Consequenses of collective violence with particular focus on the gender perspective

– secondary publication

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ABSTRACT

There is increasing focus on the gender perspective related to the consequences of collective violence. Women run a greater risk of being victims of sexual violence, but few studies have focused on gender differences with respect to physical violence, sexual violations and the impact on health.

Further research is needed on these issues as well as on the identification of evidence based interventions.

A large proportion of refugees and migrants to Denmark have been subjected to persecution and violence that may harm their ability to integrate in the new society. WHO has in its report on the relation between violence and health stressed the serious health consequences of collective violence and have described the particular problems of women [1]. Collective violence comprises war, terrorism and other violent political conflicts, genocide, torture and organized gang crime.

Migrants and refugees in Denmark may be marked by a wide spectrum of chronic, somatic and psychological health problems but they rarely present acute health problems, i.e. lesions related to acts of war or pregnancy following rape. A number of investigations have shown that the chronic health problems among refugees often worsen in the phase of asylum and are related to long-term stays in asylum centres marked by insecurity [2, 3]. A recent Danish study has shown a higher suicide rate among asylum seekers compared to Danes, and discuss the consequences of the long waiting time in the asylum centres and refused permission to stay compared to the importance of traumatic events prior to the arrival to Denmark [4].

No randomised trials have been carried out of the relation between exposure to different forms of violations during armed conflicts and specific health symptoms. Studies of the acute consequences have primarily focused on the consequences of sexual assaults on women [5]. Research on armed conflicts and chronic health damage has focused on the mental disorders and particularly on posttraumatic stress syndrome (PTSD) and has shown gender differences in the risk of developing PTSD [6]. Apart from that few studies have focused on possible gender differences in the relation between health problems and collective violence.

The present review focuses particularly on studies that elucidate the health problems among women due to armed conflicts as well as results from the few studies specifically comparing the relation between violence and health in men and women respectively [7].

BACKGROUND

Within the last century we have seen significant changes in the character of war and armed conflicts. Previously, the majority of the human losses were soldiers. Civilians comprised only few percent of war victims in contrast to the present where up to 90% of war victims are civilians, and at least half being women and children [8]. Terror directed against civilians or genocide has become a mean to obtain political, religious, territorial or economic advantages. According to WHO about 310,000 persons died due to collective violence in 2000 and UNHCR estimates that we presently have 17 million refugees worldwide.

Violence against men during armed conflicts is primarily part of direct acts of war. During flight and later stay in refugee camps, men do not have the same risk as women for becoming victims of physical and sexual violence. Women and children comprise up to 80% of the population in refugee camps and are in particular risk of abuse and violations. Armed conflicts usually destroy the structure of the local community, and the functions of particular importance for the welfare of women and children cease, e.g. protective social network, access to prophylactic health interventions, vaccinations and protection against sexual violations. The loss of provider and social network may seriously change the social situation of refugee women. There is a need for particular interventions to protect women and children against violations, and hence, UNICEF, UNHCR and WHO have approved guidelines to prevent gender based violence under humanitarian catastrophes [9]. Red Cross has studied the effect of armed conflicts on women's health and stressed that there often are insufficient resources in refugee camps to prevent serious health problems among women and children [10].

Sexual violations increase the risk of HIV/AIDS. During armed conflicts the prevention of HIV/AIDS is highly defective. Furthermore, at present every fourth African country is involved in an armed conflict, most of these countries have a high prevalence of HIV, also among combatants.

Men run a greater risk of physical violence than women. Both in peace and war, there are gender differences in the character of this violence. Most violence against women takes place in the private domain, inclusive in refugee camps. It is accompanied by a feeling of shame and remains frequently hidden. Rape of women may be a part of ethnic cleansing, but soldiers may also use it as a mean of oppression of the male partners of the women. Women and girls are further frequent victims of forced prostitution and trafficking during flight or stay in refugee camps. As an example the majority of tutsi-women under the genocide in Rwanda were sexually assaulted, and in Sierra Leone unaccompanied refugees and forcefully moved children comprise the majority of prostitutes under age [1].

GENDER DIFFERENCES IN HEALTH PROBLEMS RELATED TO VIOLENCE

The majority of studies of the relation between armed conflicts and health problems are based upon studies of refugees and asylum seekers in another country than that of the conflict. Thus, it may be difficult to distinguish between health problems caused by exposure to collective violence and problems that are a consequence of a long-term stay in an asylum centre [3, 4]. In the refugee camps the majority of health problems will be of an acute nature and not the more chronic consequences of the armed conflicts. Women remain to a greater extent than men in the refugee camps and have less access to health services and they may also have another tradition than men in actively seeking help and counselling from strangers. This may be one of the reasons for the apparent higher occurrence of chronic health problems among women exposed to collective violence [5].

Within the last ten to fifteen years, we have experienced an increasing awareness of violence as a serious public health problem, particularly in women. Many countries have carried out surveys that elucidate the extent, the characteristics and the consequences of violence against women. But the investigations elucidating the possible gender differences in the relationship between physical violence, sexual violations and health problems are scarce. According to Danish register data and data from the national health survey in 2000 a number of somatic and psychological health problems are signifi-

cantly related to poor self-reported health among female victims of physical violence but not among male victims. Elements of sexual humiliation and shame characterise the violence against women and have been shown of importance for its health consequences [7].

We do not have similar data on the possible gender differences with respect to the somatic health consequences of collective violence. But among women who have been victims of collective violence we find a high prevalence of depression, anxiety, PTSD, substance abuse and suicide attempts. Women and children also have a higher risk than men to develop long-lasting psychological problems as a consequence of the traumatic events during conflicts [6]. The most common complaints are emotional lability, lack of energy, apathy, sleep disorders, hopelessness, cognitive problems, and sexual dysfunction. Among women sexual violation frequently results in chronic feeling of shame and disabling guilt feeling.

The reactions to psychological and sexual traumata are quite universal, but the severity of the problems and how you cope with them vary from culture to culture and may also reflect how the country of exile treats migrants.

CONCLUSION

On a global level the gender perspective of collective violence receives increasing attention and it is recognized that there is a need for a range of interventions directed towards women, men and children [9]. The recognition of rape under armed conflicts as a war crime is a clear step forward in relation to the protection of women and children. But it needs to be followed by easy access to counselling and preventive interventions in the refugee camps. The particular risk of women for HIV/AIDS contagion has not been given sufficient attention, and it has not lead to an effective intervention strategy.

Danish doctors have to be aware of the very different symptoms of war traumata among the various ethnic groups, both in men and women, and to be conscious of the fact that vague and uncharacteristic complaints in refugees and migrants may be a consequence of traumatic events.

The health of refugees may deteriorate under the frequent long-lasting stays in refugee camps and later in asylum centres. A relatively large proportion of migrants in Denmark will later present physical and mental problems in need of treatment. These are not only a burden for the individual but also for the Danish health system. Thus there are both humanitarian and economic reasons to start early interventions already in the asylum phase.

WHO has stressed the need for more research on the sequels of collective violence and which interventions that most effectively could limit the health problems among the victims of war. Combining cohort and register studies may be beneficial in elucidating the possible importance of length of stay in asylum centres.

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