



Women on the Other Side of War and Poverty: Its Effect on the Health of Reproduction

Ayşe Cevirme¹, Yasemin Hamlacı^{2*}, Kevser Özdemir²

Abstract

War and poverty are 'extraordinary conditions created by human intervention' and 'preventable public health problems.' War and poverty have many negative effects on human health, especially women's health. Health problems arising due to war and poverty are being observed as sexual abuse and rape, all kinds of violence and subsequent gynecologic and obstetrics problems with physiological and psychological courses, and pregnancies as the result of undesired but forced or obliged marriages and even rapes. Certainly, unjust treatment such as being unable to gain footing on the land it is lived (asylum seeker, refugee, etc.) and being deprived of social security, citizenship rights and human rights brings about the deprivation of access to health services and of provision of service intended for gynecology and obstetrics. The purpose of this article is to address effects of war and poverty on the health of reproduction of women and to offer scientific contribution and solutions.

Keywords: Poverty, Reproductive health, War

Introduction

Throughout the history of the world, the ones who had confronted the bitterest face of poverty and war had always been the women. As known poverty and war affects human health either directly or indirectly, the effects of this condition on health and status of women in the society should not be ignored. This study intends to cast light on the effects of war and poverty on the reproductive health of women. For this purpose, the face of war affecting the women, the problem of immigration, inequalities in distribution of income based on gender and the effects of all these on the reproductive health of women will be addressed.

War and Women's Health

Famine, synonymous with war and poverty, is clearer for women; war means deep disadvantages such as full destruction, loss of future and uncertainty for women. Wars are conflicts that destroy families, societies and cultures that negatively affect the health of community and cause violation of human rights. According to the data of World Health Organization (WHO) and World Bank, in 2002 wars had been among the first ten reasons which killed the most and caused disabilities. Civil losses are at the rate of 90% within all losses (1).

War has many negative effects on human health. One of these is its effect of shortening the average human life. According to the data of WHO, the average human life is 68.1 years for males and 72.7 years for females. It is being

thought that severe military conflicts in Africa shorten the expected lifetime for more than 2 years. In general, WHO had calculated that 269 thousand people had died in 1999 due to the effect of wars and that loss of 8.44 million healthy years of life had occurred (2,3).

Wars negatively affect the provision of health services. Health institutions such as hospitals, laboratories and health centers are direct targets of war. Moreover, the wars cause the migration of qualified health employees, and thus the health services hitches. Assessments made indicate that the effect of destruction in the infrastructure of health continues for 5-10 years even after the finalization of conflicts (3). Due to resource requirements in the restructuring investments after war, the share allocated to health has decreased (1).

Mortalities and Morbidities

The ones who are most affected from wars are women and children. While deaths depending on direct violence affect the male population, the indirect deaths kill children, women and elders more. In Iraq between 1990-1994, infant deaths had shown this reality in its more bare form with an increase of 600% (4). The war taking five years increases the child deaths under age of 5 by 13%. Also 47% of all the refugees in the world and 50% of asylum seekers and displaced people are women and girls and 44% refugees and asylum seekers are children under the age of 18 (5).

As the result of wars and armed conflicts, women are

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¹Department of Nursing, Sakarya University, Sakarya, Turkey. ²Department of Midwifery, Sakarya University, Sakarya, Turkey.

*Corresponding author: Yasemin Hamlacı, Department of Midwifery, Sakarya University, Sakarya, Turkey. Tel: +905556080628,

Email: yaseminhamlaci@gmail.com



facing injuries, disabilities, death, unwanted pregnancy and its complications, genital fistula (bladder-vagina, rectum-vagina), and psychiatric disorders such as post-traumatic stress disorder (PTSD), depression, anxiety, sexual dysfunction, alcohol and substance addiction and suicide (5).

The women are also responsible for nutrition and care of children, patients and elders in the family when their spouses are not with them during war, providing food, water and other requirements of the family, and for protecting the members of the family. During conflicts they have difficulties in providing these (6).

Sexual Abuse and Rape

In recent years, it is being reported that the frequency of rape and sexual violence has increased during war and in periods after war (5). According to the data of United Nations, the trade of about 2 million women and girls takes place each year in the world. The gang rape cases occurring during war at Bosnia, Cambodia, Liberia, Peru, Somali and Uganda are known. For instance, the sexual violence and systematic rape against women during Bosnian war had been used as an 'ethnic cleansing' tool and war weapon. About 20 000-60 000 women and girls had been subjected to systematic and gang rape at Bosnia; they had been kept at rape camps, subjected to violence and sent to concentration camps. The ones who got pregnant had been taken captive in order to prevent miscarriage, and had been forced to 'give birth to the child of enemy' (5). During the Rwanda Genocide in 1994, it is being estimated that 500 000 women were raped. At Sierra Leone, 94% of the displaced families to whom a questionnaire was applied, had informed that they were subjected to sexual assault including rape, torture and sexual slavery (7).

Systematic rape has become in today's wars as a war tactics and strategy used to assimilate, displace and break the resistance of civilians. It is sometimes being used as a war weapon, sometimes for awarding and increasing the motivation of soldiers, and sometimes as a biological weapon for transmitting sexually transmitted diseases such as HIV/AIDS (5).

According to Geneva Convention of 1949 and its supplementary protocols accepted in 1977, sexual abuse and rape intended for women during wars had been taken under the scope of 'crimes against humanity'.

The United Nations Development Fund for Women (UNIFEM) inform that factors such as history of armed conflict and ethnical properties, heterogeneous social structures and ethnical differences, political instability, women mostly not being at decision-maker positions, hindering social services by transferring the pecuniary

resources to military expenses and armament, weakness of women in economical aspect, women being deprived of health services and education, social status of women, women's rights and state of legal regulations are effective in sexual violence against women during war and conflicts (8).

During the fourth Work Women Conference and Beijing Declaration and Platform for Action which met in Beijing on September 4-15, 1995; critical areas, strategic objectives and action, corporate and financial regulations intended for the purpose of strengthening the women had been determined, and 'Women, and Armed Conflicts and Wars' had been addressed as one of the areas of strategic objective and action. The importance of complete and equal involvement of women in the resolution of armed conflicts had been emphasized, the problem of migrant women and the obligation of considering the difference of the state of women in humanitarian aids had been highlighted (9).

Migrations: Health Problems and Social Problems of Asylum Seeker and Refugee Women

One of the results of war is the migration forced by it. In 1990s, the wars and internal conflicts had forced 50 million individuals to migrate. A part of the people forced to migrate had gained the refugee status, and some had been classified as asylum seeker or displaced individuals. Most of them refuge to the poorest countries, and a hopeless picture arises in respect of both their own conditions and the country they refuge (1).

After the civil war which arose in Syria, the number of Syrian refugees in Turkey, Lebanon, Jordan, Iraq and Egypt had reached to 4 million. Most of the refugees, in other words of the sufferers are women, children and elders (Table 1).

As we observe also in the data of Disaster and Emergency Management Presidency (AFAD), majority of women living at camps consist of those in the period of reproduction. It is being guessed that women living under poor sheltering conditions encounter the problem of heating up water and thus infections due to low frequency of bathing. Especially children and pregnant women are under significant risk in respect of being subject to microbial and bacterial illnesses (10).

The Syrians, having the status of 'guest' since October 2011, had been taken under 'temporary protection regime' as per article 10 of the 1994 regulation of Ministry of Internal Affairs of Republic of Turkey. By the 'Foreigners and International Protection Law' approved in April 2013, status of international protection had been clarified, and 'refugee,' 'conditional refugee' and 'secondary protection'

Table 1. Percentage Distribution of Syrian Women Asylum Seekers Living at Camps in Turkey as per Age^a

Under Age 1 year	Ages 2-6 years	Ages 7-12 years	Ages 13-18 years	Ages 19-54 years	Ages 55-64 years	Age 65 years and over
3.6	16.4	16.8	16.4	42.4	2.7	1.8

^a Total percentage living at camps = 100.

Source: Disaster and Emergency Management Presidency 2014.

status had been defined. Even if this law is presenting a general legal frame intended for the problems of asylum seekers, it is not clear what it will bring for generation of permanent solutions for the social approval and rapport of asylum seekers especially living outside the camp (7). As well as meeting the basic needs of asylum seekers living at the camps such as sheltering and food, basic services such as education and health are also being provided. And the asylum seekers outside of the camp are unable to benefit from the services and aids as they do not have the ID card provided by the government. News regarding the Syrian women – especially living at border provinces – married by force or regarding the Syrian women who are obliged to beg in order to continue their lives in large cities, reveal the urgency of the fact. The studies intended for this subject had started to be performed by the Republic of Turkey Ministry of Labor and Social Security (11).

By April 19, 2014, polyclinic service of over 2.5 million had been provided for the Syrians living in Turkey. Also 114 physicians in total (101 native and 13 foreigners) are serving to guests at 21 health center. Analyzing the health service benefits the Syrian women received inside and outside the camps showed that 91% of the women residing in the camps and 59% of those living outside the camps received these benefits. Meanwhile 11.249 births in total had occurred as from 2011 – when the internal turmoil started – until April 19, 2014. The rate of both pregnant and breast feeding women at lodgings of Syrian living both within and outside the camp is very high. It is necessary to follow different care policies for both the pregnant and breast feeding women. Support should be provided for pregnant women during the delivery process and for breast feeding women during the nutrition process of the infants, and it should be continued based on the policies being followed in this area (10).

Lack of sheltering problems (always being close to health center and personnel) and easy access to medication are encouraging the Syrian pregnant women to live in the camps. It is being observed that majority of pregnant women are giving birth at hospitals or clinics either within or outside the camp. The vast majority of pregnant women living in camps (96%) had given birth at hospitals or clinics. This rate is 97% among women living outside the camp. The conduction of deliveries at hospitals or clinics has a vital importance in regard to the birth of healthy infants and health of women. Considering these rates, it is being observed that women realize their delivery at hospitals or clinics is in safe hands and in a healthy manner (10). In another research, women – during their living especially at metropolis cities, for instance during their stay in Istanbul – specified that they did not receive any aid for services such as family planning (preventive medicine, material, medical attempt, etc for the control of pregnancy), determination, examination and follow-up of pregnant women, vaccination, protective drug such as iron/folic acid, consultancy, health training, and that such services were not provided to asylum seekers who had applied to public health centers, family health centers and public

hospitals – being the first step health institutions – for this purpose (4).

In the article of McGinn, which covers the effects of war and its results on health and also in studies performed between 1970-1999 (12), it has been specified that fertility increases in war regions and among immigrating women and that there were insufficiencies in using family planning methods and in accessing such methods.

The women – unlike men – leave their country and refuge to other countries in order to escape from violence and oppression such as discrimination based on gender, pressure and oppression due to socio-cultural approvals, sexual abuse, violence based on gender, and domestic violence. On the issue of being more negatively affected from migration compared to men, an explanation is made relevant to carrying more risk in respect of being subject to violence – which also exists in literature of immigration – encountering the limitations of social rules more, being unable to sufficiently benefit from relationship networks and having limited employment opportunities (7).

The asylum seekers, who face the unknown health system of the foreign country, do not benefit from health services unless being obliged to. Thus, the rate of benefiting from protective and preventive health services such as the pregnancy follow-up and vaccination of children is very low especially among asylum seekers living outside the camp. The women asylum seekers encounter the risk of being subject to mental and neurological disorders more due to routine oppressions and isolated life (7).

In general terms, when we consider the effect of migration on women's health, it can be in the direction of both deterioration and recuperation. In cases when women migrate from a country with low income level to a country with high income level, the state of women in regard to health services will improve (13). And the pressure caused on migrant women by not being literate, not being able to speak the language of the country they are in and patriarchal gender regime can retain them from accessing all kinds of public institutions as health institutions. Migrant women can require the assistance of their spouses or sons in order to access the health institutions (14).

Contagious diseases (such as tuberculosis, parasitic diseases, measles, etc) peculiar to the country of migration which the migrants are not immune, diabetes, hypertension, malnutrition, irregular menstrual bleeding, tooth diseases, exposure to radioactive and other hazardous substances, sexual abuse, rape and violence are the health problems which the migrant women face the most. Moreover, they constitute a risk group for sexually transmitted diseases and HIV due to being forced to prostitution (13,15,16).

Recommendations for Improving and Protecting the Health of Migrant Women

It is required to improve the environmental conditions and to resolve the basic infrastructure problems such as water and sanitation at areas where migrants live. The properties of these new communities arising by migra-

tion should be known by the health personnel, and the appropriate health and care support which they need should be provided. Personal or group therapies should be organized to ones who are psychologically affected from migration. Clinics and policies should remove the obstacles in the use of education and health services, and the services should be easily accessible and low cost. The status of migrant women should be improved, and their inclusion in social security system should be ensured. The language problem of migrant women should be resolved, and they should be supported in learning the language of the country. At workplaces where migrants have linguistic problems trainings, warning signs and symbols should be provided in the language they understand (16-18).

Poverty

As poverty and wealth are subjective concepts, poverty does not have single common description. But in the most general sense poverty can be defined as 'people not having the opportunity to meet their basic requirements and not having minimum living standards for individuals.' According to the study of World Bank conducted in 1990, the price of food basket of 2400 calories – being the minimum calorie amount required for a person to maintain his life – had been determined as absolute poverty line (19).

Natural disasters, climatic changes, 'drought,' migrations, wars, globalization, fast population increase, unplanned industrialization, economic crisis, privatizations, loosening traditional structures, unfair tax system, inflation, unemployment, difference of ability among individuals and disability at a level of being unable to work are among the reasons of poverty (20-22).

Poverty of Women

The burden of poverty increasingly being undertaken by the women was first conceptualized and gained importance with the phrase of 'feminization of poverty' in the fourth World Women Conference Action Plan in 1995 (9). When women are assessed among themselves, they do not consist of a single homogenous group. Women groups such as the women in families with single parent, women living in rural, women asylum seekers and migrants, minority women with ethnical origin, disabled and old women who are subjected to discrimination more, are under the threat of poverty (21).

Poverty of women is based on social-gender relations and inequalities. Inequalities in the distribution and control of household income and values, difficulties in using resources, weakness in having a say on property, secondary position of women in labor markets, being unable to participate in economy due to responsibilities within the household, acceptance of low waged works with no work guarantee and social security, working as unpaid family worker, social exclusion and discrimination encountered at economic and political institutions are the causes of women to be unguarded against chronic poverty (20,23). Data of International Labor Organization (ILO) has revealed that despite the fact that women constitute 40%

of employment in the world, they constitute 60% of the working poor. The women are unable to access to labor market by equal rate, equal position and equal wage with men. According to data of 2008 of Turkish Statistical Institute, 62.3% of working women and 39.3% of working men work as unrecorded (14).

Social gender roles are extremely determinative in strategies of perceiving poverty and overcoming poverty. The social role given to men to provide for households and the role given to women to ensure the survival of family members with income constitute the basic reason of differentiation of poverty experiences as per gender (14).

Relation of Poverty Health-Illness

Sir E. Chadwick – Minister of Health of UK – had defined the vicious cycle in between economic state and health-illness as 'illness causes poverty, poverty causes illness, and this cycle of hell continues in this way' in the period of World War I. According to Chadwick, the first condition of protecting health was sanitation and the main reason of illnesses was poverty. Poverty causes insufficiency of nutrition, insufficiency of education and negative environmental conditions. This condition causes the illnesses to become more frequent, majority of income to be allocated to treatment services and protective health services to be left aside. As a result, new illnesses arise and loss of labor is encountered in parallel with new illnesses. And low income comes back as poverty (Figure 1) (24-26).

Infectious Diseases

The health of women, being smashed under the heavy weight of poverty, is also under significant threat. Many women are being subject to significant diseases due to reproductive health problems and pregnancy. The relation among poverty, health and illness simply stands out by the increase in the incidence of infectious diseases. From the perspective of being a woman, getting a contagious disease during pregnancy may cause early delivery, low birth weight infant, chronic illnesses and death.

Prenatal Services

Poverty significantly affects benefiting from prenatal services. When the indicators for our country are considered, the rate of women with the lowest Turkish Demographic and Health Survey (TDHA) – 2013 wealth level – who receive prenatal care is 91.2%, and the rate of women with the highest TDHA – 2013 wealth level – who receive prenatal care is 99.7%. Again while the rate of women with the lowest TDHA – 2013 wealth level – who deliver at home is 8.2%, it is 0% among women with the highest TDHA – 2013 wealth level. All these national and international indicators clearly show that poor women cannot sufficiently benefit from prenatal services (27).

Maternal mortalities are higher among poor ones compared to wealthy ones. According to the data of WHO, about 800 maternal mortalities had occurred every day in 2013. Maternal mortality speed had been approximately 500 in 100 000 live births in Africa, 190 in Southeast Asia

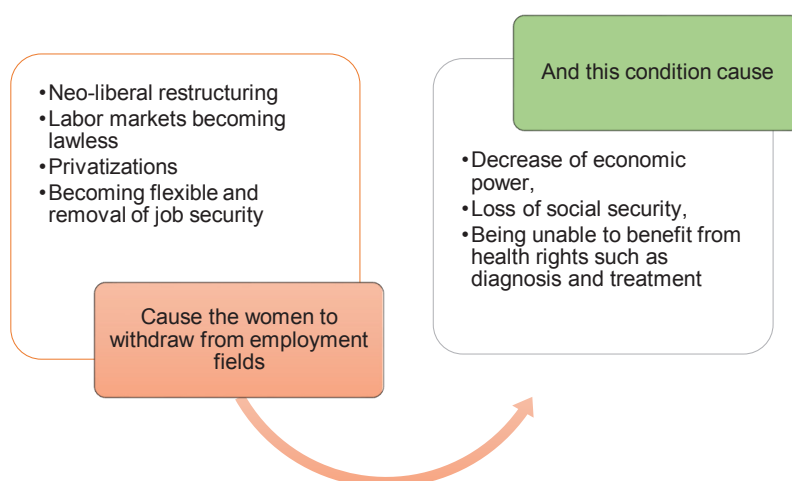


Figure 1. Cause and Consequences of Women Withdrawing From Employment Fields.

and 17 in Europe in 2013.

Nutrition

Imbalance between income distribution and lack of knowledge regarding nutrition lies behind the nutritional problems. In the studies performed in our country, thinness and fatness, iron deficiency anemia, iodine deficiency illnesses and vitamin deficiency are frequently being observed among adult women (28). Iron deficiency anemia is twice more common in women compared to men in the whole world. Moreover the significant number of women with protein-energy malnutrition in South Asia – where half of the undernourished ones live – can be given as an example of health problems related to nutrition which is being deemed as the indicator of poverty in the whole world (24).

Violence

We can show violence against women as another result of poverty. It is known that women of low and middle economic class, women who do not have a qualified work, and women who are divorced are being subject to more violence within the family and society. It is known that there is a relation between the low educational level and unemployment and incapacity in business life and domestic violence against women (29,30).

Women who encounter violence face health problems such as physical injuries, loss of consciousness, use of drugs and alcohol, depression, nightmares, distrust, insomnia, suicidal attempts, low self-esteem, social isolation, psychosomatic disorders, sexually transmitted diseases, maternal morbidity, mortality, unwanted pregnancy, unhealthy abortion, etc (30,31).

Conclusion

The destruction of economies of countries, all wealth resources enabling life and infrastructures of cities by war means poverty, chaos, threat to public health and finally collapse of health system. It shall not be forgotten that those who run away from war and refuge to a secure re-

gion in another country undertake the burden of these collapsed systems. Supporting the health services of the country combating cross-border and developing the opportunities for people to return to normal life as soon as possible is the responsibility of all nations, humanity, all institutions and all health employees.

It is required to strengthen the women – who struggle to survive, who are obliged to start life from zero along with migration and who live under the arm of poverty – by correcting their unequal positions and developing strategies. In this context, health employees should be able to define the health problems caused by war and poverty and should be a guide for the women to access the services. Moreover, they should consult the society in protection against infection and in providing antenatal controls. In addition, with the contemporary role of nurses – being the defender of women's rights and equality – they can attract attention and create awareness towards the effect of these health issues (32).

Ethical Issues

Not applicable.

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Conflict of Interests

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