This is the seventh in a series of 12 articles

ABC of conflict and disaster
The special needs of children and women

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The special needs of children

Children are more vulnerable to communicable diseases and environmental exposure than adults, have special dietary needs, and are generally dependent on their family for their material and emotional support.

Many of the most severe emergencies occur in poor countries. Poverty tends to exacerbate the impact of emergencies of all types: poor people live in low quality, damage-prone housing, often on marginal land at risk of landslide or flood. The children of the poor tend to have low nutritional status, increased exposure to communicable disease, low immunisation rates, high levels of intestinal parasites, and limited access to health care.

Queuing outside a clinic in Sudan

Risk assessment for humanitarian emergencies

- What health effects is the given shock likely to have on the population?
  Trauma, environmental exposure, disease transmission, and access to food and other necessities
- What were the conditions before the emergency?
  Adequacy of health services, immunisation coverage, nutritional status, etc
- What is the local capacity to respond to needs?
- How quickly will those needs arise and relief will be required?

Earthquakes, floods, and other physical shocks

Trauma in these events may affect children disproportionally. In the 1976 Guatemala earthquake child mortality was generally higher than that of adults, but low in those less than 1 year old, attributed to the fact infants slept with their mother and were thus protected. Serious injury increased steadily with age, an effect assumed to result from the greater susceptibility to injury with increasing age.

In the 1971 Bangladesh cyclone children aged less than 10 years made up about a third of the population but accounted for half of all deaths. Many people survived this storm by clinging to trees. Mortality was particularly high in young children and in women older than 15 years, probably because of women trying to protect small children, the relative physical weakness of these groups, and the effects of exposure as the cyclone continued for many hours.

Economic consequences of disasters

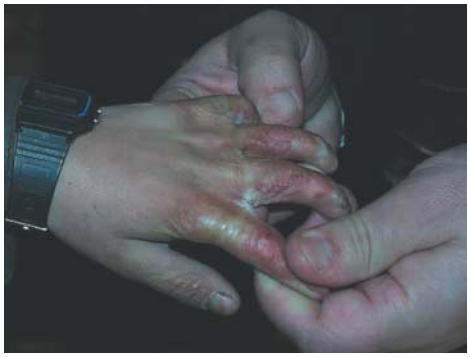
The economic impact on families affected by disasters may be considerable. Houses, standing crops, domestic food stocks, livestock, and goods may be lost.

Crop failure and an increase in the price of food may lead to famine. The initial damage is often exacerbated by a fall in wages and the price of assets as many people attempt to find work and to sell livestock and other household goods to obtain food. In Malawi in 2001-2 an economic crisis was triggered by low food production because of flooding and the high price of fertilisers and other farm inputs and was aggravated by a reduction in national stocks. The poorest households had no food reserves and few assets, and, as the price of the staple maize increased almost fivefold, they could not obtain enough food.

The effects of economic shocks are typically three:

- Increased malnutrition rates due to a fall in the quantity and quality of food. Households may be reduced to consuming only cereals or roots, creating difficulties in feeding small children.
- Intensification of poverty. The loss of assets may reduce people to destitution. Even households that can survive may do so only by sacrificing expenditure on items such as education, soap, and clothing. Want may increase exposure to disease, such as HIV infection from increased prostitution.
- Population movement to roadsides and urban areas in search of food.

Malnourished child and mother in a Nepalese clinic

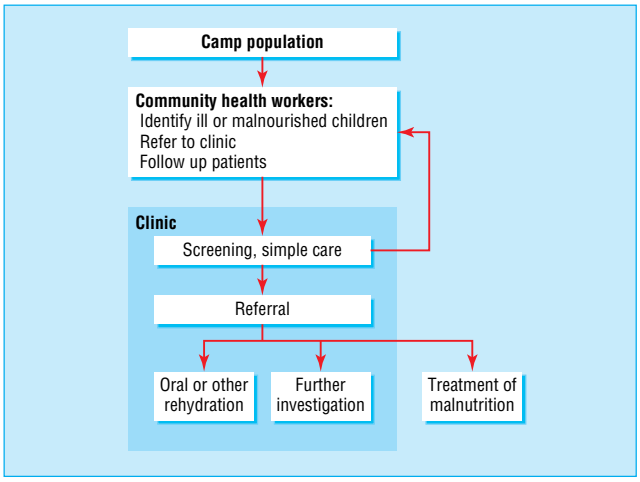


Doctor assessment of untreated burns in a displaced people's camp

Population displacement to camps

Camps, whatever their origin, pose grave risks to life and health, particularly for children. High concentrations of people with low immunisation rates and high levels of pre-existing disease and without sanitation or adequate food supplies are optimal conditions for disease transmission through water, food, personal contact, and vectors. Most mortality in children results from measles, diarrhoeal and respiratory diseases, and malaria.

Camp populations often depend heavily on food aid, sometimes little more than cereal, and pellagra and scurvy have been known to become epidemic. The management of health and malnutrition is now largely standardised. Progress is tracked by monitoring mortality and anthropometric nutritional status.



Organisation of food distribution in camps for displaced populations

War and conflict

Unicef estimated that, in 2001, 300 000 children younger than 18 years were acting as soldiers, guerrilla fighters, or in combat support roles in more than 50 countries around the world. Often, children are abducted from their families at very young ages (their parents may be killed), exposed to drugs, and forced to commit acts of barbarity.

At the end of a conflict, the children's greatest problems often relate to their fear of attack by community members when they go home. Girl mothers and their children are often stigmatised and neglected. Formerly abducted children often report that their greatest stress is not the residues of past violence but their inability to secure an economic livelihood. Many desperately desire education but have no resources or are too old to return to school.

Opinion is divided on the management of the psychological effects of emergencies on children. Some agencies argue for active intervention; others claim that this is therapeutically unproved and often impractical on any scale and that the best approach is to remove children from the brutality of war and restore them to social normality as quickly as possible, such as through family reunification when possible.

Child art during the war in Sarajevo, indicating some of the psychological shocks that children experienced

Special needs of women

It is essential to recognise the wider reality of women's lives if we are to establish and protect their human rights in emergency situations and if those providing aid in these crises are to meet their responsibilities.

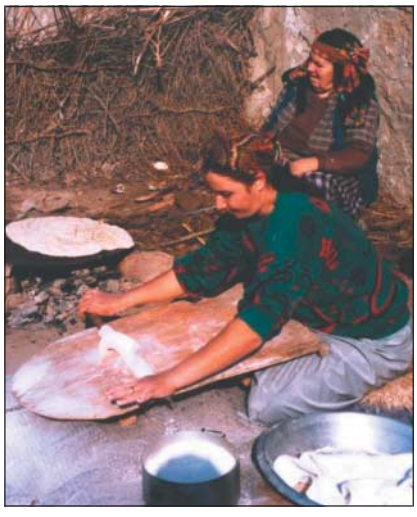
Recognition

To understand how to respond to women, we need to find out what has been their experience of flight or persecution. Have they families or land left behind, have they had to grant sexual favours to cross borders or for humanitarian assistance? We need to ask questions and to pay attention to the answers, not to attach inappropriate cultural values to the answers or to deny their reality.

We need to explore the strategies women use to survive, bearing in mind that these may not always be to their own benefit (such as feeding everyone else in the family before themselves). Finally, we need to know what women can do; what is their untapped potential for coping and for providing longer term solutions to crises.

If women and girls feel that they have not been believed, they quickly learn that there is no point in telling painful and stigmatising stories. In many societies women are unwilling to speak if there are men present who can "say it better," or they are silent about their experiences for the sake of "moving on."

Similarly, women will often not insist on their ideas being heard. Humanitarian workers may struggle to create the space



Women preparing food in a displaced people's camp

"Please listen to me; It would be good if you would listen to me' (girl soldier)"

From: Kearins YE. *The Voices of Girl Child Soldiers*. New York: Quaker United Nations Office, 2002

(or allow women to create their own space) for women to show solutions to the problems that they or their community face.

There is a belief, particularly in Western models of therapy, that it is wrong or dangerous to ask women about traumatic experiences if there is no time or space to follow it on. In humanitarian crises there is often no such time or space, yet not to ask because of these limitations may mean the difference between surviving and merely existing for many women. We have to ask ourselves whom we are really sparing if we don't ask the questions that elicit painful or difficult answers.

The rights based approach to women's experiences

International law is clear that just because people are victims of an emergency they do not lose their entitlement to dignity and respect. Women will often be the first to deny themselves in favour of others, particularly children or male partners, but any such discrimination in provision of services is contrary to international law and standards. The fact that women do cope, at least externally, means that, without a rights perspective, it is easy to relegate them to second place, be it for humanitarian assistance, appropriate health care, or provision of facilities.

Listening to women and adopting a rights perspective mean that humanitarian workers are less likely to impose their own understanding on a given situation. For example, girls and young women associated with demobilising soldiers may be assumed to be legitimate family members or "camp followers" and may thus be deprived of any independent benefits when appearing at demobilisation facilities and assumed to be content to go with their "husband" to his home, even if they were abducted from somewhere completely different.

Violence against women is so much a part of modern conflicts and other crises, and women are so silent about it and silenced by it, that it is easy to lose a sense of outrage and to forget that this is a gross human rights violation.

Responsibilities of workers involved in humanitarian crises

Workers have a responsibility not to exacerbate problems and not to participate (directly or indirectly) in ill treatment, but they also have a responsibility to ensure that women are treated with full human rights. It can be difficult to be the lone voice for women's rights when there is peer pressure to be passive in the name of neutrality or confidentiality.

When non-governmental organisations learn of acts of physical violence they often have to decide how to record that information so that the twin objectives of providing information for justice and maintaining their neutrality (so they can work in similar places in the future) are both met. It is not a matter of compromising one objective for the other, but of finding ways to pursue both.

Responsible treatment also means keeping abreast of the relevant law. It was only in 2002 that the International Criminal Tribunal in The Hague defined sexual offences as a crime against humanity. Similarly, it is only relatively recently that sexual violence in refugee camps has been identified by relief agencies as an issue that needs formal attention and response.

Conclusions

Humanitarian workers must make special efforts to understand what women have experienced and what contribution they can make to finding solutions to the crisis and must treat women with dignity and respect. This means providing assistance without discrimination, which in turn means paying attention to women's particular needs and situations. The responsibility of medical staff to provide appropriate treatment does not end as the woman leaves the tent or clinic but continues into accurate and impartial recording.

"Both the experience of conflict itself and the impact of conflict on access to health care determine the physical health and the psychological well being of women and girls in very particular ways. Women are not only victims of the general violence and lack of health care—they also face issues specific to their biology and social status. They add to the complexity of the picture, women also carry the burden of caring for others, including those who are sick, injured, elderly or traumatised. This in itself is stressful and often contributes to illness"

From: Rehn E, Johnson-Sirleaf E. *Women, war, peace: The independent experts' assessment*. New York: Unifem, 2002

Treatment of women affected by humanitarian crises*

- Psychosocial support and reproductive health services for women to be an integral part of emergency assistance and reconstruction
  Special attention should be paid to those who experienced physical trauma, torture, and sexual violence
  All agencies providing health support and social services should include psychosocial counselling and referrals
- Recognition of the special health needs of women who have experienced war related injuries, including amputations, and equal provision of physical rehabilitation and prosthesis support
- Special attention to providing adequate food supplies for displaced women, girls, and families to protect health and to prevent the sexual exploitation of women and girls
- United Nations, donors, and governments to provide long term financial support for women survivors of violence through legal, economic, psychosocial, and reproductive health services
  This should be an essential part of emergency assistance and reconstruction
- Protection against HIV/AIDS and provision of reproductive health through implementation of the minimum initial services package as defined in *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* (WHO, UNHCR, UFPA, 1999)
  Special attention must be paid to the needs of particularly vulnerable groups such as displaced women, adolescents, girl headed households, and sex workers
- Immediate provision of emergency contraception and treatment for sexually transmitted diseases for rape survivors to prevent unwanted pregnancies and protect the health of women

*Adapted from: Rehn E, Johnson-Sirleaf E. *Women, war, peace: The independent experts' assessment*. New York: Unifem, 2002. Though written for conflict settings, the recommendations are equally applicable to other humanitarian crises

Further reading

- Sphere Project. *Humanitarian charter and minimum standards in disaster response*. Geneva: Sphere Project, 2004 www.sphereproject.org
- Publications from the Pan American Health Organisation www.paho.org/disasters/
- Bracken PJ, Petty C. *Rethinking the trauma of war*. London: Free Association Books, 1998

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