Internal displacement and gendered economic strategies in Turkey

by Esra Erdem, Neçet Özevin and Ceren Özselçuk

Between 1984 and 1999 continuous low-intensity conflict between Turkish security forces and Kurdish insurgents in south-east Turkey led to the evacuation of around 3,500 Kurdish villages and produced one of the world’s largest IDP populations – estimated by NGOs at around three million.

Can Kurdish IDPs return from the cities to which they fled? What strategies are needed to help displaced Kurds resume disrupted livelihoods? How can Kurdish women be empowered to play a major role in reconstruction?

Internal displacement in Turkey took place as a result of:

- revenge attacks from security forces attacked by the Kurdistan Worker’s Party (PKK)
- flight born of fear of attack by the security forces or PKK
- forcible evacuation for reasons of ‘military security’
- villagers escaping pressure to join pro-government village guards
- abuses of power by village guards using violence to settle old disputes
- state-imposed embargoes on delivery of food and medicine
- military closure of areas needed for grazing

IDPs have neither received compensation, been allowed to return to their villages nor been given the choice of settling in a new locality of their own choosing. Given the discrimination they face, only some 20% of IDPs have thought it worth taking formal legal steps against injustices suffered and a mere 0.2% have won a ruling in their favour. The majority of IDPs - facing problems of chronic unemployment, health, nutrition, shelter, safety, discrimination, police harassment and denial of access to public services - would like to leave urban shanties and return to their villages. However, the structural reasons leading to displacement remain in place. The Turkish state is still unable to develop a democratic political response to the Kurdish issue.

Current efforts to address the Kurdish IDP problem are not meeting with success. Focused on the integration of IDPs into local economies, resettlement in model villages and the development of a modern agro-industry in Kurdish populated areas, they are derived from the dominant modernisation paradigm which views the economy in Kurdish-populated regions as characterised by rural backwardness. Conventional plans ignore gender issues and the multifaceted survival strategies employed by displaced Kurdish women before and after their flight. They can offer little more than a limited range of low-paying jobs for a skilled population who instead deserve the chance to use their capacities to become economic actors in their own development. IDPs will continue to constitute a cheap, unskilled labour force for the urban informal sector.

The centre-piece of state-led development plans is the massive Southeast Anatolian Project (GAP) to construct a series of hydroelectric dams and to open new areas for irrigation, thus supposedly encouraging the cultivation of high value, globally marketable products. GAP is controversial. The scheme has embarked on a few pilot projects to assist those newly displaced by dam construction but is completely ignoring the needs of the far greater number of local people previously displaced by conflict and discriminatory policies. GAP has led to the loss of productive fertile land and forests. The project only pays lip service to participatory rhetoric. Forced migration will continue to recur in Turkey, and cannot be reversed, until there is a decisive shift away from the authoritarian and militarist system (that finds its articulation in the 1980 constitution), the systematic ethnic discrimination practised by the security courts, draconian emergency laws, unpunished abuses of human rights and denial of the right of democratic organisation.

A participatory research project we are developing - working with IDPs in a number of urban settings - aims to make a modest contribution to political and economic democracy in
During flight their health is endangered by extremes of temperature, lack of shelter, food and clean water and psychological stress. The WHO principles of primary health care can be used for medical evaluation and for designing relevant health services that should be provided to displaced populations.

During a two-month stay at an ICRC referral clinic for Kurdish refugees in northern Iran in 1991, evaluation of the causes for referral of patients to second line health care produced evidence of the great strains suffered by the displaced. Before tents were distributed patients had had to remain outside for three days in cold and rainy weather. Mothers lost their milk and women had abortions during their flight.

Our team of six members – three doctors, a midwife and two nurses – ran a referral clinic for 80,000 refugees and treated 120-160 outpatients and 20-30 inpatients per day. Many of those hospitalised were severely ill. The harsh conditions caused a substantial rise in morbidity and mortality mainly caused by respiratory tract infection, diarrhoeal disease and malnutrition. In the unhygienic conditions in the camps, scabies and epidemics of typhoid fever and cholera broke out. The rise in crude mortality rate during the first weeks of displacement gradually declined.

Achieving WHO’s goal of ‘Health for all’ necessitates provision of primary health care (PHC) which covers the basic health needs of a community at an affordable cost. PHC as advocated by the WHO, has eight elements: education; local disease control; the Expanded Programme of Immunisation (EPI); maternal and child health and family planning; essential drugs; nutrition; treatment of diseases and safe water and sanitation.

A timely and effective means of rapid delivery of PHC to displaced populations is the Norwegian Mobile Medical Aid System developed by the Norwegian Joint Medical Military Services. The aim is to expeditiously reach such vulnerable groups as women and children and reduce rates of under-five and maternal mortality. The different modules in the system – a doctor’s office, surgery, maternity, rehydration/nutrition, vaccination and laboratory facilities and drugs – can provide services up to the level of hospital care. It is made available to the UN and other humanitarian organisations by the Norwegian Ministry of Foreign Affairs and may be prepared for departure from an international airport within a few hours.

Clearly the most vulnerable groups in a displaced population are small children and pregnant and lactating women. To reduce mortality in refugee emergencies, emergency PHC teams with specialist expertise in paediatrics, gynaecology and obstetrics should be ready to assist. We must not forget that successful emergency interventions depend on socio-geographic mapping prior to the emergency and on medical intelligence based on a needs approach in the acute and post emergency phase of a disaster.

Rannveig Bremer Fjær is a paediatrician working with the Joint Medical Services, Norwegian Defence Forces.

Email: rannveig.fjaer@c2i.net

Providing health services to the displaced

by Rannveig Bremer Fjær

Displaced people are vulnerable because their resources have been depleted by war, conflict or natural disasters.