The Trauma of ongoing War in Chechnya

Quantitative assessment of living conditions, and psychosocial and general health status among war displaced in Chechnya and Ingushetia

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EXECUTIVE SUMMARY

This report presents the findings of two quantitative surveys conducted by MSF among the displaced populations in Ingushetia and Chechnya to gain information on living conditions and health status. (The main findings are presented in the table below). People interviewed had been displaced for at least five years. We found a population living in unacceptable conditions, traumatized by conflict, and in fear of their safety. Physical and mental health needs were significant, but access to appropriate services is at best problematic. The authorities are currently undertaking a policy of moving people, against their will, from Ingushetia to Chechnya, but conditions in both locations are unacceptable and this will do nothing to improve the plight of this vulnerable population. The authorities must ensure protection and appropriate living circumstances for this displaced population. This will require greater attention from the international community to this conflict that has been largely ignored for the last decade.

	Chechnya *(16-20 Feb 2004)*	Ingushetia *(26-30 Jan 2004)*
Displacement history (n)	256	283
1994	48%	37%
1999	41%	54%
Displaced more than once	92%	82%
Wish to return home	86%	86%
Reason for not going home		
lack of shelter	78%	46%
insecurity	10%	49%
Living Circumstances		
Poor shelter against weather	4%	38%
Unable to keep warm	18%	40%
Poor toilet facilities	73%	90%
Insufficient food	50%	41%
Dependence on outside assistance	95%	94%
Insecurity		
Present		
Fears for personal safety	67%	38%
Loss of family member in past 2 months	7%	9%
loss due to violence	39%	19%
Past experiences		
Arrests/disappearances		
Family	53%	50%
Friend/neighbour	80%	62%
Attack on house/village	70%	73%
Cross-fire	62%	60%
Ariel bombardments	81%	78%
Mortar fire	72%	69%
Destruction of property	79%	81%
Witnessed killings	23%	24%
Detention	10%	10%
Kidnapping	7%	7%
Loss of someone close	89%	83%
Family	54%	37%
Neighbour	69%	63%
Loss of property	97%	88%
Loss of possessions	99%	95%
Health Status		
Frequent physical complaints in past 6 months	46%	53%
Poor access to medical services	54%	47%
Poor access to medicines	62%	55%

INTRODUCTION

Situation in Chechnya

Conflict in Chechnya has resulted in over a decade of violence, human rights abuses, criminality and poverty. The capital, Grozny, has been razed.[1] All over the country, private houses are in ruins. the economic and sanitary infrastructures of the main towns have been destroyed, and all local resources and productive capacities have collapsed. Since 1999, the start of the second war, thousands of civilians have been killed or are missing in a climate of impunity.

More than four years after the beginning of the second war in Chechnya, Russia's forces continue to fight small groups of independence fighters. Intensive bombing campaigns have been replaced by daily low-level warfare against "terrorists"[2] fought by around 80 000 Russian troops in a territory of half a million inhabitants.[3] International attention is virtually non-existent, despite regular reports by international and Russian human rights organisations of human rights abuses such as torture, rape, murder and disappearances, looting, restrictions on freedom of movement and expression[4].

As part of the President of the Russian Federation Vladimir Putin's political process of "gradual normalization" of the area, the administration of the territory was transferred to a pro-Russian Chechen: Akhmad Kadyrov, made official through a dubious election process[5] in October 2003. The conflict appears to have become more of an internal civil war between rival Chechen factions, instead a war for independence.

The illusion promoted by the Kremlin that the war is over was recently shattered with the assassination of President Kadyrov on 9 May 2004. The more recent military raid launched jointly by Chechen and Ingush fighters against Russian and pro-Russian forces in Ingushetia on 22 June 2004 has extended the conflict to the small neighbouring republic of Ingushetia. With 98 reported deaths and 104 wounded[6], this is the first time the federal forces have reported so many casualties in the second Chechen war in Chechnya.

Situation in Ingushetia

The last decade of conflict in Chechnya has resulted in a steady flow of internally displaced persons (IDPs)[7] seeking refuge throughout the region. Around 260 000 Chechens were displaced to neighboring Ingushetia, finding shelter in tent camps, and collective squats - called *Kompakni*i or sponatenous settlements - comprising farms, sheds, train wagons, disused or still operational factories. A limited number found enough money to rent private accommodation or live with relatives.

The majority of IDPs depend on small and precarious sources of revenue, and are therefore constantly forced to make compromises between decent food, lodging, clothing, medical care and transport.

The living conditions of tents camps and sponatenous settlements (Kompakniki) are poor. In a 2003 MSF survey[8], 54% of the families interviewed in tent camps in Ingushetia stated that their tents either leaked, did not have protection from the cold, or had no flooring. There is bad sanitation, lack of basic necessities, and poor access to health care.

Despite these poor living conditions, the vast majority of the displaced persons (98%) said they did not want to go back in Chechnya because of fear for their family's safety[9] and because their homes in Chechnya had been destroyed.

Forced repatriation of IDPs

Since the signing of an agreement planning the "voluntary" return of displaced to Chechnya [10] in May 2002, the Russian government has increased pressure on the Chechen displaced population. With the help of the pro-Russian Chechen and Ingush authorities the Russian government began to close all the official IDP tent camps.

Several measures have been taken by the authorities to induce return to Chechnya:

- Pressure on displaced in the camps has included physical, psychological and administrative harassment, the cutting-off off basic services such as gas, water and electricity, and intense propaganda about imminent camp closures[11].
- Orders passed by the Ingush authorities directly limiting assistance programmes from international humanitarian organisations [12]. In February 2004, the authorities banned the construction of new shelters to accommodate IDPs evicted from two tent camps (Bart and Sputnik) who wished to stay in Ingushetia. Attempts to improve or replace existing unsuitable shelters and tents has also been prevented.

Repatriation continues despite the fact that people do not want to return to Chechnya, the disruption to children's schooling, the lack of proper shelter in Chechnya, and the continuation of the conflict and insecurity.

The recent extension of the conflict in Ingushetia has changed the humanitarian situation of the IDPs. Around 50 000 IDPs still remain in Ingushetia, including 24 000 in Kompakniki. The deterioration of the security situation and the parallel repression by the authorities of the IDPs has increased the pressure on the displaced population to leave Ingushetia[13].

Immediately after the attacks in Ingushetia all international aid staff evacuated and for several days it was very difficult for national staff to operate. Even now, the International Community's ability to work in Ingushetia is hampered by the fact that most international staff have been unable to return.

MSF IN THE NORTH CAUCASUS

Humanitarian assistance, provided mainly by international agencies, remains an important external support to the population, both in Ingushetia and in Chechnya. However, aid operations in the Northern Caucasus are threatened by extremely high levels of insecurity: since 1995, more than 50 international humanitarian aid workers have been abducted, some of them have been murdered. As a result, the number of international and national staff working in the region has been drastically reduced. During the kidnapping of Arjan Erkel, head of mission for MSF in Dagestan, from the 20 August 2002 to the 11th April 2004, all activities were suspended in Dagestan and operations in the North Caucasus were severly affected.

The space for humanitarian operations has been reduced year after year by pressures from the Federal and local authorities, ranging from administrative obstacles (visas and registration, tax and accountancy inspections, refusal of required building authorizations) to coercive actions (checks, confiscation of equipment). Direct access to beneficiaries in tents camps has also been blocked several times (e.g. in September and December 2003) and security is never guaranteed.

MSF has been present in the North Caucasus since 1992, bringing assistance to the Chechen refugees from the Ingush–Ossetian conflict. Following the war in Chechnya, MSF began programmes in Ingushetia, Chechnya and later in Dagestan.

In Ingushetia MSF run antenatal and gynaecological clinics, paediatric clinics and provides general health care in Nazran, Karabulak, Sleptsovskaya and Malgobek. Mental health support is offered to IDPs in the spontaneous settlements. Donations of medical material, equipment and medicines are made to most of the government health structures in Ingushetia.

MSF also works in improving the basic living conditions of the refugees in Ingushetia, through the provision and repair of shelter, distribution of heating stoves, blankets, mattresses and other non-food items. MSF carries out water and sanitation programmes, providing water points, latrines, collective showers and washing areas.

In Chechnya, MSF provides medicine, medical material and medical equipment to 30 health care structures. MSF has also carried out small rehabilitation works in the health structures in Chechnya.

Emergency mental health support is given to victims of traumatic events and their families in Achnoy-Martan and hospital number 9 in Grozny. Two mobile teams are addressing integrated mental and basic health care needs of people living in Temporary Accommodation Centres (TACs) in Grozny. Recently MSF began supporting the treatment of TB patients in Gudermes and Nadterechnaya.

To inform the future direction of the assistance programmes, MSF undertook quantitative surveys at the beginning of 2004 among the displaced populations on both sides of the

border – both in the spontaneous settlements in Ingushetia and Temporary Accommodation Centers housing returned refugees on the Chechen side – to obtain information on displacement history, living conditions, and psychosocial and general health status.

METHODOLOGY

Following initial qualitative health needs assessments, MSF started programmes to assist the displaced population in the spontaneous settlements in Ingushetia in May 2003 and the Temporary Accommodation Centers (TAC) in the area of Grozny, Chechnya in February 2004. A quantitative population survey of all spontaneous settlements and TACs was planned to establish baseline data on the living circumstances, health and psychosocial status, and inform the future direction of the humanitarian assistance programme.

The survey questionnaire, based on assessment tools used by MSF in other conflict settings[14] looked at five issues: baseline demographics and displacement history; living circumstances; indicators of psychosocial status; general health; and psychosocial coping mechanisms. A final section of the questionnaire contained general questions regarding what sort of assistance the population expected from an aid organization like MSF.

While the primary aim of this survey was to better understand and meet the needs of the population, MSF also has the duty whenever possible to bear witness to the impact of war upon civilian populations, which is the reason for making this report available publicly.

Different aspects of the questionnaire

The relationship between extreme traumatic experiences and health problems (physical and mental) is fairly well established.[15] To establish the extent of psychosocial problems among the IDPs, issues that are associated with increased vulnerability of (trauma-related) psychological problems in other settings have been used. These include questions on past experiences (e.g. exposure to and witnessing of violence, loss of family and friends) circumstances of displacement, and current support mechanisms.

The extent to which the past and actual suffering contributes to or exacerbates health problems is difficult to define in a causal way, and the questionnaire does not pretend to establish diagnostic levels of (mental or physical) health disorders. The diagnosis of psychological disorders, and in particular post-traumatic stress disorder (PTSD), should be assigned with care for several reasons. First, not all disorders after traumatic events can be described in terms of PTSD. PTSD is far from being the only possible disorder after traumatic events, and the picture is complicated by the fact that co-morbidities are not uncommon.[16] Second, Western conceptual frameworks on psychological stress and mental disorders cannot be automatically transferred to different countries and cultures.[17] Finally, no diagnostic questionnaires or tools have been (culturally) validated for this region.

However, based on general findings about relationships between traumatic experiences and (general) health concerns, some measure of people's health and psychosocial needs can be gained.

Demographics

General demographic data (age, gender etc.) were obtained. The length of the exposure to temporary living circumstances is associated with higher likelihood of developing symptoms of psychological distress.[18] Therefore, questions on displacement history, wishes to leave the settlements, and preferred locations of return, were also included in this section.

Living circumstances

People who have been displaced are often faced with a number of practical as well as physical problems. The quality of the recovery environment has a direct bearing on their health, including mental health.[19] Several questions on the availability of water and sanitation, food and physical shelter were included in the questionnaire.

Feelings of controllability and safety influence the positive coping with adverse (traumatic) experiences.[20] Furthermore, ongoing (chronic) stress caused by feelings of insecurity and dependency can deplete physical and psychological resilience, resulting in chronic physical and mental problems.[21] Questions on feelings of physical safety and dependency on external resources were included to assess this area of concern.

Psychosocial status

A number of studies have shown that multiple exposures to traumatic events (either the same or different events) are associated with higher levels of symptoms of PTSD.[22] The intensity of a traumatic event,[23] the severity of the incident,[24] and the extent of the physical injury, can all contribute to its development.[25]

Evidence increasingly suggests that the differences between Western and non-Western populations in terms of their experiences in traumatic circumstances are not major, and that there is a 'universal' vulnerability for certain traumatic events. In a study on lifetime events and PTSD in 4 post-conflict settings (Cambodia, Gaza, Ethiopia, and Algeria) it was found that conflict-related events after age of 12 years were significantly related to PTSD in all 4 samples.[26] In another study, the health of a large group of refugees that escaped from various conflict areas in the world was researched (community sample) in their country of settlement. Across the board, exposure to a physical traumatic component (experienced/witnessed physical violence and torture, experienced a life-threatening event), and separation from family was found to be a strong indicator for ill health.[27]

General Health Questionnaire

The General Health Questionnaire 28[28] (GHQ 28) has been widely used for many years to screen general health in community settings[i]. Four subjective indicators of health are assessed: somatic complaints, anxiety and insomnia, social dysfunction, and depressive feeling. 28 questions are used in the assessment, for each of which one of four answers is proposed: less than usual; as usual; more than usual; and much more than usual (Lickert-scale). Because 'as usual' is hard to define in times of chronic conflict or long-term displacement we asked the interviewees to compare their situation of the last two months with the situation before (which in terms of the conflict was the same). By doing this, life in conflict is defined as 'normal'. Such an approach can be justified by the goals of the survey: to assess the immediate and current health needs of the IDPs.

Physical health

People suffering from chronic or traumatic stress often report non-specific complaints such as headaches, stomach problems, general body pain, dizziness or palpitations[29]. Open questions were used in this survey to find out the type and order of priority of the health complaints. Closed questions were used to find out the availability, accessibility of medical services and drugs. Answers to these questions were registered using a Lickert scale.

Coping and support needs

The last section of the questionnaire included questions aimed at obtaining subjective information regarding how the population coped with their problems, whether and how psychiatric disorders are distinguished, and suggestions on what additional support was needed.

Survey Methodology

Survey staff

Twenty survey staff was recruited from the existing MSF psychosocial project staff. Counselors were invited to volunteer for the execution of the survey. The majority of survey staff had worked in MSF psychosocial projects in the Caucasus for 3 years, and had received extensive training and clinical supervision by mental health professionals. It was made clear that refusal would not affect their employment, and all staff members were free to stop their activities at any moment if they judged their activities to be counterproductive to the program, or were worried about their own safety, or that of the IDPs. No such concerns arose.

Five survey teams of four counselors were composed; team members were excluded from surveying people in camp areas where they worked.

[i] The GHQ is also used to detect non-specific psychiatric problems of individuals in primary health care settings in the survey we only focused on it as community screening tool.

Training

Training was done over 2 days in January 2004, and included the nature and purpose of survey, confidentiality of the data and information, survey techniques, data registration and assignation of individual tasks. Members practiced interviewing skills on each other.

Despite the extensive counseling background of the survey staff special attention was given on how to deal with extreme emotions. Both direct care and follow-up support was available to all survey participants. During the survey MSF staff received a daily debriefing, during which also emotional issues could be raised.

Translation

On the advice of national staff the questionnaire was translated in both Russian and Chechen: most of the population speak both languages, and the Russian language has more possibilities for translating emotional concepts. Two different interpreters translated the initial questionnaire from English into Russian and Chechnya. A second pair of translators interpreted the questionnaires back into English. Differences in the translations were discussed and agreed upon by the translators in consultation with an expatriate and Chechen mental health expert. The survey team discussed the resulting draft together with MSF team members and the resulting draft was tested on MSF staff not previously exposed to the survey before a final draft was established.

Selection & sample size

Once permission of the appropriate authorities was given, the survey was conducted from 26 to 30 January in Ingushetia and from 16 to 20 February 2004 in Chechnya.

Ingushetia

The target population was divided over 143 spontaneous settlements. Though the size of settlements differed, housing conditions did not, all people living in tent-like arrangements within empty buildings. The official population number was 21,901 distributed over 4,107 households (average household 5.3 persons). In reality, the population size was dynamic as people moved frequently to locations that are perceived as better (for example because there is more humanitarian aid).

Survey methodology was based on well-established methodology for health surveys.[30] Given an assumed prevalence of trauma-related psychological problems of 20%,[31] an average household size of 5.3 members, a precision of 5% (confidence interval 95%), and an assumed drop-out rate of 5%, sample size was set at 283 (n=283), which is adequate for systematic sampling in a population of about 21,901. The sampling interval set at 16.

Chechnya

The target population was those living in the TACs (20) inside or outside Grozny. People were living in room or 'apartment' like facilities. The population in the TACs varied. Officially, 29,510 persons and 5,572 households were registered (average household 5.7). However, according to authorities and based on their observations approximately 3520

households were permanently present. Given the average household, the population was estimated at 20,064.

Using the same assumptions as for Ingushetia – assumed prevalence 20%, average household size of 5.7 members, precision of 5%, assumed drop-out rate of 5% – the sample size was set at 256 (n=256) which is adequate for systematic sampling in a population of about 20,064. The sampling interval set at 14.

In both sites the number of interviews was matched with the number of inhabitants on the available official lists. Households in each spontaneous settlement or TAC were randomly selected by spinning a pen to establish the starting point of the survey. Survey participants had to be aged 18 or over. To avoid selection bias due to the fact that males tend to answer the door, a coin was tossed before knocking on the door. If the person answering the door was the 'wrong' gender, the interviewer asked for the opposite gender of approximately the same age. If no one of the desired gender was present the person answering the 'door' was interviewed. If nobody answered the door the adjacent household was selected.

The survey staff met little resistance: nobody refused to participate, and survey staff reported that the majority of IDPs were glad to help, although a degree of distrust was apparent in settlements or TACs were MSF did not otherwise work.

The interview

Questions were put as factually and simply as possible, with a short explanation given if anything was unclear. All participants were asked to respond to the questionnaire during the interview: they were not allowed to fill in the questionnaire later nor were they permitted to study the questionnaire in advance. The Russian version of the questionnaire was offered first.

All interviews were done during the day, with an average of four interviews conducted daily by each team member. Interviews lasted a maximum of 60 minutes. Complete surveys were sought. To avoid exceeding the interview time it was explained that direct and short answers were necessary, and extra discussions or conversations were avoided. Interviewers were permitted to stop or interrupt when they deemed the questions to be too emotionally upsetting. When the counselor believed that the participant needed follow-up support, referral to professional counselors was facilitated. None of these incidents occurred.

A number of ethical issues were taken into consideration. Interviewers had to respect confidentiality at all times; survey results were given under anonymity, and guarantees of anonymity were given to each participant, together with a clear explanation of the purpose of the survey and the uses to which survey results would be put. It was made clear to participants that they would not receive any compensation for participating in the survey, and that they could decide at any moment to stop the interview without giving a reason.

Forms were registered anonymously. Data were entered in a spreadsheet in EXEL, data were analyzed by EXEL and EPIINFO-6.

RESULTS

The survey results of both the Chechen Temporary Accommodation Centres (TACs) and the Ingushetian spontaneous settlements (Kompakniki)are presented below. The outcomes are very similar and therefore the results are only clearly separated when they differ. If not, the distinction in text is shown by using: (C:) for results from Chechnya and *(I:)* for those from Ingushetia.

Demographics

Age/gender/ ethnicity

The vast majority (C: 97.7%; *I: 89.4%*) of interviewees were Chechen, most of the rest being Ingush (C: 1.2%, *I*: *8.8%*). Despite randomization females are over-represented in both surveys (C: 70.3%; *I: 65.4%*); this was probably due to the fact that the survey was conducted during the day, when males were absent.

The average number of family members of those interviewed was 4.3 in Chechnya and *5.8* in Ingushetia (official figures C: 5.7; *I: 5.3*), of which 13.9% in Chechnya and *12.5%* in Ingushetia are under five years old. Together with the age group 5-17 the population under 18 is a substantial part of the TACs and spontaneous settlements (C: 37.2%, 412; *I: 40.4%, 711*).

Details of the age distribution and gender can be found in Annex 1.

The majority of interviewees had finished secondary education (C: 57.4%, 147; *I: 56.5%, 160*) or higher (C: 29.3%, 75; *I: 27.6%, 78*). One in six (C: 13.3%, 34; *I: 15.6%, 44*) of people surveyed had attained at most primary-level education.

Displacement

The first displacement mainly occurred in two periods, consistent with periods of severe conflict in Chechnya: 1994/1995 (C: 47.6%, 122; *I: 36.8%, 104*) and 1999 (C: 41.0%, 105; *I: 54.4%, 154*). This meant that the majority (C: 92.2%, 236; *I: 82.2%, 244*) of those interviewed had been displaced for at least five years.

The region from which the IDPs have fled is related to the intensity of the conflict. Half came from Grozny (C: 66.4%, 170; *I: 52.3%, 148*). Of those in the TACs one fifth (C: 17.6%, 45) and in the spontaneous settlements approximately a third came from Urus/Aknoy Martanovsky (*I: 29%, 82*).

The majority of people surveyed have been displaced two till five times (C: 83.1%, 212; *I: 56.6%, 160*). Most people indicated a wish to return home (C: 86.3%, 220; *I: 85.9%, 243*). The main reason for not returning among those interviewed in the TACs was lack of shelter (C: 78.4%, 200), lack of security (C: 9.8%, 25)[ii] and poor living circumstances (C: 7.1%, 18). For people in Ingushetia lack of shelter is also important *(I: 45.6%, 129*).

[ii] Note: "lack of security" is relative to the current situation. This wil be discussed in the conclusions.

However, the lack of security is reported as the main reason for not returning (*I: 49.1%, 139*).

Returnees to Chechnya

The IDPs that returned to Chechnya were 'housed' in TACs came from Ingushetia (61.9%, 140), other parts of Chechnya (25.7%, 58) or elsewhere (9.8%, 25). Before arriving in the TACs the IDPs lived in tented camps (65%, 147), private accommodation (15%, 34) or spontaneous settlements (13,3%, 30).

The reason for returning to Chechnya was poor living circumstances (28.7%, 66), people felt home sick (26.1%, 60) or were tempted by the compensation offered by the authorities (17.4%, 40). Only a few were forced to return (1.7%, 4) directly, with more forced to return indirectly through the closing of the camps (12.2%, 28). One in ten (C: 9.6%, 22) thought the situation would normalize.

The TACs are intended for short stay only. While the majority of the people have been in these centres less then a year (C: 52.9%, 135), a substantial number have already been there for between one and two years (C: 34.1%, 87), or longer (C: 12.9%, 33).

Living Conditions

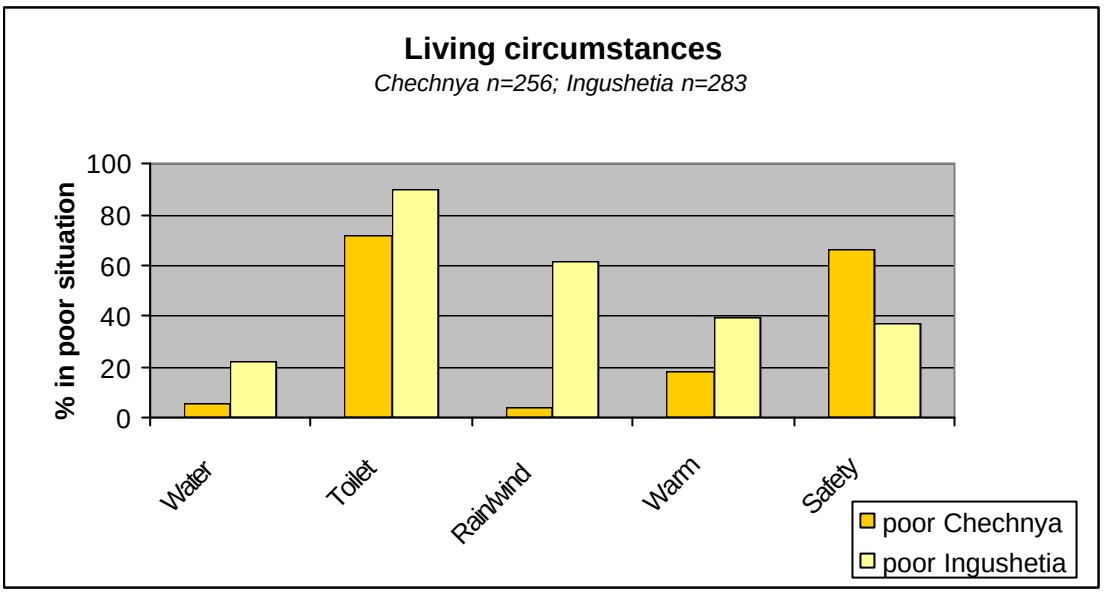
Availability of food and dependence on charity

Most of the people interviewed (C: 49.4%, 126; *I: 59.4%, 168*) said they always had at least two meals a day. However, a third (C: 36.5% (93); *I: 29.3%, 83*) had two daily meals only 3-5 days a week, while several (C: 13.3% (34), *I: 11.3%, 32*) had two daily meals only 1-2 times a week. Almost all of the respondents are entirely (C: 64.1%, 164*; I: 42%, 119*) or highly (C: 31.3%, 80; *I: 52.3%, 148*) dependent on charity. Only 1 in 20 (C: 4.6%, 12; *I: 5.6%, 16*) are self-sufficient.

Physical conditions

Graph 1 gives an overview of living circumstances in the Chechen TACs and Ingush spontaneous settlements. In Chechnya and Ingushetia almost all are able to obtain water (C: 94.5%, 242; *I: 77.7%, 220*) at least 3-5 times a week. In Chechnya the water source is a bladder or tanker (52.3%, 134) or communal tap (30.1%, 77). In the Ingush settlements the majority (*76.3 %, 216*) receive water from a communal tap.

Graph 1



Toilet facilities are poor[iii] for the majority (C: 72.4%, 184; *I: 90.1%, 255*) in both locations, resulting in observable unhygienic situations.

Most of the interviewees in Chechnya (95.7%, 242) indicated that their accommodation offers adequate protection against wind and rain. Still, 18.4% (47) are unable to keep their living quarters warm in the winter. In the spontaneous settlements in Ingushetia, in contrast, one third of interviewees (*38.2%, 108*) indicated that their accommodation is not protected against wind, rain or water, and a substantial number (*40.2%, 113*) are unable to keep their living quarters warm in the winter. (Annex 2).

Feeling unsafe

Two thirds of people in Chechnya – twice as much as in Ingushetia – indicated that they never or only occasionally feel safe (C: 66.8%, 171; *I: 37.5%, 106*). Since the start of the conflict the arrest or disappearance[iv] of friends (C: 27.7%, 71; *I: 25.8%, 73*) or neighbours (C: 51.6%, 132; *I: 36.4%, 103*) was common. Among the nuclear family the disappearance of siblings (C: 15.6%, 40; *I: 20.1%, 57*), nieces/nephews (C: 16.8%, 43*; I: 18.4%, 52*), and aunts/uncles (C: 16.0%, 41; *I: 7.4%, 21*) were reported most often, while it was not uncommon that partner disappeared (C: 4.3%, 11; *I: 4.9%, 14*).

[iii] Poor= not available, or shared and outside

[iv] Arrest= the person is confirmed to be arrested by the authorities. Disappeared= the person is taken by the authorities or rebels without confirmation

Past events

Feelings of safety are subjective and can be related to the current situation but may also be the results of past exposure, experience of or witnessing of traumatic experiences. People surveyed were asked questions on a number of events[v] that are known to occur frequently in Chechnya or in armed conflict generally.

Recent exposure and self experienced

People were asked to indicate whether they had been exposed[vi] to conflict related violence in the last month.

In Chechnya thirty-two people (13.7%) indicated exposure to violence, reporting over 60 events in the past month. Most frequently mentioned were: mopping up[vii] (more then 22) and to a lesser extent attacks and crossfire (both more then 8 times). Apart from having been present (exposed) 4 people (1.6%) were threatened personally in violent events like maltreatment (3 times) and forced labour (2 times).

In Ingushetia less people (*I: 4.6%, 13*) reported exposure to a total of 31 violent incidents in the past month. However, in contrast to Chechnya the self-experienced violence is higher. Twenty-five IDPs (*8.8%*) had been directly targeted by violence themselves in the last month. The majority of these (18 times) had been detained/taken hostage.

Exposure (since the start of the conflict)

Interviewees were asked to indicate their exposure to war related violence since the start of the conflict. All IDPs saw 1994 as the start of the conflict. It was found that few (C: 6%, 15, *I: 2%, 5*) have escaped the conflict. Exposure to violence since the start of the conflict was similar for both groups in Chechnya and Ingushetia.
The most common events included attack on house or village (C: 69.5%, 178; *I: 72.5%, 205*), cross fire (C: 61.7%, 158; *I: 59.7%, 170*), aerial bombarding (C: 80.5%, 206; *I: 77.7%, 220*), mortar fire (C: 71.5%, 183*; I: 68.6%, 194*), taking risks to find food (C: 46.5%, 119; *I: 44.2%, 125*), burning of houses (C: 44.5%, 114, *I: 41.3%, 117*), destruction of property[viii] (C: 78.9%, 202*; I: 80.6%, 228*), and exposure to mines (C 27.3%, 70; *I: 18.7%, 53*). The majority of IDPs (C: 80.5%, 206; *I: 76.7%, 217*) had exposed mopping-up operations at least once (Graph 2).

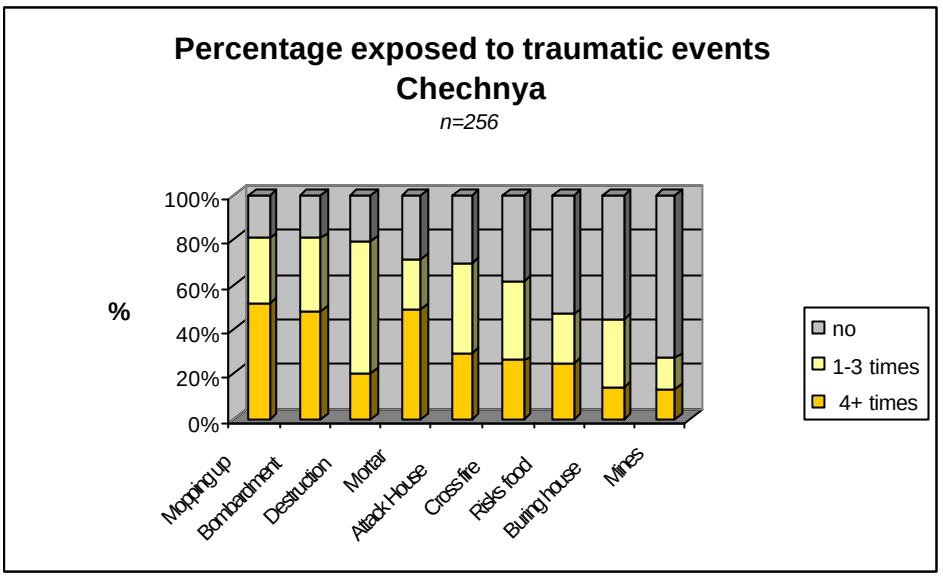
[v] The interviewee could choose from the categories: attack on village or house, caught in cross fire, explosion of mines, aerial bombing, mortar fire, risk-taking to acquire food, burning of houses, destruction of properties, or mopping up actions

[vi] Exposed is defined as being present but not personally involved

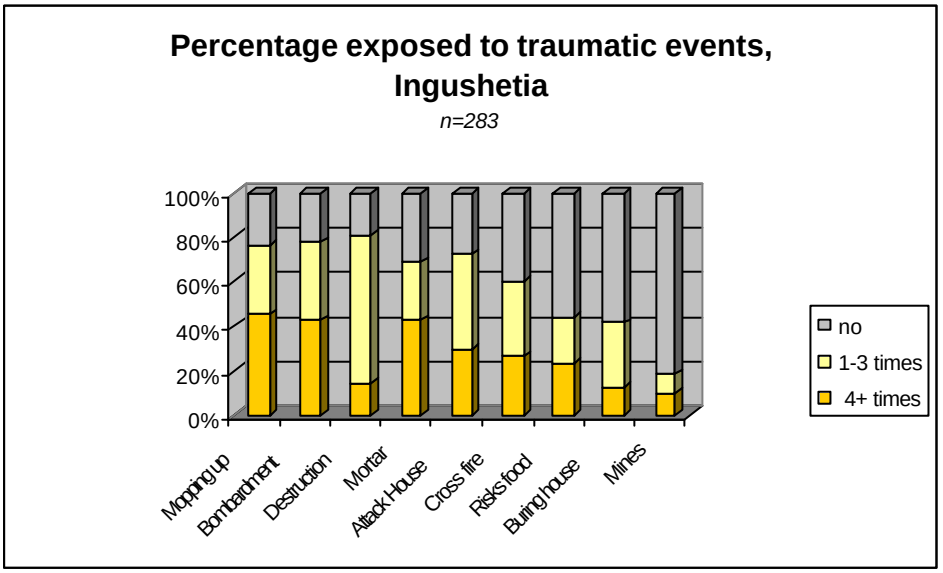
[vii] Mopping up= (often very violent) operations used by the army to identify ' terrorists' among civilian population.

[viii] The distinction between house and property is useful since some IDPs were able to save everything but their house while others lost all their possessions but their house. The possession of a house facilitates the return usually.

Graph 2 A



Graph 2 B



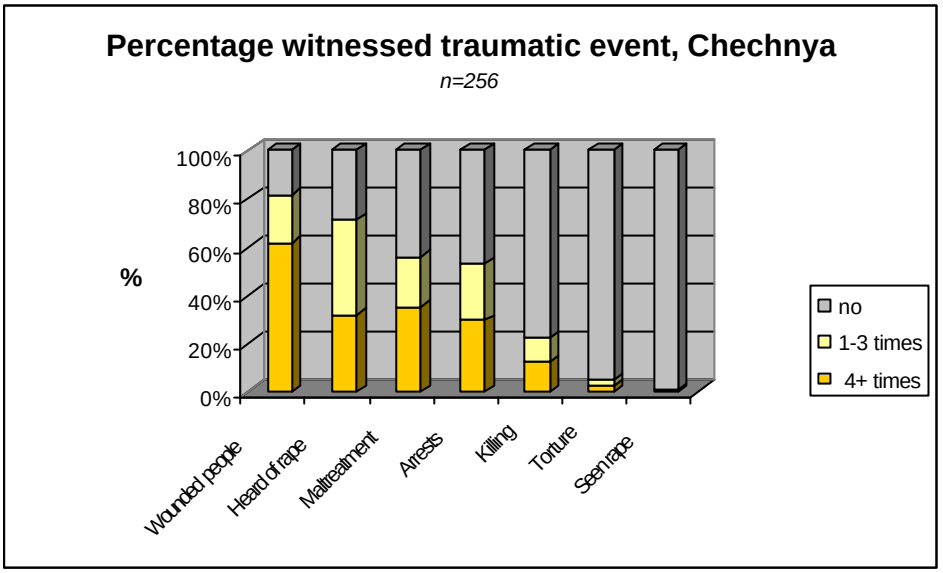
Witnessing violence (since the start of the conflict)

Witnessing extreme violence is associated with psychosocial and mental health problems, including PTSD[32]. The level of witnessing traumatic events was similar in both Chechnya and Ingushetia. In Chechnya only 20 people (7.8%) and in Ingushetia only 13 people (*4.6%*) did not witness a violent event. More then one in five (C: 22.7 %, 58; *I: 24.1%, 68*) witnessed the killing of people, while over 80% (C: 82.0%, 210*; I: 86.2%, 244*) had seen wounded people since the start of the conflict. Nearly half of people interviewed witnessed arrests (C: 53.1%, 136; *I: 48.4%, 137*) and maltreatment (C: 56.2%, 144; *I:*

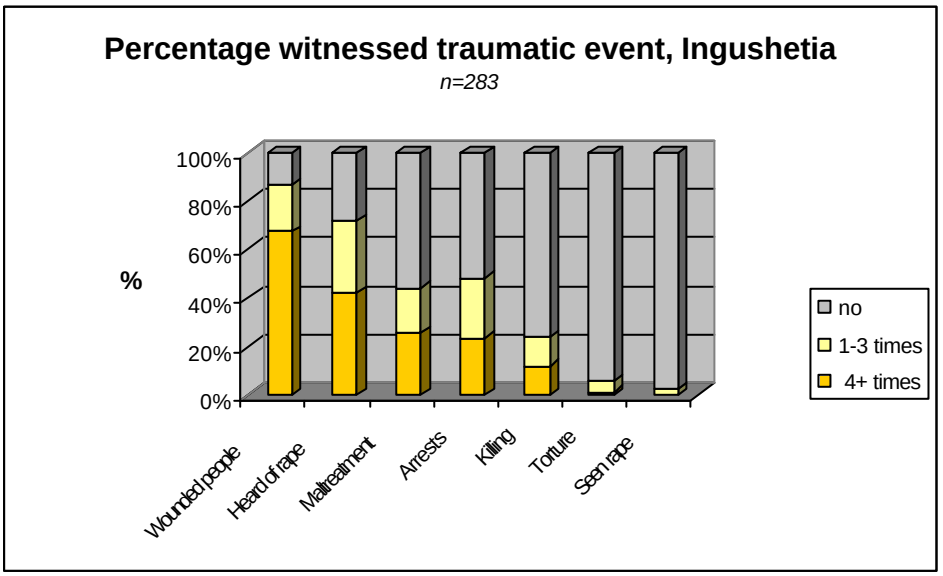
44.5%, 126). Several people (C: 5.4%, 14; *I: 5.6%, 16*) had been witness to torture. (Graph 3).

Many people (C: 71.1%, 181; I: 72.1%, 204) had heard about incidences of rape but only a few had witnessed it (C: 0.8%, 2*; I: 2.5%, 7*).

Graph 3 A



Graph 3 A



Personal experienced violence (since the start of the conflict)

The witnessing of violent events can be traumatic. To experience violence or life-threatening situations personally is even more so[33]. In Chechnya 34.6% (88) respondents personally experienced violence. In Ingushetia this was slightly lower: *28.3%* (*80*). The type of violence experienced was similar in both locations: maltreatment (C: 25.8%, 66*; I: 20.5%, 58*), detention and hostage (C: 9.8%, 25; *I: 9.5%, 27*), arrest/kidnapping: (C: 7.0%, 18*; I: 7.4%, 21*), and forced labour (C: 5.8%, 15; *I: 8.1%, 23*) were the most frequent events experienced by IDPs.

Over 1 in 10 people (C: 12.5%, 32; *I: 11.7%, 33*) had been injured by violence. Torture (C: 2.7%, 7; *I: 3.9%, 11*) and mine injuries (C: 0.4%, 1; *I: 1.8%, 5*) were also reported. One person in Chechnya reported sexual violence.

Recent mortality

In the past two months 28 people from 19 families had died in Chechnya and 26 people from 24 families in Ingushetia. Over 7% (C: 7.4%, n=256; *I: 8.5%, n=283*) of the interviewed had lost a member of the nuclear family.[ix] The majority (C: 64.3%, 18; *I: 65.4%, 17*) of deaths are male.

In Chechnya the main cause of death was violence (C: 39%, 11) – reported as mine accidents, terrorist acts, and bombardments. In Ingushetia one fifth deaths were violence-related *(I: 19.2%, 5*). Cardiovascular diseases and other chronic diseases accounted for 53.6% of recent deaths in Chechnya and *73%* in Ingushetia. Accidents caused 7.1% and *8%* of the deaths in the nuclear families respectively.

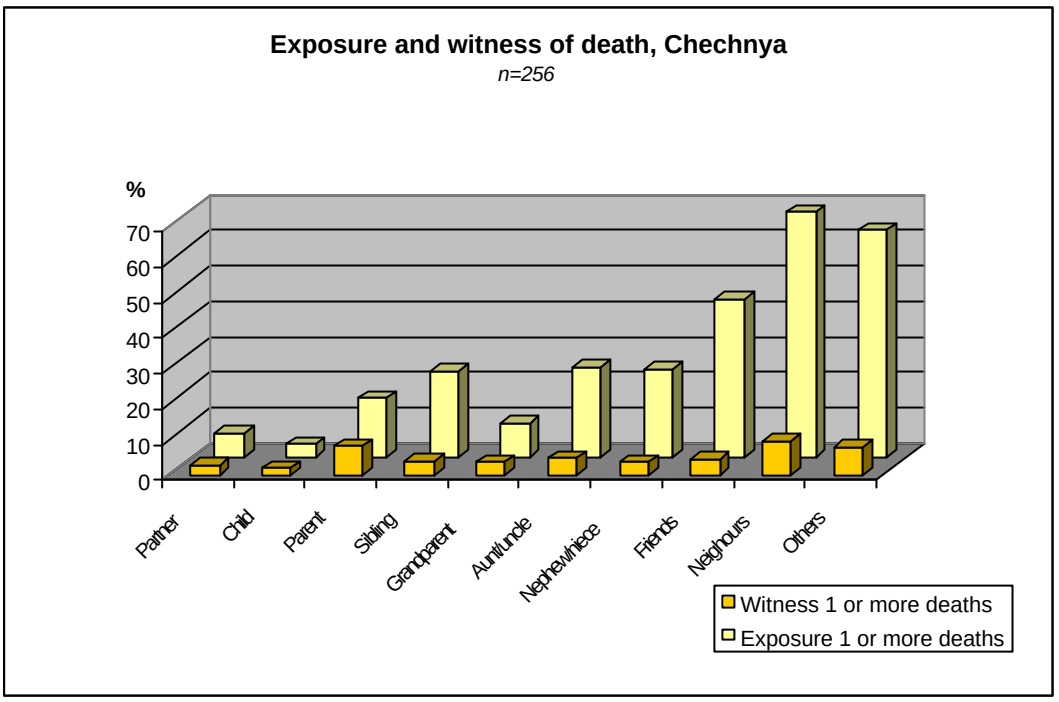
Death of relatives, friends and neighbours (since start conflict)

Since the start of the conflict over half of respondents (54.1% 143) in Chechnya and over a third (*37%, 105*) in Ingushetia reported at least one loss in the nuclear family (Graph 4). A similar number (C: 99, 38.7%; *I: 35.7%, 101*) lost at least one more distant family member. Over a third of people had lost a friend (C: 44.1%, 113; *I: 34.6%, 98*) while almost two-third of interviewed had lost a neighbour (C: 68.8%, 176; *I: 62.9%, 178*). Overall, in Chechnya only one in ten did not lose someone close (11.2%, 32); in Ingushetia this figure was less (*17.3%, 49*).

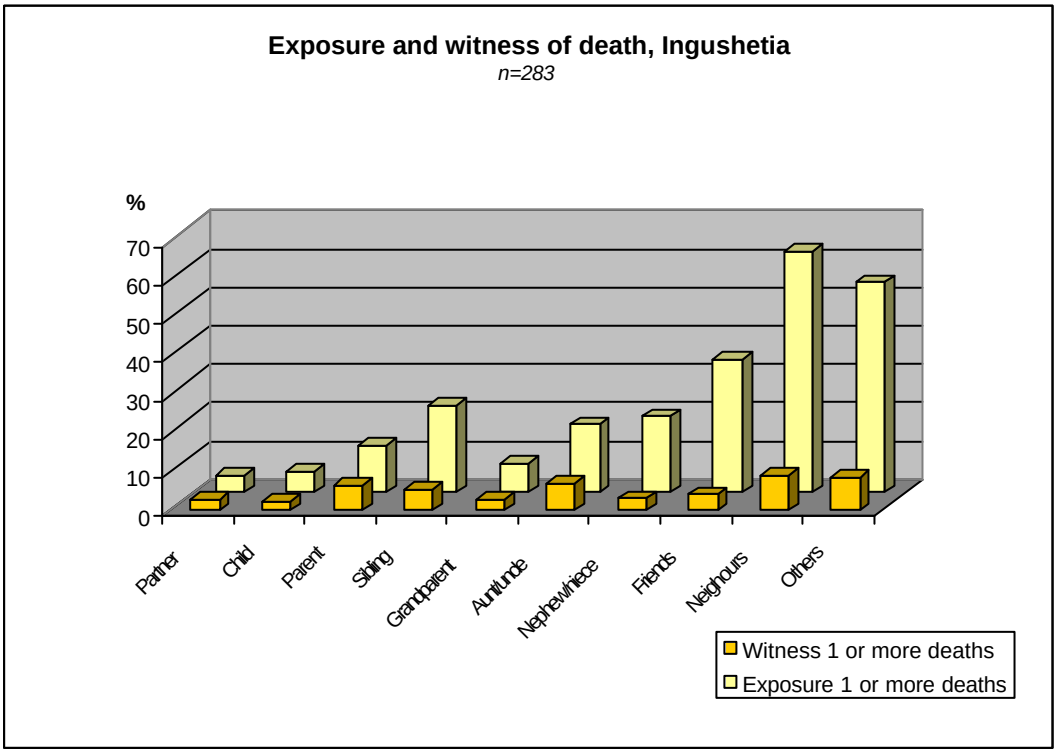
Some respondents actually witnessed the violent death of those close. About one sixth (C: 14.9%, 38*; I: 15.2%, 43*) of respondents witnessed the death of a nuclear family member, with less (C: 6.3%, 16; *I: 8.8%, 25*) witnessing the death of a more distant family member, as is to be expected for a witnessing event. A number of the interviewed witnessed the death of friends (C: 4.3%, 11; *I: 4.2%, 12*) and neighbours (C: 9.4%, 24; *I: 9.2%, 26*). (Annex 3).

[ix] Nuclear family is here defined as Father/Mother, Brother/Sister, Husband/Wife, and own children.

Graph 4 A



Graph 4 B

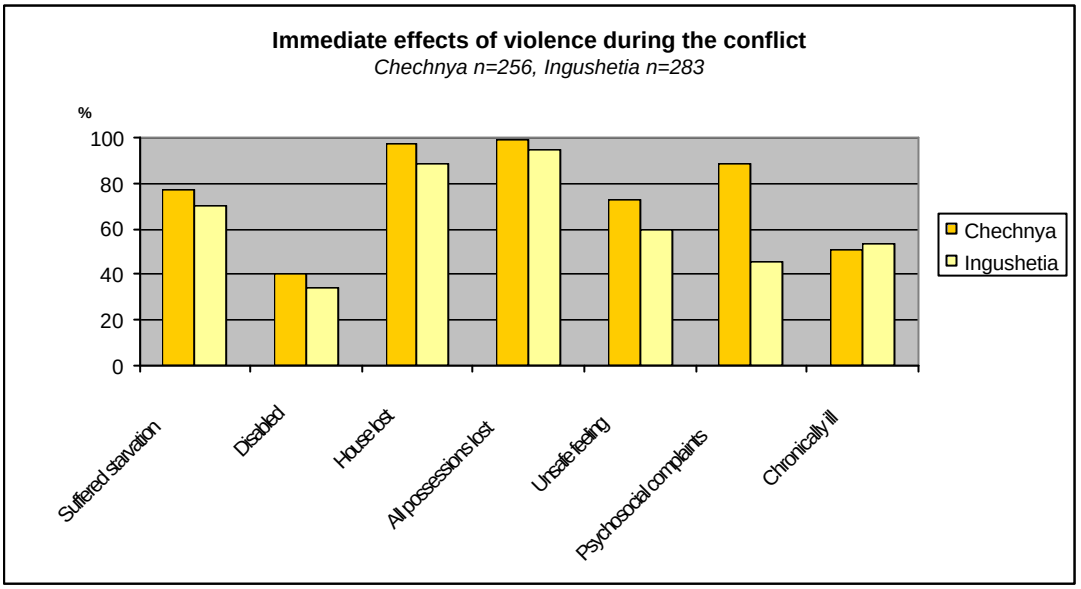


Immediate effects of violence (since the start of the conflict)

The majority (C: 77.0%, 197; *I: 70%, 198*) of those interviewed had suffered from starvation (Graph 5). A third (C: 40.2%, 103; *I: 33.9%, 96*) indicated some form of disability (physical, auditory or visual). Nearly all had lost their house (C: 97.3%, 249; *I: 88.3%, 250*) or possessions (C: 99.2%, 254; *I: 94.7%, 268*).

A significant number of people (C: 73.0%, 187; *I: 60.1%, 170*) felt constantly unsafe throughout the conflict. Incidences of chronic physical illness were high (C: 50.4%, 129; *I: 53.4%, 151*). Psychological/psychosocial complaints were nearly double in the Chechen sample (C: 88.7%, 227; *I: 45.2%, 128*).

Graph 5

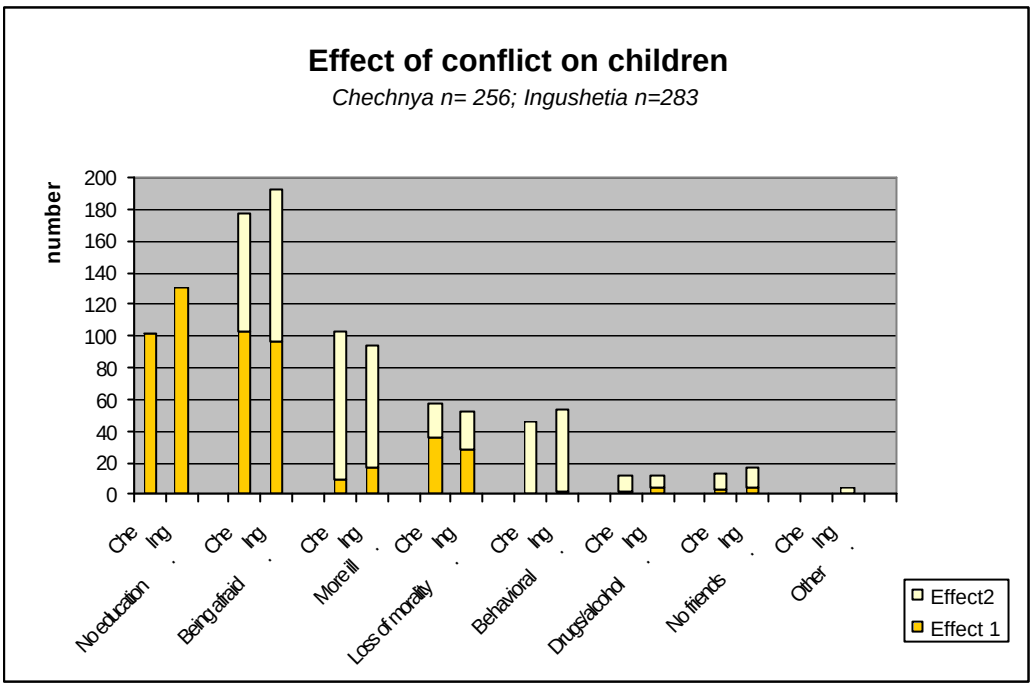


Effect of the conflict on children

People were asked what effect the conflict had on the children (Graph 6). They could indicate two consequences: most important and second most important. The most important effects according to respondents were in Ingushetia lack of education (C: 39.5%, 101; *I: 46.3%, 131*), and in Chechnya fear (C: 40.2%, 103; *I: 34.3%, 97*). Others mentioned loss of morality and values (C: 14.1%, 36; *I: 9.9%, 28*), and illness (C: 3.9%, 10; *I: 6%, 17*).

In the series of second most important effects fear (C: 28.9%, 74; *I: 33.9%, 96*) and illness (C: 36.3%, 93; *I: 27.2%, 77*) scored highest. Behavioural changes (C: 17.5%, 45, *I: 18.4%, 52*) and loss of morality and values (C: 8.2%, 21; *I: 9.9%, 28*) were also indicated as important. It is remarkable that, taking both responses into account, over two-thirds of people said that fear was the most important effect on children (C: 69%, 177; *I: 68%, 193*)

Graph 6



Approximately one quarter of the parents with boys (C: 25.0%, 124; *I: 26.8%, 142*) and one third of the parents with girls (C: 31.6%, 133*; I: 29.4%, 170*) indicated that none or only some of their children attended school.

Physical Health

General Health Questionnaire 28

The GHQ 28[34] is used as community screening tool. The general health questionnaire 28 is not validated for the Caucasus and no threshold (or cut off) score has been defined for this survey. Although we found the GHQ 28 to be well accepted and easy to administer, scores have to be interpreted with caution.

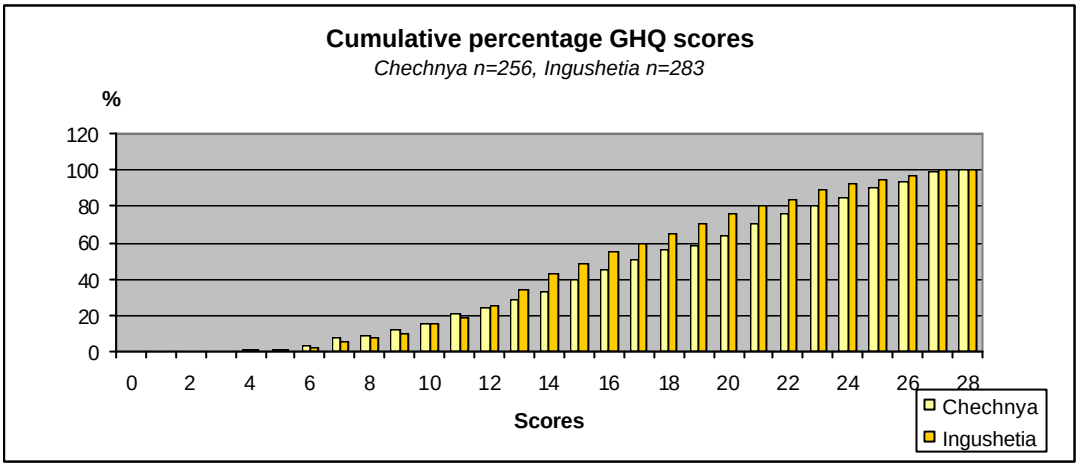
As recommended, the two first categories were scored 0 while the last two answering categories were scored 1. A total score is obtained by summing the item scores. A cut off score of 5 was used,[35] meaning that those answering positively to 6 questions would be considered a 'case'.

In both populations extremely high number of person were considered at risk of ill health (C: 98.8%, 253[x]; *I: 98.2%, 278*[xi]). In other words a low percentage of people was found not at risk (C: 1.2%, 3[xii]; *I: 1.8%, 5*[xiii]).

[x] 95% confidence interval: 98.8% (CI: 96.6% - 99.8%)
[xi] 95% confidence interval : 98.2% (CI: 95.9% - 99.4%)
[xii] 95% confidence interval: 1.3% (CI: 0.2% - 3.4%)

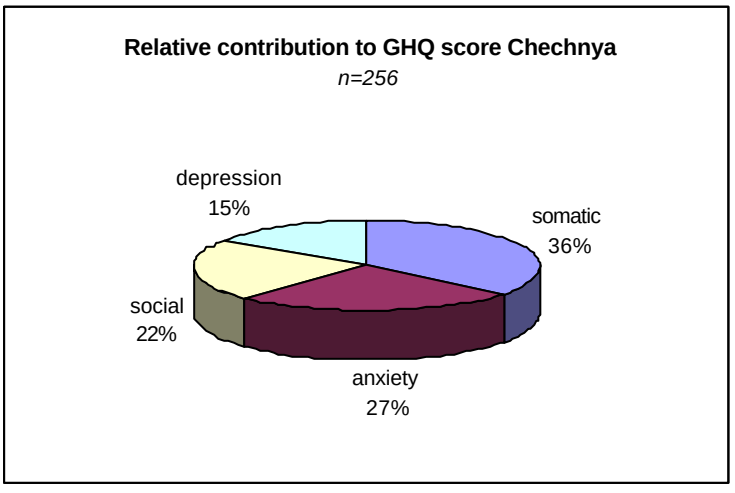
When the cut off score was raised to 11 (as was used for a previous study following the Kosovar conflict[36]) still around 80% of the population is at risk (C: 78.5%, 201[xiv]; *I: 81.3%, 230*[xv]). (Graph 7.)

Graph 7



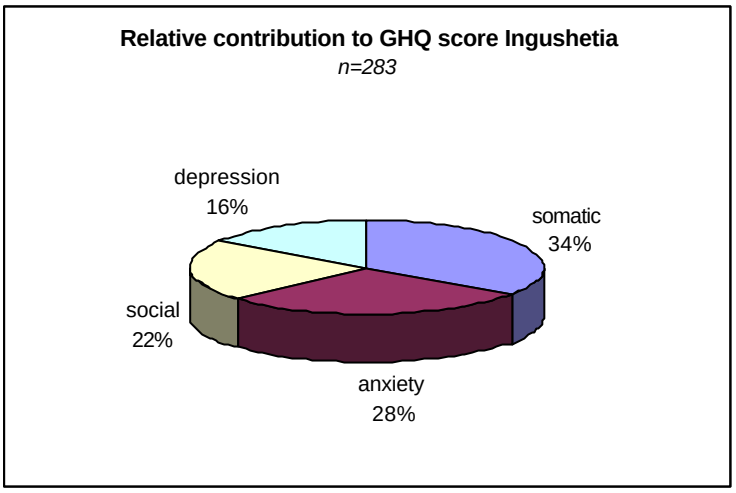
The questions of the GHQ 28 are categorised in 4 subscales[xvi] representing somatic complaints, anxiety & insomnia, social dysfunction and feelings of depression. These subscales are not designed to make a specific diagnose, and are not independent from each other[37]. However, for assessment of general health of a community it is helpful to identify subscales that are proportionally higher then others (Graph 8). The subscale on somatic symptoms (C: 36%, *I: 34%)* is the highest together with anxiety (C: 27%, *I: 28%*) in both populations.

Graph 8 A



[xiii] 95% confidence interval: 1.8% (CI: 0.6%-4.1%)
[xiv] 95% confidence interval: 78.5% (CI: 73.0% - 83.4%)
[xv] 95% confidence interval: 81.3% (CI: 76.2% - 85.6%)
[xvi] Lickert scoring (0, 1, 2, 3) was used to establish the subscale scores.

Graph 8 B



Subjective health experience

A 4 points scale (Lickert-score) was used to score the items about subjective health. Note that the following description is not a diagnosis but refers to the subjective feeling of the respondent about his/her health.

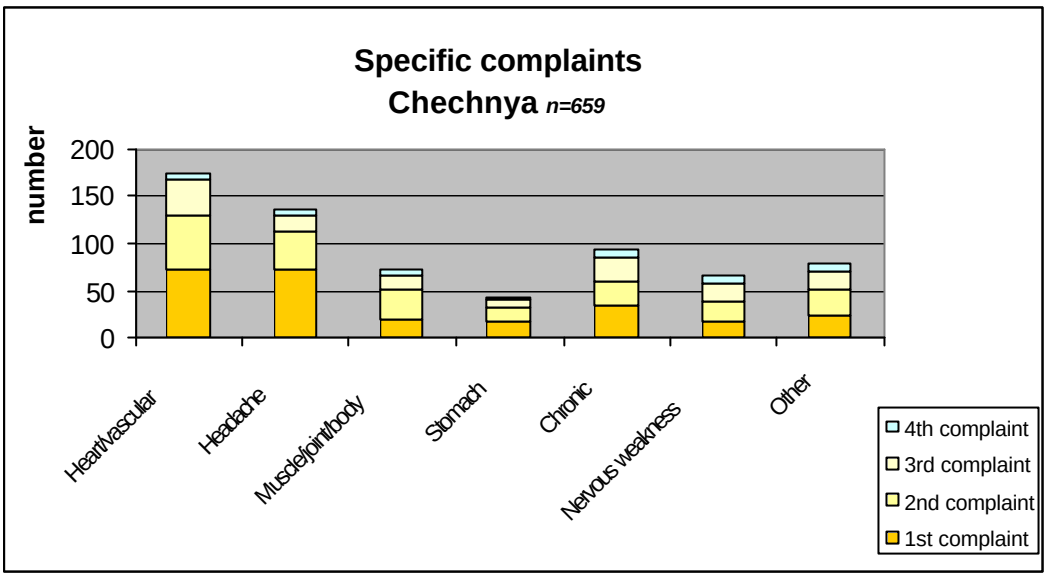
It was found that the majority (C: 51.6%, 131; *I 60.4%, 171*) indicated feeling often unhealthy, with only a small percentage of the respondents (C: 3.9%, 10; *I: 3.2, 9*) indicating that their health was not a concern (Graph 9).

A similar number of respondents reported having had specific symptoms in the 6 months prior to the survey. About half of respondents reported experiencing physical complaints often (C: 45.9%, 117; *I: 53.4%, 151*) and a third reported that these occurred sometimes (C: 30.6%, 78; *I: 28.3%, 80*). Few people (C: 5.5 %, 14; *I: 6.7%, 19*) reported suffering no physical symptoms the past 6 months.

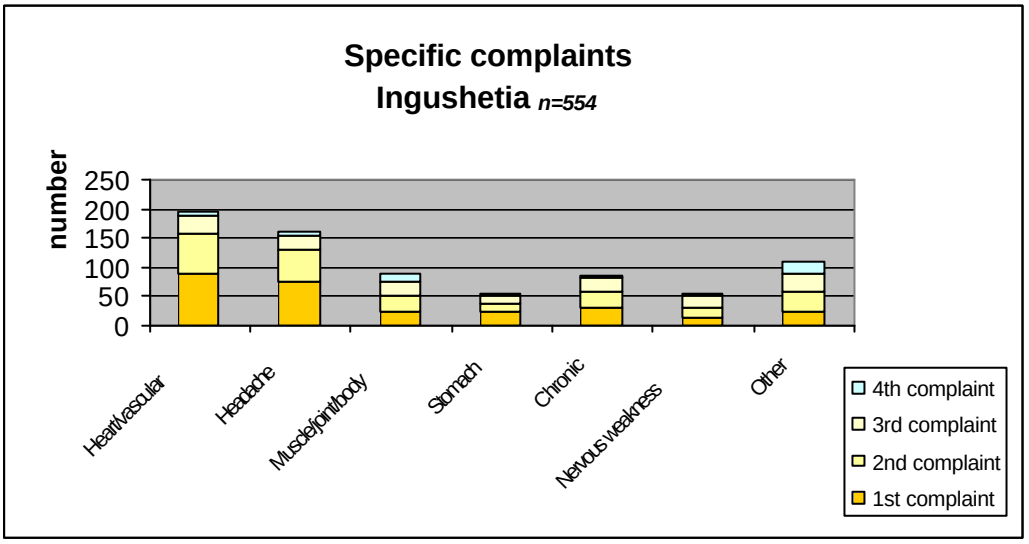
Types of complaints

To get an impression of the type complaints experienced over the past 6 months, respondents were asked to indicate complaints (maximum of four) in order of priority. All answers (C: 659; *I: 752*) on these open questions were then grouped in categories (Graph 10). Most respondents had multiple complaints in the past 6 months. A considerable number of respondents (C: 26.3%, 173; *I: 26.3%, 198*) indicated cardiovascular problems; headaches were the second most-frequently reported complaint About 10% (C: 21%, 135 of all answers; *I: 21.3%, 160*) reported muscle or joint pain. Chronic disease (C: 14.0%, 92; *I: 11.3%, 85*), nervous complaints (C: 9.9%, 65*; I: 7.3%, 55*) and stomach complaints (C: 6.1%, 42; *I: 7.3%, 55*) were also reported.

Graph 10 A



Graph 10 B



Availability and accessibility health services and drugs

Lickert-scores were used to find out frequency, use, availability and effectiveness of the various services over the past four weeks.

Approximately four percent had not visited health services at all over the past 4 weeks (C: 41.4%, 106; *I: 42.2%, 119*). Half of respondents reported the medical services were either often (C: 12.5%, 32; *I: 13.1%, 37*) or sometimes accessible (C: 33.2%, 85; *I:*

40.1%, 113), but a considerable number indicated the medical services were rarely (C: 37.5%, 96; *I: 27.3%, 77*) or not at all accessible (C: 16.8%, 43; *I: 19.5%, 55*).

Over fifty percent reported difficulties in accessing drugs stating they were rarely (C: 35.9%, 92; *I: 30.1%, 85*) or never (C: 25.8%, 66; *I: 24.8%, 70*) available. The rest stated that drugs were often (C: 11.3%, 29; *I: 14.5%, 41*) or sometimes available (C: 27.0%, 69; *I: 29.8%, 84*). Approximately one quarter (C: 25.8%, 66; *I: 24%, 68*) did not use any drugs the last four weeks. Half of the responds (C: 57.8%, 148; *I: 48.1%, 136*) do not use alternative health services at all while an almost equal number of people use them sometimes (C: 13.7%, 35; *I: 20.5%, 58*) or rarely (C; 18.8%, 48; *I: 19.1%, 54*).

General Items

Conflict and signs of psychological distress

Interviewers were asked by means of open questions to cite a maximum of 5 examples of signs that indicate a person is disturbed or is feeling upset. The answers on this open question were categorized as appearance (e.g. mimics, facial/eye expression, gesticulation, glance/tiredness), behaviour (overactive, aggressive/quarrelling, talking a lot/loudly, upset, confused, irritability/conflict, angry, nervous/panic), mood (fear, anxiety, cry, despair, worry, troubled, despair, lost, bad/sad/depressed mood), numbness (silent, withdrawn, amnesia, absent minded, apathy, not talking, alcohol abuse), and social consequences (unsociable).

A majority mentioned behaviour (C: 67.1% (492 out of 733 answers); *I: 53.5% (442/826 answers)* and mood (C: 19.2% (141/733 answers); *I: 25.3% (209/826 answers*) as the most important signs emotional disturbance. To a lesser degree numbness (C: 11,9%; *I: 11%*), social attitude (C: 0%; *I: 6%*) and appearance (C: 1.8%; *I: 4%*) were mentioned.

Extent psychological problems

Two thirds of respondents (C: 80.1%, 205; *I: 66.8%, 189*) agreed with the statement that the conflict has triggered mental disturbance or feelings of being upset. Only a small minority disagrees (C: 1.2%, 3; *I: 1.8%, 5*) or said they did not know (C: 2.7%, 7; *I: 5.3%, 15*). Nearly all respondents (C: 87.1%, 223; *I: 80.2%, 227*) indicated that they have family members that have difficulty in coping with their disturbance or upset feelings. A small minority disagreed (C: 4.3%, 11; *I: 9.2%, 26*) or said they did not know (C: 8.6%, 22; *I: 10.6%, 30*).

Coping mechanisms

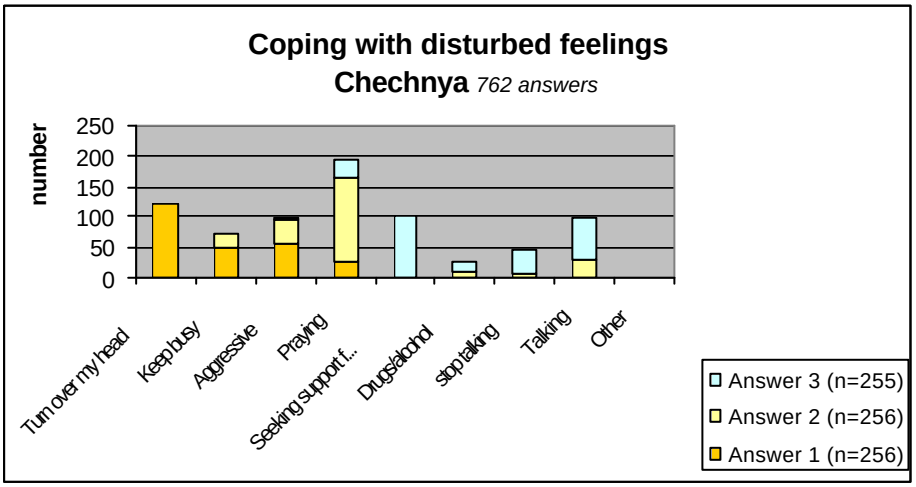
Coping mechanisms are activities that people do (or not do) to help them deal with their problems and intense emotions. According to cognitive processing theory two psychological processes are central to coping with extreme events: intrusion and avoidance[38]. Intrusion is the state in which the survivor unconsciously re-lives his traumatic experience. To balance the pain and discomfort associated with the memories

and emotions people modulate the number of intrusions through denial and avoidance mechanisms. Under normal circumstances this coping process lasts approximately one month. However, people living under constant threat and strain may show coping behaviours that have become more permanent.

Survey participants were asked to choose, in order of priority, the three most important coping strategies from a series of categories. The categories were: turn my head[xvii], keep busy, aggressive behaviour, praying, drugs/alcohol abuse, stop speaking to people, talk to others, seeking support from family and other. Most people indicated in their first response (C: n=256; *I: n=283*) that 'turning their head' (C: 48.0%, 123; *I: 46.3%, 131*) was the most common way to cope with a problem. Keeping busy (C: 19.5%, 50; *I: 20.8%, 59*), aggressive behaviour (C: 21.9%, 56; I: 18%, 51), and praying (C: 10.5%, 27; *I: 14.1%, 40*) were also common. Talking to others was hardly stated as a coping mechanism in the first answer.

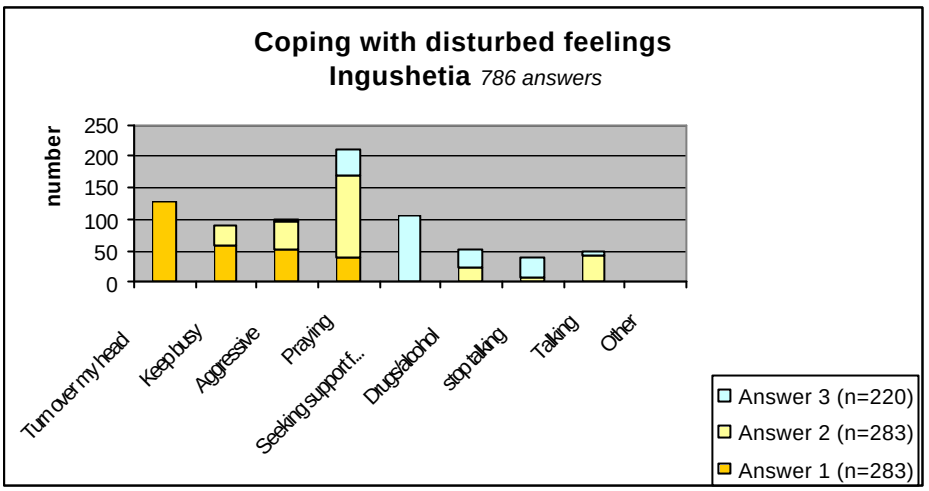
For the second response, the most preferred option was praying (C: 53.3%, 137; *I: 46.3%, 131*). Talking seemed to increase (C: 12.5%, 32; *I: 14.1%, 40*); keeping busy was less common; (C: 9.4%, 24; *I: 16.3%, 46*) some people managed through aggression. (C: 15.6%, 40; *I: 16.3%, 40*). In the third and last option people stated they preferred the support of the family members (C: 39.6%, 101; *I: 37.5%, 106*). Talking to others was also stated as important, (C: 25.9%, 66*; I: 24.7%, 70*) while aggression decreased (C: 1.2%, 3*; I: 0.7%, 2*). Drugs and alcohol use remained stable in the second and third answer (respectively C: 5.1%, 6.7%; *I: 9.2%, 9.9%*). (Graph 11).

Graph 11A



[xvii] ' To turn head' is a Chechen expression for withdrawing from other people to contemplate, think over what has happened and to come to terms with what happened.

Graph 11B



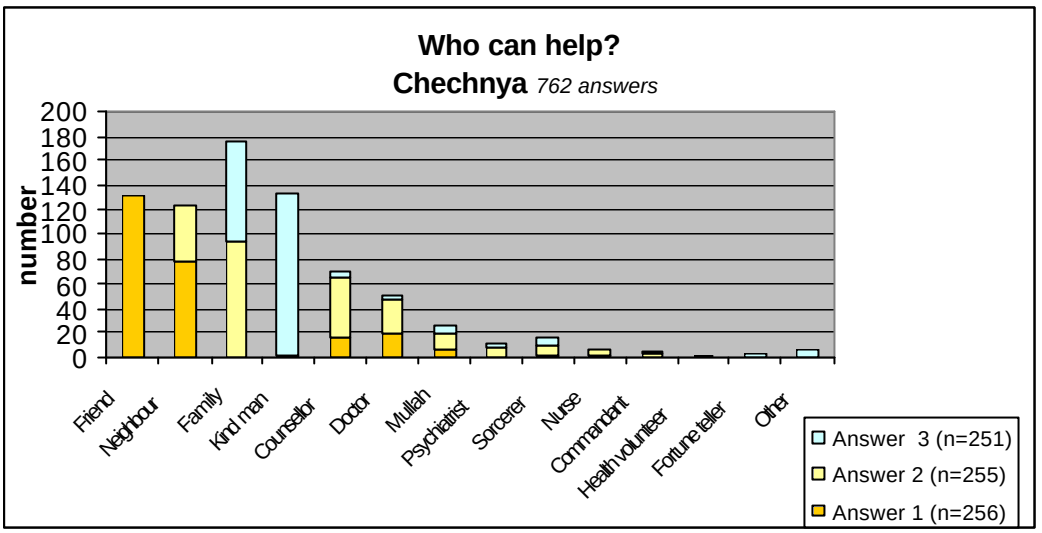
Where to get support or help?

To find out what social support is used the respondents could choose from pre-designed categories: friend, neighbour, nurse, doctor, counsellor, health volunteer, psychiatrist, commandant[xviii], Mullah, sorcerer, family member, kind man[xix], fortune teller, and other. All respondents answered three times. In their first answer (C: n=256; *I: n=283*) friends (C: 51.6%, 132; *I: 47%, 133*), and neighbours (C: 30.9%, 79; *I: 26.1%, 74*) were cited as most important. Health staff – doctor (C: 7.4%, 19; *I: 12%, 34*) or counsellor (C: 6.3%, 16; *I: 9.5%, 27*) – was also regarded as important sources of support.

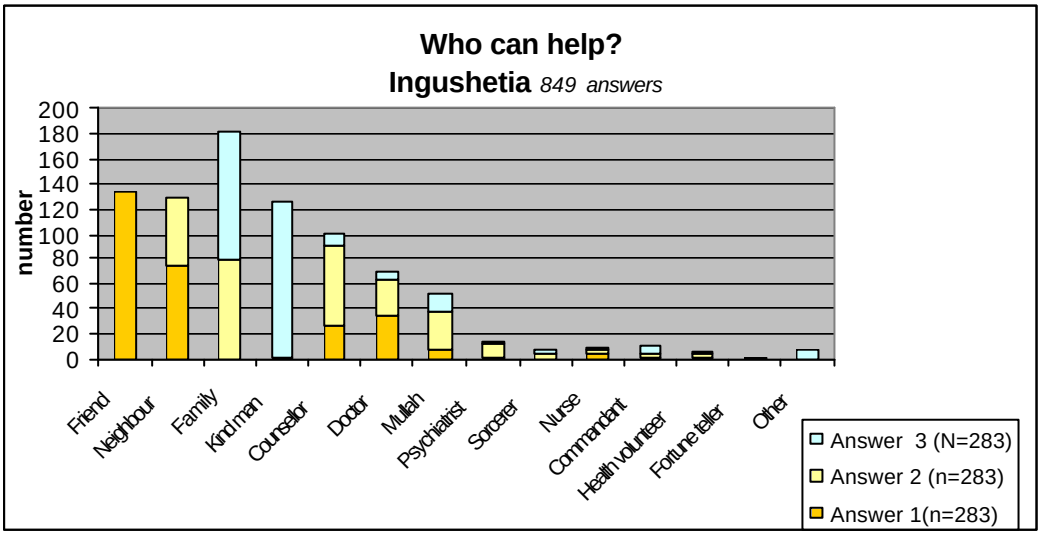
The second series of answers (C: n=256; *I: n=283*) show an increase of the role of family members (C: 36.9%, 94; *I: 27.9%, 79*), counsellor (C: 18.8%, 48; *I: 22.3%, 63*), and Mullah (C: 4.7%, 12; *I: 10.6%, 30*). The role of neighbours decreased (C: 18.0%, 46; *I: 19.1%, 54*). As the third and last option (C: n=251; *I: n=283*) people use mostly the support of family members (C: 33.1%, 83; *I: 36.4%, 103*), and kind men (C: 53.0%, 133; *I: 43.5%, 123*). See also Graph 12.

[xviii] Commandant is the one who is responsible for the spontaneous settlement. It should not be associated with military.
[xix] Kind man is a respected person from the community who helps people with all kinds of problems.

Graph 12 A



Graph 12 B

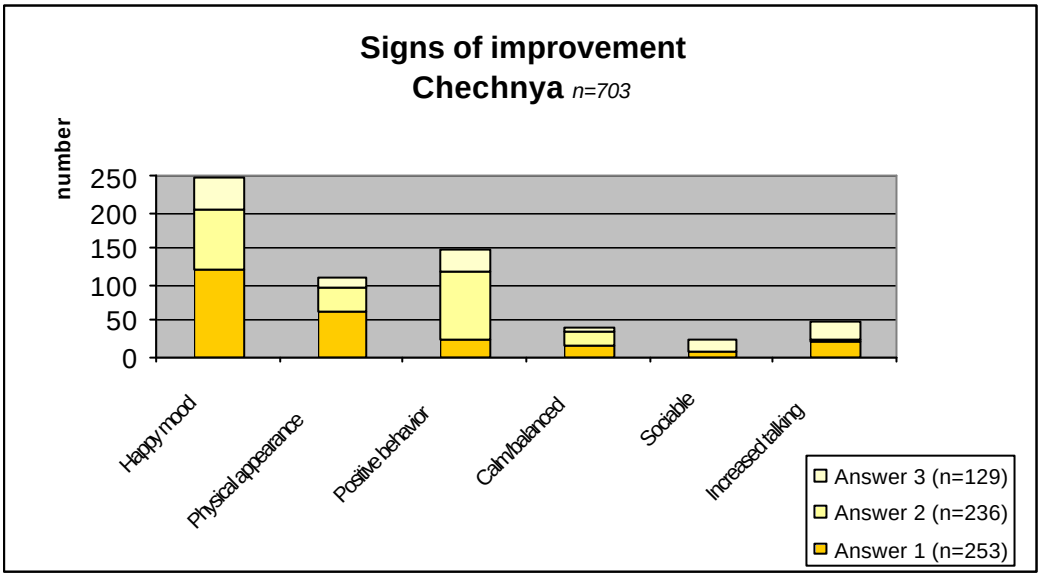


Signs of psychological improvement

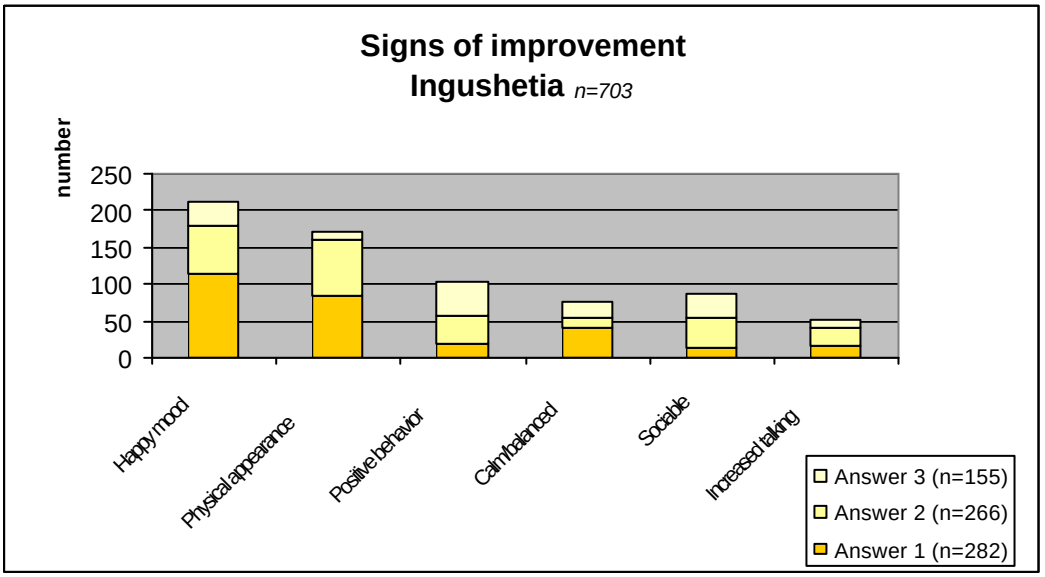
To increase our understanding it is important to know how common people observe psychological improvement in people suffering from feeling upset. The respondents were asked by means of an open question to describe observable signs (maximum 3) of psychological improvement. The answers were categorized as physical appearance (e.g. eyes, mimicry, shining eyes, laugh, light gate), positive behaviour (e.g. active, dance, energetic, well disposed, give to charity), happy mood (e.g. cheerful, funny, merry, singing, soft voice), calm/balanced (e.g. gentle, confident, tender, even-tempered), social able (e.g. kind, considerate for others, hospitable, make visits, make gifts) and increased talking.

Graph 13 shows the overall scores on the various categories divided in first (C: n=253; I*: n=283*), second (C: n=236; *I=266*) and third (C: n=129; *I: n=155*) answer (total answers: C: n=618; *I: n=703*). When all answers are taken together a happy mood (C: 40%; *I: 30%*), positive behaviour (C: 24%, *I: 15%*) and physical appearance (C: 18%; *I: 24%*) are the best indicators of psychological improvement. Less mentioned are such being sociable (C: 4%; *I: 12%*), being calm/balanced (C: 7%; *I: 11%*) and increased talking (C: 8%; *I: 7%*).

Graph 13 A



Graph 13 B



Psychiatric illness

Over half (C: 59.8%, 153; *I: 57.2%, 162*) said they knew somebody who suffered from mental illness. Because asking people to distinguish between psychiatric illness and psychological or psychosocial problems would not be realistic, interviewees were asked, in open questions, to name two behavioural traits associated with mental illness.

For both Chechnya (n=249) and Ingushetia (*n=281*) the first five most important responses were as follows: aggression/fights (C: 36.1%, 90; *I: 34.9%, 98*), abnormal behaviour (C: 36.5%, 91; *I: 33.8%, 95*), strange speaking (C: 12.5%, 31; *I: 11.7%, 33*), withdrawal (C: 11.2%, 28; *I: 12.5%, 35*) or other (C: 3.6%, 9; *I: 7.1%, 20*). The second set of responses (C: n=216; *I: 241*) were: aggression/fights (C: 25.9%, 56; *I: 27.0%, 65*), abnormal behaviour (C: 28.2%, 61; *I: 20.7%, 50*), withdrawal (C: 25.0%, 54; *I: 23.7%, 57*), strange speaking (C: 15.3%, 33; *I: 18.3%, 44*), or other (mainly expression and mood) (C: 5.6%, 12; *I: 10.4%, 25*). Many of these are indicators of psychiatric illness such as schizophrenia, acute psychosis.

Suicide

Suicide is a sin in the Muslim religion as in many others therefore a taboo subject. Nevertheless, nearly ten percent (C: 8.2%, 21; *I: 9.9%, 28*) of the people knew somebody who had attempted suicide. However, this percentage cannot be taken as a prevalence (all response could refer to a single incident).

Assistance for psychiatric complaints

Interviewees were asked to indicate three places where mentally ill go or are taken, in order of priority. The first place where the respondents (C: n=249; *I: n=278*) would go is a psychiatrist/psychiatric dispensary (C: 41.4%, 103: *I: 34.4%, 95*), the hospital (C: 28.9%, 72; *I: 26.1%, 74*), and the Mullah (C: 17.3%, 43; *I: 25.4%, 72*). As a second choice people (C: n=198; *I: n=232*) indicated: the Mullah (C: 46.5%, 92; *I: 44.4%, 103*), psychiatrist/psychiatric dispensary (C: 18.7%, 37; *I: 39.6%, 67*) or the witch doctor (C: 12.1%, 24; *I: 15.5%, 36*).

Intervention

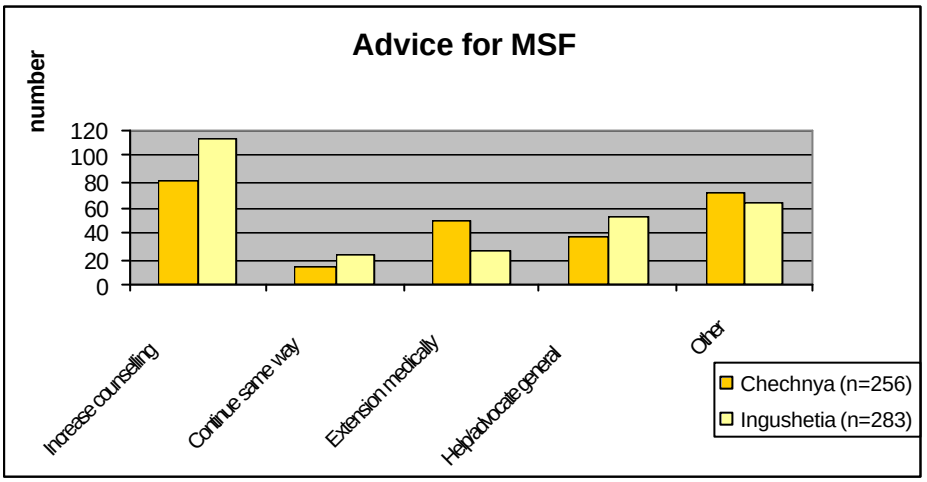
The beneficiary perspective on specific psychosocial interventions was obtained from the respondents to inform project activities. A large majority of the interviewees (C: 98.0%, 251; *I: 96.1%, 272*) thought it is useful to talk to someone they trusted when disturbed or upset. Many (C: 81.6%, 209; *I: 87.2%; 246*) were also familiar with talk-therapy. Of those who were aware of talk therapy (C: n=209; *I: n=269*) most also thought it was useful (C: 96.2%, 201; *I: 81.3%, 230*). Many interviewees (C: 76.2%, 195; *I: 81.3%, 230*) said that one of their family members could benefit from counselling or talk therapy.

MSF is better known in Ingushetia (*I: 59.2%; 167*) than in Chechnya (C: 39.8%, 102). Therefore in Chechnya most people (C: 74.8%, 190, n=254) had no contact with MSF in

the past. In Ingushetia this is much lower (*I: 38.3%, 108*). When asked if they would use psychosocial services if they were provided by MSF most (C: 97.3%, 249; *I: 81.3%, 230*) said they would use them.

Interviewees were asked to give MSF some advice for future activities (Graph 14). The answer on this open question was after analysis grouped as: increase counselling activities, continue in the same way, increase medical assistance, and help and advocate on their behalf. Most responses (C: 31.6%, 81; *I: 40%, 114*) indicated that MSF should to increase their counselling activities. Some (C: 19.5%, 50; *I: 9.5%; 27*) suggested MSF increase its medical activities. A number of people (C: 14.8%, 38; *I: 18.7%; 53*) advised MSF to advocate on their behalf.

Graph 14



Conclusions

The survey outcomes in both settings differ in only minor respects. Despite randomisation, females were found to be over-represented in both surveys (C: 70%; *I: 65%*). This reflects official lists which state that females predominate. Another explanation is that interviews were conducted during the daytime, when males tend to leave the settlements in search of work.

Displacement

The first time of displacement, as well as the region of origin, is related to the intensity of the conflict. The majority said they were displaced in 1994 or 1999 (C: 41%, *I: 54%*) implying that they are at least five years displaced. During this time the majority relocated two till five times (C: 92%, *I: 82%).* The duration and frequency of displacement imply that the groups in both locations are qualified as 'chronically' displaced.

Nearly all of the interviewed wished to return. However, the main reason for not returning to their homes differs between the two samples. The majority of the interviewed in Chechnya indicated the lack of shelter as main reason for not returning home. Lack of security was not considered important (10%). This is in contrast to those interviewed in the spontaneous settlements in Ingushetia, for whom insecurity is the most important consideration for not returning home. This is logical if it is considered that those in the TACs were already subjected to insecurity, while for those in the spontaneous settlements the security situation in Chechnya is still a threat and less of a reality.

Our findings contradict a general popular belief that IDPs try to keep their status for reasons of secondary gain (e.g. access to humanitarian aid etc.). The question of return is in both groups rather hypothetical: there is simply no shelter (let alone home) to return to.

Living circumstances

The living circumstances in the TACs are slightly better than those in Ingushetia. However, the conditions in both locations have serious shortcomings. They impede on long-term stay and affect health negatively.

Toilet facilities in both locations are poor and observably unhygienic. Over one third of the people living in the spontaneous settlements indicated that their accommodation is not protected against wind, rain or water. One in five people in the TACs are unable to keep their living quarters warm in the winter.

People in both bcations indicated food shortages, and dependency on outside help is high.

A basic right of IDPs for safety and security cannot be guaranteed in either of the locations. A substantial number of people - one third in Ingushetia and two-thirds in Chechnya - rarely feel safe. This is justified given the reported frequency of loss of family members in the two months prior to the survey, and ongoing mine accidents, terrorist acts, bombardments, arrests and disappearances.

The difference between the higher exposure in Chechnya and a higher self-experience in Ingushetia may indicate that in Chechnya the general climate of violence triggers feelings of insecurity whereas these feelings in Ingushetia may be caused by a higher targeted violence towards the IDPs.

The findings on the living circumstances and feelings of safety cannot be considered as a magnet for IDPs to move to Chechnya (from Ingushetia) or to stay in the TACs. Despite this a substantial number of people (47%) stayed longer then one year in the TAC. It implies that both groups of IDPs lack alternatives. They are trapped in their unsafe and unhealthy setting.

Encounters with violence

A number of studies have shown that frequent exposure to traumatic events is associated with higher levels of mental health problems and poorer physical health[39]. The levels of exposure, witnessing and self-experiences we found in these surveys raises serious concerns about the physical and mental health of the IDPs and many others that are living in Chechnya.

Almost everyone reported some exposure to violence including attacks on houses and villages, cross fire, aerial bombarding, mortar fire, burning of houses, destruction of property[xx], and exposure to mines. The majority of the IDPs had been exposed to mopping-up operations at least once.

Witnessing extreme violence is associated with psychosocial and mental health problems, including PTSD[40]. More then one in five witnessed the killing of people, while over 80% had seen wounded people since the start of the conflict. Nearly half of people interviewed witnessed arrests and maltreatment.

Rape is very likely underreported. Sexual violence is a taboo topic in Chechnya, but is known to occur. Organizations working with Chechen refugees report a high incidence of sexual violence[41]. Many people had heard about incidences of rape but only a few had witnessed it, and only one person reported being raped.

Approximately one third of the interviewed directly experienced war related violence. The type of experienced violence is similar. Maltreatment was reported the highest in both locations, followed by detention and hostage, arrest/kidnapping, and forced labour. Over 1 in 10 were injured by violence.

Some consequences

Violence is associated with human and material loss. The impact of the war in Chechnya is devastating. Only 10% of people in Chechnya did not lose someone close. In Ingushetia this figure is 17%.

Nearly two-thirds of people interviewed in both locations lost a neighbour, while half of those interviewed in Chechnya and over a third in Ingushetia reported at least one loss in the nuclear family.

The majority of those interviewed had suffered from starvation and nearly all had lost their house or possessions.

The reported exposure, experiences, human and material losses are very high and match the results of similar survey after a conflict that is known for its brutality: Sierra Leone. [42]

[xx] The distinction between house and property is useful since some IDPs were able to save everything but their house while others lost all their possessions but their house. The possession of a house usually facilitates the return.

Children

A substantial number of children are affected by the violence and current living circumstances. In Chechnya the most important effect is fear, while in Ingushetia lack of education was mentioned as the most important problem. Approximately one quarter of the parents with boys and one third of the parents with girls indicated that none or only some of their children attended school.

Physical Health

The General Health Questionnaire 28 (GHQ 28) [43] was well accepted and easy to administer. Using the recommended cut-off score for this questionnaire, answers indicated that nearly all IDPs were suffering from health complaints such as somatic complaints, anxiety/insomnia, depressive feelings or social dysfunction.
To compare with other conflict situations a more conservative cut-off score was applied. The average mean of a GHQ 28 population study after the war in Kosovo was used. If the average mean of 11.1 from this study[44] is used in our study a substantial number of respondents still suffer from general health problems (80%). This may indicate there are differences between the Caucasus and Kosovo surveys regarding general health effects after mass violence. The negative effects in Chechnya being much bigger. However, this finding remains speculative and only validation of the GHQ 28 in both Kosovo and Chechnya can further verify this possibility.

Our findings on open questions inquiring for the interviewees' perspectives on their own health confirm the GHQ 28 findings. In both Chechnya and Ingushetia over half indicated feeling frequently unhealthy, reporting physical complaints in the 6 months prior to the survey.

The type of health complaints confirms the high proportion of (traumatic) stress related complaints also found in the GHQ 28. Heart complaints, though traditionally high in the former Soviet Union, represent one quarter of all complaints mentioned, while non-specific physical complaints like headaches and muscle/joint/body pain further confirm the importance of (traumatic) stress in the symptoms presented.

The pervasiveness of (traumatic) stress complaints is worrying and requires special attention from the health structures. At the same time we found the accessibility to and availability of official or traditional health services and medicines problematic in both locations. A further support to existing health structure is necessary.

Psychological health

Those who responded are able to differentiate between psychiatric ill and psychological complaints. The outcomes indicate that Chechen and Western perspectives on differentiating and treating mental health are similar.

People reported high rates of psychological complaints during the conflict. The severity of (traumatic) stress and fear suffered by those in the TACs may account for an almost double amount of psychological complaints compared with those displaced in Ingushetia. It is also possible that the reported high level of insecurity felt among the population in the TACs influenced the outcome. People still feel they are in the middle of the conflict and may therefore report a present, high level of complaints. At least two thirds of those who responded in both locations agreed with the statement that the conflict has triggered mental disturbance or feelings of being upset. To cope with their feelings, people tended to 'turn their head' [xxi], keep busy, or act out through aggressive behaviour.

Such coping strategies appear to have only limited effect: nearly all respondents indicated that they have family members who have difficulty in coping with their feelings of despair. A happy mood, positive behaviour, and attention to physical appearance, were said to be good indicators of psychological improvement.

If people have psychological problems they turn to friends and neighbours; health staff are perceived as less important. The fact that people first turn for support to people outside their family may indicate a desire to avoid a personal problem becoming a family one.

Interviewees were also asked to indicate three places where mentally ill go or are taken, in order of priority. The first place where the respondents would go is a psychiatrist/psychiatric dispensary or hospital.

We have serious concerns whether the existing mental health structures are able to deal with these massive needs. People's personal coping resources seem depleted. The health staff (including psychiatrists) is working under heavy pressure and clinical psychological services are poorly, if at all, developed. The contrast between psychological needs and the availability of services justifies further humanitarian action in this area.

Intervention

A large majority of the interviewees thought it useful to talk to someone they trusted when disturbed or upset. Many were also familiar with talk therapy. Of those who were aware of talk therapy most also thought it was useful. Over three-quarters of those interviewed in both locations said that one of their family members could benefit from counselling or talk therapy. When asked if they would use psychosocial services if they were provided by MSF, most said they would use them.

[xxi] To turn their head is a Chechen expression for withdrawing from other people to contemplate, think over what has happened and to come to terms with what happened.

MSF Input

MSF has started its intervention in the TACs in Chechnya only recently (February 2004). This is related to the extent MSF is known by those interviewed. In Chechnya 40% of the are aware of the work of MSF; 60% in Ingushetia. This is also reflected in the number of people who previously had had contact with MSF: 62% in Ingushetia, and 25% in Chechnya.

The advice given by the displaced for future MSF activities differ between the two sites and the extent of knowledge of MSF has to be taken into account here. Over a third of those who responded in both locations indicated that MSF should increase their counselling activities. One in five people in Chechnya and one in ten in Ingushetia suggested MSF increase its medical activities.

People fear the international community will forget them. A relatively high number of people - 15% in Chechnya and 19% in Ingushetia - wanted MSF to advocate for the cause of the IDPs.

Epilogue

Recent developments in the Caucasus have overtaken the situation surveyed in early 2004, with the authorities rapidly closing the spontaneous settlements in Ingushetia and sending the IDPs back to the Chechen Temporary Accommodation Centres.

However, the recent events are part of a longer chain of events. This assessment is merely a snapshot of a long-standing situation as indicated by previous reports[45]. The current situation of the IDPs needs to take into account past events as well as future trends.

The waves of displacement correlate directly with the history of the conflict in Chechnya. The first wave of displacement resulted from the beginning of the conflict in 1994—the 'first' war-; the second wave of 1999 was connected to the beginning of the 'second' war. As the conflict continues so does the cycle of displacement. The return process is obviously connected to the progress of the war, but is also connected to political considerations. This situation has resulted in a cycle of displacement, return, displacement, return. Each family has its own story to tell of how many times they have fled and returned, and how many times and where they have been displaced to while outside of Chechnya.

Therefore, the history of displacement is not a simple matter of one group of displaced waiting for the conflict to end before returning. Factors influencing an IDP's decision to return or not typically have revolved around security and housing issues. Security relates to memories of trauma already suffered as well as uncertainty about the contemporary security situation back in Chechnya. Housing issues relate to what has been lost and perceived opportunities to regain a viable life. And of course security and opportunity co-mingle in the process of decision-making.

Many who return to Chechnya from Ingushetia are simply changing their status from being IDPs outside to being IDPs inside Chechnya. Though the nature of the conflict has changed over the years, security, housing and economic opportunity issues remain vital, so that many who have moved to a TAC in Chechnya are still far from being able to return home. What will happen to IDPs in TACs remains an important longer-term question. Also at issue is the future of those IDPs who, for whatever reason, cannot or will not return to Chechnya, even to a TAC. But in the end, if things return to 'normal,' it goes without saying that the IDPs will eventually want to go home.

The current policy of moving people, against their will, from one inadequate and insecure location to another will only worsen the plight of this vulnerable population. The Russian authorities must guarantee a safe environment; ensure the protection of civilians, as well as appropriate living conditions (including access to health services, sufficient food, shelter and sanitation) for this displaced population. The international community should pay greater attention to this conflict that has been largely ignored for the last decade.

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2 As referred to officially by President Putin

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Annexes

Annex 1: Age and sex distribution

Chechnya

Age-group	**Individuals Interviewed**			**Family composition of those interviewed**		
Years	Male %	Female %	*Total number (n)*	Male %	Female %	*Total number (n)*
0-5				51.9	48.1	*154*
6-17		100	*2*	47.3	52.7	*258*
18-25	17.6	82.4	*34*	47.9	52.1	*194*
26-45	25.7	74.3	*140*	42.7	57.3	*323*
46-59	39.1	60.9	*69*	51.0	49.0	*147*
60 plus	54.5	45.5	*11*	54.8	45.2	*31*
Total	29.3	70.3	*256*	47.4	52.6	*1107*

Ingushetia

Age-group	**Individuals Interviewed**			**Family composition of those interviewed**		
Years	Male %	Female %	*Total number (n)*	Male %	Female %	*Total number (n)*
0-5				44.7	55.3	*208*
6-17				42.3	57.7	*503*
18-25	44.4	55.5	*36*	56.8	43.2	*329*
26-45	29.5	70.5	*156*	40.5	59.5	*395*
46-59	41.1	58.9	*73*	51.1	49.9	*174*
60	35.3	64.7	*17*	39.0	61.0	*59*
Total	34.8	65.2	*282*[45]	44.6	55.4	*1668*

Annex 2: Living circumstances

	Chechnya		*Ingushetia*	
	Number	*%*	Number	*%*
Water availability				
NA			1	
Always	184	*71.9*	220	*78.0*
Sometimes	58	*22.7*	45	*16.0*
Rarely	13	*5.1*	15	*5.3*
Never	1	*0.4*	2	*0.7*
Total	*256*		*283*	
Water source				
NA	2		1	
Water bladder	72	*28.3*	34	*12.1*
Water tanker	62	*24.4*	20	*7.1*
Surface water			3	*1.1*
Tap in house	43	*16.9*	9	*3.2*
Tap outside	77	*30.3*	216	*76.6*
Total	*254*		*283*	
Toilet facility				
NA	2			
No proper toilet	2	*0.8*	3	*1.1*
Private inside	52	*20.5*	7	*2.5*
Private outside	18	*7.1*	21	*7.4*
Shared outside	182	*71.7*	252	*89.0*
Total	*256*		*283*	
House protected wind/rain				
No	11	*4.3*	108	*38.2*
Yes	245	*95.7*	175	*61.8*
Total	*256*	*100.0*	*283*	
House warm				
NA			3	
No	47	*18.4*	111	*39.6*
Yes	209	*81.6*	169	*60.4*
Total	*256*		*283*	
Feelings of safety				
Always	20	*7.8*	84	*29.7*
Most of the time	65	*25.4*	93	*32.9*
Occasionally	94	*36.7*	71	*25.1*
Never	77	*30.1*	35	*12.4*
Total	*256*		*283*	

Annex 3: Death of family members

Number and % of people who have lost a family member or have witnessed the death of a family member

	Lost				**Witnessed their death**			
	Chechnya		**Ingushetia**		**Chechnya**		**Ingushetia**	
	%	n	%	n	%	n	%	n
Partner	6.6	*17*	4.2	*12*	2.7	*7*	2.8	*8*
Child(ren)	2.5	*9*	5.3	*15*	2.0	*5*	2.5	*7*
Parent(s):	2.5	*9*	12	*34*	8.2	*12*	6.7	*19*
Sibling(s)	23.8	*61*	22.6	*64*	3.9	*10*	4.6	*13*
Grand parent(s)	9.4	*24*	7.4	*21*	3.5	*9*	2.8	*8*
Aunt/uncle	25.0	*64*	21,2	*60*	4.7	*12*	7.1	*20*
Nephew/niece	24.6	*63*	19.8	*46*	3.5	*9*	3.2	*9*