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Culture, Gender and Health in the Humanitarian Context

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Introduction

The current crisis in the Middle East caused one of the largest migrations in the recent history. More than 5 Million refugees in its neighboring countries, 7.6 million internally displaced and hundreds of thousands of migrants passed through Turkey and Greece toward Northern Europe [1]. Addressing the outcomes and consequences of this influx required profound efforts from the humanitarian sector. Multi-disciplinary approaches were developed and used within the context of this crisis, taking into account cultural differences between the Persons of Concern (POC) and the agencies involved.

Gender medicine within traditional societies is a crucial and fundamental component to address in the context of migrants on the move. Research shows that females are more vulnerable in humanitarian crisis; hence, there is a need to prioritize gender medicine [2,3]. Moreover, the reality of masses on the move, often in crowded buses and trains might increase the probability of sexual abuse, Gender Based Violence (GBV) and human trafficking [4-12]. Likewise, destabilized populations are more prone the human trafficking, where women and children are the prime victims.

A recent report describing a field clinic in Presevotransit camp on the border of Serbia and Macedonia, (FYROM) raised a few gender related medical issues. The camp was established by the local government for registration and humanitarian support delivered to the migrants on their way to Northern Europe between 2015-2017.

In the report, physical trauma was diagnosed mainly in men (64%), probably due to war injuries. The infrequent reporting of injuries in women could possibly be due to having other priorities (e.g. child-care). Obstetrics and Gynecology (OBGYN) complaints rate was considerably low (1.8%) in comparison with other studies conducted with Syrian refugees in settled camps [13] showing rate of 6.95% of ObGyn reports. This gap might be due to language and cultural barriers: The medical team included Arabic speakers, but almost no staff member spoke languages originating from Afghanistan or some parts of Iraq [14].

Evidence from the clinic described above shows that reproductive health or Sexually Transmitted Infections (STIs) were not addressed in the clinic. It might be the result of cultural barriers preventing complaints from the clinic's visitors; lack of diagnostic tools; lack of time and resources; lack of privacy in the clinic or low awareness of the medical staff.

Discussion and Recommendations

Cultural differences within the humanitarian context are amplified and require extra care. Especially as it comes to sensitive issues such as gender and health in traditional societies [15-17]. The findings described above might be a result of these differences, but when it comes to aid, practitioners are expected to perform in a pro-active manner. Several practices exist to address gender related health issues:

A. Practices such as including female practitioners affiliated with the culture of the patients, employing mediators rather than translators, experts in women's health and the possibility of

spatial separation in the clinic to allow privacy for women. This privacy could be achieved by referring the patient to a separate space within the clinic where her male escort will not attend, and the separation should be subject to the patient consent. Moreover, medical mangers should consider allocating separate time slots only for women during the clinic opening hours.

B. To use a general approach and method of diagnoses through a protocol using specific questions related to gender health. It is advised to include a blank paper with a schematic body figure where the patient is asked to point the area of pain.

C. Suggesting and distributing feminine hygiene kits mainly to women at the reproductive age; and making contraception available to both men and women.

D. Distribution of contraceptives should be considered after consulting with community leaders and after deep confidential survey. Contraceptives, among other preventive methods, should be recommended as preventive measures to STIs, and not only to unwanted pregnancy.

E. Reaching out the women who seem to be leaders, and recruit them to advocate for women's health.

F. Sexual abuse and GBV medical outcomes in relief and humanitarian context are hard to prevent due to the increased vulnerability of women. An education program initiated and managed by an external agency requires a deep and long familiarity with the community addressed, which may not be possible to perform in people in transit. We recommend a policy of "Do no harm" – by which medical teams do not engage in subject of trauma and sexual abuse unless there is an adequate follow-up program to take care of the victims.

To conclude, the agency and its staff deployed in the field should keep in mind the question of- who is the most vulnerable, and what are the optimal measures to address this vulnerability without doing harm. We failed to find validated data or sufficient researches conducted on similar setting of migrants on the move. We call upon researchers and practitioners to promote data collections and reports about similar cases.

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Compliance with Ethical Standards:

A. No funding was received.

B. All the authors declare no conflict of interest.

C. This paper does not contain any studies with animals performed by any of the authors.

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