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Health Effects on Women from Systematic and Organized Violence in the Middle East:

How Humanitarian Organizations can Lessen
the Gender Inequality Gap

By
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An Honors Thesis Submitted in Partial Fulfillment of the
Requirements for Graduation from the
Western Oregon University Honors Program

Dr. Patricia Flatt
Thesis Advisor

Dr. Gavin Keulks,
Honors Program Director

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Abstract

Altruism, service and giving back are emphasized frequently in the United States today. One such way to participate is to donate money, resources or time to humanitarian aid organizations who can effectively utilize those resources to help those in need. However, humanitarian aid organizations and the general public are often only aware of general medical needs of the targeted population without much knowledge on gender specific health problems that arose from pre-existing patriarchal social structures (Mazurana, 2013). Systematic and intimate violence targeting women is one way patriarchal structures are maintained, particularly in the Middle East. These forms of violence often cause many health complications in women that are unaddressed by both healthcare institutions of those countries and by humanitarian aid organizations.

The purpose of my thesis project is to bring awareness of these unaddressed health complications women face in the Middle East as well as propose some ideas of how to address them to both humanitarian aid organizations and to the general public, who donate to these organizations. I will accomplish this by composing a scholarly literature review of how violence effects women's health and what humanitarian aid organizations can do to treat these complications with the resources they have.

I. Introduction to Systematic and Organized Gender-Based Violence in the Middle East and Current Debates in Addressing the Issue

Introduction

Violence against women is given little attention in the academic world, yet is a widespread and growing concern (Ghanim, 2009). Up until recently, systematic and intimate violence against women was focused through a broad sociological lens as a mechanism of forcing women into submission in strong patriarchal societies, such as those found in the Middle East (Cottingham, 2008). These forms of violence include but are not limited to: honor violence/killings, female genital mutilation (FGM), domestic violence and sexual violence. Current research is primarily focused on specific health effects of physical and sexual violence against women. These types of violence have been shown to play an important role in women's survival rates in areas of conflict, particularly the Middle East.

Seventy-five percent of reported honor violence against women in Muslim regions today were committed by the woman's male family members for being insubordinate and resulted in death (Chesler, 2010). One hundred and twenty five million women and young girls have undergone female genital mutilation in Africa and the Middle East. It has also been estimated that 2 million more women and young girls each year in these areas will undergo female genital mutilation by male family members in their own homes (WHO, 2014). These women face numerous complications arising from the procedure such as infections, hemorrhages, severe loss of blood and child birth problems with little to no medical assistance (Ghanim, 2009). The medical assistance they do receive is from altruistic humanitarian aid organizations, who aren't

always aware of these health issues unique to women suffering from organized and intimate violence (Mazurana, 2013). Since gender-based violence cases go largely unreported, this leads to unintentional inequality of health care given to men and women by humanitarian organizations, furthering the gender inequality gap (Mazurana, 2013).

Paradox of Feminism: The Dilemma of Difference

How to effectively address the growing concern, however, is up for debate. Essentially, the question asks if the disadvantaged group, in our case, women, should be integrated by providing similar treatment or should they be provided special treatment, thereby further separating the disadvantaged from the advantaged, in our case, men. This classic “Dilemma of Difference,” coined by Martha Minow, has sociological and political roots in the education sector, particularly in special and ESL (English as a Second Language) education but can be applied to differences in healthcare by gender. Minow asks in her work whether the disadvantaged children should be provided accommodations so that they can meet the same standards as other children or should the disadvantaged children be integrated into the system and treated similar to their classmates? The solution, she claimed, almost always depends on the situation and, even then, usually differs between perspectives of advantaged and disadvantaged groups (Minnow, 1990).

Similarly, the dilemma arises when addressing violence against women, especially in the medical humanitarian context. With so little resources available for humanitarian aid, should women under the care of these organizations be treated as equal subjects of need, indistinguishable from other types of victims, or should they be treated differently so they can

receive the critical care they need. Referred to instead as “Paradox of Feminism” in this context, a term coined by Joan Scott, the dilemma lays the ground work for contextually analyzing whether to classify violence against women as distinct medical conditions in critical situations that humanitarian aid responds to (Scott, 1996).

Historically, humanitarian protocol fell on the side of integration in the dilemma. In other words, humanitarian groups treated women’s health issues the same as men’s. However, “violence against women” became a human rights legal concern in 1980s, stimulated by the Rwanda genocide, where rape was central weapon in armed conflict (Merry, 1998). Soon after, feminist movements pushed rape to be recognized medically as a form of violence. In the late 1990s, rape, among other forms of gender-based violence, became a medical concern for humanitarian organizations (Ticktin, 2011). With significantly higher numbers of female gender-based violence victims as opposed to males, medical complications due to gender-based violence became more highly associated with women instead of men. As a result, humanitarian protocol shifted from integration to separation of women’s health from men’s, focusing mostly on gender-based violence as a medical issue that prevents women from the same chances of survival or quality of life as men (Ticktin, 2011). For example, Medical Teams International, a relatively new humanitarian aid organization, started out focusing on children’s health as innocent victims of wars, disasters and poverty. Their focus has now expanded to include women since women are characterized as caregivers of these innocent victims, classifying them also as innocent victims (Post, 1999). Other older humanitarian aid organizations, like Medecins San Frontiers (MSF): Doctors Without Borders, have now added specific sections in the their campaigns addressing sexual violence as a separate medical concern for women (Medecins San Frontiers, 2015).

Yet medicalizing gender-based violence has a strange effect of also erasing gender, leaving only a suffering body that needs to be healed without a focus on the overlying social problem that caused the suffering in the first place (Tickin, 2011). In other words, it could draw so much attention to the issue it becomes normalized in its problematic state. This is the main concern Mariam Ticktin addresses when tackling the question whether women should be given special treatment by humanitarian aid organizations. She argues that humanitarian organizations are actually serving to reproduce patriarchal social order, rather than challenging it when they bring so much attention to gender-based violence against women as a special medical concern (Tickin, 2011). With increased public exposure as a social issue, there is a danger that such violence becomes normalized as inevitable instead of improvable.

In addition, Ticktin argues that segregating gender-based violence against women as a separate medical concern violates the original intent of humanitarian aid. One of the key principles of humanitarianism is maintaining neutrality in politics, only serving those in medical need without discrimination (Tickin, 2006). If humanitarian aid organizations don't refrain from taking actions that benefit one side over the other, it causes international policy discrepancies and can have financial consequences. By distinguishing gender-based violence against women as a unique medical issue in need of special care, it in turn sheds light on the political context which allowed for the violence to occur in the first place. Depicting women as victims to societal invasion of their bodily health places blame on the violence-inflicting parties, thereby showing a political basis instead of remaining neutral. Similarly, humanitarian aid organizations are also required to provide equal aid to all in need without discrimination. By providing specialized care for victims of gender-based violence and women's health, Ticktin argues that it could draw

already limited supplies and humanitarian health workers away from children and men in need of care, thereby allowing for unequal humanitarian health care provided between gender groups (Ticktin 2006).

On the other hand, Dyan Mazurana, makes the argument that sex and age are key factors in predicting and/or analyzing how people are affected by natural disaster or conflict. Sex and age matter when it comes to who lives and who dies. They both affect the conditions and resources available to that person, which places persons of some groups at a larger disadvantage than others. The purpose of humanitarianism, as stated before, is to serve those in medical need without discrimination. Mazurana argues that without gathering extensive data and performing analyses on who needs which resources, the humanitarian aid in question can't, by definition, be deemed impartial since certain victim groups will be disadvantaged in comparison (Mazurana, 2013). Therefore, in order to treat all equally, as is the mission of humanitarian groups, unique gender-based medical conditions need to be considered when providing aid.

Falling to the side of separation instead of integration, Mazurana emphasizes the importance of using Sex- and Age-Disaggregated Data (SADD) when preparing for humanitarian response. SADD is referencing data that is disaggregated according to gender and age in order to examine relationships between groups and extenuating variables rather than an overall trend. It allows for extensive evaluation of power dynamics that limit access to valuable resources or place additional obstacles for one gender over the other. This kind of data can be obtained by both quantitative and qualitative methods. For example, SADD is easily obtained by methods including, but not limited to: clinical records, census samples, supply distribution lists, surveys, morbidity and mortality statistics, focus-group academic studies, in-depth one-on-one interviews,

and various other ethnographic methods (Mazurana, 2013). In obtaining a variety of situational data, contextual analysis for the particular region and crisis will allow for awareness of the different needs, as the effects of crises are immense and variable across a population.

For example, in the Indian Ocean tsunami of December 26 2004, Oxfam carried out household surveys and found that of those who had died, between two thirds and three quarters were women (Oxfam, 2005). In some villages, all of the women and children were reported to be dead. To understand why there was a disproportionate number of female deaths, Oxfam researched and published a briefing explaining the context of which the tsunami occurred:

“In rural coastal areas many men were out fishing at sea, and many survived, as the waves passed under their small boats. The waves hit the shore, flattening the coastal communities and killing many of the women and children, most of whom would traditionally be at home on a Sunday morning. In agricultural areas, men were often out in the fields, working, or doing errands away from the house, or were taking produce to markets. Again, women were at home with children, and when the wave struck, lost vital seconds in trying to gather children to them.

The sheer strength needed to stay alive in the torrent was often also decisive in who survived. Many women and young children, unable to struggle to stay on their feet, or afloat, in the wave, simply tired and drowned. Women clinging to one or several children would tire even more quickly.” (Oxfam, 2005).

Looking at the event in a cultural context, women in Indonesia were situationally disadvantaged due to their typical gender roles and the timing of the wave. Since the tsunami occurred on a Sunday, most women and children would have been inside their homes doing

housework while most men would be out fishing. The farther the boats from the shore, the smaller the wave that would passively flow underneath. Conversely, the waves, once they hit the shore, would crash heavily on land, destroying the village homes. Location of job duties, determined by traditional gender roles, determined chances of survival during this natural disaster. This case study became an important academic argument for using SADD, favoring separation of gender when assessing medical conditions in humanitarian missions rather than integration (Mazurana, 2013).

While Ticktin compiles a strong argument for integration of genders since resources are limited in humanitarian programming, the biological and socioeconomic variances are, however, undeniably distinct between the sexes. So distinct in fact, that maintenance of health for each sex are also vastly different, and thus, form separate spheres of medicine. Such distinct separate spheres of medicine indicate that men and women can't be evaluated the same medically without missing important diagnostic information. Treating women the same as men in medicinal contexts can compromise their health, thus leading to unequal medical care (Inter-Agency Standing committee, 2006).

Of course separating men's and women's health leads to some additional consequences. For example, Obstetrics and Gynecology (OB/GYN), the biological and psychological study of the conditions that affect women reproductively, is its own unique speciality of medicine. Both historically and currently, this kind of specialized care can be portrayed as a luxury for well-to-do women in developed countries, as only those women could afford it. Depicted as a luxury, it has social implications that have crossed from developed to undeveloped countries (Ticktin, 2011).

OB/GYN as a speciality faces many hurdles to be socially accepted as necessary for maintaining the health of women, even in developed countries. If it is not depicted as luxurious, it's association with abortion leads to a morally nefarious image, as has been observed with Planned Parenthood clinics in the United States. The social and religious controversy surrounding the issue limits the accessibility to these services for many low-income women in certain areas of the United States. This in turn constricts these women from obtaining other health services related to family planning and reproductive health (Stevenson et al., 2016). Family planning definitions include cancer screenings, both cervical and breast cancer, pregnancy counseling and tests, provision of contraceptive services, screening and treatment of Sexually Transmitted Infections like Gonorrhea, Syphilis, Chlamydia, and Hepatitis (42 Code of Federal Regulations).

For example, effective January 1 2013, Texas excluded Planned Parenthood clinics from a Medicaid Wavier Program, called the Texas Women's Health Program (WHP), after transitioning the financing for the program from 90% federal to 100% state funds since these clinics were associated with legal abortion services (Shin et al. 2012). In 2010, WHP served 948,658 patients, including 345,079 children and 253,457 Medicaid beneficiaries. For this population, Texas low income health clinics provided 113,114 pap smear tests, among other disease and cancer screenings (Shin et al. 2012). It is important to note that nationwide, of the pap smear tests provided by Planned Parenthood to low income populations of ages varying from 10 to over 50 years old, it was found that 2.3 percent found abnormal results that indicated early or late stages of cervical cancer and Dysplasia, with unusually high numbers of abnormalities in young women, both sexually active and inactive (Sadeghi et al. 1988). Since Planned Parenthood

Clinics served 50 percent of the Texas population under the Texas Women's Health Program prior the reform, it is estimated the impact of defunding Planned Parenthood Clinics will increase the number of women that will unknowingly progress to later stages of cervical cancer and dysplasia in the coming decades due to a lack of access to affordable cancer screenings at low (Shin et al. 2012).

The overlying social constructs favoring religious and moral ideals over women's reproductive health in the US paints an image to the rest of the world of justifiable acceptance in devaluing women culturally. This becomes problematic because the US, among other developed countries, provides a number of humanitarian medical services to developing countries or countries in temporary need. The subtle biases of major world powers, such as the US, influences and/or reinforces the idea of gender inequality to developing countries through media interfaces and also through humanitarian aid efforts. For example, the US reinforces a patriarchal culture worldwide via a lack of attention to women's health needs in the homeland, which continues on humanitarian missions abroad.

The question of whether to treat female patients as separate with distinguished needs or as equal recipients of humanitarian health care still stands today, especially when allocating limited humanitarian resources. However, it is clear in the United States that treating female and male patients as equal recipients of US health care by taking away access to specialized female reproductive health clinics negatively affects women's health (Shin et al. 2012). Women in low-income areas are less likely to discover cervical cancer and dysplasia in the early stages, thus decreasing the possibility of positive health outcomes in the future. It appears to be quite clear that an approach focusing on the physiological and cultural differences between the genders

might be more beneficial in promoting positive health outcomes for women, both in the United States and in prominent conflict zones, such as the Middle East, that will have higher need of humanitarian resources.

II. Causes of and Health Effects on Women from Different Types of Structural Gender-Based Violence in the Middle East

Domestic Violence: What It Is and Health Consequences

70-90 percent of women in Pakistan experience domestic violence (Parrot, 2007). Despite these statistics in Pakistan, similar statistics are difficult to find for other Middle Eastern countries (Ghanim, 2009). Incidents of domestic violence are rarely reported and tend to be kept out of the public eye. The incidents that are reported are often dismissed by authorities as private family matters or mere trivial complaints (Ghanim, 2009). Authorities aren't necessarily wrong when they assume instances of violence are about family matters. Husbands are most likely to commit physical violence against their wives where as violence against widowed or divorced women are most likely from a brother (*Al-Sharq al-Awast*, 2008). On the other hand, young unmarried women are most likely to be battered by a father, uncle or older brother (*Al-Sharq al-Awast*, 2008).

Research has shown that while physical domestic violence occurs in all socioeconomic classes in the Middle East, it is more likely to occur in lower income families (Ghanim, 2009). Families of higher income experience less gender based violence against women, and typically the type of violence psychological or verbal rather than physical (Ghanim, 2009). Within low income families, research shows that most triggers for physical violence fall under three categories: unmet gender or family expectations, conflicts with in-laws, and alcohol abuse (Keenan, 1998).

This widespread neglect and/or normalization of violence has lead many, including women, to believe it is customary, or just another part of life. Case reports have found that violence against women could occur for any number of reasons ranging from a daughter coming home late, untimely household work, or “bombarding husbands with too many questions” (*Mail and Guardian*, April 2006). Even more interesting, a study by the the Supreme Court for Women in Bahrain found that when it surveyed Bahrain citizens, 80 percent believed that sexual problems and unsound sexual relations are the reasons for the physical and psychological violence against the wives by their husbands (*Al-Sharq al-Awsat*, 2006). This study reports that most Middle Eastern civilians believe that something trivial, a mere normal marital problem, is the ultimate cause of the abuse and not the abuser. In trivializing and masking the issue, the abusers are not held accountable legally or socially for the violence they committed. As a consequence, women have come to expect physical violence as a consequence of marriage and men develop the mentality it is their right to inflict violence as a method of control. There are even some Middle Eastern women who also engage in victim blaming other women, thus reinforcing the normalization of physical abuse (Ghanim, 2009).

Since physical violence from relatives or intimate relationships is quite common in the Middle East, the lack of reports and trivialization of episodes from authorities conceals a plethora of negative health consequences for the battered women (Ghanim, 2009). According to a study done by UNIFEM in November 2007, at least 122 women have died from complications due to physical violence from family members in Jordan between 2000 and 2003 (IRIN, 2007). If death isn't the final result, many victims remain in hospital beds for multiple days as a result of the injuries (*Middle East Online*, 2008). For example, among a group of Egyptian women who

have been beaten at least once since their first marriage, 10 percent said they required hospital attention for at least one of the injuries sustained during at least one of their assaults (El-Zanaty et al., 1996).

Injuries sustained from physical violence vary in number, type and severity. Ranging from bone fractures, external lacerations, and brain damage to internal injuries and bleeding, these physical symptoms could have lasting effects that impact health much longer than when the injuries are visible (Campbell, 2002). Improper bone replacement or lack of antibiotics for an open wound can lead to fatal medical complications like secondary breaks, torn ligaments or infection. Other chronic health effects from physical abuse include chronic back pain; headaches; gastrointestinal problems; poor cardiac outcomes; and neurological disorders such as fainting and seizures (Campbell, 2002)

Physical violence has also been found to have harmful effects on women's reproductive system. Battered Egyptian women have been shown to have higher rates of unwanted or mistimed pregnancies than non-battered women. Battered Egyptian women are also more likely to begin antenatal care later (or not at all), and to terminate pregnancies compared to their non-battered counterparts (Boy et al., 2008). A study of Saudi women found that battered pregnant women had a higher risk for abruptio placentae, fetal distress, and preterm delivery (Rachana et al. 2008).

Unfortunately, many women in the Middle East, especially those from lower income families where physical violence is more prominent, have little to no financial access to the health care needed to properly heal from the injuries (Ghanim, 2009). In addition, even if the family has the financial means to bring a battered woman to the hospital, they often don't as a

way to control the victim. Without financial independence from families, victims often don't have any power in advocating for their own health (Ghanim, 2009).

Of course, many psychiatric consequences also occur as a result of domestic violence, especially in those who experience frequent episodes of domestic violence and stay in abusive relationships. Post-Traumatic Stress Disorder, substance abuse, addiction, and dissociation are all common among domestic violence victims (Stark 1996).

Another psychiatric consequence of violence against women is female suicide. Of a population of 176 women at Yale-New Haven Hospital who committed or attempted to commit suicide, 70.4 percent were found to have been or suggested to be a victim of physical violence. Seventy-one percent of the same population were also found to have attempted suicide within 6 months of an assault event from their partners or male family members (Stark, 1996). However, female suicide attempts after a single isolated assault event are relatively rare. On the other hand, women in abusive relationships, where assaults are continual, suffer substantial risk for general psychiatric problems, like suicide and drug abuse (Stark and Flitcraft, 1991). Up to 80 percent of females who attempt suicide give marital or ongoing relationship conflicts as a reason for suicide attempts (Bancroft et. al., 1977).

Since psychiatric problems appear more significantly in women subject to ongoing abusive relationships, many psychologists have started emphasizing the role of repeated assault events in relation to suicide, developing the theory of *Battered Woman's Syndrome* (Stark, 1996). One of the developers of this theory, Lenore Walker (1977-1978) emphasizes the depressive pattern of learned helplessness in abusive relationships as a risk factor of suicide because they believe there is nothing they can do to escape the violence. Other psychologists cluster female

suicide under Post-Traumatic Stress Disorder (PTSD) because victims are overwhelmed by intense fear, anxiety and loss of control that overwhelms the victim's normal coping mechanisms, characteristic to PTSD (Stark, 1996).

It is important to note that current research in the Middle East suggest that suicide rates peak among young women aged 15-29 years old (Rezaeian, 2010). This age range correlates to the age ranges of early marriage and the age of becoming an accountable adult in the family in the Middle East. For example, a study by the Supreme Council for Family Affairs in Qatar surveyed 2,778 female Qatar University students aged 17-25 (*Gulf Times*, 2008). Of these young women, 63 percent had been beaten by male relatives or husbands. Forty-seven percent of this group disclosed they suffered from mental disorders, such as depression, as a result of the abuse. Two percent admitted they attempted suicide (*Gulf Times*, 2008). This suggests that there is likely a connection between perceived unmet expectations of women in the Middle Eastern household- both in marriage and in childhood household-, and the frequency of domestic abuse, and suicide.

Female Genital Mutilation: What It Is and Health Consequences

According to the World Health Organization, Female Genital Mutilation (FGM), also known as "Female Circumcision," includes all procedures that involve partial or total removal of external female genitalia and any other injury to female genital organs for any cultural, religious or otherwise nontherapeutic or non-medical reasons. There are several different forms practiced today. The most common include Type I: Excision, or removal, of the clitoral hood with or without removal of all or part of the clitoris; Type II: Total removal of the clitoris with part or all

of the labia minora; and Type III: Removal of all or part of external genitalia as well as stitching or narrowing of the vaginal opening, leaving only a small hole for urine and menstrual flow, also called infibulation (WHO, 2007).

WHO and Amnesty International estimate between 130-135 million have undergone female genital mutilation in the world and over 2 million girls are at risk each year, mostly in Africa and the Middle East (WHO, 1998). UNICEF reveals that there is little variation, probably negative correlations, between education level/household wealth and the prevalence of FGM in Middle East. This indicates that it is no more likely for a girl from a wealthy family or higher education level than their less wealthy or less educated counterparts to undergo some form of FGM in the Middle East (UNICEF, 2005).

On the other hand, no matter the type, FGM is usually performed on girls between the ages of 4 and 7 with no ability to mentally understand the situation or legally provide consent. It is often done with consent of the families by traditional practitioners in improvised, unmedicated and unsanitary conditions; leading to severe pain, trauma and high risk of infection in the girls (Ghanim, 2009). One woman reported undergoing FGM in her own home by nonprofessional male family members after being woken up in the middle of the night and dragged to the bathroom (El-Saadawi, 2007). WHO lists several short and long term consequences of FGM, including severe pain and shock: uterine, vaginal and pelvic infections; urine retention and bladder disorders; hemorrhaging; damage to external reproductive organs; infertility; anxiety; post-traumatic stress disorder; and depression; death; menstruation; pregnancy; and child birth complications, which increases both female and child mortality rates (WHO, 2017).

Hemorrhaging, one of the common early complications of all types of FGM, can lead to shock and death, especially in small children (Toubia, 1994). Prolonged lesser bleeding can lead to anemia, septicemia (blood poisoning), stunted growth of poorly nourished children and young teens. Similarly, prolonged bleeding has been known to cause gangrene, a condition in which tissue dies due to lack of oxygenated blood flow to certain areas of tissue (Toubia, 1994). Since FGM can interfere with urine drainage if not done properly, chronic urinary tract infections are common and can lead to urinary stones and kidney damage (Toubia, 1994). Neuromas, or nerve tumors, are also common and can interfere or be damaged during sexual intercourse (Baasher, 1979). Infection of the wound due to unsterile conditions and improper healing can also lead to tetanus and other severe bacterial or viral infections (Toubia, 1994).

FGM of all types also have effects on childbirth in later years (Toubia, 1994). Exit of fetal head can be obstructed in circumcised women, thus possibly leading to fetal death, fetal brain damage due to lack of oxygen, or necrosis of the septum between the vagina and bladder. Strong contractions with little success in normal vaginal delivery can also lead to vaginal and perineal tears (Warsame, 1989). Since there are usually complications in delivering vaginally for circumcised women, rates of unnecessary cesarian-sections for women having undergone FGM is much higher than non-circumcised counterparts (Toubia, 1994).

While there has been little research done about the psychological effects of FGM, findings have indicated that most women and girls who have undergone FGM experience cognitive dissonance between the desire to please their communities and the trauma experienced from the operation, especially in areas where female circumcision carries high social value (Baasher, 1979). Many girls and women have also reported developing depression and chronic

anxiety over the physical appearance of their genitals and/or infertility, as measures of their worth, which can in turn lead to high blood pressure and decreased immune system functionality (Toubia, 1994).

A recent study of 137 women who had been affected by FGM found that 86 percent had problems reaching orgasm, likely a combination of psychological and physical complications from female circumcision (Catania et. al., 2007). However, there is hope. In the same study, 15 women who had undergone type III FGM, or infibulation, were able to undergo a surgical reversal called defibulation. Fourteen out of the fifteen women reported being able to reach orgasm after defibulation (Catania et. al., 2007). The results from the above study suggest not only a correlation but also causation effect of FGM on a woman's ability to orgasm, a critical part to pleasure and sexual health.

Interestingly, girls who have undergone FGM often grow up to support FGM and take an active part in their daughters' mutilation (Ghanim, 2009). According to UNICEF, 79 percent of women in Sudan and 71 percent of women in Egypt support FGM; the countries with the two highest FGM rates, which are 89 percent and 97 percent respectively (UNICEF, 2005). It is likely that the severe psychological trauma associated with mutilation severely affects women's relationships to other people, including their own children. Researchers Alice Walker and Pratibha Parmar suggest women feel betrayed by parents and family members after undergoing mutilation, thus contributing to a culture of silent pain, mistrust and indifference (Walker et al. 1993). Many mothers will make promises to their daughters, claiming the circumcision is a rite of passage to womanhood that will end in improved beauty. Some mothers have even been

documented to show gratitude towards the men who performed the procedure while their daughters still cried out in pain (Ghanim, 2009).

Honor Killings: What It Is and Health Consequences

The United Nations estimates that more than 5,000 women are killed worldwide in the name of honor each year (Parrot, 2006). These murders mainly occur in deeply rooted patriarchal cultures; namely the Middle East, North Africa and some parts of South Asia (Kulczycki, 2011). For example, in Pakistan, 600 women were killed alone in 2003 to preserve family honor (Ghanim, 2009). A recent study by the UN Development Fund for Women (UNIFEM) reveals a quarter of all female Jordan citizens that were killed were suspected of involvement in an unapproved relationship or loss of virginity (IRIN, 2007). However, only 15 percent of the women were murdered after the suspected adultery was actually proven. The study also shows 45.1 percent of these murders are committed by victims brothers, 15 percent by husbands and 14 percent by a close relative (IRIN, 2007). Honor killings are common in the Kurdish areas of Turkey, Iraq and Iran, where Kurdish women are killed almost every other day for supposedly dishonoring their families (*Sunday Times*, 2004). Traditionally a taboo subject, honor killings have recently gained more attention from human rights organizations with the growth of international media and an increase in the number of published studies on the topic (Kulczycki, 2011).

It is conventionally believed that honor killings occur mostly in rural tribal areas. It has been proposed that men of lower socioeconomic status with little material wealth are more likely to commit honor killings against female relatives because all they have is honor (Ghanim, 2009).

Also, rural areas are associated with lower formal education levels, less resources and earlier marriages, which could be contributing factors to honor killings (Kulczycki, 2011). Contrarily, a United Nation report indicates that this trend appears to be an urban phenomenon. The report shows that the majority of honor crimes are committed in major cities rather than in rural or tribal areas (IRIN, 2006). However, this could be because that the number of honor crimes actually reported is higher in cities than in more traditional and conservative rural areas (Ghanim, 2009).

The current statistics do not fully portray this underreported phenomenon in the Middle East, nor the severity of the problem. Along with a large number of cases going unreported, many of the honor crimes are disguised as accidents or suicides, with male relatives claiming the victim was suicidal or had accidentally fallen off a balcony or cliff (Ghanim, 2009). Victims are often put in unmarked graves and records of their existence are eradicated, or they are reported missing to the police by male relatives (Kulczycki, 2011). In the cases that are reported, perpetrators often go unpunished, dismissed as a family matter, or are given short sentences (Ghanim, 2009). For example, one Syrian girl reports witnessing a classmate cheerfully walking into the police station boasting loudly “I have killed my sister to save my family’s honor” and “I hand myself over to justice” as he handed them a dagger covered in fresh blood. Two police officers amicably chat with the boy as they fill out the paperwork and leisurely walk him to his cell. He was imprisoned for 6 months then became a profitable baker and notable voice in the village (Shaaban, 1988).

Many cases aren’t described as honor killings because male relatives force victims to either choose to commit suicide or be murdered by a family member (Ghanim, 2009). Most

women choose suicide (OMCT, 2003). Victims that escape attempted honor crimes and taking cover at women's shelters told stories of how they were ordered by male relatives to kill themselves, often locked in rooms with a gun or rope. Some said they were instead given a knife and expected to slit their wrists in front of the relatives so they could bleed out in front of them (*Los Angeles Times*, 2007).

While this phenomenon appears to solely be a Middle Eastern and North African problem, honor killings have recently surfaced in North America and Europe with communities of immigrant or second generation Muslims, where women are mutilated or murdered to protect the family honor (Kulczycki, 2011). In addition, police investigations in Sweden have found seven cases of young Muslim women falling off balconies from 2007-2008 alone. Three of the cases resulted in death with the other four resulted in severe injuries. Police suspect this could be a new pattern of hidden homicide or forced suicide of young Muslim women (Swedish *Metro*, 2008). Whether Western countries are ready or not, it is clear this crime trend is growing worldwide (Kulczycki, 2011).

In most of these cases, the women killed are teenagers for reasons associated with contaminating family honor; which relate to the perceived misuse of female sexuality; most notably suspected marital infidelity and premarital sex (Ghanim, 2009). Other documented cases have also listed reasons of females contacting persons of different faiths, initiating a separation or divorce, being a victim of rape, and even flirting (Kulczycki, 2011).

While many honor killings result in death, survivors of attempted murders find themselves suffering from mental health complications. Social isolation from family and community for surviving the murder limits access to necessary healthcare for proper healing of

these injuries, which can lead to other long term health problems (Ghanim, 2009). If the murder attempt utilized psychological manipulations or coercion based on fear, there can be psychological health consequences resulting from systematically eroded self-esteem of the survivor (Gov. Canada, 2016). These psychological health consequences include depression, anxiety, substance abuse and Post Traumatic Stress disorder (Campbell, 2002).

Sexual Violence: What It Is and Health Consequences

Women and young girls in the Middle East experience many forms of sexual violence; including; sexual harassment, incest, child marriage and rape. Of the four forms, sexual harassment and incest have the least amount of information available (Ghanim, 2009). In Egypt, 66 percent of women experience sexual harassment in their workplace. However, due to lack control over their own finances, they are unable to leave their jobs (Tadamun, 2003). Incest, although believed to be rare by Middle Eastern civilians, is actually shown to be quite common. Sixty-eight percent of Egyptian men and 64 percent of Egyptian women have heard of, or personally know incest cases (Tadamun, 2003). Additionally, a study done by the National Council for Social Research finds there are approximately 20,000 cases of rape in Egypt every year with 60 percent being cases of incest (Syrian Women Observatory, 2008).

Strongly tied to honor, child marriage is a common solution in the Middle East to avoid girls losing their virginity before marriage, which would contaminate the family honor (Ghanim, 2009). Other common reasons for child marriage including families that sell their daughter into marriage for money, fear of abduction, and the cultural belief that a young bride can be easily shaped into a dutiful wife (Ghanim, 2009).

Child marriage is found to be prevalent in many countries within the Middle East. For example, a United Nations report estimates 57 percent of girls in Afghanistan are married before the age of 16. Similarly, 16.3 percent of girls are married before the age of 15 in eastern and southeastern regions of Turkey (*Yemen Observer*, 2007). Fifty-one percent of all women in Turkey are married without their consent, even though Turkish law requires consent of both parties for marriage (OMCT, 2002).

Sana University found in 2006 that 52 percent of girls were married by the age of 18 in Yemen, with the average age of marriage between 12 and 13 years old (*New York Times*, 2008). In 25 percent of marriages in Yemen, the age difference between spouses exceeds 14 years (*Yemen Observer*, 2007). With such a large age difference in spouses, the prospect of creating a successful marriage is slim, especially since the girls are merely children themselves and can't take care of their husbands or family. In addition, many girls are forced to marry their husbands against their will or are too young to fully give consent to the marriage (Ghanim, 2009). The large age difference leads to a large power difference between the spouses in which the male is expected to maintain that power difference by any means necessary, including rape and physical violence. Due to this culture of male dominance over women, young married girls experience continuous and frequent episodes of rape and/or physical violence from their older husbands (Ghanim 2009).

While instances of rape are extremely common in the Middle East, there is a lack of accurate statistics showing the frequency of rape cases due to social consequences from reporting. For example, Palestinian legislature requires a woman to be accompanied by a male guardian when reporting, namely her brother or father, in order for the rape case to be valid

(Ruggi, 1998). Similarly, in Islam, the law requires four witnesses for a rape case to be valid. If this condition is not met, it is highly likely the victim will be accused of adultery, which is punishable by incarceration, flogging or stoning (Ghanim, 2009). In many other cases, if a victim decides to come forward, they are often blamed for the incident. As a result, they can be ostracized from their family via incarceration because they broke the moral code of premarital or extramarital sex, thus staining the family honor. The majority of women found in Libya social rehabilitation facilities, which are essentially fronts for prisons, were locked away in these facilities only because they are victims of rape (Ghanim, 2009).

Unfortunately, a number of Middle Eastern countries both perpetuate and legalize the raping of women (Ghanim, 2009). Traditionally, the rapist is asked to marry the victim since marrying a non-virgin is unacceptable in many Middle Eastern cultures. This so-called “compromise” allows the victim to marry and the rapist to legally avoid jail time. Many rapists agree to marry the victim to avoid incarceration, but most divorce the victims shortly after to look for a new wife. This leaves the victim socially and economically without any prospect. The victims are accused of further staining the family honor merely because she was divorced and was raped. Afterwards, many victims end up locked up in various centers or killed for family honor (Ghanim, 2009).

Rape and sexual violence, especially intimate partner violence, increases during times of stress, like natural disasters or war conflicts (Carroll 2016). For example, rape and sexual violence are noted to be used by a number of religious fundamentalists during civil wars (Ghanim, 2009). Similarly, Palestinian war histories are filled with both rape cases and threats of rape to women of the opposing region (Shalhoub-Kevorkian, 2009). These cases of rape or even

just the threat of rape increases and/or reinforces the restrictions already in place for young women. These restrictions include curfews, prohibitions against leaving the house without a male guardian, inability to access finances or manage family property, and more. The idea behind limiting women's power socially and economically is to lessen the threat of rape for maintaining family honor (Ghanim, 2009). However, it has had the opposite effect. Systematically limiting women's power leads to a cultural belief among both men and women of male superiority, thus leading to the belief of men's inherent right to women's bodies since men have to protect women's bodies from enemy men who attempt to use women's bodies as war weapons (Shalhoub-Kevorkian, 2009).

There are a large number of associated negative health consequences with rape. Women who experience rape and sexual abuse are three times as likely to develop gynecological problems, which include but are not limited to: chronic pelvic pain, vaginal bleeding, vaginal infection, painful menstruation, fibroids, pelvic inflammatory disease, and urinary tract infections (Campbell, 2002). Most sexually coerced women also experience damage to the urethra, vaginal wall, and anus (Outlook, 2002).

One of the most deadly consequences of rape is increased contraction of HIV and the eventual development of AIDS (Watts et. al., 2002). A large number of men who commit rape have unsafe sexual practices. In particular, they tend to have a large number of partners and don't use condoms or other methods to protect against STIs (García-Moreno et. al, 2002). HIV contraction rates among women in the Middle East continues to increase today (Shawky et. al. 2002).

Health risks for rape victims increase with younger ages. Teenage and young adult women in their 20s are at the highest risk for unintended pregnancy and, as a consequence, unsafe abortions for preserving the family honor (Outlook, 2002). In addition, girls under the age of 15 are five times more likely to die from childbirth or pregnancy complications than women in their twenties (UN Dpt. Int. Economics and Social Affairs, 1991). Girls under 15 years old are also at higher risk for obstetric fistula, or the development of a hole between the vagina and rectum or bladder, caused by prolonged and/or obstructed labor (UNFPA, 2002).

Lastly, female survivors of rape are more likely to develop mental health disorders including depression, generalized anxiety, and substance abuse (Outlook, 2002). In addition, sexually abused and raped women are three times as likely as non-abused women to develop PTSD (Campbell, 2002). As a consequence, female survivors of rape and sexual abuse are twice as likely as non-abused women to consider suicide (García-Moreno et. al, 2002).

Causes of Systematic and Organized Gender-Based Violence in the Middle East

Starting in 1979 in Iran, past failures of governing agencies led to the rise of political Islam in many Middle Eastern countries. Disguised as a religious revolution to reintroduce the highly praised Islamic religion as a method for improving citizen lives, the political movement quickly crossed the barrier between the religious realm into the social, cultural and economic sectors. While the movement claimed to be ‘fixing’ the ‘broken’ governing system, the actual priorities of this movement quickly emerged as decreasing women’s rights and increasing patriarchal control over women. Laws were quickly introduced or amended to restrict female

control over family finances, personal clothing choice, divorce, and the ability to work outside the home (Ghanim, 2009).

Islam both contains and emphasizes patriarchal values that reinforce gender inequality through several written verses of the religious doctrine Qur'an:

Men have authority over women because Allah has made one superior to the others, and because they spend their wealth to maintain them. Good women are obedient. They guard unseen parts because Allah has guarded them. As for those from whom you fear disobedience, admonish them and send them to beds apart and beat them. Then, if they obey you, take no further action against them. Allah is high, supreme. (Q 4:34, Women)

Allah has thus enjoined you concerning your children: A male shall inherit twice as much as a female. (Q 4:11, Women)

Women are your fields: go, then, into your fields as you please. (Q 2:223, the Cow)

Based on many verses of the Qur'an, the view of many Islamic followers equates obedience of a wife to her husband with obedience to Allah since Allah favors men over women. Obedience to Allah, the supreme being, is considered to be morally good. Men, as the favored gender of Allah, also serve as agents of Allah, with special rights to enforce obedience of women (Al-Torki, 1986). However, a relationship based on one party's obedience to the other is a concrete expression of power. As a result, gender-based violence is invited to be the agent for maintaining this power difference, especially in familial and intimate relationships (Ghanim, 2009).

Also according to the Qur'an, women are the inherit property of men since men must spend their wealth to take care of women. This notion invites a cultural acceptance of male dominance and male sexual entitlement to any and all women, whether or not she consents. Conversely, marriage is the only allowed form of sexual and romantic interaction between men and women (Ghanim, 2009). This discrepancy between the opposing rules of Islam instead falls on the women. On one hand, men are supposedly entitled to women, however, women must maintain their virginity for marriage while also staying obedient to all men, who often have conflicting demands. For example, male family members expect their female family members to maintain their virginity, even if it means dying to do so, while other men expect her sexual compliance outside of marriage (Ghanim, 2009). This imposed double standard places women between a rock and hard place, often with inevitable negative consequences.

In addition to the religious influence of Islam, many Middle Eastern patriarchal cultures emphasize the importance of "Rujuleh" or manhood (Shalhoub-Kevorkian, 2004). Stemming from the verses of Qur'an implying male ownership of women and their sexuality, a man's masculinity and importance in the family is directly related to his control over his female relatives' sexualities. In order to achieve this, they must deny other men sexual access to his female relatives by imposing strict control over the female relatives' bodies (Ghanim, 2009). This is seen in many aspects of daily life for these women; from curfews and mandatory escorts to required dress and lack of access to the world outside the home. If a female relative transgresses or is suspected of transgressing by flirting or having relations with a man deemed inappropriate, he is expected to

maintain the family honor by punishing her. The notion of punishing women for their transgressions against the family invites various forms of violence (Ghanim, 2009). This power inequality between men and women is argued to be the root cause of violence against women as men are expected to maintain the power difference via violence, neutralizing women's potential within these cultures (Parrot et. al, 2006).

III. The Role of Humanitarian Aid in Improving Gender Equality

Sex- and Age-Disaggregated Data as a Method of Improving Gender Equality in Humanitarianism

SADD, as discussed by Mazurana in previous sections, can be specifically applied to many humanitarian sectors (Mazurana, 2013). SADD matters, in short, because gender and age dictate who is affected, how and to what degree. Gender and age play a huge role in determining one's social role and responsibilities, which dictate where and what each person will be doing in the event of a crisis (Mazurana, 2011). This creates unequal risk factors, and thus unequal victimization, between the gender groups (Inter-Agency Standing Committee, 2006).

However, to use SADD most effectively, it must be both continuously collected and properly applied to ongoing gender analysis. Gender analysis examines the relationships between men and women as well as relationships among same gender groups. This type of analysis explores how power dynamics shape social roles, responsibilities, access to resources, and either constraints or advantages of each gender group within the population. The information obtained from these analyses is crucial in determining where and how resources are distributed in the event of a crisis (Mazurana, 2013).

Continuous collection of data both before and in the early stages of humanitarian response allows for quicker development of the procedures that work for all members of the regional population for the particular crisis. Since cultural context or politics change frequently, the measures taken in the past for equal care may not continue to work, thus emphasizing the importance of continuous data. If not properly applied or if SADD was not collected in many of

these instances, the outcomes could have been significantly different. Often, the current outcomes favored men over women (Mazurana, 2013).

For example, in 2003, the Darfur region of Sudan faced a humanitarian crisis involving large-scale weaponized sexual violence against civilians as a tactic to scare civilians of all ages and genders into submission (Patrick, 2007). Of course, the knowledge of sexual and gender-based violence came later after continuous gathering of SADD and ethnographic information, but the gender analysis did slow down sexual and gender-based violence around camps (Mazurana, 2013). Upon start of the war, civilians lived in communal camps or villages. The job duties of women in these camps includes gathering water and firewood. These tasks required them to search for firewood and water in places that were great distances away from the camps. Women who went alone or in small groups were often targeted by belligerents in the area and became victims of rape or violence (Patrick, 2007). Despite the chronic under-reporting, more than 200 rape victims were assisted per month by Medecins San Frontiers (MSF) during 2005 (Patrick, 2007). In August of 2006, the International Rescue Committee reported 200 assaults over five days at one camp (IRC, 2006). Although many other potential gender inequalities were taken into consideration, like water usage, humanitarian organizations were unaware of the trends in firewood gathering and assault until a few years later (Mazurana, 2013). Only then were more procedures put into place in attempting to lower assault rate. These included allotting financial resources to bring firewood directly into the camp and placing emergency shelters for those displaced by the war closer to forests (Mazurana, 2013). Though there wasn't much early data collection and implementation here, the continued data collection and gender analysis allowed for humanitarian groups to redistribute resources as needed later on.

Another example comes from the 2009 refugee crisis in Swat Valley, Pakistan. The Pakistan army and Taliban forces increased fighting within Swat Valley, turning the area quickly into a dangerous war zone. As a result, millions of Pakistan civilians fled their homes, most having to seek shelter at refugee camps (Swat Youth Front, 2009). World Food Programme, a branch of the United Nations, distributed food to registered civilians in camps based on previous census and other government data. However, after a review of food receipts, WFP found that 95 percent of men collected their food rations but only 55 percent of women had collected their food rations (Mazurana, 2011). Clearly, there was an access problem for women in Pakistan during this crisis (Cosgrave, 2010). A closer look at the social structures based on religious and cultural context within the Middle Eastern country identifies the causes for difference in food access.

As discussed previously, the Qur'an distinctly favors men over women since men must use their resources to take care women (Ghanim, 2009). As a result, a man's masculinity is culturally dependent on his ability to both provide for women and maintain the family honor via control of his female family members' sexualities (Shalhoub-Kevorkian, 2004). Women, on the other hand, are considered ideal only if they are obedient to their husbands or male relatives. Both a woman's and the family's worth are dependent on her virginity and fidelity in marriage. Consequently, men maintain the family honor by controlling their wives or female relatives by constricting who they can talk to without male supervision, for fear of sexual transgression (Ghanim, 2009). It was likely that the men weren't allowing their female relatives to collect their food rations for the same reason; fear of sexual transgression (Cosgrave, 2010).

Similarly, as noted before, gender-based sexual violence increases drastically in times of stress, such as armed conflict and natural disasters (Carroll, 2016). It is likely that many women suffered physical health consequences of sexual violence during this time of high stress, such as

gynecological problems, STIs, and unwanted pregnancies (Campbell, 2002). These health consequences likely lead to inability to travel and receive their food rations within the camps. Since sexual violence is often not reported in the Middle East, the humanitarian organizations wouldn't immediately have the information to address why a smaller percentage of women than men received their food rations (Mazurana, 2011).

SADD based gender analysis, though excellent in theory, can be difficult to put into practice. SADD requires ethnographic research via in-depth interviews and surveys of the population in addition to statistics found in clinical reports (Mazurana, 2013). Humanitarian organizations, already limited in resources, funds, and workers, are also the only ones available for conducting the ethnographic research needed for SADD (Mazurana, 2011). Crunched for time, money and workers, many humanitarian organizations consider gender analysis development to be a waste of effort (Ticktim, 2011). As a consequence, humanitarian organizations are not as evidence-driven as they should be, which in turn leads to unnecessary excessive spending in some areas and lacking in others (Mazurana, 2013). However, more research needs to be done in finding methods for quicker data collection and analysis for fast, effective and equal distribution of humanitarian resources in future crises (Benelli, 2012).

Breaking the Silence: Focusing on Reproductive Health Education Programs in Humanitarianism

Many women in areas of disaster and conflict have limited opportunities for contact with healthcare providers (Mazurana, 2011). UNFPA recommends humanitarian health to take advantage of when women and children do reach out for medical assistance by starting

conversations about gender-based violence. UNFPA outlines several steps for humanitarian health care professionals in integrating gender-based violence education into existing health programs. These steps include: ask about abuse, provide training to health care professionals, facilitate screening, empower clients, offer appropriate services and reach out to the community (Stevens, 2001).

While it is important to ask women in high risk areas if they have or are being abused, however, it may be unethical if not done confidentially and appropriately (Outlook, 2002). Training humanitarian health care professionals to search for signs when treating women for reproductive problems can be a useful way in identifying abuse survivors (García-Moreno, 2007). Additionally, health care professionals need to know when and which women want additional help. Many women find talking to health care professionals about their abuse therapeutic and empowering (Heise, 1999). However, a WHO multi-country study found that other women don't seek help after experiencing abuse because of embarrassment, fear of consequences, or acceptance of abuse (García-Moreno, 2002). To reach survivors who do and don't immediately seek help, UNFPA believes in providing sensitivity training to humanitarian health care providers for supporting abused women emotionally while providing medical care (Outlook, 2002).

After screening for abused women during clinic visits, it is vital that survivors are offered appropriate resources (Outlook, 2002). For example, women who suffer intimate partner violence often need discrete STI testing and to keep contraception use a secret. Women who have been raped often need counseling, emergency contraception, prophylactic antibiotics or antiretroviral therapy. Women of all gender-based violence also need referrals for medical,

psychological, and legal follow-up (Creel, 2001). In many cases women also need referrals to shelters if they don't feel safe returning home (Outlook, 2002).

While many of the education interventions happen in the humanitarian clinics, much can be done outside the clinical settings to help prevent and address gender based violence. Health care professionals can gain support of other community leaders, like politicians, who can focus on implementing gender-based violence awareness programs. Implementing these awareness programs by educating community members about the prevalence and health effects of gender based violence can start changing attitudes and cultural norms (Outlook, 2002). Educating the community about legal, social and human rights for survivors of gender based violence can also reach victims who wouldn't have otherwise come into the clinics (Outlook, 2002).

Jijenge! Women's Center for Sexual Health, piloted a community awareness of gender based violence in Igogo, low income and semi-urban community in Mwanza, Tanzania (Michau, 2002). This project included both public awareness and clinical aspects. Public awareness used a variety of media to share information about gender based violence including: public discussions, radio programs, and print material (Michau, 2002). This project also put together a watch group trained to intervene whenever they witnessed violence (Outlook, 2002). The reproductive clinic in this project provided counseling and referrals to police stations, social welfare agencies, legal services and other hospitals while giving reproductive health care, but only after careful screening and sensitivity training (Michau, 2002). The results of the program show that people are willing to discuss gender-based violence and intervene against violence, they just needed the right kind of leadership. The results also show that anti-violence messages and information are best received over time from multiple resources. Lastly, the results also showed that women reacted best when service providers showed sensitivity and were well connected with other

community resources for client referral (Outlook, 2002). Programs like these have potential in conflict ridden areas of the Middle East, where violence is high yet community education is low. Since these programs can be implemented in humanitarian health care clinics, the message can reach a wide audience, both men and women alike (Outlook, 2002). The first step in solving the problem is often identifying and bringing awareness to the issue.

IV. Conclusion

Humanitarian health care can have a significant impact on addressing gender based violence through SADD and education programs (Outlook, 2002). SADD, though still new to research in the humanitarian sector, has shown promise when utilized correctly via gender analysis. As shown by several examples, both gender and age matter within the context of the crisis due to various social, cultural, and religious factors governing the population [(Mazurana, 2011), (Patrick, 2007), (Cosgrave, 2010)]. Social structure dictates who is affected, how and to what degree within a crisis. Gender roles and type of responsibility can determine location of gender groups during a crisis; such as collecting firewood outside the town in Darfur, or working in the on-shore house with children during the Indian Ocean tsunami [(Patrick, 2007), (Mazurana, 2013)]. Gender roles can also determine who receives resources based on cultural priorities, such as the inability for some Pakistani women to receive their food rations due to male superiority (Cosgrave, 2010). Rapid and ongoing gender analysis allows for humanitarians to examine the root causes for gender inequality during the crisis, and later providing possible solutions. While more research needs to be done for quick yet efficient gathering of SADD, it is clear that such information can be invaluable to humanitarians when ensuring equitable distribution of resources (Mazurana, 2011).

In particular, SADD can be extremely helpful in examining unaddressed health concerns for women during crises. Although there hasn't been much research in using SADD solely for medical needs, social structure also dictates type and quality of medical care received, which can be analyzed using SADD. For example, various patriarchal social constructions can limit access to adequate health care (Ghanim, 2009). Many women in Middle Eastern countries are required

to have a male guardian accompany them in receiving health care. In addition, gender-based violence as an accepted form of patriarchal power, subjects Middle Eastern women as a group to a variety of negative physical and psychological health consequences different from their male counterparts. SADD in conjunction with gender analysis identifies the root causes for the discrepancies between gender groups in health needs (Mazurana, 2011). This is invaluable for humanitarian organizations when working to develop effective methods for providing quality yet equal medical care within each unique individual crisis. With the increasing number of armed conflicts in the Middle East, it is highly likely that these civilians will need humanitarian help in the future. In combination with the information on Middle Eastern social structure and the health implications of systematic gender-based violence as well as future SADD data, humanitarians can start to close the gender gap in this conflict-ridden region.

Humanitarians can also employ community awareness and education programs of gender based violence at their clinic sites. Providing information across multiple media platforms and within humanitarian clinics can inform many violence victims of their rights and other resources available, just as shown in the Jijenge! Tanzania project (Michau, 2002). Such projects have potential in Middle Eastern countries where rates of both violence and humanitarian need are high. If such programs are implemented and executed properly, such as completing steps outlined by UNFPA, cultural beliefs can start to shift - decreasing acceptance, and also occurrence, of violence (Outlook, 2002). By decreasing tolerance of violence through community education, the power gap between men and women, which is maintained via violence, can finally decrease (Ghanim, 2009).

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