Sexual Violence and Refugee Women from West and Central Africa

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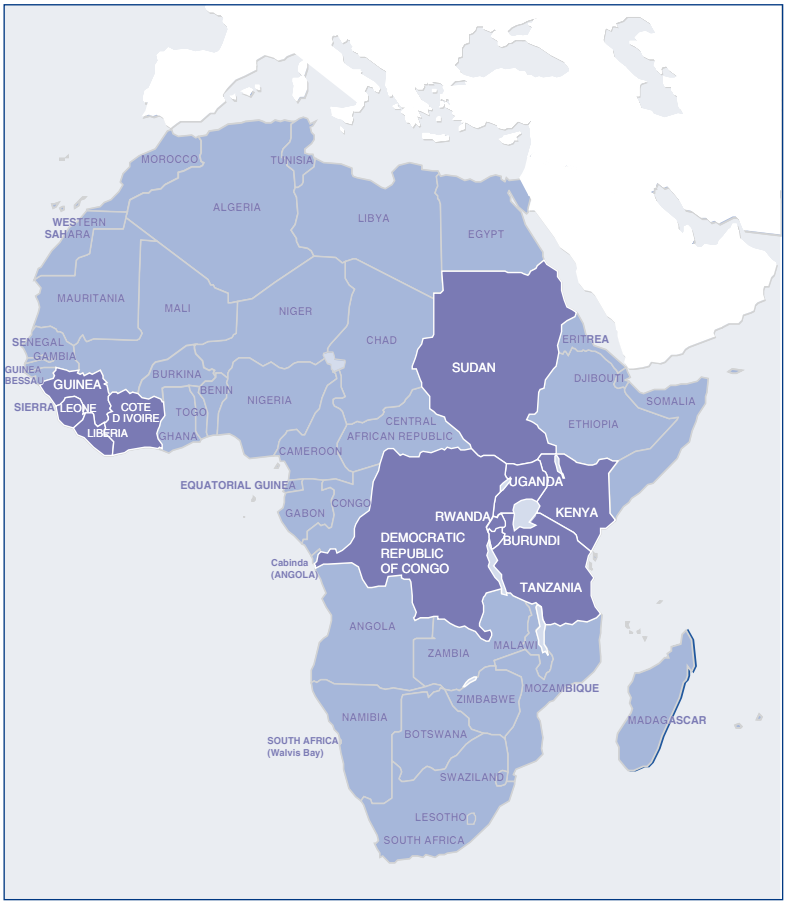
Refugees from African countries are the major focus of Australia's current Humanitarian program comprising around 70% of all refugee and humanitarian entrants in 2004-05. This trend will continue with Africa identified as a regional priority of the Humanitarian Program. The majority of refugees are from southern Sudan, however there are increasing numbers coming from other African countries including Liberia, Sierra Leone, Burundi, Rwanda and the Democratic Republic of Congo (DRC). Many of these recent arrivals have endured prolonged periods under harsh conditions in refugee camps, or among the local population in neighboring countries such as Guinea, Uganda, Kenya and Tanzania. As new and emerging communities, they are small in number and have few support networks to assist them. Of special concern among the new arrivals are women, many of whom have been particularly affected by war-related violence.



In addition to persecution and serious human rights violations which affect all refugees, women are often subjected to sexual violence including rape, torture and mutilation, and sexual slavery. Such violence is prevalent during armed conflict but also occurs frequently in camps and other places where women seek refuge. Persistent insecurity and deprivation caused by their forced displacement mean that women have been unable, or afraid, to obtain medical, psychological and social support.

Many women enter Australia under the Woman At Risk program and are often the sole head of household. They must assume new roles and responsibilities as they face the burden of caring for their children without the support of traditional extended family. Their children may have different biological fathers and women may be caring for the children of family members who were killed or disappeared. In addition, the pressures of resettlement, having to adapt to a new language, culture and way of life, can be stressful and deter women from seeking assistance. The trauma of sexual violence can seriously impact on the physical and mental health of refugee survivors long after it has occurred. Despite their resilience, feelings of shame, guilt, distrust, depression and low self-esteem may prevent women from seeking help or offering disclosure. Women may have had little access to physical health care and culturally may have no concept of seeking help for psychological problems. Through sensitive and appropriate interventions, GPs and other health professionals in Australia can contribute to the health and well-being of these women and support them in the process of recovery.

Woman At Risk (Visa Subclass 204)

Australia introduced the Woman at Risk visa class in 1989 in recognition of the priority given by UNHCR to the protection of refugee women in particularly vulnerable situations. This program identifies women who are extremely vulnerable, without family protection and in danger of victimization and abuse. About 5,000 Woman at Risk visas have been granted since 1989 and the government currently reserves around 10.5% of its refugee quota. Recent intake from Africa includes women from Liberia, Burundi, Sierra Leone, Congo and Sudan. *It is important to note that women who have experienced similar circumstances may also enter under other humanitarian and migrant categories.*

War and Sexual Violence in West and Central Africa

Civil wars have ravaged many countries in Africa in recent decades. Though the causes and nature of the conflicts are complex, the fighting in Liberia, Sierra Leone, Côte d'Ivoire, Sudan, Rwanda, Burundi and the Congo (DRC, formerly Zaire) have all been characterized by ethnic violence, systematic human rights abuses, extensive destruction, poverty and massive flows of refugees. Many refugees have had to flee persecution continuously. For example, recent Liberian arrivals fled the civil war in Liberia in the nineties seeking refuge in Côte d'Ivoire. In 2002, rebels from Liberia and Côte d'Ivoire attacked the region where the refugees were living and they were forced to flee again, this time to Guinea.

Liberia: Sexual violence is reported to have affected up to 40% of women during the 14 year civil war.

Rwanda: An estimated half a million women were raped during the 1994 genocide.

Sierra Leone: Up to 50% of all women were subjected to sexual violence, including rape, torture and sexual slavery.

Burundi: A 1999 survey estimated that one in four Burundian refugee women in northern Tanzania had been a victim of rape or serious sexual harassment.

http://www.irinnews.org/webspecials/GBV/default.asp

Violations targeted against civilians were perpetrated by government and resistance forces and included killings, arbitrary arrest and torture. Rape and other forms of sexual violence against girls and women reached epidemic proportions in all of these countries. Sexual violence included gang rape, abductions for sexual slavery, beatings and mutilation. Even the elderly and the very young were not spared. The widespread use of child soldiers included girls who were subjected to sexual abuse and also forced to commit violence, often under the influence of drugs.

Seeking Refuge: No Protection

Women continued to face security risks in refugee camps. The breakdown of traditional protection mechanisms, a climate of impunity, and stigmatization of the victim contributed to high rates of rape and sexual harassment. Despite food insecurity, the fear of attack would prevent women from undertaking normal activities to supply food, water and firewood for their families. Many were forced into sex to obtain food rations or other supplies. Levels of domestic violence in camps are also high as family and social structures which protect women have been destroyed and with them the norms that would prevent sexual violence against women. High levels of frustration and insecurity associated with the loss of male traditional roles contributes to domestic abuse against women.

Violence against women is defined by the UN Declaration on the Elimination of Violence against Women, adopted by the General Assembly on 20 December 1993, as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life". It is a form of gender-based violence and includes sexual violence.

Sexual violence includes sexual exploitation and sexual abuse. It refers to any act, attempt, or threat of a sexual nature that results, or is likely to result in, physical, psychological and emotional harm. Sexual violence is a form of gender based violence.

http://www.irinnews.org/webspecials/GBV/Definitions.asp

Country	Life Expentacy at Birth (years) (a) (2003)	Under 5 Mortality Rate (b) (2003)	Maternal Mortality Rate - Pregnancy related (c) (2000)	Lifetime Risk of Maternal Death (2000)	Total Fertility Rate (d) (2003)
Liberia	41	235	760	1 in 16	6.8
Sierra Leone	34	284	2000	1 in 6	6.5
Burundi	41	190	1000	1 in 12	6.8
DR Congo	42	205	990	1 in 13	6.7
Rwanda	39	203	1400	1 in 10	5.7
Sudan	56	93	590	1 in 30	4.3
Australia	79	6	8	1 in 5800	1.7

Source : UNICEF http://www.unicef.org/statistics/index_countrystats.html
(a) Years a newborn is expected to live on prevailing patterns of mortality.
(b) Per 1000 live births.
(c) Per 100 000 live births.
(d) Average number of live children born to a woman during her lifetime.

Specific Health Concerns:

Refugee women who have suffered traumatic events such as sexual violence have particular physical and psychological health needs that require special attention. Most will have had poor access to healthcare prior to arrival in Australia. Pre-arrival health screening is not comprehensive, its purpose being to prevent possible public health risks. An awareness that women may have been exposed to sexual violence will assist in early identification and intervention. A sensitively conducted health care consultation can also make a significant contribution to psychological recovery, providing reassurance to those who feel they have been irreparably harmed and help to re-establish their sense of self-worth.

Specific health issues related to sexual violence include:

Acute Injuries and Gynaecological Problems

- damage to cervix, upper vagina, vulva, anus and rectum, urethra, uterus and oral cavities, fistula and other internal injuries
- broken bones: untreated because of inability to access health services
- soft tissue damage
- amenorrhoea/dysfunctional uterine bleeding, sexual dysfunction

Sexually Transmitted Infections and HIV AIDS

- increased risk due to exposure to high rates of sexual violence and lack of access to appropriate testing and services in the aftermath of rape and sexual violence
- low level of awareness of how diseases are contracted and spread; lack of knowledge/access to condoms for prevention, limited ability to negotiate safe sex
- STI's may include Chlamydia,Gonorrhoea,Syphilis
- Hepatitis B and C are more common as a result of rape, in-utero transmission, unsterilised and reused medical equipment
- all refugees over 15 will have undergone HIV testing in pre-arrival health screening, however this process may fail to detect a recent infection

Nutritional Deficiencies

- common to women as a result of prolonged deprivation in refugee camps/settings
- inadequate access to clean water and nutritious food may cause long-term vitamin and mineral deficiency
- menstruation and breastfeeding both contribute to nutritional needs. May require iron and folate supplementation
- high rate of intestinal parasites among some refugee populations may lead to malnutrition
- diseases endemic to Africa, eg malaria and schistosomiasis, can contribute to nutritional deficiency and chronic ill-health
- micro-nutrient deficiency disorders eg vitamin D deficiency
- diet-related disorders eg non-insulin dependent diabetes mellitis
- eating disorders as a result of past trauma and torture eg poor appetite, anorexia, excess consumption

Pregnancy and Childbirth Complications

- pregnancy may be the result of rape with associated feelings of shame and rejection
- high fertility rates increase susceptibility to complications, nutritional deficiency, low birth weights
- scarce and often inadequate health services in camps or in communities where refugees have lived including maternal and neonatal care, unattended births, unsafe abortions, unsterilised equipment, poor sanitation, high infant mortality rates may create anxiety regarding pregnancy and birth, eg in DRC, 42,000 women died in childbirth in 2001 (IRIN)
- effects of Female Genital Mutilation (FGM), see below
- aspects of ante-natal, labour and post-natal care (eg examinations, medical instruments) may invoke memories of past torture or assault
- may lack knowledge of family planning and access to contraception
- a lack of familiarity with hospital settings and procedures may cause confusion and anxiety

Psychosomatic and Psychological Effects

- somatic symptoms such as back pain, migraines, fatigue, general muscular aches and pains, fibromyalgia, chronic pelvic pain
- psychological symptoms may include Post Traumatic Stress Disorder (PTSD), anxiety, depression
- psychological problems may include low self-esteem, shame, social isolation
- marital and relationship problems, including feelings of rejection, guilt, anger and blame. Male family members may feel guilt over their failure to protect their female relatives
- no, or limited concept of, psychological illness, or talking and disclosure as a way of improving health

Female Genital Mutilation (FGM) (also known as female circumcision, traditional female surgery or female cutting)

- defined by WHO as: 'all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons'
- practiced in different forms in many African countries including Liberia, Sierra Leone and Sudan. Prevalence varies eg in Sierra Leone, approximately 90% of girls are circumcised as part of their initiation into womanhood. Not practiced in Rwanda and Burundi
- women may be unwilling to discuss; there is a spectrum of opinions and attitudes regarding FGM within African communities. It is important to approach discussion in general and non-judgemental ways
- complications can include vulval scarring and pain, chronic pelvic pain, urinary tract infections, incontinence, obstructed menstrual and urinary flow, obstructed miscarriage and childbirth, vaginal and perineal damage during delivery, difficulties and pain with sexual intercourse
- Australia is committed to prevention through education and legislation. Information, referral, support and advice available through Family and Reproductive Rights Education Program (FARREP) (see referral information)

Compliance

- women are more likely to suffer high rates of illiteracy and lack confidence in dealing with authority which may affect their ability to understand questions and disclose relevant information
- *informed consent:* in the medical context this requires an understanding of decisions made in relation to health matters. This impacts on medical advice, referrals, prescriptions etc. Language and cultural barriers, as well as unfamiliarity with western health systems and procedures can make many tasks seem complex, even distressing for the client eg filling a prescription, arranging an X-ray
- the lack of interpreter resources for people from new emerging African communities may affect compliance
- in some circumstances refugee women may continue to suffer domestic violence in Australia

Investigative and Procedural Implications

Identifying Survivors of Sexual Violence

- **women will rarely identify themselves as a survivor of sexual trauma**
- information about the country of origin and general queries about the time and circumstances of departure, life as a refugee and the journey to Australia, will help to establish the *likelihood of exposure to sexual trauma*
- general questions that convey sensitivity and understanding may also be helpful, eg *Terrible things have happened to many women who have been forced to leave your country. Have you had any terrible experiences that are causing you pain or affecting your health now?*

Variation of responses

- different cultures, experiences and understandings naturally mean there is variation among women in their responses and their willingness to talk about sexual health, gynaecological issues, STI's and FGM. *What is taboo for some, may not be for others.* It may be helpful not to refer directly to specific conditions but ask generally about sexual and reproductive health
- *a gradual approach* to assessment and management will help build rapport and trust

Support and Familiarity with Health Services

- allow adequate time, women are generally unfamiliar with our health care system and services, including appointment systems, referrals and Medicare
- many women have never had a breast examination, a pap smear or an internal examination
- important to ask about complementary or traditional therapies as well as medication prescribed by other healthcare practitioners
- be aware that patients may be concerned that their traditional health beliefs may be dismissed as superstitious
- help to facilitate appropriate support structures that link women with services, resources and networks to support them
- consider use of specifically developed patient education materials which explain diseases, investigations and procedures in community languages (see referral information)

Gender of Practitioner

- male practitioners should consider offering female clients referral to an experienced female practitioner or gynaecologist, particularly if investigation or treatment of gynaecological problems is required for general medical care

Potential Investigations

- STI's – consider non-invasive procedures eg first pass urine for Chlamydia and Gonorrhoea; blood tests for HIV, Hep B, Hep C and Syphilis
- pap smear examination: *allow adequate time* and a sensitive and empathic approach. If patient has had FGM, the use of small speculum may be necessary or referral to a practitioner experienced in this situation
- breast examination: may be unfamiliar and require explanation
- mammography: consider use of **BreastScreen** which employs female ultrasonographers
- pelvic ultrasounds: a transvaginal pelvic ultrasound will require much explanation and use of a female technician where possible

Torture and Trauma

- physical examination and other aspects of the consultation may be reminders of past torture and trauma. Consider this when planning specialist medical, surgical or gynaecological referral
- physical symptoms, eg muscular and joint pains may be somatic expressions of torture and trauma

Interpreters

- whenever possible use onsite female interpreters to optimize communication, build rapport and reduce anxiety
- it may be difficult to arrange interpreters in the preferred language of some newly-arrived refugees from African countries
- reliance on family members may compromise privacy and discourage disclosure

Referral

- facilitate referral by including *relevant information of client's refugee experiences*
- refer where possible to services offering female practitioners and interpreters
- consider practical difficulties including financial cost, transport and childcare
- consider consultation with, or referral to, specialist agency and/or resources (see referral information)

> ***... there is an opportunity to build dignity with every human encounter. Given that it is the human hand that has perpetrated violations it is the human hand that has the power to heal wounds. The quality of relationships can however, be undermined when workers face the sheer immensity of needs. To deal with being potentially overwhelmed, overly distant styles of working can occur, whereby women's problems are minimized or overlooked. Alternatively, some workers respond with 'rescuing' that diminishes the power of women. Awareness of such responses and the implications for ways of working require sufficient levels of support and professional development.***

Kaplan I and Webster K "Refugee Women and Settlement: Gender and Mental Health" Allotey P (ed) (2003) *The Health of Refugees: Public Health Perspectives from Crisis to Settlement,* Oxford University Press, UK

The Victorian Foundation for Survivors of Torture (VFST) provides direct care to survivors of torture and trauma in the form of counselling, advocacy, family support, group work, psycho-education, information sessions and complementary therapies. The VFST also plays an important developmental role with service providers through training, consultancy, research and capacity-building.

The following information was compiled to help build an understanding among service providers of the needs of refugee women who have suffered sexual violence. For further information and referral, a select list of agencies and resources is provided below.

Specialist Referral (Victoria) and Resources:

Medical Services

Melbourne Sexual Health Centre http://www.mshc.org.au/index.cfm

The Royal Australian College of General Practitioners (RACGP) http://www.racgp.org.au/refugeehealth/

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG 2004) Medical responses to adults who have experienced sexual assault: an interactive educational module for doctors. Information and an order form available at http://www.ranzcog.edu.au/sexual-assault-module.shtml

The Royal Children's Hospital Immigrant Child Health http://www.rch.org.au/paed_handbook/cph/index.cfm?doc_id=2502

BreastScreen Victoria http://www.breastscreen.org.au/

FGM

Family And Reproductive Rights Education Program (FARREP): Royal Women's Hospital Ph: 03 9344 2211

Mercy Hospital for Women Ph: 03 9270 2222

Monash Medical Centre Ph: 03 9594 6666

DHS Victorian Government Health Information website FARREP http://www.health.vic.gov.au/vwhp/farrep.htm

Clinical Practice Guidelines can be accessed on: http://www.rwh.org.au/rwhcpg/womenshealth.cfm?doc_id=4343

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG 1997) Female Genital Mutilation: Information for Australian Health Professionals http://www.ranzcog.edu.au/publications/pdfs/FGM-booklet-sept2001.pdf

Australian Institute of Family Studies FGM Bibliography http://www.aifs.gov.au/nch/bib/fgm.html

Psychosocial and Psychological Care

Victorian Foundation for Survivors of Torture (VFST) Ph: 03 9388 0022 http://www.survivorsvic.org.au/

Centre Against Sexual Assault (CASA) Ph: 1800 806 292 http://www.casa.org.au/index.php/1

Victorian Immigrant and Refugee Women's Coalition (VIRWC) http://www.virwc.org.au/

Immigrant Women's Domestic Violence Service http://www.iwdvs.org.au/home.htm Ph: 03 9898 3145

Resources for Clients and Workers

DHS Community Language Health Information & Resources: http://www.healthtranslations.vic.gov.au/

Royal Womens Hospital Well Womens Website On Line Fact Sheets in community languages: http://www.rwh.org.au/wellwomens/whic.cfm?doc_id=2422

BreastScreen Victoria translated publications http://www.breastscreen.org.au/

Working Women's Health 03 9482 3299 http://www.workingwomenshealth.asn.au/

Background Information

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Hill P, Lipson J, Meleis A I (2003) *Caring for Women Cross-Culturally* F.A. Davis Company, Philadelphia.

Human Rights Watch (2000) *Seeking Protection : Addressing Sexual and Domestic Violence in Tanzania's Refugee Camps* http://www.hrw.org/reports/2000/tanzania/

Human Rights Watch (2005) *Seeking Justice: The Prosecution of Sexual Violence in the Congo War* http://hrw.org/reports/2005/drc0305/

IRIN (2004) *Our Bodies -Their Battleground: Gender-based Violence in Conflict Zones* http://www.irinnews.org/webspecials/GBV/gbv-webspecial.PDF

Kemp C & Rasbridge L, (2004) *Refugee and Immigrant Health: A Handbook for Health Professionals.* Cambridge University Press, Cambridge. Also see associated website:

Refugee Health Immigrant Health website: http://www3.baylor.edu/~Charles_Kemp/refugees.htm

UNHCR (2003) *Sexual and Gender- Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response* http://www.rhrc.org/pdf/gl_sgbv03_00.pdf

UNICEF (2005) *The Impact of Conflict On Women and Girls In West and Central Africa And The UNICEF Response* http://www.unicef.org/publications/files/Impact_final.pdf

UNIFEM Women War Peace http://www.womenwarpeace.org/

WHO (2005 revised edn) Clinical Management of Survivors of Rape: Developing protocols for use with refugees and internally displaced persons. http://www.who.int/reproductive-health/publications/rhr_02_8_clinical_management_survivors_of_rape/

Women's Commission for Refugee Women and Children http://www.womenscommission.org/