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## The Relevance of Gendered Approaches to Refugee Health

A Case Study in Hagadera, Kenya

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Gender is increasingly recognized by social scientists as a significant vulnerability criterion in forced migration (Sapir 1993), and several international aid agencies have recently developed a gender policy (UNHCR 1995a). Before rushing blindly to establish a parallel fashion trend in refugee public health, it seems sensible for health professionals to reflect carefully on the relevance of gender as a public health risk factor in crisis situations. What *is* the evidence for gendered differences in health in crisis situations? *Do* women have specific health needs in these situations? Are the health staff of relief programs aware of gender issues and do they implement specific health interventions targeting women? What is the rationale for such differential intervention? What is the impact of such specific interventions? To shed some light on these questions, we did a review of a refugee health program in Kenya.

### Introduction

A gendered approach to health and illness first of all examines differences in disease manifestations between men and women, and

their perceptions of, and meanings given to, these events (Feldmeier, Poggensee, and Krantz 1993). It also looks into the gendered aspects of health care delivery (be it curative or preventive), and the consequences of intentionally and unintentionally gendered care. As health programs in emergencies focus greatly on facilitating survival, on the surface they seem only legitimately concerned with the biological question of vulnerability differentials: who is most at risk of dying? Aiming to decrease overall mortality in a more efficient and equitable way, they often target specific groups within a refugee population. The labeling of such a population subgroup as 'vulnerable' is linked to the perception of their increased mortality and morbidity (Davis 1996). In this regard, the particular vulnerability of under-five children and pregnant women in emergency situations caused by forced migration has been well established. However, gender morbidity differences are not solely biologically related. They are strongly influenced by social context, for example, by the position women and men occupy in society, the access each gets to services, and the kind of medical care each receives.

The assumption underlying this study is that the particular social context of a refugee camp will affect the health needs of all refugee women in it, not only those of pregnant and lactating women. The way that women's health needs in general are affected by forced migration and camp life needs to be clarified. Our case study of a refugee health program in Kenya addresses two related questions. First, is there any evidence for general gender differences in health needs in emergencies in this situation? Second, to what extent are health professionals aware of such gender differences (real or anticipated), and do they undertake specific action to address them?

## **Background**

Because of civil war and famine in southern Somalia, more than two hundred thousand people crossed the Kenyan-Somali border in 1991-2. In 1997, an estimated one hundred twenty thousand of them were still living in three camps around the northeastern town of Dadaab: Ifo, Dagahaley, and Hagadera. This is a very arid area in which the local population are mainly cattle farmers who suffered losses in the droughts of 1992 and 1996. This study focuses mainly on the Hagadera camp. A nongovernmental organization (NGO), Médecins Sans Frontières (MSF), has been in charge of health care delivery to refugees in this camp since May 1992. Health services in Hagadera are organized according to an agreement with the Ministry

of Health (MOH) that reflects Kenyan national health policies. These services and programs are based on a model of refugee health care that was empirically developed within the MSF over the years to target health priorities in refugee camps (MSF 1997).

The health service in this camp is organized on a classic two-tier basis: a first line, where basic curative and preventive care is given, and a referral hospital for the cases needing higher level technical care. In Hagadera camp, male auxiliary nurses of Kenyan nationality are in charge at the three first-line health posts (HP). They finished secondary school and received limited training during the early phase of the refugee program. The HP offers a complete package of preventive services, including immunization, antenatal care, and family planning (FP). However, the package of curative care available is limited. The auxiliary nurse prescribes from a limited list of eight essential drugs, and no direct access to the hospital is allowed except for emergency cases. On average, between 20 and 30 percent of HP patients are referred to the hospital. In the hospital, a medical doctor is in charge, supervising a team of clinical officers. Paramedical and medical certified staff in the hospital are Kenyan nationals, seconded by MOH. Most of them are male, except for midwives. Only some of the Kenyan staff speak the language of the Somali refugees.

Very early on in the emergency, relief workers also established a network of community health workers (CHWs) from within the refugee community to actively bridge the gap between the organized health service and the community. Almost all of them are male, as prior CHW training in Somalia and the ability to read and write are criteria for their selection. CHWs are responsible for vital event surveillance and health promotion activities. Traditional birth attendants (TBAs), selected from the refugee community, have been involved in antenatal and delivery care activities from the beginning of the refugee program. At the time of the study, MSF employed two European expatriates in the camp: a male medical doctor and a female nurse.

## **Methods**

To examine the available evidence for gender differences, we tried to identify and assess the specific health problems of refugee women in Hagadera. We reviewed the data from the health information and surveillance system for the period September 1992 to November 1996. This quantitative information (Centers for Disease Control 1992)<sup>1</sup> was coupled with qualitative data from six focus group

discussions held with women in Hagadera camp in November 1996. We used qualitative methods to address the second question of the extent to which health professionals working in this program were aware of gender issues and undertook specific action. Interviews with traditional birth attendants, community health workers, auxiliary nurses, midwives, doctors, and medical coordinators provided information on their awareness of the specific health needs of women refugees and of the services provided.

## Refugee Women in Hagadera: Are Their Health Needs Different?

War, famine, and forced migration do not affect women and men in the same way. Often men lose more of their previous public sphere status than women when they seek asylum in refugee camps. Also, the demographic structure of the population in a refugee camp is often profoundly altered, which cannot but affect the role and position of both men and women in the refugee community. Hagadera's population statistics show that the overall sex ratio (M/F) in 1994 was 0.99 (UNHCR 1994). Even so, within the age classes, sex ratios were not homogeneous, as shown in Table 10.1.

**Table 10.1** Sex Ratio (M/F) by Age Group in the Dadaab Camps, 1994

Age (years)	Ifo	Dagahaley	Hagadera	Total
0-4	1.15	1.07	1.06	1.08
5-18	1.18	1.10	1.03	1.07
19-44	0.93	0.95	0.89	0.92
>45	1.31	1.33	1.19	1.26
<b>Total</b>	<b>1.09</b>	<b>1.06</b>	<b>0.99</b>	<b>1.05</b>

In each of the camps there seems to be a 10 percent surplus of women in the nineteen to forty-four age group, and a striking 30 percent deficit of women in the age group over forty-five years. Selective in- and out-migration seems the most plausible explanation. Adult men were/are probably more involved in military and/or economic activities outside the camp. As a consequence, female-headed households are probably more frequent in the camp than they were in the home country. Elderly women might have stayed

behind in Somalia more often than elderly men when families migrated, or might have experienced higher mortality during the crisis. The forced migration from Somalia clearly does not affect both sexes in the same way.

Notwithstanding a lack of sex-specific morbidity surveillance data, there is other evidence that life in the refugee camp has been more unhealthy for women than for men. Maternal mortality ratios in Hagadera camp were very high (above 1,000 per 100,000 live births), despite a well-functioning and accessible operating theater located inside the camp, where cesarean sections were of a good standard. Most maternal deaths were attributed to anemia in pregnancy and eclampsia. An outbreak of hepatitis E at the end of 1992 also resulted in high mortality among pregnant women.

Gender inequities in food distribution also were apparent, and nutritional problems were common. Indeed, the food situation had worsened dramatically since August 1995, when the WFP individual ration was gradually decreased from 2,100 kcal. to 1,700 kcal. a day (Boelaert et al. 1997). Over a sixteen-month period, the average quantity of food received on distribution days reached the minimum requirements of 1,900 kcal. a day *only two times*, as indicated by data from food basket monitoring. This was clearly a particular problem for poor and destitute households, estimated to make up 50 to 60 percent of the camp, who relied on the WFP ration for 85 to 100 percent of their food. Using the global acute malnutrition rate as an indicator, we found a significant increase in the prevalence of acute malnutrition rates: 28 percent of six- to fifty-nine-month-olds<sup>2</sup> had a weight/height index below minus two z-scores or else had edema (95 percent CHI 24.0–32.0 percent).<sup>3</sup> Under such circumstances, pregnant women are differentially at risk of nutritional deficiency diseases such as scurvy and anemia because of their increased dietary needs. Scurvy had been a constant problem in the camp, and during the latest outbreak (July–October 1996), 508 cases were recorded.<sup>4</sup>

A food assessment mission by a joint SCF/WFP/UNHCR team in October 1996 noted that women were not involved in any way in pre- or post-food distribution discussions and planning, and that they received unequal treatment during food distribution. As the UNHCR report notes, “Women are treated particularly badly when they question the size of their ration, to the point where they no longer feel it is worth inquiring and often do not have the time to waste arguing” (UNHCR 1996).

But health differences stretch beyond the mere physiological consequences of childbearing. Access to health care more generally seems to be different for men and women. For example, detection

of tuberculosis (TB) showed striking gender differentials in Hagera. As elsewhere, the incidence of TB here is, in all probability, equal among men and women (Hudelson 1996). However, only 20 percent of enrolled patients were female at the start of the TB program in 1993, according to the medical coordinator. As the result of an information distribution effort by health workers, case detection in females increased, and the proportion of females enrolled in the TB program rose to approximately 40 percent in 1996. The medical coordinator attributed the low case detection rate for women at the start of the TB program to the perception that the social stigma attached to a TB diagnosis is more important for a Somali woman than for a man, and stigmatization prevented women from seeking care. It was believed that a woman with a known TB diagnosis faced expulsion from her family or lost her chance to get married.

Compliance with treatment also shows gender difference. One pertinent study looked specifically at gender with regard to the nutritional programs in Ifo and Dagahaley. Although the nutritional survey found no difference in malnutrition prevalence between boys and girls at the time, there were striking differences in the outcome parameters of the supplementary feeding (SF) program (Quillet 1994). A feeding program was organized in which malnourished children received high-energy milk twice daily, plus a take-home ration of biscuits. This provided a total of 1,585 to 1,770 kcal. a child per day. Mean weight gain in girls nevertheless was significantly lower (3g/kg/day vs. 3.6g/kg/day), and girls were more likely to stop participating in the program and less likely to be discharged than boys. Higher defaulting in girls was believed to be partially the result of mothers relying on daughters to help them with the household tasks.

These gender differences in weight gain were also attributed to possible gender preferences in intrahousehold food allocation in an overall situation of food shortage. Substitution and sharing are commonly observed phenomena in food emergencies. Substitution occurs when enrollment of a child in a feeding program has the unfortunate consequence that the child in question will not get any more food at home. Sharing occurs when the supplement given to a malnourished child as a dry or take-home ration is shared by the other family members. It is possible that these phenomena of substitution and sharing among refugees might be gender-specific, as gender-unequal food distribution within poor or food-short households is a commonly observed phenomenon around the world (see Nordstrom, this volume).

In November 1996 women refugees were asked about their health problems and their opinion about health services. They quite consistently pointed to the low level of care they were receiving at the first-line health posts. They lacked confidence in the skills of the auxiliary nurse and in the potency of the essential drugs they received. Their satisfaction seemed higher with the hospital service. Overall, it was their view that the main problem was not health care, but rather the very precarious food situation in the camp. Completely dependent on food rations that were insufficient both in quantity and quality, women expressed their anxiety about physical weakness, about anemia in pregnancy, and about the dangers of multiple pregnancies under such precarious conditions. They said they were going to the health service chiefly to look for substitutes for food: vitamins, iron tablets, and drugs. They consistently expressed their distress about the overall state of dependency in which they were living.

## **Are Health Workers Aware of Gender Issues in Health, and Do They Act on Them?**

The particular vulnerability of women and girls in complex emergencies is now recognized among social scientists (Slim 1995). As a result, generalized poverty can no longer be the exclusive key social determinant of vulnerability. Moreover, epidemiological evidence confirms that women face a higher mortality risk than men in both natural and man-made disasters (Sapir 1993). This higher risk cannot be explained by biological factors alone. Field-based health professionals dealing with complex emergencies may not be aware of the significance of gender-specific vulnerability. To them, purely biological factors may seem more straightforward and important to address, resulting in targeted programs such as antenatal care. It is not clear to what extent health professionals themselves unconsciously offer gender-unequal care. Although relief organizations recently have produced a number of gender policy papers, it seems important to investigate what is going on in the field.

At Hagadera, both NGO and MOH staff are confronted daily with undernourished and anemic pregnant women. Nevertheless, no specific effort has been made so far to document these anecdotal observations with the kind of gender-specific epidemiological data that could be used for policy and program development advocacy in the current food shortage crisis. An analysis of the monthly medical



reports from the Hagadera camp showed that no gender-specific morbidity data is routinely collected, with the exception of hospital admission data. If differences exist, they will go by unrecorded. Even the demographic structure of the refugee population is only roughly known, and there is no accurate gender breakdown. Indeed, the standard method for monitoring malnutrition in refugee populations worldwide does not include gender-specific analysis of collected data (UNHCR 1991). It is thus not surprising to find that out of the eight nutritional surveys performed in Hagadera since 1992, only two give gender-specific results. They show no significant difference in the malnutrition prevalence rate between boys and girls. A global malnutrition figure can, however, mask important and significant sex-specific differences, such as those shown in our reanalysis of the most recent survey done in August 1996. The global acute malnutrition rate was then 18.2 percent, 14.4 percent for girls and 21.8 percent for boys ( $p=0.004$ ). This is a striking and unexpected difference against a background of a deteriorating nutritional situation for the whole population.

As mentioned earlier in the case of the tuberculosis and malnutrition (SF) program, gender differences in health are sometimes noticed by health professionals, and sociocultural hypotheses are often put forward to explain them. The accuracy of these hypotheses is difficult to assess, as they remain plausible but speculative. For example, gender preference in intra-household food allocation in times of overall food shortage sounds plausible, but has not been verified.

Summarizing, we can say that while the literature suggests that refugee women and girls will be more vulnerable, in the field health data is not always analyzed in a gender-specific way, and differences can go unnoticed or untreated. When differences are observed, they are often attributed by health workers to sociocultural factors—attributions that rarely stem from careful observation of the social organization of the camp.

### ***Gender-Specific Interventions and Programs***

Specific health programs directed at camp women exist, but they exclusively address only problems related to the physiological differences between men and women. During the emergency phase, for example, specific food supplements were distributed to pregnant and lactating women. Another major health problem for women in the camp has been sexual violence (Wilkes 1993). The security in and around the camp has not been good: killings and rapes by bandits have very frequently occurred when refugees go out to fetch firewood. This problem has been linked to the precarious, unprotected

conditions women face, and to clan rivalries in the area (Hoerz 1995; see also Matlou, this volume).

A policy of care for victims of rape has been established by camp authorities and is strictly followed by camp agencies, including the health services. If a raped woman reports to the health service, she is examined by a medical doctor in the maternity premises. Emergency contraception is offered and usually accepted. A confidential medicolegal report is drafted. Counseling is offered, and women are referred for psychosocial assistance. It is acknowledged, however, that only the most courageous women come forward to say they have been raped, and that focusing only on self-reporting rape victims ignores the root problem.

In early 1994, health professionals started exploring the demand for family planning (FP) services. In discussions with camp leaders, traditional birth attendants, and community health workers, refugee women and men showed great reservations about FP. Although the negative outcomes on women's health of multiple pregnancies under camp conditions were acknowledged by refugees themselves, the community focus appeared to be on having as many babies as possible. A Kenyan Somali nurse-midwife who is well accepted by refugees is now in charge of the program. The success of the FP program is higher in the health posts than in the hospital. An explanation given by the midwives was that women apparently prefer the easy access and the polyvalence of the first-line health posts. Moreover, as many women try to hide their practice of FP from their husbands, they find it easier to go to the HP rather than to have to explain why they went to the hospital. However, FP is far from universally accepted, as shown during focus group research in November 1996. As one person put it, the "UN wants to kill our children, they want us to have family planning."

The health service thus offers specific services directed to women. Given the above programs (antenatal care, care for rape victims, and family planning), the question might be raised as to whether the male, non-Somali speaking health workers are able to establish effective communication with women refugees, and to what extent women's health problems are in fact effectively dealt with. From the limited evidence provided by the focus groups, there seems to be a significant problem with the health posts. In particular, women did not have confidence in the auxiliary nurses. Their medical skills were questioned. As one person stated, "In the health post they always give the same drugs to everyone, and they don't ask for the complaints. Everybody receives already prepared, old drugs in envelopes.... They give drugs like UN gives the food. Drug distribution." Male refugees expressed similar concerns.

## **Are Health Emergency Programs for Refugees in Need of a More Gendered Approach?**

Women and children in crisis situations are often spoken of as innocent victims by relief agencies, and they are given close media attention in the never-ceasing pursuit of private donor generosity. The innocent victim image pertains to a certain mythology cultivated by Western relief organizations—a mythology that suggests that societies in violent conflict could be easily divided into active (male) fighters and passive (female) victims. This is of course rarely true. Data about the part women took in the genocide in Rwanda are but an extreme example of the active role women play in societies in conflict (Summerfield 1996; see Nordstrom and Matlou, this volume). To engage in more gender-related health programs exclusively because of the ‘ideological’ (if not commercial) image of the innocent victim would be the worst service to render to refugee women.

Moreover, the current biomedically oriented criteria for the identification of ‘vulnerable groups’ need to be reexamined from an epidemiological perspective. In a recent paper, Davis (1996) identified the disproportionately higher mortality risk adults and children over five years of age faced in emergencies when compared to children under five. This evidence contrasts with the current practice among relief workers, which is to aim health and nutrition interventions at children under five years of age. As Toole (1996) points out, the historical focus on under-five children can be explained by three elements: (1) an objective analysis of mortality patterns in previous emergencies; (2) the availability of affordable measures to prevent the most common causes of childhood deaths; and (3) an emotional concern for the plight of children on the part of the public who form the donor base of most relief agencies. One lesson to be drawn from this study is that health professionals cannot avoid independent, on-site assessment of specific emergency situations, as each emergency is different. Relief workers today tend to stick too closely to standardized intervention schedules and, in doing so, can miss major gender-specific risk differences within their target population. In the Hagadera case study, there has been almost no gender-specific analysis of the health problems of refugees. This is partly explained by lack of data, but this lack is rather poorly rationalized by standard epidemiological surveillance practice, which collects only data relevant for action. This practice in turn implies that gender-specific information was at some point judged to be irrelevant to what health professionals did, apart from the biologically determined events associated with childbirth. Nevertheless, we found indications that

overall health risks for women are disproportionately increased in the camps and therefore warrant specific attention.

A gender-sensitive approach to health care in refugee emergencies, however, might instead be a matter of better, rather than more, care. The demands women express today are hardly taken into account. It is a general and understandable observation that, in acute emergencies, health professionals spend very little time discussing health issues with the community; in addition, they are hindered by significant language and cultural barriers. This pattern unfortunately tends to persist long after the initial emergency is over. Moreover, there is often a strong gender bias in communication between officials, workers, and refugees, as shown very clearly by Sommers (1995). The representatives of refugees who can most effectively transmit their demands to relief officials are mainly men with a university education. Only a small percentage of women typically speak the language of the relief officials (Sommers 1995). It can be assumed that the demands of women are rarely heard or taken into account, either at the policy or at the field implementation level.

Is a gendered approach relevant to emergency health programs? The relief workers we interviewed feared that the glossy gender policy papers so far produced by international agencies might constitute a dead end for those in the field, as they seem to focus almost exclusively on reproductive health. In the field, it was observed that recently introduced 'specific programs' directed at women still address the issue from a biological perspective only, and as such seem to ignore the fact that gender cannot be reduced to sex. As documented previously, women's specific health needs are not limited to the reproductive domain only. Women's increased health risk is linked to their social positions and statuses within their societies, which in some cases will limit their access to food and other resources in the refugee camp, as it did at home. An exclusively technical and selective intervention will probably not address this key issue.

Gender is an important determinant of health status in refugee situations. However, the causal pathway is as yet far from understood. Although there is growing awareness in international agencies and NGOs about the role of gender in forced migration, strategies to address the issue in the provision of health care are still immature. The first priority today seems to be to better understand and document a variety of field situations. Much gender-specific epidemiological data is needed, complemented with qualitative studies of health promotion and health services. The most urgent intervention needed, however, is to effectively improve communication between health workers and women in refugee camps.

## Notes

1. Epidemiological surveillance was done in the camp since September 1992, according to standard methodology, described by CDC (1992). All data from the surveillance data base were reviewed over the period 1992–96.
2. In emergencies, general malnutrition rates are estimated using data from the under-five children, for this population is the most sensitive to acute food shortages that translate into an immediate and important weight loss. The use of this measure does not imply that responses are targeted only to this age group.
3. The global acute malnutrition rate is an indicator used to estimate the severity of malnutrition in a population. It is measured by the proportion of children from six to fifty-nine months with a weight/height index below minus two Z-scores and/or with edema (NCHS/CDC/WHO reference curves).
4. No gender-specific anthropometric data for adults were available.