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The Darfur Crisis: Associated Mental Health Problems Among Internally Displaced Women

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This study aimed at investigating the effects of the Darfur crisis on the mental health of internally displaced women; in particular, the traumatic events and resulting living conditions inside camps for internally displaced persons. It was hypothesized that a high prevalence of nonpsychotic psychiatric symptoms would be found. Participants were 212 internally displaced women in Darfur between 15 and 80 years old. Participants were interviewed using two measures: the General Health Questionnaire (GHQ-28) and another questionnaire specially designed to assess living conditions and relief services. Results showed that 72% of the participants were classified as nonpsychotic psychiatric cases. Findings also imply that living conditions inside camps need to be improved and security should be provided or enforced.

Keywords *Darfur, internally displaced women, living conditions, psychological distress, relief supplies*

INTRODUCTION

The Darfur region is located in western Sudan and composed of three states: North Darfur, West Darfur, and South Darfur. These three states are large, comprising 250,000 square kilometers (approximately the size of Texas), with an estimated population of 6 million people. The armed conflict in the Darfur region began around 2002; however, the scale of conflict increased noticeably in February 2003 (United Nations, 2005). Various significant factors that

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have contributed to the conflict in Darfur are poverty, marginalization of the region by the successive national governments, political neglect, disputes over grazing rights and use, and disputes about land ownership. These factors led to a rebel movement organized by two major factions: the Sudanese Liberation Army (SLA) and Justice and Equality Movement (JEM) (de Waal, 2004).

The armed conflict destroyed hundreds of villages, and many thousands of people were killed as a direct or indirect result. The war victims witnessed killing of relatives, rape of women, and loss of property. Moreover, 2,152,163 people were internally displaced within Darfur and hundreds of thousands took refuge in neighboring Chad (United Nations, 2007). Many of the internally displaced persons (IDPs) were grouped in camps inside Darfur where they experienced a lack of security, unemployment, and harsh living conditions. *Internally displaced persons* are those who stay within their own national borders in time of natural or man-made disasters while those who are forced to flee to other countries are categorized as *refugees*. The Darfur conflict has been described as a “humanitarian disaster” and “demographic catastrophe” (Hoile, 2008, p. 1). Accordingly, the international community (including the United Nations and aid agencies) has been involved with the crisis, and the world’s largest humanitarian relief operation has been launched (Hoile, 2008). War experience and displacement were the major factors endangering the mental health of Darfurian IDPs (Hamid & Musa, in press).

Mental health problems may represent the most burdensome form of human suffering (Roberto, Chaya, Fares, & Khirs, 2006). Studies in war-affected populations have reported high rates of mental health problems (Hashemian, Khoshnood, Falahati, et al., 2006). Miller et al. (2002) studied the relative contribution of war experiences and exile-related stressors to levels of psychological distress in two groups of Bosnian refugees: clinical and community. Bosnians in the clinical group were attending a mental health clinic. The results showed that level of daily activities (exile-related variables) and loss (a war-related variable) were the strongest predictors of depression in the clinical group. Hadi, Llabre, and Spitzer (2006) found in their study of Kuwaiti children and their mothers that mothers whose husbands were arrested and mothers whose husbands were missing during the Iraqi invasion of Kuwait in 1990 also showed significantly more depression than a control group. In their studies, Beiser (1990), Mollica et al. (1993), and Rumbaut (1991) found that, among displaced populations, the likelihood of developing symptoms of psychological distress in their temporary accommodations (e.g., camps) was associated with length of stay. In their study of the mental health of Afghani IDPs, Cardozo et al. (2004) found that women and the disabled reported lower levels of mental health compared to the counterparts. There was also a significant relationship between traumatic events and mental health outcomes.

Despite the growing attention on the Darfur crisis, research focusing on the challenges and associated mental health problems faced by the IDPs is scarce. This study provides valuable data on mental health problems in a high-risk group following an armed conflict where data are hardly available due to limited and restricted access for external researchers. This mixed methods study aimed at investigating the effects of the Darfur crisis—in terms of traumatic events and resulting living conditions inside the camps—on the mental health of internally displaced women. In the Darfur armed conflict, women were especially targeted by assaulters and exposed to sexual violence, maltreatment, and aggression. The IDP camps were characterized by before overcrowding, lack of appropriate social services, and being located in an unfriendly environment. We expected a high prevalence of nonpsychotic psychiatric symptoms among these displaced women in the camps.

METHODS

Participants

A sample of 212 internally displaced Muslim women in Darfur agreed to be interviewed. Their ages ranged between 15 and 80 (mean = 34.1). About 75% of them were married, 15.6% were single, and 6.7% were widowed. Participants were displaced in early 2003, through 2004, to mid-2005 (31.3%, 65.1%, and 3.3%, respectively). About 44.3% of them belonged to the Fur tribe, 21.7% to the Zaghawa tribe, and the rest belonged to other tribes. These demographic characteristics are presented in Table 1.

Procedures

Participants were selected from three camps around the towns of Fasher (Abu Shoak camp, 52.4%) and Nyala (Utash and Seraif camps, 47.6%). The

Table 1 Demographic Characteristics of the Participants (Internally Displaced Women)

Demographic characteristic	<i>n</i>	Percentage
Marital status		
Married	158	75.0
Single	33	15.6
Widowed	14	6.7
Year of displacement		
2003	65	31.3
2004	138	65.1
2005	7	3.3
Tribal affiliation		
Fur	94	44.3
Zaghawa	46	21.7
Other	72	34.0

Abu Shoak camp is much larger, in terms of population and geographical size, than the Utash and Seraif camps. Each camp was divided into four areas; that is, east, west, south, and north. Participants were selected from each area (one from each tent) according to their availability. This sampling technique is more likely to be described as stratified sampling. Participants (female IDPs) were interviewed in July 2005 by us and two other interviewers (a man and a woman) who were trained in how to interview and collect data from IDPs. A mixed methods research design was used.

Measures

Two sets of questionnaires, translated and back-translated from English to Arabic, were used as interview tools. The first questionnaire was especially designed for the purpose of this research and it consists of three parts: 7 questions exploring demographic information, 21 questions on living conditions, and 3 questions exploring displacement history. Examples of questions in the first part include information such as tribal affiliation, marital status, age, and number of family members. Questions in the second part investigated security status in camps, camp management, activities inside camps, sufficiency and quality of food supplies, quality of shelter, and employment opportunities. Questions in the third part inquired about the date of displacement, date of camp entry, and the exact cause of displacement. All questions the first and third parts were open-ended while questions in the second part were mixed: some were open-ended and some were Yes or No questions.

The second questionnaire was the General Health Questionnaire (GHQ-28; Goldberg & Williams, 1991). The GHQ is a widely validated measure for assessing nonpsychotic psychiatric disorders in both community and clinical settings, including those affected by violence (Cardozo, et al., 2000). This questionnaire was administered to measure distress, depression, anxiety, social dysfunction, and somatic symptoms. The GHQ-28 was subjected to factor analysis by us. The analysis yielded four subscales, consistent with the original GHQ subscales that gauge somatic symptoms, depression, anxiety, and social dysfunction. The mean score on the scale for this study was 14.9 ($SD = 8.4$, alpha reliability = 0.94).

There are two methods of scoring the GHQ; the first is the GHQ scaling method (0, 0, 1, 1) and the second is the Likert scaling method (0, 1, 2, 3). The former is appropriate for recognizing nonpsychotic psychiatric cases and the latter for survey research (Swallow, Lindow, Masson, & Hay, 2003). In this study, the GHQ scaling method was used. For differentiating psychiatric from nonpsychiatric cases, the GHQ scoring system with a cutoff point of 4 or more is usually used. But, using a cutoff point of 4 or lower reduces specificity and increases sensitivity and, accordingly, increases the chances for false positive cases (Anderson, Sestoft, Lillebaek, Gabrielsen, & Memmingsen, 2002). However, using a cutoff point of 9 or 10 increases

specificity and gives a reasonable sensitivity. Consequently, this leads to less false positive cases. Goldberg et al. (1997) reported 10 studies that used cutoff points between 4 and 9. Our study uses a cutoff point of 9.

RESULTS

Living Conditions

Descriptive analysis of direct questions on living conditions inside camps showed that over 80% of the participants reported that living conditions inside camps were not satisfactory. More than 74% stated that camps were located in insecure areas. About 65% of participants were jobless. In response to an open-ended question about the gap in relief services, participants reported that camps were lacking many services such as clean water (19%), sanitation (45%), compatible shelter (27%), firewood (27%), and schools (8%).

Regarding food services, 84.4% of the participants reported that distributed food amounts were insufficient while 68% of them indicated that the food type was not compatible with their culture. About 26% reported that some of their relatives died due to malnutrition while 40.6% reported having malnourished relatives. In response to an open-ended question about lack of food supplies, participants reported that services were lacking vital items such as meat (67.3%), milk and tea (41%), soap (22%), and millet and sorghum (42%). When responding to an open-ended question inquiring about gaps in food supplies, more than 65% of the participants reported that there was a gap in sugar supplies. In addition to inadequate supplies, there was also the problem of participants being provided with food items not found in their local food culture. When participants were asked to identify unfamiliar ingredients in food supplies, a number of them reported that soya cooking oil, lentils, and wheat were unfamiliar (57%, 8.1%, 9.9%, respectively).

The General Health Questionnaire

When a cutoff point of 9 was used, 72% of the participants were classified as nonpsychotic psychiatric cases. Pearson product-moment correlation analysis revealed a significant association between age and social dysfunction ($r = 0.14$, $p < 0.05$), showing that the older the age, the more social dysfunction was reported. As shown in Table 2, the number of family members was negatively associated with general distress ($r = -.17$), depression ($r = -.14$), and social dysfunction ($r = -.19$). The larger the family size, the less general distress, depression, and social dysfunction were reported. No other significant correlations were found.

Two-tailed independent sample *t*-test results indicated significant mean differences between IDPs in the Nyala camps and Fasher camp for general distress ($t = 3.59$, $df = 208$, $p < 0.01$), somatic symptoms ($t = 5.52$,

Table 2 Correlations Between Age, Family Size, and General Health Questionnaire Subscales ($n = 212$)

	General Distress	Anxiety	Depression	Somatic Symptoms	Social Dysfunction
Age	.11	.06	.02	.13	.14*
Family size	-.17*	.13	-.14*	.11	-.19**

Note. Significance levels were based on two-tailed tests.

* $p < .05$.

** $p < .01$.

$df = 208$, $p < 0.01$), anxiety ($t = 3.35$, $df = 207$, $p < 0.01$), and social dysfunction ($t = 3.48$, $df = 207$, $p < 0.01$). Participants in the Nyala camps reported more distress, somatic symptoms, anxiety, and social dysfunction compared to their counterparts in the Fasher camp.

The t tests also showed a significant difference between employed and unemployed participants in general distress ($t = -3.95$, $df = 201$, $p < 0.001$), somatic symptoms ($t = -4.02$, $df = 201$, $p < 0.001$), depression ($t = -2.22$, $df = 199$, $p < 0.05$), anxiety ($t = -3.94$, $df = 200$, $p < 0.001$), and social dysfunction ($t = -3.37$, $df = 200$, $p < 0.001$). The unemployed scored higher in all of the above-mentioned dimensions.

The t -test results further yielded a significant difference between participants who lost and those who did not lose one or more of their loved ones due to malnutrition in general distress ($t = 3.04$, $df = 206$, $p < 0.01$), somatic symptoms ($t = 2.60$, $df = 206$, $p < 0.01$), depression ($t = 3.53$, $df = 204$, $p < 0.001$), and anxiety ($t = 3.08$, $df = 205$, $p < 0.01$). Those who lost their loved ones scored higher in these dimensions.

The t -test results also revealed a significant difference based on date of displacement in general distress ($t = 3.63$, $df = 197$, $p < 0.001$), somatic symptoms ($t = 2.27$, $df = 197$, $p < 0.05$), depression ($t = 3.85$, $df = 196$, $p < 0.001$), anxiety ($t = 3.50$, $df = 196$, $p < 0.001$), and social dysfunction ($t = 2.61$, $df = 196$, $p < 0.01$). Participants who were displaced in 2003 consistently showed higher scores on all these dimensions compared to those who were displaced in 2004.

One-way analysis of variance resulted in significant differences related to marital status in general distress ($F[2, 204] = 3.30$, $p < 0.05$), somatic symptoms ($F[2, 204] = 3.86$, $p < 0.05$), and social dysfunction ($F[2, 203] = 4.96$, $p < 0.01$). Married participants scored higher on distress and social dysfunction compared to unmarried women and widows while widows scored higher on somatic symptoms compared to married and single women.

DISCUSSION

The majority of the participants (80%) were generally dissatisfied with living conditions inside the camps. This can be attributed to many disadvantages

associated with the nature of the camps and their environments. The first is that the camps were not located in secure areas as indicated by the majority of participants. For example, during data collection, we witnessed some chasing and shooting between government soldiers and armed men around one of the camps. Second, health and social services such as sanitation, clean water, and schools were not sufficient. Further, job opportunities were scarce (only 35% of participants had jobs) and this represents an inconvenient situation for Darfurian women who take part in income-generating activities and contribute to the cost of living. Third, shelter (tents) was not appropriate to protect against harsh weather (heat, rains, winds, cold, etc.) and did not secure privacy. The tents were made of plastic sheath and closely erected and overcrowded; that is, one tent for each household which consists of seven members on average. It is clear that such tents do not provide any sense of privacy nor do the latrines, with one latrine shared by 10 households.

The amount of food distributed was considered insufficient by the vast majority of participants. Further, many vital food items were not provided, including millet, sorghum, milk, meat, vegetables, spices, dry okra, tea, and other local food ingredients. Over one quarter of participants reported that some of their relatives died because of food shortage. This reflects the seriousness of the food problem and the need to tackle this problem more efficiently. The quality of food provided by the relief agencies was also not suitable and did not match the local food culture. For instance, aid agencies provided wheat, lentil, fish and soya cooking oil, but Darfurians are used to sorghum, millet, and peanut cooking oil. This led many of the IDPs to sell and exchange their portion of relief items for local food. We recommend that aid agencies provide relief items that are consistent with the food culture of the beneficiaries. A study by Musa, Hamid, and Alghorani (2009) on the needs assessment of relief agencies emphasized the importance of identifying popular foods for target beneficiaries. Failure to do that could possibly result in complicated health problems such as malnutrition.

The prevalence of symptoms of psychological distress among the internally displaced women in Darfur in this study is consistent with previous reports of high prevalence rates in war-affected populations (Cardozo, Bilukha, Gotway, et al., 2005; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Scholte et al., 2004).

The positive association between age and social dysfunction highlights possible difficulties encountered by older internally displaced women in their new social environment. Alternatively, older IDPs may have had a high level of social dysfunction even before being displaced due to limited mobility and activity. This result is consistent with findings of a previous study on IDPs (Roberto et al., 2006). The negative association between the number of family members and general distress, depression, and social dysfunction might suggest that large families in Darfur represent a form of social support that provides a better chance to cope with distress and other mental health

problems, or that members of large families are less prone to such problems. In this study, family and Muslim beliefs were considered to be significant resources for emotional and social support; that is, almost all participants responded negatively to statements in the GHQ related to ideas suggesting ending their lives. They commented on such statements by stressing that their beliefs do not permit such acts (committing suicide). This result is consistent with findings of Scholte et al. (2004), and Cardozo et al. (2000), and de Jong et al. (2007).

The higher levels of general distress, somatic symptoms, anxiety, and social dysfunction among the unemployed and internally displaced women around Nyala may hint at the complex nature of these relationships. These results could be explained in light of the miserable living conditions and high rates of unemployment in camps around Nyala. For instance, these camps were extremely crowded compared to the camp by Fasher. Mental health and its link with low income has been documented in earlier studies (Roberto et al., 2006; Wilkinson, 1997). It is clear that IDPs displaced in 2003 experienced higher rates of various mental health problems such as general distress, somatic symptoms, depression, anxiety, and social dysfunction. Since the conflict in Darfur erupted in February 2003, IDPs displaced in 2003 were among the first war victims and the most affected group. In 2003, IDP camps were not yet established and relief operations had not yet begun. Accordingly, these IDPs might have faced critical situations such as lack of food, security, and shelter before their admission to camps.

The tendency of married participants to be prone to higher levels of general distress, somatic symptoms, anxiety, and social dysfunction may suggest that married internally displaced women find themselves under more pressure as they shoulder social responsibility in contributing to family living expenses. Marital roles require women to have the main responsibility for caregiving and, accordingly, they have little time for their own needs (Kastrup, 2004). Furthermore, Darfuri women are known to take a leading role in income-generating activities for the household. Being in camps represents a situation that threatens the meeting of such a role.

This study has some limitations such as the use of a cutoff score of 9 with the GHQ. Although a standard cutoff score of 4 or 5 (Goldberg & Hiller, 1979) is used by many studies, using a higher cutoff point will undoubtedly lower the prevalence rate of distress. More focus in future studies could be directed toward intervention and toward traumatized victims of sexual or physical violence since these issues were not addressed in this study. Islamic religious values and counseling could be incorporated in future intervention studies as previous studies in Afghani IDPs reported that spiritual practices and religion in general were used as coping strategies and sources of emotional support (Murthy & Lakshminarayana, 2006). A further limitation is the descriptive nature of this study; a more fine-grained analysis could be used to allow predictability of distress and other mental health problems. In spite of these

potential limitations, this study provides valuable data on war-related mental health problems in a high-risk group following an armed conflict where data have been scarcely available due to limited access for external researchers.

CONCLUSION AND IMPLICATIONS

This study highlighted mental health problems among internally displaced women in Darfur following the armed conflict that started in 2003. The study was conducted in three IDP camps located around the towns of Nyala and Fasher. Lack of security was the sole reason for internal displacement in Darfur since all participants were victims of war. The following four factors could have led to the dissatisfaction of internally displaced women with living conditions inside the camps: (a) lack of employment, (b) unsuitability of shelter and food items, (c) lack of sanitation and social services, and (d) lack of security around camps.

Nonpsychotic psychiatric disorder symptoms were highly prevalent among the displaced women; in particular, those who were displaced in 2003. Displaced women in camps by Nyala seemed to experience more mental health problems than those in the camp by Fasher. This can be attributed to the relatively better living conditions inside the camp by Fasher, as witnessed by us.

Displacement and experiences of armed conflict have significant impact on the mental health of victims. Findings of this study imply that attention should be directed toward provision of psychosocial support services for internally displaced women in Darfur. More attention should be directed toward psychological rehabilitation services. Islamic religious beliefs and practices may be reinforced as coping resources. The camp environment should be enhanced and food supplies should be compatible with the local culture. Moreover, social services like schools should be provided and security around the camps needs to be maintained. International aid organizations are the main actors in supporting IDPs; however, the armed conflict threatens aid operations, and a number of aid workers have been abducted and some killed. Provision of security, community development, implementation of social services, and enhancement of living conditions are highly recommended. Moreover, the international community should play a more positive role in putting an end to the suffering of Darfurian IDPs and the Darfur crisis.

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