a full history and perform a physical exam. Some women are so badly injured that they require referral for reconstructive surgery and very often these kinds of services are not available in the field, and risky security doesn't allow women to be moved. What to do in such cases? It's an open question.

Many barriers exist to the proper implementation of a protocol for responding to and documenting episodes of sexual violence. First of all, there is a lack of skilled personnel. Sometimes structures providing basic health are lacking. Switching to the victim, the greatest barrier is her reluctance to report an abuse. One way forward is to employ sufficient numbers of female healthcare workers. In an ideal scenario, at least 50% of healthcare workers should be women to ensure access to a same-sex healthcare worker for medical examinations.

Looking at examples of the two different aspects – examples which I personally witnessed – helped me to see some glimmer of hope in an otherwise dark picture.

South Sudan

In December 2013, political in-fighting between President Salva Kiir and his deputy Riek Machar escalated, soon including other opposition groups and spreading beyond the capital. The conflict has seen armed militias aligned along ethnic lines engaged in combat and attacking civilians *en masse*. In the last five years, it is estimated that nearly 400,000 people have died: at least half from conflict, the other half from hunger and disease.

The photos published in this article were taken by Alessandra Testoni during her mission in South Sudan.

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At the same time 1.9 million others have been internally displaced, and more than 2.4 million live as refugees in neighboring countries, including Uganda, Ethiopia, and Sudan; the vast majority are women. The men are engaged in the fighting.

Women and girls are especially vulnerable to sexual violence during war and civil conflict, whether in the midst of fighting, while escaping from their homes, or even once inside camps for refugees, whether Places of concentration (PoCs) or Internally displaced people (IDPs). Many families become separated during the chaos of fleeing sexual violence and when men leave to fight. Women must then support their families on their own, and they may become easy prey for men seeking to take advantage of their vulnerability. At border crossings, women may be forced to endure rape as a "price of passage". Even refugee camps may offer no refuge, as women's lack of economic power leaves them open to sexual exploitation and coercion. Many women find themselves left without protection in a culture of violence fed by conflict and social chaos.

The former Special Representative of the Secretary-General on Sexual Violence in Conflict, Mrs Zainab Hawa Bangura, in October 2014, during her first visit to South Sudan since the outbreak of the conflict, said: "What I witnessed in Bentiu is the worst I have seen in my almost 30 years in dealing with this issue. This is because of the combination of chronic insecurity, unimaginable living conditions, acute day-to-day protection concerns and rampant sexual violence". "The bodies of women are the battleground of this conflict. In the words of a woman activist I met, 'It is not just about rape, it is to inflict unimaginable pain and destruction.'"

Such are the kinds of realties that gender-specific medicine must deal with in a humanitarian framework. It is thus extremely important to prepare the human resources, both medical and paramedical, and facilitators.

To this end, an interesting project to address the psychosocial needs of IDPs (mainly women and children), based in two PoC sites, was implemented by Interna-

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tional Organization for Migration (IOM) and funded by Italy. Of particular concern were the needs of girls and women, as many households were female headed (70% to 100% of households). This situation combined with overcrowded spaces and the hyper-sexualization of life on site, made women and girls more vulnerable to increases in risky sexual behavior and gender-based violence. These interventions proved particularly beneficial in preventing further stagnation and escalation of psychosocial problems, against an absence of effective, specialized social, psychosocial and clinical referral mechanisms. The project adopted a community-based, integrated approach, with specific attention to women and young women.

By enhancing women's psychosocial resilience, the project worked towards contributing to the protection of female conflict-affected populations. The risk of not addressing acute psychosocial needs within and between communities in a scientific, medical, comprehensive and sustainable way is that these unanswered needs may become drivers of more entrenched conflict in the future.

The project aimed, to the extent possible, to standardize concepts and semantics on psychosocial support in emergencies through strong collaboration with partners on the ground, including key South Sudan health and academic institutions, as well as to systemize psychosocial support training within the country.

The project was strongly guided by the principles and approach established with the IASC guidelines on mental health and psychosocial support in emergency settings. Figure 1 highlights the implemented activities according to the pyramid of services as designed in the IASC guidelines, based on direct service delivery and capacity building.

Specific activities

All activities were organized on the basis of a rapid Mental health and psychosocial support (MHPSS) assessment. Some of the proposed activities were in response to the rapid MHPSS assessment conducted in the PoCs.

The assessment was participatory and focused on identifying not only needs, but also resources and resilience within the individuals, families and communities.

The activities were implemented following the pyramid of psychosocial interventions in emergency and split into direct service delivery and capacity building.

Level 1. Basic services and security. A MHPSS expert was constantly attached to the Camp coordination and camp

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management (CCCM) Cluster in order to provide support and guidance in the mainstreaming of MHPSS through its response design and implementation. Part of the responsabilities of the MHPSS expert was to offer training to CCCM and multisector humanitarians on the mainstreaming of MHPSS approach within their work. But this was the general part. In addition, to have Psychological first aid (PFA) as a first minumum-standard response, it was crucial to equip partners and affected populations with the capacity to provide such intervention.

Level 2. Community and family support. This entailed the provision of a three-week training course on implementing psychosocial services via a psychosocial mobile team, selecting IDPs from the PoCs, thence enabling them to provide PSS services to their community. The training also included gender-based violence awareness, especially as linked to existing referral pathways and mechanisms.

Level 3. Focused support. Selected members of the psychosocial mobile teams in the two PoCs were qualified to provide counselling, especially targeting young women and the provision of individual counselling to the women. The counsellors were also trained on how to conduct appropriate referrals. Realizing that appropriate specialized services are scarce in this environment, referral will often focus on ensuring support to Gender-based violence (GBV) and protection cases, referring them to appropriate services.

Figure 1. Intervention pyramid for mental health and psychosocial support in emergencies. Source: IASC guidelines on mental health and psychosocial support in emergency settings, IASC 2007.

Level 4. Specialized services. A small portion of individuals suffered from serious mental disorder. It was no less crucial to provide accessible specialized services. Availability of such services in South Sudan was (and still is) extremely scarce. A psychologist was recruited to provide psychotherapeutic help to women needing such specialized intervention. The psychologist provided her services at the two PoCs, and sought to strengthen ties with other health actors on the ground so as to provide support across the mental health and psychosocial support spectrum. The project improved the psychosocial wellbeing and mental health of IDP women and young women living in protected areas, through dedicated psychosocial, counseling and referral services. There was also a parallel enhancement of the capabilities of the humanitarian and national systems in the psychosocial domain, marked by specific focus on gender-specific medicine through dedicated training of humanitarian actors and community resources.

The pyramidal matrix of this mental health intervention, focused on gender-specific medicine, proved to be an innovative pilot project from several viewpoints, one being the gender issue applied to mental health. What came out of the project was a belief that it is not possible to intervene in emergency contexts and on such a sensitive issue as gender mental health without the gradual involvement of different population segments and in coordination with all the humanitarian actors involved.

Gender-specific medicine in the humanitarian context is at the center of a very complex network that cannot be separated from security, protection and dialogue and integration with its beneficiaries. As to scientific and medical roles, gender-specific medicine in the humanitarian response plays a dual role: medicine first and foremost, and then an instrument of humanitarian gender-equality diplomacy.

Gender-specific medicine is also a matter of access

Accessibility is the first real obstacle to delivering care to women in areas of crisis. Once again, South Sudan offers a negative paradigm, starting from the maternal-child care field.

According to the Emergency Obstetric and Newborn Care (EmONC) needs assessment, only 16.8% of the expected deliveries take place in health facilities and only 6.5% in facilities able to respond to a possible complication. There are remote areas of the country where only 2.7% of major direct obstetric complications are assisted in adequate facilities. The guarantee of assistance to women is not only undermined by the availability of very few facilities with acceptable levels of care, but also

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by the fact that over 90% of the health referrals are accomplished by the women's own means (donkeys, bicycles, very often on foot).

An interesting project was implemented by Italian NG Doctors with Africa CUAMM in Rumbek North County just after the outbreak, between 2014 and 2015. It targeted increased availability of basic and emergency healthcare services in the maternal and child environment, through the strengthening of the national health network.

In February 2014, when the NGO began its intervention, four Primary Healthcare Units (PHCUs) and one Primary Healthcare Center (PHCC) had just been built, but the services continued to be provided in traditional huts and carried out by unpaid volunteers. They operated with the few drugs and instruments delivered occasionally by Rumbek, as these facilities are not included in the list of those suited to receiving supplies from the central Ministry of Health. At the end of the emergency project eight months later, the four Units and the Center were fully and continuously operational; wear and tear of buildings and infrastructure were targeted by a maintenance intervention, and were adequately equipped; the staff was properly hired and bettered by constant supervision and training; the Ministry gave official recognition and supplied them with drugs and consumables. In view of the vastness and territorial complexity, as well as the scattering of the population, a decision was made to reactivate two additional PHCUs, still hosted by the original facilities, but otherwise benefiting from the same intervention.

The country can therefore count on a total of seven functioning health facilities. The basic package of preventive maternal and child services (vaccinations, prenatal examinations, health education, nutritional screening) and outpatient examinations is made available by the Center five days a week, while reception, admission and assistance in the most serious cases is available 24/7. They are qualified to deliver up to the level of Basic Emergency Obstetric Care Plus. At each Health Unit, examinations are performed five days out of a week, and vaccinations and prenatal examinations once a week. These latter two services are provided by a mobile team. In the country there still are eight mobile teams active. In addition to supporting the PHCUs on a weekly basis, they perform village-level outings, especially in areas not served by any structure.

This combination of static and mobile services has brought significant improvements in terms of access to and use of the maternal healthcare system.

The difference between the first quarter of 2014 and the first quarter of 2015 in terms of outpatient examinations is considerable: the number of patients has tripled (Figure 2).

During the period of implementation of the project (approximately from the 3rd quarter of 2014 to the 1st quarter of 2015) there was a constant increase. The sharp drop between September and October, probably linked to climatic and security conditions, was compensated at the beginning of the dry season and the new year.

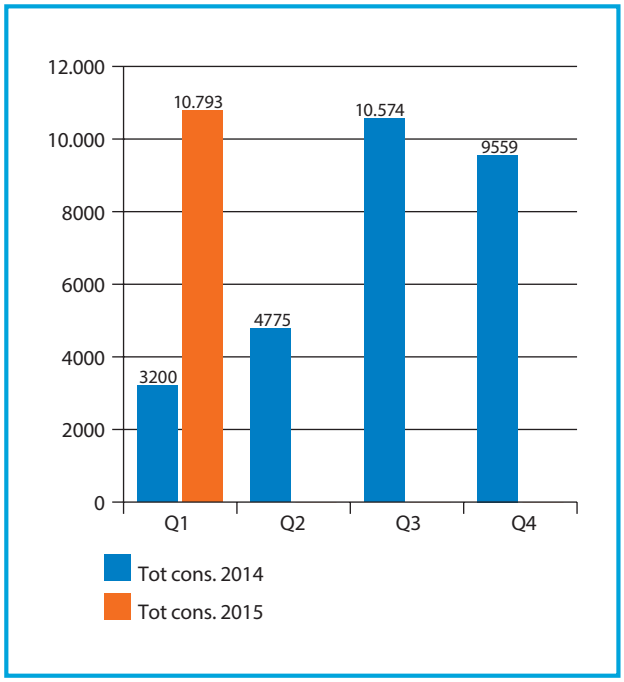

Figure 2. Rumbek North County: total consultations 2014/2015 per quarter. Source: CUAMM.

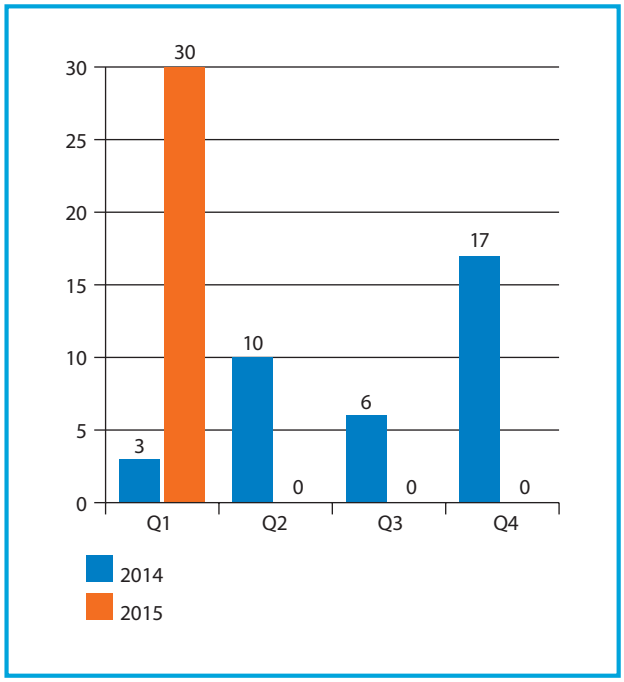

Figure 3. Deliveries in Maper PHCC 2014/2015. Source: CUAMM.

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The gradual extension of the health network and the increased confidence of the population have contributed to this encouraging situation.

The number of assisted deliveries remained low throughout 2014, with the Center's performance affected by the rainy season, during which the PHCC are relatively stranded compared to other Payams, with the ambulance unable to travel on secondary roads. However, it is encouraging to see that the beginning of the dry season has led to an exponential increase in access, a sign of growing confidence in the system, despite occurring in a context like maternal health, where deep-rooted traditions and family dynamics exist (Figure 3). The involvement of traditional midwives and the strengthening of the referral system, added to the recruitment of qualified midwives, have certainly contributed to the positive trend.

Conclusions

Those shown above are small yet interesting and successful examples. They are not the only ones available, but nonetheless, bearing in mind the huge challenge the issue is, the situation is far from being satisfactory. There is still much to be done for the achievement of a gender health standard protocol in humanitarian responses at least. We are still in the field of attempts. But the path is open indeed. And, I can testify directly, the interest of humanitarian actors is growing and the collective efforts towards the goal as well. In humanitarian interventions, health represents a priority sector.

In light of the internationally recognized urgency of intensifying efforts and in line with the needs assessments on the field, an increasing attention will be given to the promotion of health issues in humanitarian contexts more directly related to gender as rapes, physical and mental abuses, maternal and child health and the reduction of maternal mortality.

The route has just begun, we can say frankly, and very complex because it involves many elements, first of all cultural processes and gender medicine at the forefront to work on it.

Conflict of interest statement: the Author declares no conflicts of interest.

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