WOMEN SPEAKING ACROSS THE BORDER:

THE IMPACT OF THE BORDER AND THE CONFLICT ON WOMEN'S HEALTH AND ROLES

DERRY WELL WOMAN

IPH

Women Speaking Across the Border:
The Impact of the Border and the Conflict on Women's Health and Roles

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The Cross Border Women's Health Network has been developed and is led by Derry Well Woman. The Network is committed to collaborative action to improve health status and reduce health inequalities both within the North West of Ireland and other parts of Ireland.

NETWORK MEMBERS:

Northern Ireland Statutory Organisations
Business in the Community, Cooperation and Working Together (CAWT), Centre for Cross Border Studies, Derry City Council, Equality Commission for Northern Ireland, Fermanagh District Council, Limavady Borough Council, Northern Ireland Housing Executive, Omagh District Council, Social Security Agency, Strabane District Council, Western Education and Library Board, Western Health and Social Care Trust, Western Health and Social Services Board

Northern Ireland Voluntary Organisations
Derry Well Woman, Fermanagh Women's Network, Foyle Women's Aid, Foyle Women's Information Network, Roe Valley Women's Network, Strabane & Lifford Women's Centre

Republic of Ireland Statutory Organisations
Combat Poverty Agency, Department of Social Inclusion, Donegal County Council, Donegal Education Centre, Donegal Vocational Education Committee, Health Service Executive – North West Division, Leitrim County Council, Leitrim Vocational Educational Committee, Sligo County Council, Sligo Education Centre, Sligo Vocational Education Committee

Republic of Ireland Voluntary Organisations
Border Action, County Leitrim Partnership, Donegal Women's Network, Inishowen Partnership, Inishowen Women's Information Network, Inishowen Women's Outreach, Sligo Leader Partnership, Women's Health Council of Ireland (of Ireland)

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The study has attempted to privilege and respect the voices and position of its contributors and any discussion or analysis of their words was an attempt to honour their perceptions and interpretations, not to challenge or undermine them in any way.

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Leslie Boydell, Associate Director, and Jorun Rugkåsa, Research Officer (until September 2006), IPH, were responsible for leading this research. Siobhan Livingstone, Research Assistant (until May 2007) IPH, undertook the fieldwork and initial analysis.

Jennifer Hamilton, Senior Research Officer, Institute for Conflict Research, co-authored the literature review and Katy Radford, Independent Researcher co-authored the final report.

EXECUTIVE SUMMARY

This research was commissioned by Derry Well Woman and carried out on its behalf by the Institute of Public Health in Ireland in association with the Institute for Conflict Research and Rethink.

The research had two distinct aims:
- to improve understanding of the impact of the border and of the conflict on both sides of the border on women's health
- to improve understanding of women's roles, particularly as they impact on mental health, in post conflict society.

The research was conducted with a view to its recommendations being used to inform the work of the Cross Border Women's Health Network as well as other cross border health forums or organisations responsible for service planning and delivery.

The findings of this research are based on a series of 31 in-depth interviews and one focus group with women both north and south of the border and on one focus group and six interviews with women who were specifically consulted as service providers.

Six principal themes emerged from the interviews:
- women's role in the family and in local communities
- poverty and disruption
- the value placed on health issues
- perceptions and meaning of the border and the conflict
- support networks
- women's contribution to community peace building.

Within these themes a number of cross-cutting issues are to be found. These include:
- the impact of the peace process
- different manifestations of trauma
- positive and negative coping strategies
- processes of normalisation
- the medicalisation and pathologisation of mental health issues
- social capital and networks of support.

The findings and themes from the primary research are discussed within the context of a wide-ranging literature review that explores material from Ireland, UK and internationally. The literature review considers three distinct areas:
- impact of conflict on health
- impact of borders on health
- role of women during and after conflict.

The material has been shaped to consider how violence, disruption, displacement and turmoil as a consequence of conflict, impact on the health and wellbeing of women.

Irrespective of their faith, ethno-political background or location, many women's lives were impacted on by the conflict. Restrictions were placed on their ability to 'live a normal life' or to access particular goods, services or social activities because of the border and the conflict.

The peace process has brought with it the potential for advancements in the general and mental health of women of all ages in Ireland. While women may continue to face some structural barriers in being able to access services, mental health and wellbeing is now more readily recognised as being crucial to healthy communities and societies.

The role of women in their families and in local communities developed and strengthened as a result of the conflict. Increased responsibilities were not necessarily accompanied by increased support systems. As a result, women's general health and wellbeing was often considered secondary to those of other family members. The coping mechanisms they called on sometimes compounded underlying and undetected ill health.

For many women, the disruption to day to day life caused by poverty was exacerbated by the conflict. It impacted tangibly on the life choices they made about where, with whom and how to engage in wider society. Being forced reluctantly into the labour market because of adverse family circumstances, including the loss of the family's breadwinner through death, injury and incarceration, enabled some women to achieve a degree of independence, but for most, it came as an unwelcome necessity in an already busy life.

The value and significance of support networks and the core role that could be played by the family was recognised. It was suggested that during the conflict, women living in urban Catholic communities and those with family members imprisoned, were able to access practical and emotional community support networks more easily than women from rural and border Protestant communities and those with connections to the security services. The churches were recognised as offering some assistance to women but were not considered to be well connected to wider networks of support.

Since the ceasefires and the Good Friday Agreement (1998), women reported being increasingly willing to become involved in cross-community and cross-border community development initiatives on shared issues such as health and education. They consider that they are actively contributing to a 'post conflict' society by sharing resources, personal experiences and history with women from other traditions.

Women reported that they and health practitioners are now placing more value on gender specific health care and that an increase in cross border cooperation for health care provision was a tangible benefit of the peace process.

At the height of the conflict, the significance of the impact of the border on women's lives was in part dependant on their cultural identity, place of residence and degree of their involvement with the conflict. Attitudes to crossing the border were changing rapidly and significantly with a reported increased willingness to do so. Women now consider the border in one of three ways: an unimportant concept, in name only, that has little or no real impact on their lives; an unacceptable barrier dividing the country; or an acceptable demarcation of their country's boundaries.

RECOMMENDATIONS

1. Community development and skill development for women needs to be supported and resourced to enable them to engage in civil society, take up public appointments and contribute to political parties. This particularly applies to women from a Protestant background.

2. The North West Women's Health Network is central to maintaining focus and momentum in the North West on the wider determinants of women's health. Derry Well Women should continue to be resourced to drive the Network so that it can achieve important health outcomes for women in the North West.

3. Action is needed to strengthen gender mainstreaming and the promotion of women's health and wellbeing throughout the public health sector North and South. The recommendations of the National Women's Strategy 2007 – 2016 in the South and the action areas and strategic objectives of the Gender Equality Strategy 2006 – 2016 in the North provide clear direction on what needs to be done and should be implemented.

4. The statutory sector should identify and ensure the provision of appropriate services for women experiencing hidden mental health problems and domestic violence resulting from the conflict and undertake work to address the stigma associated with these conditions.

5. The statutory sector should support interventions for young children who have no direct experience of the conflict but whose parents may still be suffering the consequences.

6. Further research is required into the challenges faced by women living in border areas during the conflict. There should be a particular emphasis on vulnerable groups such as women with disabilities, women who are carers, families of ex-combatants and other armed groups who live or lived in border areas, and mobile groups who cross the border frequently such as Travellers and migrant workers. Research into the trans-generational nature of trauma should also be considered. The emphasis of research should be on developing the evidence base for interventions that reduce inequities in health for women.

7. An investigation of the current and potential use of cross-border services for women should be undertaken. A new focus on all-island policy development and EU health strategy is driving need for public services such as health and social care to serve an increasingly mobile population.

1. INTRODUCTION

This study began from the premise that despite a wealth of academic, policy and practice-based material addressing the conflict in and about Northern Ireland, there is a paucity of literature and documented evidence that directly considers the narratives, experiences and perceptions of women who have lived in the border regions of Ireland.

By addressing a gap in the current literature on women in border areas, this study contributes to debate concerned with the legacy of the past. Working from a gendered perspective, it considers health and wellbeing by incorporating the voices of women who lived through the conflict and who did not consider themselves to have been directly involved in acts of violence. Some of the women who participated had family members who were former combatants, either in the security services or in other armed groups, and a number of contributors had family members who were ex-prisoners. Participants were connected to the conflict by dint of where they lived, events they had witnessed, their experiences of violence and intimidation, and/or their engagement in political parties or groups active in the conflict. A small number of women considered they had no direct or indirect experience of the conflict.

The health and social wellbeing of women who lived in border areas is explored with reference to how their mental health was affected by restrictions they faced in moving freely across the border, by their capacity to access goods and services, by their opportunity to visit neighbours, friends and family, and by perceived and actual threats of violence.

The roles and expectations of women associated with the conflict are analysed in relation to a gendered division of labour, to their caring and domestic responsibilities and their socio-economic position. While the reactions of some women can be found to vary on the basis of their religious affiliation and on which side of the border they lived, a number of the issues they raise can be considered common ground between participants. While their responses were managed individually, the participants demonstrate a familiarity, shared understanding and insight into others' experiences and perceptions.

The report accepts the premise that traumatic experiences have impact across generations and recognises the changing political context in which this research was carried out.

2 LITERATURE REVIEW

> *The way in which men and women experience and deal with the consequences of conflict depends on gender roles and relations prior to the conflict and how they were re-negotiated during wartime* (Walsh, 2000: p2).

2.1. INTRODUCTION

This literature review will explore the impact that conflict and borders may have on the lives and roles of women by exploring published research from Ireland, UK and internationally.

Conflict in any society has an impact on individuals and communities. Batniji and colleagues, discussing disasters, including conflict arising from political violence, state that this 'is a time of flux in cultural and religious beliefs and practices, historical understanding, ethnic identity, and family and community relationships' (2006: p1854). A premise for this literature review and of the Cross Border Women's Health Study of which it is part, is that the effects and experiences of conflict are gendered and that this should be recognised in any analysis. Furthermore, women's experiences of conflict are diverse. For example, Morgan (1996) reporting from a range of conflict torn societies (including South Africa, the Middle East, Bosnia, Rwanda and Northern Ireland) states that women's experiences throughout conflict situations worldwide are 'over-simplified and over-generalised'. They are often limited to commenting on women's 'moderate' views, which make them 'potential peacemakers' and write about women as if they are a single homogeneous group, ignoring the enormous diversity of their experiences, skills and backgrounds. Meintjes *et al.* (2001: p5) also emphasise the fact that 'women who live through conflict do not fall into a single group'. This research will contribute to a more detailed analysis of how experiences during and after conflict may vary with gender and recognises that conflict may lead to changes in and re-negotiation of gender roles.

Conflict in society causes disruption to daily routines, social movement and displacement, loss of jobs and the shock of death and injury. Civil conflict is known to impact on the economy through slowing economic development, reducing capital investment and increasing military and security expenditure. 'Unemployment and poverty typically increase and fewer resources are devoted to health services' (Tomlinson, 2007: p35).

The overall aims of the research are:

- to improve understanding of the impact of the border and of the conflict on both sides of the border, on women's health
- to improve understanding of women's roles, particularly as they impact on mental health, in a post conflict society.

To reflect these aims, this literature review has been divided into the following sections:

- The impact of conflict on health
- The impact of borders on health
- The role of women in a post conflict society.

2.2 THE IMPACT OF CONFLICT ON HEALTH

Bloomfield (1998) recognised that the conflict in Northern Ireland had significant impact on health status both of surviving victims and their families and the families of those killed. While a study by Cairns and Wilson in 1989 concluded that many people in Northern Ireland

managed to cope effectively with the stress created by the Troubles, subsequent reports would suggest that many have been affected socially, psychologically and economically (SSI, 1998). Morrissey and Smyth (2002: p3) indicate that:

> *Any serious attempt at assessing the human impact of the Troubles was deemed premature until the beginning of the peace process of the 1990s…Any examination of humanitarian damage due to the Troubles whilst the conflict was ongoing was likely to underestimate it…*

2.2.1 The effects of the Troubles in Northern Ireland

Throughout the Troubles in Northern Ireland residents both North and South of the border were affected. 'The Cost of the Troubles Study' reported that nearly 3,700 people were killed and an estimated 40,000 injured (Fay *et al.*, 1999). Of those killed approximately 200 were women. For each individual killed or injured there are many more who have been affected socially, psychologically and economically (SSI, 1998). In many instances the psychological impact is compounded by physical and social problems such as disablement, loss of a home and/or displacement (Smyth *et al.*, 2001). The combination of death and injury represents a primary human cost of the Troubles. In addition, other forms of trauma derive from grief, imprisonment or intimidation (Smyth and Hamilton, 2002). Ruane and Todd (1996) state that nearly half the Northern Ireland population, and in some areas up to 80%, know someone who has been injured or killed in the conflict. The Northern Ireland Government defines the victims of the Troubles as 'the surviving physically and psychologically injured of violent conflict related incidents and those close relatives or partners who care for them, along with those close relatives or partners who mourn their dead'. (OFMDFM, 2002: p1). The number of victims in the aftermath of the Troubles is therefore difficult to calculate but is much higher than the numbers who have been killed or injured.

In the early years of the Troubles there was disagreement as to the effects of violence on the population. Some maintained that observable negative effects of exposure to violence had occurred (Fraser, 1971; Fraser *et al.*, 1972) whilst others supported the view that traumatic symptoms rapidly improved after a violent event and that those exposed to violence coped successfully (Lyons, 1974; Cairns and Wilson, 1989). The conflict was not found to increase referrals for mental health services (Loughrey, 1997). This may, however, reflect the responsiveness of services themselves rather than need. Over the years the understanding of trauma and social problems has improved. Since the ceasefires of 1994 and the Omagh bomb in 1998, there has been increased interest in the psychological effects of the Troubles (Curran *et al.*, 1990; Hough and Vega, 1990; Dillenburger, 1992; Smyth and Hayes, 1994; Bolton, 1996; Fay *et al.*, 1999).

The effects of the Troubles are not evenly distributed. Political violence occurred more frequently in some areas than in others. 'The Cost of the Troubles Study' (Fay *et al.*, 1999) aimed to ascertain the overall impact of political violence on the population of Northern Ireland. Table 1 compares the death rate (from Troubles related deaths) per 1,000 population (based on 1991 Census figures) of those who lived in each of Northern Ireland's 26 district councils and the deprivation score from the Robson index for each council area. The death rate in Belfast was 30% higher than in the next worst district council, Armagh. Table 1 highlights high death rates in all the border counties (emphasised in bold). Troubles related deaths include deaths to residents of Ireland, North and South, and army personnel.

Table 1: Troubles related death rates per 1,000 population (1969-99) (COTTS)

District Council	Death Rate	Deprivation Score
Belfast	4.13	29.98
Armagh	**2.48**	**-3.10**
Dungannon	**2.38**	**14.40**
Cookstown	2.05	9.72
Strabane	**1.89**	**31.33**
Derry/Londonderry	**1.74**	**19.96**
Craigavon	1.61	-9.44
Fermanagh	**1.61**	**11.95**
Newry and Mourne	**1.58**	**16.15**
Magherafelt	1.36	7.83
Castlereagh	1.06	-35.07
Lisburn	1.05	-28.80
Newtownabbey	0.99	-30.53
Banbridge	0.81	-14.87
Down	0.72	-10.75
Limavady	0.71	5.86
Omagh	0.68	9.36
Ballymoney	0.58	3.11
Carrickfergus	0.51	-26.10
Coleraine	0.45	-16.11
North Down	0.44	-42.46
Antrim	0.44	-13.18
Ballymena	0.41	-15.74
Larne	0.41	-7.45
Ards	0.40	-27.50
Moyle	0.27	11.05

2.2.2 Impact on self-reported health and mental health

'The Cost of the Troubles Study' (Fay *et al.*, 1999) explored the effects of the Troubles on health in Northern Ireland. Over one thousand (1356) people were surveyed and almost 45% of respondents described their health as excellent or very good. Only 8.5% viewed their health as poor. When asked about how the Troubles had affected their lives, 44% reported feelings of distress and emotional upset while 39.6% agreed or strongly agreed that the Troubles had left them feeling 'helpless'.

The effects varied according to location (*ibid.*). In electoral wards with a high intensity of Troubles related violence, levels of reported poor health were more than twice the levels in low intensity wards. High intensity wards also exhibited a greater degree of general deprivation. Poor health could therefore be a consequence of both the Troubles and of deprivation. Of those in high intensity wards 33% cited troubles-related trauma as a factor influencing a change in their health compared to 11% in medium and 6% in low intensity wards. Similarly, a study by Cairns *et al.* (2003) found that those who viewed themselves as being victims of the Troubles had lower psychological wellbeing.

2.2.3 The effects of conflict on mental health

The evidence that the experience of conflict is associated with worse mental health is strong (Tomlinson, 2007) and those who have experienced most violence have significantly higher levels of depression. Evidence suggests that women react differently to trauma than men in that they are more likely to experience Post Traumatic Stress Disorder (PTSD) than men and their symptoms can be more complex and enduring (WHO, 2000).

In a recently published and very comprehensive review of the impact of the Northern Ireland conflict on mental health and suicide, Tomlinson (2007) argues that much of the evidence is conflicting and that the picture is complex and inconclusive. He puts forward two views as to whether or not the Troubles have had an impact on mental health and suicide. One view emerging from the literature is that the Troubles did not have much impact and that people in general coped well. Current levels of mental health and suicide in Northern Ireland are in line with other populations experiencing high levels of disadvantage. However, the other view is 'that the Troubles affected everything' (*ibid.*:p109), that society here has been traumatised and that levels of anxiety and depression are high. Wherever reality lies on this spectrum,

> *wars do damage people and places, and the refugee (or 'internal displacement') experience contributes further to the cocktail of economic distortion, non-employment and social disruption, including intimate partner violence, and associated levels of fatigue, inability to enjoy life, anxiety and depression. In most societies the burden of the latter falls disproportionately on women who are more likely than men to contemplate suicide, but less likely to carry it out. (ibid. p109)*

Batniji and colleagues (2006) point out that non-pathological mental health issues represent a side to the human cost of disaster which is difficult to assess or measure. Exposure to disaster has been found to 'increase the risk of depression, anxiety, and somatic complaints' (p1853). Women are particularly at risk of such impacts. These impacts are associated with prior psychiatric history, the severity of exposure to disaster and inadequate social support during the aftermath.

The World Health Organization (WHO, 2000) stresses the complex web of interrelationships which determine health, including mental health, that go well beyond the biological and individual, and acknowledges the crucial role of social context, justice and equality. Other evidence exists that women who have experienced violence of any kind, whether in childhood or adult life, have increased rates of depression and anxiety, stress related syndromes, pain syndromes, phobias, chemical dependency, substance use, suicidal, somatic and medical symptoms, negative health behaviours, poor subjective health and changes to health service utilisation (WHO, 2000).

Figures for Northern Ireland from the 2001 Health and Wellbeing Survey indicate that women are one and a half times more likely than men to report having suffered mental health problems, and rates for Northern Ireland are 20% higher than in England or Scotland. People who said that they had been affected by the Troubles were almost twice as likely to show signs of a possible mental health problem than those who said they had not been affected much (DHSSPS, 2005). Based on an analysis of the 1997 Health and Well Being Survey, O'Reilly and Stevenson (2003) found that rates of psychological morbidity were much higher in the North than the South of Ireland.

According to Curran (1988), there is evidence to suggest that certain psychological problems are more pronounced in populations exposed to civil unrest and violence. Hayes and Campbell (2000) researched the long term stress caused by the shootings on Bloody Sunday in 1972 and found that even after 25 years, 61% of the relatives of those who died showed significant clinical disturbance. This view is supported by Summerfield (2000) who found a higher prevalence of Post Traumatic Stress Disorder in populations affected by violence worldwide.

The use of prescribed sedatives, tranquillisers and antidepressants is also higher in Northern Ireland, almost twice the figure for the South (22% compared with 12%). The volume of antidepressants prescribed increased substantially between 1989 and 1999. Interpretation of this increase is difficult. There has been a parallel increase in illicit drug misuse and alcohol consumption (Tomlinson, 2007).

2.2.4 Post Traumatic Stress Disorder (PTSD)

Much of the literature refers to Post Traumatic Stress Disorder (PTSD) as a reaction to trauma. It occurs after a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (Bisson, 2007). The person has experienced intense fear, helplessness or horror when the event occurred. The symptoms must have been present for one month and have caused significant distress or impairment in social, occupational or other areas of functioning. Acute PTSD becomes chronic if it lasts longer than three months. Symptoms usually begin shortly after the trauma but can be delayed. Traumatic experiences can usually be assimilated without the development of PTSD. Characteristic symptoms include recurrent and intrusive distressing recollections, avoidance of stimuli associated with the trauma and over-arousal such as hyper-vigilance. Anyone can develop PTSD after a traumatic event but incidence increases with the severity of the trauma. It is more prevalent in women than men and people of low socio-economic status, as well as those who have experienced previous trauma. Perceived lack of social support following trauma is a contributory factor. Research from Kosovo found that those over the age of 65 were more at risk of PTSD (*ibid.*).

Although women's direct experience of conflict may be less, they may experience a negative ripple effect from the burden of living with a partner with PTSD. Veterans with chronic PTSD suffer significant interpersonal and intrapersonal difficulties with family cohesion, self-disclosure, sexual intimacy and the expression of affection, hostility and aggression (Johnson and Thompson, 2007). Research on veterans has found that their partners suffered more anxiety, depression and social dysfunction, lower self-esteem and cohesion in their families. The severity of PTSD in the husband is associated with marital adjustment, ie the greater the PTSD, the greater the burden on the marriage. Fawziyah *et al.* (2007), in research on Kuwaiti veterans of the first Gulf War, found that effective social support networks played an important role in helping women to cope with veterans' PTSD and highlighted the value of women's empowerment.

Johnson and Thompson (2007) in a review article, suggest that soldiers (or those engaged in combat) are trained to expect violence, while civilians may be less prepared and can experience higher frequency of intrusive symptoms and less emotional numbing. They also emphasise the role of family and social support as well as religious belief in protecting against PTSD following war trauma. Similarly, efforts to involve those affected by conflict in practical actions to rebuild economic and social activity, are helpful to those suffering the effects of trauma (Tomlinson, 2007).

While for some, the description and classification of PTSD has been seen as very valuable in the management of the effects of trauma, others see it as medicalisation of something that has much wider causes and implications and that in fact, the use of this category of disease does more harm than good (Tomlinson, 2007). PTSD focuses on the individual with disease as opposed to recognising the social and political context within which they are located and may increase feelings of marginalisation and victimisation.

Fay *et al.* (1999) in 'The Cost of the Troubles Study' distinguished between differing levels of Troubles-related traumatic experiences. Many people had frequent experiences of 'low intensity' violence or disruption. They included being stopped and searched by security forces, or being caught in a bomb scare and feeling unsafe, which could be considered to have had an attritional effect in raising stress but not causing PTSD (Manktelow, 2007). Others experienced severe and distressing events, such as seeing people seriously injured or killed, having an immediate member of one's family killed or injured, or being injured oneself in a bomb or shooting.

2.2.5 Suicide

With regard to suicide, women are much less likely to take their own lives that men but those who do are more likely to have been diagnosed with depression (Tomlinson, 2007). For women, the majority of suicides occur in 25-55 year olds. However, female suicide rates in Northern Ireland are similar to other areas of the UK and Ireland.

Tomlinson highlights the unreliability of statistics on suicide and cautions the interpretation of trend data. In general, Northern Ireland's suicide data closely resembles those for the South. Recorded suicide in the North fell after the onset of the Troubles but rose thereafter. Recent increases amongst young men have been particularly worrying, with the worst figures in North and West Belfast. This has been attributed to a reduction in the high level of social cohesion existing during the Troubles. Tomlinson presents evidence that questions this claim, both the existence of high levels of social cohesion during the Troubles and the increasing level of suicides as a result of the Troubles. Male unemployment has been associated with suicide across the UK and Ireland. There is a strong association with alcohol and drug misuse. Levels of suicide in the western part of Northern Ireland (the focus of this research) are lower than in parts of Belfast.

Analysis of figures from the National Parasuicide Registry in Ireland found that Ireland has relatively high levels of parasuicide or self-harm (Corcoran *et al.*, 2004; National Suicide Research Foundation, 2005). However, comparable figures for the North are not available.

An analysis of mortality in the CAWT region (the border counties along both sides of the border) between 1989 and 1998, show levels of suicide and self-harm lower than for the rest of the island (Balanda, 2001).

2.2.6 North/South comparisons

Little research has focused on the impact of the Troubles in the South and no comparable data for this is currently available.

During the early years of the conflict many people were forced out of their homes and crossed the border to the South. Recent research by Conroy *et al.* (2005) with displaced people in the southern border counties found that while people did become established in terms of work and housing, many of them still carried the experience of being resented as outsiders and 'Northerners' and the pain of separation from their families. Conroy *et al.* (2005) describe a number of reasons why people moved from the North to the South, including 'fear of prison and arrest, experiences of internment, assassinations and violence in the surrounding neighbourhoods and persons-on-the-run' (p4). Hence this is not a homogeneous group. Participants were mainly from Catholic and Nationalist backgrounds. People who had been displaced in the 1970s and 1980s reported 'frequently feeling isolated and unwelcome but "safer" than in the North'. The researchers found it very difficult to estimate the scale of displacement but calculated that of around 22,000 people born in the North and living in the South, roughly half were displaced.

Muldoon and colleagues (2004) carried out a survey of people living in Northern Ireland and in the border counties of the South, and found that almost half the population had little experience of being affected by the Troubles. They concluded that the impact of the conflict has not been felt evenly across the population. They found that around 6% of their sample reported being 'extremely bothered' by symptoms of PTSD, such as being upset by reminders of events, avoiding thoughts of the event or being constantly on their guard. The incidence of these symptoms was twice as high in the North compared with the southern border counties. Those resident in the southern border counties reported better psychological wellbeing than respondents resident in the North and men better than women.

2.2.7 Healing, support and coping mechanisms

Manktelow (2007) refers to three coping mechanisms used to preserve mental health during the Troubles: denial, distancing and habituation. The majority of people are thought to have coped with the violence by denying its existence (Cairns and Wilson, 1989). Furthermore, a background of violence became part of everyday life to which people became acclimatised (McWhirter, 1986).

Since the initial phases of the peace process, awareness has developed about the importance of provision of services for those affected by the Troubles. The Good Friday Agreement (1998) incorporates a clear statement that commits the signatories to addressing the issue of the impact of the Troubles. It states, 'the participants believe that it is essential to acknowledge the suffering of the victims of violence as a necessary element of reconciliation' (NIO, 1998: p18).

In an overview of research on war and mental health, Summerfield (2000) suggests that caution must be taken to avoid reframing normal stress as psychological disturbance, and that stress needs to be understood in its cultural and historic context. Moreover, he concludes that personal recovery is grounded in social recovery and that rights and social justice are part of shaping this. The need to facilitate community cohesion during conflict and disasters is emphasized by Batniji and colleagues (2006). This may, however, be challenging during times of conflict, and the conflict itself may alter or change community with implications for health: 'As the community changes during disaster, the same structures that persons depended on before are often no longer available for support afterwards' (p1857). It has been recommended that in such situations, addressing structural needs (such as schools or employment) may serve to prevent social isolation. Additionally, religious activity has been found to 'bring meaning, context and purpose to psychological healing' (Batniji *et al.*, 2006: p1856). For example for Somali refugees, Islam has functioned as an 'enduring home'. Linked with the protective effect of religion are social-religious rituals such as funerals. Great distress can be caused to those unable to attend the funerals of loved ones.

Participating in purposeful activities has been found to be protective of mental wellbeing during disasters. For children, the continuity of education is particularly important. Loss of responsibilities leads potentially to loss of belonging, and 'interventions and community responses that allow persons to work towards a purpose, especially an economic purpose, and to assume responsibility, carry a strong mandate from the literature' (*ibid.*:p1857).

'The Cost of the Troubles Study' (Fay *et al.*, 1999) found that during the conflict the primary source from which people sought outside help was GPs, followed by community workers and voluntary organisations. However, the best source of help and support was reported to be family and friends. Of those who did seek help, over 40% of those living in areas of high intensity violence stated that they were unable to find adequate support compared to 29% in both middle and low intensity wards.

Tomlinson (2007) comments on the discrepancy between the findings reflected in the earlier sections of this literature review and the lack of demand on mental health services. One suggestion is that people dealt with their problems through prescriptions from GPs (as suggested above), alcohol and illicit drugs or through community organisation, religious practice and family support. With regard to attitudes to mental illness, a survey by the Health Promotion Agency in Northern Ireland (2006) found people in Northern Ireland were less likely than people in Scotland to disclose that they have a mental health problem, and fewer people in Northern Ireland see the public as caring and sympathetic to those with mental health problems. There is less optimism about the prospect of recovery.

Health and social services have been criticised in the past for their dealings with victims and survivors of the Troubles. Schlindwein (2000) found that a 'medical model' of health was used to treat those involved in traumatic events, failing to take into account the wide range of socio-economic factors shaping health, and commented that valium and sleeping tablets were the answer to post traumatic stress and peace of mind. Personal accounts from the Troubles reported by Smyth and Fay (2000) support this view with medical prescriptions appearing to be the main source available to GPs to help victims and survivors. Fraser (1971) examined prescribing patterns by GPs early in the Troubles and significantly high rates of tranquilliser prescribing of between 26 and 135% were noted in areas affected by riots. Fraser noted that these areas had other socio-demographic factors, such as high deprivation and unemployment, which may also have contributed to these high rates.

Voluntary organisations offering support to those affected by the Troubles experienced a rapid increase in requests for help after the ceasefires (Smyth, 2001). Hunt *et al.*, (1997) highlighted the need for professional help with emotional and social distress for those who had experienced trauma during the early years of the conflict. Manktelow (2001) was of the view that 'these people have had to suspend grief and need a specialised response'. Others suggest that during the Troubles, the abnormal became normalised (Gallagher, 2004).

Manktelow (2007) in a recent survey of self-help groups and service provider organisations in Northern Ireland, found that these groups believed that the Troubles have left a legacy of mental health problems. A key theme they identified was the 'overwhelming nature of Troubles bereavement which was sudden, violent and traumatic and which occurred in a political context which left the victim feeling helpless and marginalised' (p42). Grieving was repressed and often became complex, only to be faced many years later. Respondents also stated that grieving was postponed because of a damaged confidence of victims in society's willingness to offer support. Groups felt that the traditional psychiatric response had aggravated victims' distress. In their experience, many people resorted to alcohol as a coping mechanism and felt that the standard response from GPs was to prescribe medication. Manktelow (2007) concludes that the needs of victims of the Troubles have largely been left unmet by statutory social services and the chief support that people relied upon was family and friends. He found a great deal of anger and bitterness towards statutory services for their failure to offer help in the past. He suggests that because public service professionals felt the need to emphasise their neutrality, they were unwilling or unable to provide acknowledgment of people's feelings of being wronged. He concludes that the services needed by victims 'cannot simply be provided by the state, because the state is not viewed as an impartial body and cannot rectify its own past injustices' (*ibid.*: p37).

Counselling services and alternative forms of support have been emerging over the last decade. The Review of Counselling in Northern Ireland (DHSSPS, 2002) found that 72% of the counselling organisations contacted dealt with Troubles related problems. The counsellors surveyed acknowledged the impact of the Troubles on many individuals and the need to be prepared to deal with the effects. The first co-ordinated response by statutory social services to the trauma of the Troubles was after the Enniskillen bomb in 1987. Victims and their families were offered 'critical incident debriefing' which involves the opportunity to talk and share experiences and feelings (Bolton, 1996). After the Omagh bomb in 1998, the Sperrin Lakeland Health and Social Services Trust established a Community Trauma and Recovery Team to provide psychological and emotional support to everyone who was traumatised by the event (Manktelow, 2001). The principal intervention by the team was Cognitive Behaviour Therapy. According to the NICE management guidelines for chronic PTSD (National Collaborating Centre for Mental Health, 2005), all people with this disorder should be offered a course of trauma focused cognitive behaviour therapy or eye movement desensitisation and reprocessing. Drug treatment should be considered where no improvement is seen.

An evaluation of services to victims and survivors of the Troubles was carried out by Deloitte and Touche (OFMDFM, 2001). The evaluation highlighted that health service provision to victims varied with geographical location and noted an absence of a centralised strategy for victims. It also highlighted that there was a perceived need for a public health campaign to make people aware of the effects of trauma and de-stigmatisation of the concept of being a 'victim of the Troubles'. Discussions with victims' groups also revealed that they were reluctant to avail of services defined as 'government' or 'statutory', a finding that also emerged from the Cost of the Troubles Study (Fay *et al.*, 1999). This reluctance was in part explained by a degree of frustration and indeed hostility towards government services. Health and social services have recognised the gap both in service provision and uptake of support. Following the Bloomfield report (1998), Trauma Advisory Panels were established in 1999 within each health and social services board area, aiming to develop partnerships to address a range of issues relating to victims.

2.3 THE IMPACT OF BORDERS ON HEALTH

Approximately half a million people live in the border counties in the North West. This section will look at the literature on the impact of living in a border area on health and on some features of the border between the North and South of Ireland.

Social cohesion, trust, safety and sense of participation in broader society are among the factors most likely to have been affected in the border regions during the Troubles. Similar issues were flagged up as important for women's mental health in the cross border consultation on women's health and well being commissioned by Derry Well Woman (McColgan *et al.*, 2002). Mortality rates in the CAWT region have been found to be significantly higher for injuries and poisoning (14% higher than for all the island of Ireland), while mortality from homicides/assaults was 57% higher (Balanda, 2001).

The recent Comprehensive Study on the All Ireland Economy (Department of Foreign Affairs, 2006) emphasised the need to invest in the North West because of peripherality, lack of joined up action, poor infrastructure, high levels of economic inactivity and unemployment, low educational attainment and the legacy of the economic and social problems of the Troubles. Productivity in Northern Ireland and the border regions remains low compared to national averages (SEUPB 2007). Unemployment rates are higher and long-term unemployment is a persistent problem in the North and the border regions. Likewise, earnings and incomes are below national averages.

In a study of the southern border counties carried out by Harvey *et al.* (2005), the economic and social disadvantage, peripheralisation and underinvestment were recognised and they found that the corridor along the border was additionally disadvantaged. Donegal was the most disadvantaged of the border counties. Harvey and colleagues suggest from their research that the government in the South has underestimated the impact of the conflict on the southern border counties in terms of economic disadvantage, lost investment opportunities and social fragmentation. They also suggest that the 'Protestant minority community on the southern side of the border still feels sore and vulnerable while there are equally unresolved issues among the nationalist communities' (p66). Of relevance to this research, they found that women were distant from the political system and experienced lack of opportunity, had higher levels of unemployment and lower educational achievement than the rest of Ireland. There is low provision of childcare, more women work in the home and low numbers of women are involved in public life, especially in Donegal. With regard to the Protestant community, they found that they are still regarded with a level of distrust, that there is a

perception that they are less well treated by public services and they are less involved in community development. The researchers were 'struck by the extent to which … impacts of the border permeated throughout the border counties' (p89). Women identified isolation as a major impact of the conflict and the border, exacerbated by road closures and security checkpoints, causing division of families. It disrupted shopping patterns and left women feeling abandoned and with a fear of travelling north. Displaced persons had varied experiences but some felt a loss of identity, isolation and exclusion, especially women, who lost family support. Children felt the identity problems in particular. Many of these people had moved from one area of poverty to another. They found that there was no acknowledgment of the trauma they had experienced and no support offered. The authors of the report call for more investment in community development in the border counties and for civil society and community organisations to have more input into policy making and decision making structures.

Marginalisation is of particular concern with regard to the health of women in the border areas. This may be connected with levels of poverty, as well as with access to health services in rural areas and to health services in another jurisdiction. In Ireland access to health care has been an issue for people living close to the border in the South. Access to care in the North is difficult for people from the South due to differences in funding arrangements, although it may be more convenient for some people. This is an area addressed by CAWT and particularly relates to primary care and specialist services such as radiotherapy and oral maxillo-facial surgery (Blackburn and Kemp, 1996; CAWT, 2006). However there is a lack of research on this in the border areas on the island of Ireland, again highlighting the importance and necessity of this research. There is on-going cooperation between the Department of Health and Children in Ireland and the Health Promotion Agency in terms of sharing best practice, professional training and public information campaigns (Department of Health and Children, 2000).

In resolving current health provision issues for Donegal County, the role of cross border cooperation has been much debated by groups such as the Donegal Action for Cancer Care. While health consultants in Donegal initially expressed a preference to link Donegal cancer treatment services with Galway, the Health Service Executive actively promoted the idea of stronger cross border cooperation with Belfast. In November 2005, the Health Ministers from both jurisdictions[1] met and formally agreed to allow cancer patients from Donegal to be treated in the new Radiation Oncology Services at Belfast City Hospital from March 2007. This marks a shift in government policy on cross border cooperation. In the past, initiatives involving mobility of patients have typically resulted from partnership agreements between individual hospitals. Examples include the use of Altnagelvin neo-natal intensive care facilities for patients from Letterkenny and hernia operations for Craigavon patients in Monaghan Hospital. This recent arrangement on access to radiotherapy services marks an official sustainable agreement led by the two Departments of Health. The voice of the local community, Donegal Action for Cancer Care, has raised questions about the difficulties of accessing care in Belfast given that sharing services across jurisdictions has proved so difficult in the past.

While formal access to services across the border remains low, informally there is estimated to be 20,000 people who live in the South and access services in the northern health system within the North West region.

[1] The Irish Minister for Health and Children, Ms Mary Harney TD and the Northern Ireland Health Minister, Mr Shaun Woodward MP, met in Belfast on 15 November 2005 and agreed to support arrangements for cancer patients from Donegal to be treated in Belfast Cancer Centre once it formally opens in March 2007. The Belfast Centre is already treating approximately 50 Donegal patients and the new cross-border arrangements will make this service available to a larger number of patients at a centre closer to their homes.

In the border region, the conflict has had a particularly marked affect on economic and social development. Survey evidence from NISRA (2004) shows that 61% of Northern and Irish border region populations do cross the border but with Catholics more likely than Protestants in both regions to do so. In Northern Ireland, 62% of the population cross the border for short breaks and holidays but the comparable figure for the southern border regions is 8%. The main reason for people coming north is for shopping.

The border in the North West of Ireland does not represent an ethnic divide between Protestants in the North and Catholics in the South. There is a significant Catholic majority in Derry city and a substantial Protestant minority living in Donegal. However, Protestants in the North and the southern border counties were found to view the border differently. Protestants in the South view it as a barrier from conflict, while in the North, as a barrier from republicanism. Southern Protestants reported wanting to dissociate themselves from 'Paisleyism' to their fellow southerners and Irish nationalism to their northern counterparts.

> *Nationalists in this border city [Derry] are the ones most interested in events across the border and most keen for further cooperation. In this sense, they stand between Unionists and 'Southerners' (Catholic and Protestant alike) who, for the most part, are looking in the opposite direction.* (Hayward, 2005: p48)

Elsewhere border issues have been researched such as between Mexico and USA where there is more focus on economic issues and illegal immigration (International Community Foundation, 2004). In addition studies have pointed to concerns about communicable diseases such as tuberculosis and road traffic accidents (Garza *et al.*, 2004). Such issues are less marked in Ireland although in the past residents in border areas chose where to shop based on the economic climate. Recently the high death rate from road traffic accidents has been of major concern.

2.4 THE ROLE OF WOMEN DURING AND AFTER CONFLICT

> *Conflict opens up intended and unintended spaces for empowering women, affecting structural social transformations and producing new social, economic and political realities that redefine gender. (Manchanda, 2001)*

2.4.1 Women's role during conflict

The UN Research Institute for Social Development 1998 report, Women's role in conflict and post conflict society, outlines women's contribution to family, community and socio-economic life during and after conflicts (Sorenson, 1998). While it is clear that women have been directly involved in the conflict, particularly on the republican side (Morgan, 1996), much of this is at the level of providing safe houses or passing messages. The great majority of women however have little direct involvement. Whilst men commonly engage directly in acts of war and violence, women usually carry responsibility for maintaining the normality of everyday family life, sustaining family relationships, and protecting and maintaining their families' health and safety. During conflicts women tend to adopt traditionally male roles such as providing economically for the family and taking on public roles associated with social or political activity. This was the case during the conflict in El Salvador between 1980-1992 when women contributed to the financial stability of the family by developing 'outside home' work and business skills. This was in contrast to their traditional role in the home. Increased economic power contributed to increased influence in the community and women made up 30% of the left wing FMLN insurgents who were fighting against a right wing government (Blumberg, 2001).

Sharoni (2001) reports instances where women's experiences during conflict serve as a springboard for emancipation and lead to more enduring involvement in community and political activities. Using the response of nationalist women to internment in August 1971 as an example, she shows how women mobilised their local communities to resist the imposed curfew and sought to protect their homes and families from what was considered military harassment and arrests. Women took on vital roles in their communities and previously non-political women became advocates for their communities and agents for change (Sharoni, 2001). Such mobilisation of nationalist women was described as resulting from changes in men's role as the conflict escalated. With men absent from the home women's involvement in armed struggle could be interpreted as a symbol of their loyalty to their men, their family and their community. Women took to the streets, engaged in direct confrontation with the military and police and transported ammunition and messages (Morgan, 1996; Ward 1996; Aretxaga, 1997; Sharoni, 2001). The intention behind such political engagement may be to protect their homes, families and community, rather than a conscious attempt to progress an agenda of gender equality. Development of a sense of independence, self-identity and broader political awareness may therefore be an unintended effect of the conflict for many women, and one that for some leads to continued community engagement.

Women's roles vary culturally, and Protestant women have been reported as having rather different experiences during the conflict. Sharoni (2001) described their self-image as one rooted in colonial ideology. She described how many Protestant women during the conflict seemed to view themselves as simultaneously belonging to a powerful group under threat and as liberals who believe women's universal experience transcends any national or other difference, perhaps seeing themselves as already enjoying gender equality.

2.4.2 Women's role during the aftermath

> *There is no one aftermath [of conflict] because the scenarios following war are as various as the conflicts themselves. (Meintjes et al., 2001: p4)*

According to Fay *et al.*, (1999) men tend to have more direct experience of violence, being directly involved in incidents including physical attacks or sectarian verbal abuse, whereas women are more likely to witness such events. Morrissey and Smyth (2002) highlight that victims' issues, especially in Northern Ireland, are gendered. Over 90% of those who died in the Troubles were men. Men also dominated paramilitary groups and security forces. Many women, however, have been left to cope with the aftermath, such as the loss of a partner through death or imprisonment and looking after the family. Fearon states that 'women have an understanding of the actual cost of the Troubles' (2000: p163) again highlighting how they have had to cope with the outcomes of violence and conflict. Research by Training for Women Network (Potter, 2005) found that many interviewees considered women to be 'the living victims' of the Troubles. Respondents in their research felt that, as women are mainly seen as the 'sustainers of family life', they tend to be the ones that have to hold the family together and support the children during times of difficulty. Meintjes *et al.* (2001) comment that 'because public rewards (or recognition) go to those who died, women's advances – the survival strategies that kept families alive and communities together' may be disregarded (p17). In exploring women's experience of trauma, Sideris (2001) commenting on the Truth and Reconciliation Commission in South Africa, says that many women felt uncomfortable about exposing experiences of violence and some felt they had dealt with the past and did not want to open up old wounds. Closer to home, Conroy *et al.*, in their study of people displaced to the southern border counties as a result of the conflict, comment that 'a study which involves recall is mediated by the many cultural, social and political factors which individuals use automatically and spontaneously to sift and frame their memories' (p12). They also warn that recalling their experiences of conflict can 'raise deeply submerged feelings' and that people may feel 'pressure to minimise the trauma of

experience for fear of disrupting a fragile peace'. This could well have relevance for this research, being conducted some 13 years after the ceasefires.

As indicated above, many commentators discuss how women may become 'empowered' and their roles change during conflict: 'Conflict creates a confusing and contradictory dynamic in which gender identities are reified and polarized while at the same time women's roles are expanded into male-dominated areas' (Walsh, 2000: p4). This may give women a sense of strength and capacity (Sideris, 2001).

How this affects women when a society enters into a post conflict situation will vary between cultural contexts. Sales (1997) states that women who are married to men who have been imprisoned, have had to renegotiate their 'domestic roles and become more independent'. Ward (2004) highlights that although some women have emerged empowered by the experience of war, it is more common that the 'hard-won autonomy' is lost after the war ends. Meintjes *et al.* (2001: p8-9) comments that 'women's activism in managing survival and community level agency is predictably devalued as accidental activism and marginalised post conflict, as politics become more structured and hierarchical'. The clash between reality and the idealised vision of women may be bitter in the aftermath, particularly if women want to retain their new found autonomy. This was to some extent the case in El Salvador, where at the end of the conflict many women experienced marginalisation by the FMLN leaders. In Bosnia, women, who during the conflict had taken on increased economic responsibilities for their families, were, after the conflict, expected to revert back to traditional roles, making way for retired soldiers in the job market. Women's participation in the labour force declined after the conflict and the pay gap between men and women increased. At an individual level, this may be relatively insignificant compared to the safe return of husbands or sons. At a societal level, however, it may solidify traditional gender roles and make it more difficult for women to gain independence, and for those widowed or looking after those injured during the conflict, to provide economically for their families. The marginalisation of women in the labour market is a common feature in post-conflict societies (Sorensen, 1998). Meintjes *et al.* (2001) emphasise the need women feel for social transformation rather than reconstruction of the past following conflict. Meintjes *et al.* (2001) also comment on how the 'men returning with hatred for the "enemy" may clash with women who have gained a new understanding of their community and a wish for reconciliation' (p18). Meintjes (2001) highlights the 'cusp, that period between war and peace…the transition from war to peace…as a critical moment in the shifting terrain of gender power' (p64).

The aftermath of conflict has also been linked with increased domestic and gender related violence in many different parts of the world (Leslie, 2001). Post-traumatic stress, unemployment and alcoholism are provided as reasons for such increases, which is frequently seen as a purely post conflict phenomenon. The changing roles of women may became problematic when partners return to the home environment and indeed many women have reported marriage difficulties including the use of physical violence (Alison, 2003). Some have suggested that 'emphasised masculinity' among men involved in armed conflict may be related to levels of domestic violence in Northern Ireland (Muldoon and Trew, 2000). 'Legitimisation of violence during the war may effectively legitimise its use to resolve conflicts in the home' (Pillay, 2001: p35).

Turshen (2001: p84) discussing the impact of the aftermath of conflict on women, says that men attempt to reassert their control over women and 'escalate social violence, both at home and in public'. Therefore, after conflict the effects on women may be even more damaging than during the conflict period itself as evidenced by Ibeanu (2001), who found that the gender violence women experienced in wartime increased when fighting died down after the Ogori crisis in Nigeria.

Experiences of increased domestic violence and loss of empowerment among women in Northern Ireland was found by Alison (2003) in her study of female combatants in the conflicts in Sri Lanka and Northern Ireland and in unpublished work conducted by ICR for the Eastern Health and Social Services Board. Commenting on existing research seeking explanations for increased domestic violence after conflict, Walsh emphasises the links with changes in gender roles and states 'it is increasingly being recognised, however, that violence is a form of patriarchal control, exercised out of frustration in the change in gender roles and the increasing independence of women' (Walsh, 2000: p9). Morgan (1996) comments that for a long time the response to domestic violence was one of denial. Sharoni (1992) found that cultural attitudes mean that male violence against women may be excused as a response to stress and in a society experiencing conflict, it may be unacceptable to call on authorities for help and dangerous for security forces to respond.

The Northern Ireland Crime Survey 2003/2004 (Freel and Robinson, 2005) found that 19% of women have been victims of domestic violence at some time. This was 2% more prevalent in Catholic respondents than Protestants, and 7% higher in Belfast than in the West of the province. Only 39% of victims believed their worst incident constituted a crime. Only 18% of incidents were reported to the police. The definition of domestic violence used included physical, sexual, emotional, financial or social abuse. Including only threats and force and excluding emotional, financial and social abuse gives a prevalence rate of 11%. The overall rate is up 1% from 2001.

ADM/CPA (2003) also found that there was a reluctance to report domestic violence to the police in their research in Cavan/Monaghan, reporting that 100% of women waited until they were injured before they reported domestic violence to the police. It concluded that this reluctance to involve the Garda was linked to the conflict and the border. Harvey *et al.*, (2005) commenting on the low levels of reported domestic violence in Monaghan and Cavan, suggests this reflects low awareness and distrust of authority.

Potter (2005), writing about women's role in building social capital, comments on the predominance of women in voluntary and community organisations in Northern Ireland, which he says constitute the horizontal relationships identified by Putnam (2000) as important for social capital. However, women are under-represented on the structures that form the intersection between society and the Government, for example making up one third of public body membership in Northern Ireland and only 35% of directors of voluntary organisations. Women are not prominent in positions of influence either in executive roles in civil society structures, public bodies or more formal political structures, in other words, the vertical networks of society. Bloomfield (1998) emphasised the importance of community development to peace-building, which suggests that women's role in community development is making a significant but perhaps under-acknowledged contribution to creating a peaceful society in Northern Ireland. Turshen (2001) found that formal peace negotiations following conflicts in many areas of the world tend to exclude women; they 'tend to be male domains and employ discourse and practices closer to men's reality than women' (p89). Potter (2005: p17) argues that 'by equipping women who have been most affected by the conflict with the skills, qualifications and capacity to participate more fully in their communities, civil society, economic life and political structures, the chances of a sustainable peace are enhanced'.

2.5 SUMMARY

Internationally it is recognised that war destabilizes states, ethnic communities, families and individuals (Bloomfield, 1998). This literature highlights how women, although less likely to be injured or killed by conflict, are impacted by the consequences. Morgan (1996) argues how the long-term impact and consequences of violence for individuals and families has probably weighed most heavily on women. The role of women during conflict in any society changes and this change can bring about problems after the conflict ceases. This has been the case not only in Northern Ireland but throughout the world.

The impact on health both during and after conflict is important and as the literature suggests, the mental health consequences can be the most difficult to deal with. The Bamford review (DHSSPS, 2006) recognised the impact of trauma on mental health, but the trend is to look at the population as a whole rather than the specific health needs of women.

The lack of research on the impact on health of living in border areas makes it difficult to assess if this factor added to health problems caused by the conflict. In Northern Ireland, apart from Belfast itself, many border areas were more severely affected by the Troubles. The literature does however suggest that the isolation in these areas, along with economic pressures and access to health care, can have negative implications for health status. It is aimed in this research to explore this and assess if the women taking part in this study found that living in border areas affected their health status.

3. METHODOLOGY

3.1 BACKGROUND

A tender for this research was submitted by the Institute of Public Health in Ireland in association with the Institute for Conflict Research and Rethink and awarded by Derry Well Woman. The research was led by the Institute of Public Health in Ireland in collaboration with the other commissioned organisations, with each feeding into it by representation on a Steering Committee and by provision of material relating to the literature review.

3.2 LITERATURE REVIEW

The literature review was commenced at the beginning of and continued throughout the duration of the research process. It was initially used to inform the research design, to frame the project within the context of existing research and to inform the development of the research instruments. Later, it shaped the discussions in relation to issues raised by interviewees. The review explored published international research and that from Ireland and the UK investigating how violence, disruption, displacement and turmoil as a consequence of conflict may impact on the lives and roles of women. Three specific aspects were considered in depth, namely the impact of conflict and of post conflict situations; the impact of borders on health; and the role of women in a post conflict society.

3.3 SAMPLE

The qualitative fieldwork element of this study was designed to explore people's experiences and interpretations of the impact of the conflict and the border. The sample targeted community groups and individuals, with a view to giving voice to women who had not previously publicly discussed their experiences. The study population for the individual interviews was recruited by way of Derry Well Woman's existing relationships with local organisations. These included statutory as well as voluntary and community based non-governmental organisations. The primary sampling criteria included the location and age of the women. The Steering Committee and the research team made every attempt to include the voices of women who were both Catholic and Protestant and who came from a cross section of rural and urban locations and socio-economic backgrounds from both sides of the border and who had connections to both state security services and to non-state armed groups.

Thirty one individual interviews and two focus groups were carried out with women living across eight council areas.

Following initial analysis of the individual interviews, a further focus group comprising service providers and health carers was convened and six further individual interviews were conducted with service providers from both sides of the border. The purpose of these contributions was to explore and reflect with professionals responsible for delivery of relevant services, their understanding of the issues and perceptions that had emerged in the women's interviews.

To ensure that as wide a set of responses as possible were accessed, and given the complexities, delicacy and sensitivities that might be expected to arise in relation to the subject matter (as well as understanding individuals' cultural expectations), methods of interviewing and modes of recording information were tailored to meet the needs of individuals and groups. One group of women, for example, preferred to contribute to the research as a focus group as they felt it provided a 'safe' environment and was less

overwhelming than working individually. Consideration in framing questions or pursuing enquiries was given to participants' exposure to violence, their family constitution, degree of social exclusion and their opportunity to access available support and services. Given the potential that an exploration of the topics might trigger adverse health responses, a variety of organisations were identified who might provide further support to participants as required.

3.4 CONFIDENTIALITY

Ethical approval was granted by the HPSS Research Ethics Committee in September 2006. Research governance approval was sought from all HPSS organisations north of the border as required by the Ethics Committee. Informed consent and permission to participate was sought from the participants. Protocols were developed for researcher safety and for dealing with disclosure of alleged or suspected offences during data collection. All personal and medical information obtained relating to the research participants has been treated as confidential. Consequently, participants' contributions are not attributed other than by a nominal religious/ethno-political category.

Interviews and focus groups were taped, transcribed and analysed. A thematic analysis of the transcripts identified the key themes that formed the basis for the final report. Following completion of the analysis and production of this report, all tapes and transcripts will be destroyed to ensure confidentiality of the research participants.

3.5 QUALITATIVE FIELD WORK AND ANALYSIS

A qualitative approach to fieldwork was agreed and the researcher used semi-structured questions to guide individual interviews and focus groups with a view to generating data. Participants were invited to discuss and develop topics identified at the beginning of the interview. Open-ended and in-depth questioning allowed the interviewees to introduce and elaborate themes they considered important (Ritchie 2003). The topic guides for both individual and group interviews were constructed on the basis of the literature reviews and are included in Appendix 1. The methodology was chosen to enable participants to have a relative degree of autonomy and direction in the development of the research.

The focus group work created an environment where participants were able to respond to and elaborate on other's views (Lewis, 2003). It proved an effective way of accessing a diversity of responses and one that enabled the participants to clarify and reflect on their position.

The interviews with service providers both in the focus group and in the individual interviews addressed the principal research aims and in addition sought clarification about services which were historically and currently available throughout; what gaps existed; any possible developments in service provision and any specific issues that arose in relation to cross sectoral and cross border relationships and working.

3.6 RESEARCHERS' SUBJECTIVITY

The research team and the Steering Group were composed of women from a variety of different nationalities, ethnicities and religious backgrounds and who had a variety of experiences of both the Northern Ireland conflict and of living in and crossing borders within an international context. Both those conducting the research and those analysing and writing up the research findings undertook exercises in reflexivity to consider how best to present the material in as broad and unbiased a perspective as possible.

4. FINDINGS

Six key themes emerged from the interviews:
- women's role in the family and in local communities
- poverty and disruption
- the value placed on health issues
- perceptions and meaning of the border and the conflict
- support networks
- women's contribution to peace building.

Within these themes a number of cross cutting issues were identified. These include:
- the impact of the peace process
- different manifestations of trauma
- the significance of the border to health issues
- processes of normalisation
- the medicalisation and pathologisation of mental health issues
- social capital and networks of support.

The principal findings of the key themes are summarised in the following section and then expanded.

It is noteworthy that irrespective of their differing attitudes to the conflict, irrespective of whether they lived in urban or rural areas, and whether their experience of the conflict was direct or indirect, all women with families considered that their priority was first and foremost the survival and nurturing of the family.

Quotations are written in italics and only identify the women using their ethno-religious-political identity when necessary. When quotations used do not identify women, this signifies that women from both traditions were able to demonstrate similar experiences and perceptions.

4.1 WOMEN'S ROLE IN THE FAMILY AND IN LOCAL COMMUNITIES

> *Men will go out, throw stones, murder, get imprisoned, but women have to raise the children, maybe left without money. I suppose no matter how much women agree with what the men in their family are doing, they are bound to be saying why should I have to cope with this?... Women were too busy. Women had babies and they were too busy.*

SUMMARY

- Women were often precipitated into the role of principal family breadwinner as a direct result of the conflict whilst also retaining a traditional role of carer and homemaker
- Women who had family members directly involved in the conflict and who found themselves taking on multiple roles for short or extended periods, had to carefully renegotiate and re-define their status in the family when these members reintegrated into family life
- Women tended to focus their caring role to other family members rather than attending to their individual needs
- Women found their responsibilities as family carers began to extend past their own and into the community during the conflict
- Women from Catholic/Nationalist/republican communities were considered to have been encouraged and supported to develop their profile as community and political activists more than their counterparts in Protestant/unionist/loyalist communities

- Women who lived on the border had high expectations of themselves and others in relation to developing coping mechanisms to respond and adapt to the additional stresses that the conflict brought to their way of life.

4.1.1 Roles inside and outside the home

During the conflict, irrespective of their religious and political backgrounds, the majority of participants in rural areas tended to be 'stay at home' mothers. Their preferred and key role was that of principal family homemaker and within that role, many of the women expected that their husbands would transfer the responsibility of household finances onto them. Most women who assumed this role had no expectation of domestic responsibilities being shared or taken on by husbands or sons.

Similarly, women who worked outside the home spoke of expecting to work all day and then returning home to cook, clean and care for children. They accepted that males in the house would not expect to help whether or not women were in paid employment.

Some respondents in Derry and other urban areas with high male unemployment rates reported living on very low incomes. This was particularly so for those living in communities that had been disproportionately affected by internment and imprisonment. They considered that existing poverty had been compounded by the conflict and indicated that they had only been able to relieve financial pressure and sustain their roles as homemakers and carers by taking on any available paid work. For many of these women, being obliged to take work outside the home came as an unwelcome choice and was considered at the time to be an added burden and demand that had to be factored into an already crowded schedule. This was particularly commented on by the families of prisoners.

In retrospect, however, some women were able to consider paid work more positively. They felt that it had provided a means of 'social' escape that had helped them develop both personal strength and confidence and had been a stepping stone to further involvement in community development and social action.

One woman who had worked in the welfare system suggested that the majority of women assumed and were expected to assume responsibility for all social welfare and social benefit entitlements. She suggested that while men might hold legal responsibility for family's 'claims', it was women who tended to organise the process as they accompanied their husbands to make claims and they were expected to supply the names and dates of births of children: 'They were running things from behind, they had the responsibility but not the power'.

One typical and shared behavioural attribute of the women was that of self-sacrifice. This appeared to be an expected norm that they all suggested was embedded in their family and community cultures. Women from both urban and rural areas reported that they felt a responsibility to ensure that others' needs were met before their own. One woman from an urban background, discussing her parents' relationship, explained, *'He never had to worry if it was enough…She always made sure he had what he needed first… cigarettes, money for the pub and the biggest dinner. I used to see her busying herself at dinner time saying she'd sit down in a minute...covering up that she wasn't eating.'* Similarly a woman who saw her mother as a typical 'traditional' farmer's wife with a large family described her as a *'strong, self-sacrificing woman who worked hard daily. She washed, carried water from a well, clothed us, cooked for us and made the bread. She grew vegetables for us, looked after the babies and helped out on the farm as well. She was a very strong woman, a fantastic woman.'*

Both Catholic/nationalist/republican women and Protestant/unionist/loyalist women considered that Catholic communities had a tendency to encourage and support women, to become actively involved in community development and capacity building initiatives more than Protestant communities did. One woman spoke of the support she had received from within the republican movement, highlighting the way in which she had been encouraged to join a variety of educational and vocational classes. This had enabled her to re-enter formal education and to go on educational trips overseas. She spoke of how those who returned to education in colleges, universities and community education forums were in a position to apply themselves to educating other women from within their communities. She considered one of the direct benefits of this positive attitude to education was an increased politicisation and active involvement in politics for some which appeared to be missing from unionist communities. *'Even today, look at the parties…plenty of nationalist women out there…but fewer unionists.'*

4.1.2 Renegotiating roles and identities

Women whose husbands were 'actively' involved in the conflict considered that such a direct engagement often precipitated a change in women's domestic roles and for some this brought specific problems. Some suggested that if their partners were absent or less involved with family life for a period, the family had to renegotiate roles when they returned and this often caused marital conflict. One woman whose marriage broke up after the ceasefires and who described her husband as a political activist, discussed stressful and ultimately violent incidents within the home which resulted in her marital breakdown. She considered that this was in part due to her enhanced role, behaviour and attitude within the family, but recognised that her husband's negative behaviour was a direct result of exposure to violence and threatened violence from external sources.

4.1.3 Developing coping mechanisms

Participants in the study talked of women's ability to *'survive'*, and simply to *'get on with it'.* They indicated that despite the longevity of the conflict, for most people *'life simply went on as usual'.*

One woman noted that while women were busy *'holding it all together'*, men appeared to be having a different experience.

> *The women who were around then were very strong women. They were the ones who held it all together. They saw to the children, got everyone up and down to bed…even in the midst of riots or raids in the street. They cleaned cuts and bruises and kept the world ticking over where it often seemed the boys were out having fun!*

Some participants considered that the strategies that they had been able to draw upon, such as tenacity, an ability to adapt and a capacity to become desensitised to the conflict, were beneficial and helped them to cope with aspects of disadvantage manifest by the border and the conflict. None appeared to consider these strategies in a negative light but rather considered that having these mechanisms helped them to further develop a range of skills and abilities, which in turn often enabled them to develop 'a voice' both within and beyond the home.

The use and misuse of prescribed medication, alcohol and cigarettes was an issue for some women and an issue presented by the practitioners. *'Nearly all of them smoked. One woman I knew drank quite a bit and so they had problems looking after children.' 'Most of the women smoked and quite a few of them were drinking' .*

4.1.4 Women as agents of normalisation

The interviewees painted a vivid picture of daily exposure to bombs, shootings and riots at

the height of the conflict, yet they also spoke repeatedly of the need to *'just get on with it'* and how *'it just became a part of your life.'*

Women who lived in conflict flashpoint and interface areas, commented on the *'strength'* it required to ensure that their children were able to *'experience life'*. In some instances, children were actively encouraged to play outdoors despite the proximity and frequency of army patrols, checkpoints and searches. *'When you had youngsters, you had to let them out to play on the street. You couldn't have kept them in.'*

One woman spoke of the challenges her mother had faced in urging her sons 'not to get involved'. For her, 'involvement' in the conflict would have *'been the last straw. She just couldn't have taken it if they had got involved.'*

Women whose husbands were members of the security forces, and for whom it was a standard daily routine to check underneath family cars for fear of bombs, felt it was essential that they sustained *'the normality'* of everyday life in order to hold the family together. *'You had to pretend to yourself that it was a normal job he was doing. You couldn't allow yourself to think about it too much. But the threat was there. You were always on the alert, looking under the car, watching out for strangers in the area. But you had to try and make life normal for the wains.'*

Silence and avoidance, even within communities of shared political interest, were key strategies used to avoid or dissociate from the conflict or events that might lead to emotive discussions. *'We didn't talk about it at work. Even though the radio was on. We had our own views, but kept them to ourselves. Even from your best friend. I know she would have liked to say things to me, but you just didn't.'*

These women in particular, expressed a sense of discomfort with the lack of openness.

'I had a best friend whose husband was a policeman. She had five sons and I don't think it has ever been dealt with. There was a section of our community who brought their children up on lies. There are wee ones who thought their dad was a painter and decorator or that their dad was a salesman, or that he was civil servant or whatever. They never ever knew while they were young what their Dad was and then when they did know, they still had to lie. The pressure that put people under was mental.'

4.2 POVERTY AND DISRUPTION

'I felt there was no real services out there for women like me to avail of. Sometimes you felt very isolated.'

SUMMARY

- Poverty was a shared experience for many people irrespective of their ethno-political background or geographical location
- Imprisonment of a family member brought particular financial hardship to some families.
- Women living in the South and in rural and more affluent urban areas in the North were less likely than women from less affluent urban areas to have experienced the conflict. They were also more likely to dissociate themselves from the conflict
- Gender equality issues for women became subordinate to the pursuit of more general civil liberties. However, being pushed into the labour market for 'survival' enabled some women to achieve a degree of independence
- The conflict and border caused disruption to family life. Both impacted tangibly on life choices made by women as to where they felt they or their families were able to reside, to study or to pursue leisure and shopping activities.

4.2.1 Poverty, survival and independence

While all the participants considered that they had lived with a backdrop of political unrest, they considered that Derry, Belfast and the border counties were the areas worst affected by the conflict. These were also the areas that experienced the poorest socio-economic circumstances and many women considered that it was principally economic disparity and social exclusion that precipitated the violence and the conflict more generally. High levels of unemployment and poor social conditions greatly impacted on families in these areas and were experienced across the political divide.

One woman, whose mother had been widowed suddenly in the 1970s and left with five children, considered the major concern at that time was one of survival. *'My mother had to have a full time job. I believe for her the Troubles were secondary. She sat at the machine morning, noon and night. My memories of her are work, work, work, but that was typical living in the country.'*

Others interviewed reported their awareness from an early age of the difficulties their mothers had in 'stretching money' and 'making ends meet'. Some of those interviewed saw their need to earn money as heralding independence and providing them with a sense of power. One woman illustrated her determination to develop despite her husband's wishes that she remain in the home. *'He didn't want me to go back to work but I needed the money so I went behind his back and got a job before I told him…that's when I came out of my shell. When I went out to work I was an independent woman earning my own money and contributing more to the house than he was.'*

4.2.2 The impact of prison and being 'on the run'

For those women who had husbands or other family members who were imprisoned, the loss of income that imprisonment brought exacerbated already difficult financial circumstances. *'I didn't really know what to do when the Troubles came to my door – it was very stressful. We weren't political, but I had to learn about it all and stand with my head high even though I didn't agree with their actions. It was very expensive in financial terms, visiting them and making sure they got what they needed. I had other children, so I needed to take care of them as well.'*

Even when women had an ideological pride in their husbands' status as political prisoners, there were still ambiguities and tensions that having an absent partner brought to day to day family dynamics: *'We had to feed them and clothe them and get them to school, even if we were ill ourselves.'*

In addition to the financial responsibility that was placed on women by prison visits, the burden this brought in terms of spending time away from other tasks was exceptional. As one (54 year old Catholic) woman from an urban, republican area describes how *'women's time was taken up holding it all together, all you could do was be looking after children and running to the prison with food hampers and clothes.'*

Being married to someone *'on the run'* brought particular hardships to some women.

> *My own sister's husband was in jail and on the run for years – she went through all that, supporting him – she didn't have a car and was always looking for a lift and trying to get to see him and getting money and trying to take him money and food over the border for all of those years when she had a young baby.*

4.2.3 Education, media, geography and socio economic difference

A number of women reported being completely unaware of different ethno-religious, political or cultural traditions until post-primary school.

> *It wasn't until I went to secondary school at 11 years of age that I heard the words Catholic or Fenian. I came home and asked Mum what 'Fenian' meant. Mum said it wasn't a nice name for my friends. She said, 'It is not a nice name for a Catholic'. My attitude was different because I knew Catholics since I was a small child.*

Some women interviewed remarked on the lack of insight that some of their peers demonstrated in relation to experience of the conflict. It was suggested that there was a distinct divide at some schools between those who were subjected to regular body searches at checkpoints, to riots and to house raids, and those who had no understanding of such events. A number of interviewees suggested that many of their teachers and fellow pupils were unaware of the conditions in which some of their classmates were living. One woman explained,

> *We were raided…they didn't get anything, but we were up all night. Anyways, my mother insisted we all went to school. I went, but I fell asleep. The teacher woke me and when I told her what happened, you could see that look on her face…you know, not really knowing what you're talking about and wishing you hadn't said it out loud. Looking back, they had no concept of what it was like to live with that night after night…how could they?*

Some women who lived in less affluent areas felt that their experiences had lasting effects on their attitudes and values. One woman speaking of her *'daily experience of having to go walk through checkpoints to go to school,'* said she felt humiliated and dreaded going that route to school. She further added that the memory still causes her a *'tremendous amount'* of stress.

Conversely, women living in more affluent areas sometimes only acquired knowledge of the conflict from the media or through conversations with others. One woman from an affluent mixed residential area in a small town attests,

> *I came from a well off area of the town, everyone owned their own house and, looking back, it was very mixed religion wise…we weren't allowed into the town centre on our own and there were parts of the town I was never in until I was an adult. At school you would hear some of the girls talking about raids and 'the Brits' and the CS gas, but you didn't really know what it was all about. You'd hear about it on the news and you'd know it was your town, but that was it. You didn't know exactly where it was, or what it was like, because you hadn't been there.*

The majority of women interviewed for this research who came from rural areas, and in particular those living in 'mixed' rural areas not immediately close to the border, also felt that they had learned more about the conflict from media reporting than they had from personal exposure. These women were often reported their memories of shared respect for others' traditions and talked about how they valued and accepted diversity. They explained how it was commonplace to share resources such as farm equipment and to work together on each other's land. Some discussed long lasting family friendships which spanned generations explaining how parents and children visited one another's homes, supporting one another through difficult times. *'We lived in the country a good ten miles from the town and really we knew nothing of the Troubles. My parents encouraged us to think of people as people not as one thing or the other. We didn't talk about the Troubles… anything I knew about the Troubles I got from watching the news on the TV but it seemed nothing to do with us.'*

In general, those woman interviewed for the research who lived in the Republic were unlikely to attribute any negative aspects of their lives, their health or the roles they had within their families to the conflict either directly or indirectly. Many dissociated themselves from the conflict considering that it was either happening 'in another country' or it had 'nothing to do' with them.

4.2.4 Security forces/services

Reflecting the lasting effects of conflict, some women talked of their retention of feelings of anxiety and hostility towards particular sections of the community. For some women, their negative emotions were only directed at the security forces, irrespective of the level of violence that was being perpetrated by others from their own or other communities.

> *We lived night after night with shootings, riots and bombs. There were always bombs going off. And raids. I used to be physically sick. Part of that was the CS gas and part of it was nerves. I was terrified all the time. If I saw them coming up the road I'd start to cry. I hated them. I still do. Even now if I get stopped by the police I feel sick…it's nerves.*

Conversely, many women whose families were attached to the security services felt that their health and wellbeing was not adequately supported.

> *There's loads of issues that I don't think anybody really has looked at in any depth. We talk about deprived and disadvantaged communities, but there's other disadvantages - the security forces have been dropped like a hot potato. When you look at the reservists who put their lives on the line, they were more at risk than full-time Police because they were more easily accessible.*

> *There's one of my daughter's friends was killed and her father had two legs blown off because he was police. I feel annoyed because there are things said about the victims, but there's nobody there to deal with their stuff, to help deal with their grief.'*

4.2.5 Disruption to family life

Irrespective of their community background and traditions, women respondents to the study reported moving house in order to 'protect' their families. One woman in her early sixties who lived on an interface, spoke of how, on one occasion she was unable to find her four year old son following a fight breaking out on the street where they lived. After locating him across the interface, they had to walk through a 'no man's land' to return home and she decided they could no longer live there. Another woman who had lived in a mixed area, described how she was forced to move home in her sixties after experiencing intimidation which culminated in her home being burnt out.

> *We had lived in that area all our life. I was born just round the corner. It was a mixed area but gradually Protestant people moved out. We were just at the interface so there were bombs and riots every night. They were scared. I wasn't. It was my area, it was where I was from, my children were born there, our friends lived there, but eventually one night they burnt us out! We literally had to flee…our neighbours were in tears and telling us they'd protect us, but they couldn't. We had to go to save our children. It was heartbreaking.*

One woman, whose neighbour was injured in a car bomb which exploded as he was passing by, decided to change her choice of university so that her family would be less likely to worry.

I know with all honesty that the Troubles impacted on my decision about where to go to University. All my friends were going to Queens, but I made the decision not to go there because my mother would have just lost her life and would have been worrying everyday of the week if I had gone there, so I went to Coleraine.

4.3 THE VALUE PLACED ON HEALTH ISSUES

SUMMARY

- Women felt that consideration of their health was a low priority both for themselves and for service providers as it related to the impact of the conflict.
- Women who lived in neighbourhoods where violence erupted regularly considered they had developed both positive and negative coping mechanisms. Some considered that they had been left with a range of long- term emotional scars including anxiety and mistrust. Few reported seeking or being signposted to any psychiatric or psychological interventions
- Reports emerged of some women's increased alcohol intake and a culture of sharing prescribed drugs and medication
- Women considered that the current increase in cross border cooperation in health care provision was a tangible benefit of the peace process.

Given the historical period and the social context in which they were living when the conflict began, the women felt that their mental health and wellbeing was not an issue to which specific consideration had been given either by themselves or by service providers. Health did not occupy a central position in their lives. *'Life went on as normal'* as some women suggested previously (see 4.2.3). Women considered that they were desensitised to the conflict and violence and, despite living with high levels of stress, were in many instances able to develop coping mechanisms.

While only some participants in the report acknowledged that alcohol consumption was used as a coping strategy, one service provider who visited women from a number of communities, both Protestant and Catholic, reported its prevalence amongst women and witnessed many who she felt were clearly suffering from alcohol abuse. This perpsective was born out by another service provider who reported high levels of anxiety and depression amongst those with whom she was working and which she considered were intensified by high intakes of alcohol though her clients only considered they were *'taking a drink socially'* when asked about the issue. There was concern about the impact of substance misuse on other aspects of health.

I would say there's a lot of drink-related stuff simmering – there was a lot of pill-popping and I would say that has a big impact on people who are the survivors of various atrocities whether that is from paramilitaries, ex-paramilitary prisoners or security forces personnel. You know, it could have an even bigger impact as we go through the peace process with domestic violence.

Participants in the research made limited reference to depression and to general health issues specific to women, though menopause, breast cancer, mental wellbeing, childbirth and pregnancy were mentioned. One health care professional drew attention to what she termed *'restricted and limited'* attempts to identify needs or develop and seek out gender specific services.

Women's health just wasn't an issue. It's only in recent years, maybe the past five years, that I see women really taking an interest in their health. They used to just think it was their lot to live with stress and anxiety, that they weren't entitled to have a life for themselves, they were there for everyone else.' Another professional suggested that 'there was no attempt that I know of to identify any health needs specific to women.

Those participants who wanted to discuss health issues tended to do so in hushed, ambiguous and euphemistic terms using words such as 'nerves' and 'due date' to allude to specific conditions. There was little formal acknowledgement by or to the women at the time that they might be depressed. Many however, recognised that they were 'low of spirit' and there was an expectation that their GPs would prescribe anti-depressants. Many women commented on the informal sharing of prescription drugs at the time, and how it was acceptable and normal to be *'sending to a neighbour for a Roche 5 or a wee Ativan'* in stressful times and equally for a 'Solpadine' (pain killer), to numb the effects of hangovers. Those women interviewed who did report having experienced or having had contact with people living with mental health problems suggested that repeated exposure to bombings, shootings, hijackings and house raids were contributory factors: *'You were on your nerves waiting every night for him to come home safe, so of course you're a nervous wreck. I used to have to take the children up to my parent's house. I couldn't stay on my own. I'm still nervous and anxious. I wasn't like this before.'* For some women these memories had long-term implications. *'I couldn't sleep at night, every time I heard a noise I was up. Now the first thing I do to this day is look out that window because I used to see them coming to raid us through that window.'*

Women health service providers considered that there had been significant advances in health care provision in recent years and that these developments had been led or driven by the community sector. These included the availability of clinical therapeutic interventions (including cognitive behaviour therapy) to deal with anxiety, complementary therapies, personal development courses and counselling as well as gender specific screening services. One woman commented,

Services for women have definitely improved. Breast screening, cervical smears, many more female GPs – even mental health services have improved. There's stress management and all sorts of courses and psychiatric nurses available to deal with women with anxiety, to teach them how to overcome panic attacks and counselling for people now. That's a change.

Her proximity to the border enabled one woman to seek access to contraception and non-prescribed methods of birth control.

My mother, now, she saw the border as very liberating. That was the word that she used. For her to be able to get contraception across the border, it was very positive in a way. She used to let on she was going across for butter, but it was really contraception she was smuggling over. Women weren't getting the services that they should have been getting. The services weren't there and they didn't expect anything!

4.4 PERCEPTIONS AND MEANING OF THE BORDER AND THE CONFLICT

SUMMARY

- The significance of the border on women's lives was in part dependant on their cultural identity, place of residence and the degree of their involvement within the conflict
- Many women refused to cross the border for fear of their safety; others who did found the journey stressful and problematic
- The conflict, and associated tensions at the border, threatened and ruptured existing and unproblematic inter-community relationships.
- Some women considered the border as an inconvenience and disruption to their daily social routines
- Protestant women in the North and Catholic women in the South articulated a fear of crossing the border at the height of the conflict, because of concerns about safety. (This did not apply to Protestant women living in the South nor to Catholic women living in the North.)
- The peace process is seen to be having a positive impact in helping some women to address their concerns about crossing the border.

In the main, women now consider the border in three distinct forms, as:

- an unimportant concept, a border in name only, that has little or no real impact on their lives
- an unacceptable barrier dividing their country in two despite being undetectable and not difficult to cross
- an acceptable demarcation of their 'country's' boundaries.

These interpretations differed significantly from how the border was viewed at the height of the conflict.

For some, its existence then impinged profoundly, with many choosing not to cross it. This attitude was most prevalent for Protestant women living in the North and Catholic women living in the South. *'It represented war, trouble and fear. That was exactly it, in a nut shell. We kept away from it because we were nervous and were afraid that we would be targeted, maybe because of your number plates, your car registration and that.'* For some, crossing the border during that period proved to be a source of stress for entire families and this was particularly evident for those who had family members living on the other side, irrespective of their community background. One Catholic woman in the North explained,

> *If we wanted to go over on a Sunday to see our relatives, it was a whole hassle. Big queues at the checkpoint. Sometimes my father used to get really angry with the soldiers and then we would all be pulled out and made to wait while they searched the car. My parents would be fighting because my mother thought my father should just be quiet, but he didn't see it like that.*

A Protestant woman from the South attests to a similar experience: *'I'm a Protestant born and living in the South. I'm Irish. To go see relatives just four miles away in another part of Ireland, I had to travel miles and cross through an army check point. It divided the country.'* One woman who lived close to the border suggested that,

> *If you only had the occasion to go through once a year, you maybe didn't really know the set up, all they heard was through the news and they were fearful, but people who were closer and just on the borders were used to going through the checkpoints and knew usually what was going on and were used to it.*

Protestant women living in the North and Catholic women living in the South both reported that they viewed the people living on the *'other side'* as misunderstanding their identity, culture and political motivation and were concerned that they themselves had also made assumptions about others' affiliations, values and beliefs. Both groups of women considered how this attitude had changed and impacted on their willingness to reconnect with family and friends. One woman told how her father discouraged her mother and sisters from crossing the border and they did not do so for over 25 years. Another explained,

> *We have relatives in the South and we would be invited to weddings, but we'd never go, because we were frightened. They would tell us not to be stupid, they lived there all their lives, and nothing would happen to us…but we just couldn't go.' Similarly, another woman reported, 'although we're only twelve miles from the border, I was never in the North while the Troubles were on. Never. I was terrified. I know it was silly, but I just didn't want to go up there. I've been up loads of times now since the Agreement, we take days out now and visit lots of places.*

Some, Protestant women in particular, continue to see the existence of the border as a marker of *'safe space'*, there to *'protect them from harm'*. One woman from a large urban area suggested that, *'The border keeps us separate from the South, from them. It keeps us safe. It helps us stay who we are.'* Her views were echoed by a woman from a small, rural town. *'I felt safe with the border there. It was a visible reminder that this is our country.'* One interviewee discussed the attitude of a work colleague who had never been across the border until the peace process was established. Since then, they had both been involved in cross border trips.

> *I was never in Dublin, never. Hard to believe now, but I was just nervous that people down there would guess from my accent where I was from and that they would know I was a Protestant and I don't know, wouldn't like me, or I would be in danger or something. I just wouldn't go. I never even went over to the seaside with the youngsters. I was too scared. I go over the border all the time now. I love it…and I've been to Dublin!*

For some living on or near the border, the conflict threatened to disrupt an easy status quo. These women remembered the period with an explicit and articulated reluctance to have the border and the conflict impact on their existing way of life. *'You would hear tell of people who just stopped talking to or seeing friends across the border.'*

In some instances, there was a readiness to *'scapegoat Northerners'* for potential problems. One woman living in the South in an area frequented by tourists during the holiday season suggested that local people saw visitors from the North as trouble makers. *'If there was any trouble at all of any sorts – grafitti, fights, loutish behaviour, it would be blamed on 'those Northerners.' They were Northerners, so what could you expect?'* This reputation appeared to have ramifactions for southern Protestants. A number of those who were living in the South considered that the 'Northerners' were a threat to what they considered to be a peaceful way of life. They voiced concern that throughout the Troubles they were frightened that their satisfactory co-existence would be altered or changed and might result in their being no longer welcome in the South. *'We have and had a lovely way of life here. We couldn't understand what the difficulty was. We lived side by side by our Catholic neighbours with no one concerned as to what we were. We were and are just accepted as part of the community. We really didn't want anyone coming over here causing trouble.'*

4.5 SUPPORT NETWORKS

She was left alone with the baby. The family had to support her. I supported her. I moved in with her. That was my practical way of helping when he was on the run and when he was in prison, because she wasn't very political. She turned first to us and kept it in the family.

SUMMARY

- Women recognised the value and significance of support networks and the core role that could be played by the family
- Women living in Catholic communities were considered to have been able to access practical and emotional support networks more easily than women from Protestant communities
- Women living in rural areas and in isolation reported being less able to express fears, to get practical or financial assistance.
- Networks of support for Protestant women appeared to more church-based than community led
- Participants to the research felt uncertain as to whether new networks of support had developed since the ceasefires.

Within the focus groups, a number of respondents highlighted the value they placed on support networks which they considered had developed directly as a response to the conflict. Women from both communities commented that there appeared to be a culture within Catholic communities that encouraged women to seek and provide support to one another and that this was less evident in Protestant communities. Some suggested that Protestant women were *'more self reliant and reluctant to seek support from others.'* Protestant woman considered that their ethnic background did not easily lend itself to seeking support from one another as theirs was one which *'prided itself'* on self-sufficiency, self reliance and was one where cultural behaviour was often permeated by silence or a reluctance to share sensitive information.

4.5.1 Prisoner issues

All respondents felt that the republican movement had proved to be strong in providing support to prisoners' families. The Prisoners' Dependants' Fund was cited as a group which at the time had actively benefited women and their families by organising transport to make visits to the prisons as well as co-ordinating small, regular, financial assistance. One woman whose husband was an active republican spoke of how she began a support group by *'knocking on doors'*. She suggested that, *'It was all very informal. We organised it ourselves. We met in each others' houses, drank vodka or tea, smoked and talked and cried. And it helped.'*

It was suggested by some women that there was no network of support specifically for loyalist prisoner families. This perception is discussed further in section 5.5. Protestant women explained that for republicans there was a *'pride'* in their men's actions if and when they were taken prisoner on behalf of the *'armed struggle,'* whereas they suggested that loyalist partners and families and the broader unionist community were ashamed and embarrassed by their actions if they were arrested.

4.5.2 Church-based support

Irrespective of denomination, the Church in Northern Ireland is a well established source of voluntary, spiritual and material support within communities. Both Catholic and Protestant women reported that they receive a degree of practical support through formalised church-based groups. A number of Protestant women however, suggested that they had expected

to receive more emotional support from the Church and felt that this was not a strong feature of the support offered.

4.5.3 Isolation

While allegedly more a common feature for those women living in Protestant neighbourhoods, the prevalence of feeling isolated was also commented on by a number of women from Catholic communities. Some women who identified themselves as republican found they were isolated from neighbours after their homes were raided or their husbands or sons arrested and imprisoned. One woman in her sixties from a rural area commented on how she was saddened by the fact that neither her GP, her priest nor any neighbours visited her after a raid which resulted in a family member being arrested. Other women from urban nationalist housing estates were able to attest to similar experiences.

Isolation was an issue for women whose husbands went *'on the run',* either living across the border or in more *'sympathetic'* areas. Women felt they were forced to make choices between uprooting the families, (which in turn brought isolation and poverty), or of living separate lives from their husbands. In such circumstances women were reluctant or unable to share their concerns outside the family and tended to be silent and self-censor for fear of their partners whereabouts being uncovered.

Women from mixed marriages frequently found themselves in a double bind, disconnected from their communities and sometimes families, and not always accepted into the families or communities of their partners. *'Maybe this is what's been affecting my health. I suppose a lot of the time I am leading a double life. XX is very happy living here and I am reluctant to destroy that.'*

4.5.4 Women's movement

Opinion varied as to whether women's networks have continued to grow since the ceasefire. It was generally considered that one positive response to the conflict was that the woman's movement had gathered momentum and strengthened in and across both traditions during the latter years. However, as discussed earlier, the woman's movement was seen to be part of a wider struggle for civil liberties and often subordinate to other movements.

4.6 WOMEN'S CONTRIBUTION TO BUILDING COMMUNITIES

There was nothing in this area, we were very isolated with nothing to do for women or children, though the men were alright – they got out. So a couple of us got together and started to organise a few things in the local hall. We got organised, got some funding and now there's lots of things going on and we have lots of plans for the future.

SUMMARY

- Since the ceasefires and the Good Friday Agreement, women report being increasingly willing to become involved in cross community and cross border community development initiatives on shared issues (including health and education)
- Both nationalist and unionist women considered that republican women were able to 'give voice and be heard' more easily than loyalists during the conflict
- Women consider that they are contributing to a 'post conflict' society by sharing resources, personal experiences and history with women from other traditions.

4.6.1 Motivation

The willingness and ability of women to commit to building communities was reflected in that most of the interviewees were actively involved in community development for pleasure as well as for a sense of social responsibility: *'I do volunteer with a few groups in the area –*

I love it, it keeps me busy'; 'I've been involved in quite a few community initiatives over the years, education, mothers and toddlers, health projects – I sat on the committees and generally helped out'.

At the height of the conflict women, who were living with protracted and high levels of stress, often reported having to draw on individual strengths and abilities to try and garner some sense of shared community and collective support. This was felt to be particularly so for women whose family members were imprisoned. *'I was very low, but I had to get on with life. We needed to get money, so we started to knit and make things and sell them. It was all we could do. It strengthened me I suppose. Then I was approached by some local people to get involved in trying to raise money or do community development in the area. There's not much around here. Gradually I got more and more involved.'*

Interviewees provided examples of how they retained their political ideologies, but actively sought ways in which to cross the ethno-political divide by collaborating and cooperating on social welfare issues such as health, family support, education and training. One woman living on an exclusively Protestant urban housing estate was typical. She described how she works within her community to develop inter-community activities.

> *I'm still very much a unionist, but I work hard to try and make society better. I believe the days are gone when we have to accept violence as a way of life. You can stay true to your beliefs and values, but work with people to achieve things that will be mutually beneficial. You need to respect other people.*

4.6.2. Mutual benefits

An attitude of mutual cooperation has come recently to some urban areas with recognition of the current challenges facing those who have lived apart for so long. This approach is less of a novelty for those living in rural communities. Some of the women who participated in the research reflected on how even at the height of the conflict, individuals in the country would often help and expect help from neighbours irrespective of their political or religious beliefs and considered this to be beneficial to the community as a whole.

Women involved in cross community and cross border initiatives found that such work was a source of pride and satisfaction and they evidenced this through their willingness to work voluntarily on such projects. Many women expressed a growing awareness of shared concerns about raising and caring for families and in helping to instil a sense of value in diversity.

> *Women are able to relate to other women and get on with what needs to be done. You know, through this cross community work, we've come to realise that we have more in common than we have different and we have nothing to fear from the 'other side.' We've gone down to the South and teamed up with a group of other women and learnt about so much together, our shared history, all of that. They've come up here and it will just continue on like that, learning from each other and sharing our experiences. That's how we're going to change this country for the better.*

Both nationalist and unionist women considered that during the height of the conflict, women living in republican areas had 'loud and strong voices' which represented a level of community involvement, organisation and power that their counterparts did not experience.

> *The way their women went out and rattled bin lids, in a way, that was their voices being heard. They were making their presence felt by doing that. It wasn't like that in our areas. They were ahead of us. They were better organised. They knew what was going on. It's only in the last fifteen to twenty years that women in the unionist organisations knew anything about the UVF or UDA. It wasn't talked about.*

Women's groups that developed as a response to the lack of statutory support and to the community's poor social capital were thought to be beneficial to the wider community. Through the capacity building initiatives they brought, women were resourced and enabled to contribute to wider community infrastructure. Many women's groups had an educational focus and the provision of crèche facilities provided some women with the opportunity for a variety of personal development programmes. It was considered part of the 'peace dividend' that some women were able to contribute both to their community's health status as well as to their own personal and professional development by training as holistic and complementary therapists.

4.6.3 Shared health care and concerns

As discussed in 4.3, women considered that some of the recent improvements in health service delivery are due to community advocacy and lobbying as a result of the peace process. They felt this could be evidenced in increased cross border cooperation and developments. As one 60 year old woman living in Donegal commented,

> *The cross border work being done now in regard to health is really moving along. Even the whole cancer services thing in Donegal. You can see that women were aware of the possibility of services being improved, took action and got a response. Of course there's still work to be done, but it will happen. It's just a matter of keeping going. The peace process had allowed people to consider cross border working and get the benefits to the people. It can only get better.*

4.6.4 Young people

It was recognised that women encouraged and involved young people in community development to promote the material and social improvement of some mixed areas and estates. One woman who had moved onto a mixed estate became the chairperson of the residents association. *'I got the young ones involved in cleaning up the estate and keeping it looking good and getting things organised for them.'* Her experiences were similar to another woman from a different tradition. *'I began as a factory worker, became involved in union work and aware of politics through that. Then I got involved in local community groups, trying to do something to keep the young people out of trouble. We live at an interface and there can be quite a lot of sectarianism.'*

5. DISCUSSION

Section 2 draws on a body of international and local literature on how conflict impacts on health and wellbeing of women, and explores the impact on those living in border areas. Of particular relevance to this discussion of the research findings is the position outlined by Batniji (2005: p1854), which acknowledges that conflict has a direct impact on individuals' and communities' sense of identity, cultural and religious beliefs and practices and on family and community relationships. Furthermore, it echoes Meintjes' concerns (2001:5) when recognising that 'those women who live through conflict, do not fall into a single group'. While acknowledging that the size and composition of this research sample has both shaped and impacted significantly on its findings, care has been taken in writing up the material to ensure that as well as highlighting issues of specific concern to particular groups of women, commonalities and shared experiences and perceptions have also been highlighted. Any paradoxes and ambiguities arising from a comparison between this study's findings and the literature review should be considered in relation to the sample and, as with any research project, it is inevitable that questions may arise in relation to generalising out from particular individuals' experiences. It is noteworthy that the majority of the contributors to this study were either waged or unwaged community workers. Despite any limitations and shortcomings of the sample size, the findings and discussion aim to provide an enhanced understanding of the impact of the conflict and the border and will help inform the strategic and policy development of the North West Women's Health Network.

Five key cross-cutting themes emerged from the research.

5.1. THE IMPACT OF THE PEACE PROCESS

Writing during the early stages of the peace process, Morgan (1995) suggests that the long-term consequences of violence for individuals and families probably weighs the most heavily on women. Therefore, it might be expected that it is women who have most to benefit and gain by the developments and impact of the peace process.

At the time when the interviews were conducted, the promise of devolution being restored marked the political atmosphere. Consequently a number of structural, political, economic and bureaucratic changes were evolving and beginning to take place. Many of those women who were interviewed felt they had given consideration to these advancements and that they were quite rightly being heralded as a dividend of the peace process. It was felt that the climate was an optimistic one where the developments being brought about as a result of 'peace' were thought to be positive for society in general. When questioned further on this, by and large the women considered that there was the opportunity for women's interests to be specifically represented and highlighted within governmental policy development. As a process, this advancement is found to be in keeping with studies in other countries that have explored innovation and progression in post conflict societies. In discussion, participants anticipated future benefits within the context of long-term developments and planning. However, they were uncertain as to how such developments might ultimately shape their opportunities to access health services and services to deal with the trauma of the conflict. Nevertheless, all participants to the research did acknowledge the peace 'dividend' as being beneficial in developing cross-border cooperation between health service providers. *'You can get chemotherapy, radium and screenings, but you still have to go to Dublin, where with other hospitals, Enniskillen down the road, for example, we could make use of that instead. The possibility exists now, and precedents have been set with collaboration and partnerships.'*

It was noted that the lead set by political and governmental institutions increased the opportunity for funding cross-border and inter-community initiatives. This, in turn, has had an impact on confidence building. A key 'trickle-down' effect has been the confidence

instilled in the voluntary and community sectors and evidenced in their willingness to engage in inter-community and cross-border work. Writing of the visibility of women in the peace process, Fearon (2002) suggests that 'women have an understanding of the actual cost of the Troubles', and this has motivated and precipitated them to recognise the value of sharing resources, personal experiences and seeking shared histories with those from other traditions working to break down socio-political barriers to change.

The administrative, funding and practical implications that have resulted from the peace process have meant that some groups feel that they are being actively encouraged to develop work that brings them into contact with those from opposing political positions. This is particularly evident in the case of women whose family members were imprisoned as a result of the conflict and for women with family in rural communities who have been connected to the security services. Members of both communities of interest felt that the peace process had particular consequences for how they engaged or felt they were expected to engage with others. Such work provided an opportunity for considerable self-reflection which brought with it both challenges as well as resolutions. It was generally felt that there was not yet sufficient understanding of the implications of the conflict for women to 'make sense' of the impact of the peace process.

5.2 DOMESTIC VIOLENCE

While there is some evidence that women's responses to trauma and to ill health, as reported in the findings of this report, mirror that of other studies, respondents to this research were reluctant to discuss any instances of direct or indirect domestic violence. Leslie (2001) suggests that women suffered increased domestic and gender-related violence as a direct result of post-traumatic stress and concomitant unemployment and alcoholism, and the number of reported domestic violence incidents has increased since 1998. However this was a view that could not be verified through the perception of respondents in this study as only one woman reported having first hand experience of domestic violence. Attitudes to policing in Northern Ireland may have been in part responsible for an unwillingness to report domestic violence. A reluctance to do so may consequently have led individuals to deny that domestic violence was abuse.

5.3 THE SIGNIFICANCE OF THE BORDER IN HEALTH TERMS

Recognition was given to the recent advances made in the provision of cross border services. There is a body of work referring to the availability of specific medical services both north and south of the border and the implications this has for women who are in a position to access these services. Yet, there appears to be little if any references in the literature locally or internationally, which considers the impact of the existence of the border on women's health more generally. This is perhaps surprising considering that the border has a direct bearing on matters such as social cohesion (including trust and safety) and in enabling a sense of participation in broader society. These might be considered factors likely to impact on the wider social determinants of health, including access to education, goods and services, housing, travel and transport and it is noteworthy that similar issues have been flagged up as significant for women's mental health (McColgan *et al.* 2002).

Generally, at the height of the conflict, participants reported being reluctant to cross the border, associated with an inclination to consider oneself 'different' to those on the other side irrespective of ethno-political identity. This was evident in the research findings and particularly noticeable in terms of a readiness to access services. For some women, despite developments in the implementation of cross-border cooperation, this attitude was pronounced. It appeared that many were willing to accept their jurisdiction's provision as the status quo and only expected to be able to access health care on 'their' side of the border, irrespective of how far they had to travel to do so. *'People just accept that we live far away from Dublin but that's where we have to go for treatment, it's just the way it is.'*

Evidence from both the literature and the interviews demonstrates a continued high level of unmet need in relation to coping with anxiety and depressive illnesses. Participants reflecting back on their own and their families' experiences consider that practitioners demonstrated a lack of acknowledgement of the wider implications of trauma and their default position was to over prescribe tranquilisers. *'We just would meet up and talk and go to each other for a wee valium'.* Reference has been made elsewhere in this study to predictions of an anticipated increase in the number of individuals requiring support (Payne, 1998; Manktelow, 2001) and the Bamford review (2006) identifies the particular needs for young people as well as for adults in Northern Ireland for mental health services. Given the different capacity and cultural expectations of individuals in seeking and accessing support in difficult and challenging circumstances, it would be worthwhile giving consideration to obstacles, including the structural barriers both north and south imposed by the border, that impact on the accessibility of mental health service provision.

Despite their different socio-economic backgrounds, participants in this study all considered that poverty and poor social conditions have impacted greatly on both Catholic and Protestant women and were a trigger for the conflict. Furthermore, the restrictions on trading and social support networks imposed by the border particularly when the conflict was at its height, were recognised as having impinged on women's lifestyle choices. This in turn was considered by some to have impacted on women's self-esteem as well as on their physical and mental health and wellbeing. The rapidly changing demographics of the island of Ireland, and strategies such as New Targeting Social Need and the Anti-Poverty Strategies both north and south of the border, indicate that there is a recognition of the need for long-term strategic intervention for health and wellbeing. There remain a number of persisting challenges for health and wellbeing inherent in existing mechanisms, not least the remaining boundary that the border presents. It is noteworthy that despite existing work aimed at addressing adverse mental, physical and emotional ill health both north and south of the border, there are still issues for those whose life circumstances lead them to seek assistance in both jurisdictions, (including but not exclusively Travellers and migrant workers). There are particular practical, management and implementation issues for those wishing to track, provide and record the progress and treatment of women moving regularly across the border.

5.4 PROCESSES OF NORMALISATION

Both the findings in this research and in the literature explicitly demonstrate that women struggled to maintain the normality of 'everyday life', coping with the effects of changing roles and society, poverty and conflict.

The research indicates that despite the tangible effects and losses of the conflict, a variety of mechanisms were employed by women both north and south of the border to try to ensure a veneer of normalisation was maintained when and where possible. To that end, few women saw desensitisation to the conflict and its concomitant violence as negative. Furthermore, while evidence from a number of studies indicates increased levels of depression, alcohol consumption and abuse and the use of prescription and over the counter drugs (Fay *et al.*, 1999), it is perhaps a limitation of the sample used for this research that this study found little evidence of such coping strategies but an acknowledgement of its existence by the service providers, for example by the sharing of a *'Roche 5 or a wee Ativan'* and the women who *'met in each others' houses, drank vodka or tea, smoked, talked and cried'.*

The findings from the study closely echo those of both Sorenson (1998) and Blumberg (2001), in suggesting that women carry ultimate and overall responsibility for the normality of everyday family life, sustaining relationships, protecting and maintaining the family's health and safety and adapting their norms of behaviour to take on what were considered

more 'masculine' roles such as providing economic stability. Morrisey and Smith (2002) highlight this as being particularly pertinent for those women whose families have had to cope with the loss of a family member through death and imprisonment. This additional strain can also be evidenced in the research on women whose husbands or other family members were members of the security forces or 'on the run'.

In keeping with recent material (Tomlinson 2007) that argues much current evidence into the effects of conflict on mental health is complex and inconclusive, so too would it prove questionable here to attempt any analysis of the rationale, extent, results of and responses to the strategies of normalisation utilised by women. However what is evident are a number of recurring mechanisms that were employed, namely avoidance, dissociation and acceptance. Consequently, the only conclusions we can draw at this stage in this particular report, is that further work both in practice, policy and research terms would be beneficial to all the stakeholders.

5.4.1 Avoidance and denial

Two particular routes to avoidance were revealed in the research findings: geographical relocation and the service providers' acknowledgment of psycho-social avoidance through the use of alcohol and prescription drugs. As discussed in 4.2.4, some women chose or had to remove themselves from the negative impact of the conflict by moving house or by making choices that would impact on where they studied or worked.

While there is no longitudinal data to draw on that has considered the long-term impact of the use and misuse of prescription medication in the context of the conflict, Fraser (1971) found that there were significant increases in transquilliser prescribing in areas most affected by riots. Some of the participants to this research concurred with Fraser's findings when they reported increased alcohol intake and the common practice of 'sharing prescriptions'.

5.4.2 Dissociation, denial and distancing

The lack of direct experience of, or strong interest in the conflict by women living in the South was of particular note. There is limited data available or literature relating to the experiences and responses of women in the South. While this may be reflective of women's position more generally in society at that time, it is suggested here that this finding might not be gender specific, but relevant more generally. Given the proximity and potential impact of the conflict, this was an unexpected finding. The lack of connectedness has been described in common parlance as 'the silence around the North' and, while this condition is perhaps best exemplified in Seamus Heaney's well-used expression 'whatever you say, say nothing', numerous examples were offered of how women, particularly in the work force and other shared public spaces, were reluctant and unwilling to discuss their concerns and experiences.

A number of participants to the research who lived in the southern border counties, viewed the conflict as *'simply an inconvenience'*, due to the delay and disruption to shopping trips or visits to relatives. Some from the southern border counties reported looking to the North with sympathy whilst others expressed hope that *'the Troubles wouldn't spread down here'*, eager that *'it would all work out'*. These women recounted stories that demonstrated how they felt themselves *'safe'* from the conflict and the disruption to evenings out by shootings, bombings or bomb scares which were viewed as 'a good night out wrecked' rather than any threat to safety. One woman explains how,

> *we used to go out into the town at night despite what was going on. I remember being in (name of Bar) one night and we were all put out…a bomb scare…our biggest concern was that we wouldn't be able to go down to get chips on the way home. We had no notion that we might be caught up in something.*

5.4.3 Acceptance, habitation and subversion

The ability and choices made by women, to accept (albeit temporarily) and come to terms with their condition with a view to overcoming the negative and damaging effects of the conflict, was apparent from the interviewees. There was also evidence of women finding ways in which to subvert their situation and the status quo. In both situations, women were motivated to harness and draw on their experiences to benefit others and to work towards rebuilding their communities. While this was often precipitated by need in adverse conditions, it brought some positive individual and collective results. The process echoes the evidence within local and international literature indicating that women are enabled to become advocates and agents for change and able, as outlined in DHSSPS (2005: p15), to 'improve a sense of social cohesion, trust, safety and sense of participation – key elements of social capital'.

5.5 THE MEDICALISATION AND PATHOLOGISATION OF MENTAL HEALTH PROBLEMS

The widely quoted 'The Cost of the Troubles study' suggests that up to 80% of the population knew someone who had been injured or killed in the conflict and that interviewees to that study viewed their health as poor with 44% reporting distress and emotional upset (Fay *et al.*, 1999). The 'valium sandwich' and a reliance on prescribed medication to numb and subordinate mental health problems has been considered in a number of previous studies (Fay *et al.*, 1999; ICR, 2004; Smyth and Fay, 2000, Schlindwein, 2000). However many of these earlier studies suggest that while 'the majority of people in Northern Ireland managed to deal effectively with the stress generated by the Troubles', it is also important to flag up the unidentified need for further research into the likelihood of trans-generational trauma.

The negative impact of the conflict on mental health has been considered in a number of studies (including Fay *et al.*, 1999; Cairns *et al.*, 2003; Curran, 1998; Hayes and Campbell, 2000; Summerfield, 2000; Curran and Millar, 2001; ICR, 2004; DHSSPS, 2005; Bamford, 2006), from which evidence emerges that suggests that psychological problems are more pronounced and prolonged in populations exposed to civil unrest and violence. In developing this study, therefore, the research team anticipated that there would be a high reported incidence of mental health problems amongst the participants. Despite these recent studies, however, the reported lack of importance placed on women's mental (as well as general) health in this study is noteworthy, particularly when viewed within the context of the contradictory and partial evidence presented in other data and the fact that the majority of previous studies were not gender specific.

Manktelow (2007) examining the impact of the 'Troubles' on mental health found a vulnerability to depression and anxiety with victims suffering ill-health caused by long-term stress and the employment of coping mechanisms which in themselves added to stress levels. Batniji *et al.* (2006: p1857) highlights the need for a continuity in education and stability for children and young people at a time of conflict, however the long term and inter-generational impact of the conflict in and about Northern Ireland has not yet been adequately researched and the interviews carried out here would suggest that this is an area which might benefit from additional attention.

Participants in the study demonstrated familiarity with a variety of mental health conditions including anxiety, stress, depression and agoraphobia. The additional responsibilities and new challenges that presented with women's renegotiated roles as a result of the conflict were identified in the research as bringing a *'heavy burden to bear'* for some. This in turn resulted in increases in stress, emotional and mental health problems, particularly so for those women who were displaced or disconnected from family members and from other networks of support. With no materialisation of any assumed or predicted rise in mental health problems and psychiatric interventions as predicted in, for example, Payne (1998), Curran and Millar's (2001) study indicated that the conflict may not have impacted on the

mental health status of individuals to the extent where they became clinically depressed or required psychiatric intervention. Based on the interviews undertaken for this study, we suggest that women and their families are only now beginning to reflect on the consequences of the conditions they were subjected to during the height of the conflict. *'I suppose then you just got on with it, you didn't have time to think about it.'* In addition to acknowledging the time-lapse that can occur in seeking and requiring support, there must also be some acknowledgement of the stigma which still surrounds mental ill health and which acts as a barrier to presentation within a medical and clinical setting.

In keeping with the findings of Fay *et al.* (1999), the findings of this research suggests that the effects of the conflict are distributed unevenly across geographic locations and socio-economic groups and it was those living in areas of economic deprivation who felt the effects of politically motivated violence most strongly. These were individuals with fewer social and capital resources to address the concomitant 'fall out' in their health and social wellbeing. Manktelow (2001) suggests that it is only recently that people are beginning to come forward to address the legacy of the conflict and this would appear to reflect the views of the study's participants whose noticeable reticence to acknowledge any need at the time was considered as a coping mechanism.

For some, the stigma attached to seeking mental health services remains high despite current health promotion and education work aimed at addressing this in both jurisdictions. The literature and findings of the report suggest that intergenerational and hidden mental health issues are one of the most difficult legacies of the conflict to address and will require specific consideration in future provision of support, education and intervention programmes.

5.6 SOCIAL CAPITAL AND NETWORKS OF SUPPORT

A number of the participants volunteered the names of organisations they felt should be credited with being particularly supportive to the participants. *'Those were the thinkers that probably kept me sane'.* These included the Irish Countrywomen's Association, Women's Aid, Women's Centres, Women's Refuges, Omagh Self Help and Support Group, the Women's Information Network, British Legion and the Prisoners' Dependants Fund.

It was generally felt that the most reliable sources of emotional and practical help for women came from family and friends. It is noteworthy that no respondents to the research named health professionals, such as health visitors or community midwives, as sources of support and doctors were considered principally to be conduits to medication.

Women regularly reported that their communities developed a variety of informal and formal networks of support. In keeping with Sharoni (2001), the conflict offered a liberating opportunity for some women to explore other aspects of their identity and potential. A burgeoning community and voluntary sector encouraged and enabled women to provide facilities for their children, such as mother and toddler groups, playgroups, youth clubs and other activities. However, as community development at this time received poor financial support, wider family and community support and fundraising occurred and was sustained through the organisation of jumble sales, 'sales of work' and 'socials', all of which provided means by which to socialise and 'escape from the bombings'. While much of this work was carried out in distinct and discrete communities, women living in mixed communities looked to each other for support, and a number of participants discussed their attempts to maintain personal friendships and networks of individuals from the 'other' community and some women talked of their attempts to escape tensions and intimidation by consciously moving into mixed areas.

For some women, particularly those for whom the conflict and the border impacted significantly on their lives, the enhancement and extension of their roles in the family from nurturer to provider may have been in part responsible for an increased sense of 'certainties' that entrenched and embedded community polarisation. Sharoni (2001) suggests that Protestant women believed themselves to belong to an elite and powerful group and consequently did not seek out ways to build capacity within their communities nor any particular political networks of support. This absence of community building in Protestant communities was also reflected in our study. Furthermore, the lack of community infrastructure in loyalist communities is manifest in the perceived narrow focus of community development initiatives (DSD, 2005). Conversely as Sharoni suggests, (and as demonstrated by the participants in this research), nationalist women have chosen to seek out and subsequently have found more opportunities for community development. It frequently transpired that the ultimate destination of this route was some form of political representation in the North. At the time of writing the Northern Ireland Assembly comprises 108 assembly members of whom only eighteen are women, twelve coming from Nationalist parties, three from the DUP, one from the PUP and the remaining two from the Alliance party. And while it has been suggested that women in some 'post conflict' situations regress from any autonomy and support mechanisms they developed during the conflict (Sorensen, 1998), with marginalisation in the labour market a common feature, this would not appear to be the case for women who took part in this study.

Community-based aid for individuals was found to be more prevalent within Catholic/nationalist/republican communities than in Protestant/unionist/loyalist ones with the church in both communities playing an acknowledged, sometimes significant but often under-developed supporting role. The variation in community support and the social and material capital tallied with the findings from the Taskforce on Protestant Working Class Communities (DSD, 2005). This report demonstrated fragmentation and rivalry within some Protestant/unionist/loyalist communities and a concomitant weak community infrastructure with poor community development skills and networks, requiring well facilitated support to address the current deficit. It would appear that there are a variety of grounds that have resulted in the disparity between communities, not least because of divergent cultural norms where, for example, self-reliance and 'holding your own counsel' is highly valued in some communities whilst communal and mutual support is considered more of a norm in others. It is also noteworthy that irrespective of community background, existing networks of support may break down in the case of arrest and imprisonment. The resultant stigma, shame and fear which accompanies a period of incarceration can further mitigate against individuals exploring new avenues of support. Accurately determining the factors which contribute to inaccessibility and reluctance to engage with available mechanisms and networks of support, could assist in the future development of appropriate forms of community based and led social capital.

Finally it was widely recognised by the interviewees that the conflict has enabled the development of the women's sector. The work of various women's groups was seen as pivotal to the ongoing contribution that women could and were making to developing a shared and post conflict society.

6. CONCLUSION

By revisiting the key issues raised in the report it is evident that irrespective of their faith, ethno-political background or location, many women's lives were impacted on by the conflict. Restrictions were placed on their ability to 'live a normal life' or to access particular goods, services or social activities because of the border and the conflict.

By way of conclusion, it can be seen that the peace process has brought with it the potential for advancements in the general and mental health of women of all ages on the island of Ireland. The improvement will continue if future developments in planning and service delivery remain cognisant of the presenting and underlying issues in women's health that relate directly and indirectly to the conflict. While women may continue to face structural barriers in accessing services, their own and their families' mental health and wellbeing is more readily recognised as being crucial to healthy communities and societies in general.

Women's role in their families and in local communities developed and was strengthened as a result of the conflict. However increased responsibilities were not necessarily accompanied by increased support systems and, as a result, women's general health and wellbeing was often considered secondary to those of other family members and the coping mechanisms they called on sometimes compounded underlying and undetected ill health.

The disruption to day to day life caused by poverty was exacerbated by the conflict, a common experience for many women and this impacted tangibly on the life choices they made on where, with whom and how they could engage in wider society. Being forced reluctantly into the labour market because of adverse family circumstances, including the loss of the family's breadwinner through death, injury and incarceration, enabled some women to achieve a degree of independence, but for most, it came as an unwelcome necessity in an already busy life.

Women considered that they and health practitioners were now placing more value on gender specific health care and that an increase in cross-border cooperation in health care provision was a tangible benefit of the peace process.

At the height of the conflict, the impact of the border on women's lives was in part dependant on their cultural identity, place of residence and the degree of their involvement with the conflict. Attitudes to crossing the border have changed rapidly and significantly with an increased willingness to do so being reported. Women consider the border in one of three ways: an unimportant concept with the border in name only with little or no real impact on their lives; an unacceptable barrier dividing the country; or an acceptable demarcation of their country's boundaries.

The value and significance of support networks and the core role played by the family was recognised. It was suggested that during the conflict, women living in urban Catholic communities and those with family members imprisoned were able to access practical and emotional community support networks more easily than women from rural and border Protestant communities and with connections to the security services. The churches were recognised as offering some assistance to women but were not considered well connected to wider networks of support.

Since the ceasefires and the Good Friday Agreement, women report being increasingly willing to become involved in cross-community and cross-border community development initiatives on shared issues such as health and education and consider that they are actively contributing to a 'post conflict' society by sharing resources, personal experiences and history with women from other traditions.

7. RECOMMENDATIONS

The important role that women have played in building civil society and contributing to peace has often been underplayed and merits greater acknowledgement. Based on this research study, the researchers make the following recommendations:

1. Community development and skill development for women needs to be supported and resourced to enable them to engage in civil society, take up public appointments and contribute to political parties. This particularly applies to women from a Protestant background.

2. The North West Women's Health Network is central to maintaining focus and momentum in the North West on the wider determinants of women's health. Derry Well Women should continue to be resourced to drive the Network so that it can achieve important health outcomes for women in the North West.

3. Action is needed to strengthen gender mainstreaming and the promotion of women's health and wellbeing throughout the public health sector north and south. The recommendations of the National Women's Strategy 2007 – 2016 in the South and the action areas and strategic objectives of the Gender Equality Strategy 2006 – 2016 in the North provide clear direction on what needs to be done and should be implemented.

4. The statutory sector should identify and ensure the provision of appropriate services for women experiencing hidden mental health problems and domestic violence resulting from the conflict and undertake work to address the stigma associated with these conditions.

5. The statutory sector should support interventions for young children who have no direct experience of the conflict but whose parents may still be suffering the consequences.

6. Further research is required into the challenges faced by women living in border areas during the conflict. There should be a particular emphasis on vulnerable groups such as women with disabilities, women who are carers, families with ex-combatants and other armed groups who live or lived in border areas, and mobile groups who cross the border frequently such as Travellers and migrant workers. Research into the trans-generational nature of trauma should also be considered. The emphasis of research should be on developing the evidence base for interventions that reduce inequities in health for women.

7. An investigation of the current and potential use of cross-border services for women should be undertaken. The need for public services, such as health and social care, to serve an increasingly mobile population is being driven by new focus on all-island policy development and EU health strategy.

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APPENDIX

Appendix 1 – Topic Guides for Individual and Group Interviews

Topic guide: In-depth interviews with participating women

- Tell me a little bit about yourself and your life (growing up, school, education, work, marriage/children, key events).
- How would you describe living in the border area at the height of the conflict?
- How do you think the border affected women in general? (Positives: cohesions, support, camaraderie: Negatives: isolation, mourning, breadwinners, tension, stress, marital relationships, concern for family etc.)
- How do you think it affected your family and/or your community?
- How do you think it affected you? (physically, mentally, emotionally)
- What kept you going during that time? (informal support, women's groups, statutory)
- Do you think you in some way are still affected by your experiences?
- How would you describe the changes in your life now/ after the conflict has ended? What are the key issues? (changes in activities, roles, opportunities, everyday life)
- How would you describe women's lives now/ after the conflict has ended? What are the key issues? (changes in activities, roles, opportunities, everyday life)
- Do women in this area get the help and support they need?
- Do you get the help and support you need?
- What changes would you most like to see in the future? (generally and in relation to service provision)
- Are there any issues that you think are of relevance that we have not talked about?

Topic guide: focus groups with support and service providers

- How would you describe the situation for women living in this area during the conflict?
- What are the main health issues for women that emerged out of the conflict?
- How was that reflected in the provision of services and support? What was the role of women's groups and support groups more generally in the services and support provided?
- What are the main changes for women now/ after the conflict has ended?
- How is that reflected in the provision of services and support?
- How would you describe the role of women regarding the mental well-being of families and communities (i) now (ii) during the conflict?
- How well is the particular situation of women living in this area reflected in the policy directives you are working towards?
- How easy is it to work along a border? What are the main issues that emerge? (generally and in relation to service provision)
- What changes would you most like to see in the future? (generally and in relation to service provision)
- [themes that emerge in the in-depth interviews will be included for discussion as appropriate]
- Are there any issues that you think are of relevance that we have not talked about?

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