Structural Violence and Health-Related Outcomes

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Contributor: Gloria Macassa

In recent years, there has been a revival of the term “structural violence (SV)” which was coined by Johan Galtung in the 1960s in the context of Peace Studies. “Structural violence” refers to social structures—economic, legal, political, religious, and cultural—that prevent individuals, groups and societies from reaching their full potential. In the European context, very few studies have investigated health and well-being using an SV perspective.

Keywords: structural violence ; health outcomes ; social determinants of health ; Europe

1. Introduction

In recent years, there has been a revival of the term “structural violence (SV)”, which was first coined by Johan Galtung in the 1960s in the context of Peace Studies [1]. Others argue that the terminology attempts to give weight to how the effects of SV are to some extent an “impairment to human life needs” [2], which would prevent someone from meeting their needs. According to Gilligan, SV is mostly invisible and embedded in longstanding “ubiquitous social structures, normalized by stable institutions and regular experience” (e.g., resulting in differential access to resources, political power, education, and health care) [2]. In addition, Farmer argued that SV is closely linked to social injustice as well as to the social machinery of oppression [3].

Although SV has drawn research attention in the fields of sociology and anthropology, it has only in recent years been brought into the research discourse of the health sciences and, specifically, the public health sciences. According to De Maio and Ansell [4], the potential of SV theory in studying health outcomes lies in its focus on deeper structural roots of health inequalities rather than in it being a passive approach centered on the social determinants of health (SDHs), i.e., a social epidemiological approach [4]. Traditionally, the social epidemiological approach identifies social characteristics that affect the pattern of disease and health distribution in a society in order to understand its mechanisms [5][6][7].

The concept of SV has similarities with the concept of “structural determinants of health” The term “structural determinants of health” refers to mechanisms that generate stratification and social class divisions in society and that simultaneously define an individual’s socioeconomic position in terms of “hierarchies of power, prestige and access to resources” [8]. De Maio and Ansell [4] argue that the terms “SV” and “structural determinants of health” call attention to the societal arrangements that exist upstream from the “behaviour and biology of individuals; they both extend the traditional social determinants of health model by prioritizing the causal force of structural forces” [4]. However, SV has a distinct etiology, as it describes health inequalities as an act of violence, arguably adding something that the “structural determinants of health” term lacks.

There still is an ongoing debate on what precise aspects should be measured to enable the use of SV theory in social epidemiology [4]. Research using the SV approach has increased over the past 30 years, especially in the Global South (low and middle-income countries) as compared with the Global North (mostly the US and Canada). It is argued that the extensive use of the SV lens in the Global South has been fueled by the need to better understand historical and political trauma, gender inequality, and poverty [9][10][11][12][13][14].

Combining different strategies (fieldwork, analyses of public policy documents, observation, and interviews with indigenous peoples and managers), Teixeira and Da Silva attempted to establish correlations between interpersonal violence and SV along democratic processes of public policies building in Indigenous health care [13]. In their study, they proposed that SV in health needed to be interpreted against the backdrop of a broader discussion on the construction of Indigenous citizenship that included tutelage and political participation in the politics of health practices in Brazil [13]. In a study carried out in Sub-Saharan Africa, Joseph used community and country-level inequalities in gender relations, human rights violations, and globalization as markers of SV, and related them to maternal health care [14]. In addition, social globalization was the most significant predictor of adequate maternal health care [14].

In the Global North (i.e., high-income countries), research applying the SV lens to study health outcomes has addressed the situation of immigrants and other disadvantaged societal groups [15][16][17][18][19][20][21][22]. In the US, in a study investigating how fear among Hispanic migrants undermined the risk for diabetes, Page-Reeves et al. demonstrated that structural forces directly inhibited access to appropriate health care services and created fear among immigrants, further undermining health and nurturing disparity [17]. The authors observed that although fear was not directly associated with diabetes, participants nevertheless felt that there was a connection to their health outcomes [17]. Furthermore, in a study that explored the impact of access to health care on the lives of at-risk populations in Florida, Mead found that factors such as finances, mental health needs, personal issues, and lack of childcare prevented patients from accessing health care.

Using the SV framework, Banerjee et al. [22] found that, compared with their Scandinavian counterparts (in Denmark, Norway and Sweden), Canadian frontline care workers reported higher rates of violence [22]. The participants in their study reported structural factors such as insufficient staff, heavy workload, lack of decision-making autonomy, inadequate relational care and rigid work routines [22].

In the European context, however, very few studies have investigated health and well-being using an SV perspective. This lack of research is set against a backdrop of increasing reports of structural violence experienced by certain groups throughout the continent (e.g., sexual workers, ethnic minorities, etc.) Therefore, we sought to review studies that used an SV framework to examine health-related outcomes across European countries. what types of studies (in terms of design) were conducted and in which countries they were carried out; and (b) what dimensions were used to conceptualize SV across the identified studies.

2. Analysis on Key Findings

This section presents the characteristics (in terms of country of origin, and design) of the studies included in the review as well as descriptions of the conceptualization of SV, and key findings for each of the studies.

The eight studies that met the inclusion criteria were published between 2010 and 2021. Two were from Spain [23][24] and two from France [25][26], and one each was from Ukraine [27], Russia [28], the three countries Sweden, Portugal, and Germany [29], and the UK [30]. Seven studies used a qualitative method design; one study used a mixed (qualitative and quantitative) design. Sample size varied from 5 [30] to 209 interviewees [28] (see **Table 1**).

Table 1. Studies included in the review (*n* = 8).

Author, Year/Country/Reference	Study Objective	Design, Sample, and Method of Analysis	Conceptualization of Structural Violence (SV)	Health-Related Outcome (s)	Findings
Sanchéz-Sauco, 2019/Spain/[24]	**To contribute to closing the current gap in the literature that holistically examines socio-cultural influences on perinatal drug dependency.**	**Qualitative study (semi-structured interviews)/thematic analysis Perinatal substance use and/or drug dependency in 10 pregnant women.**	**Socio-cultural factors**	**Substance use/drug dependency**	**The criminalization and stigmatization of addiction, and the risk discourse elucidate the multi-layered social barriers that drug-dependent women experience when seeking rehabilitation services.**

Author, Year/Country/Reference	Study Objective	Design, Sample, and Method of Analysis	Conceptualization of Structural Violence (SV)	Health-Related Outcome (s)	Findings
Rodríguez-Martínez and Cuenca-Piqueras, 2019/Spain/[23]	To investigate how sexual harassment in the workplace intersects with other forms of direct and indirect violence towards Spanish and unauthorized migrant women working in sex and domestic work who have suffered direct and indirect violence.	Qualitative study/multi-level intersectional analysis Interviews with 32 Spanish and unauthorized migrant women (Latin American, Eastern European, and African).	Power imbalance and discrimination (related to working as a sex worker and immigrant status)	Intimate partner violence/sexual harassment	Findings were that the interviewed women did not consider verbal abuse as sexual harassment and attributed the abuse to their work. In addition, they perceived sexual harassment to be linked to respect and not to love. The authors indicated that sexual harassment had less devastating consequences for women than did intimate partner violence.
Larchanché, 2012/France/[25]	To identify obstacles for undocumented immigrants to realize their health care rights.	Qualitative participant observation, critical review of legislative debates and reports related to health care of migrants (*n* = 5)/ethnographic analysis.	Social stigmatization, precarious living conditions, fear created by restrictive immigrant policies	Health care access	Findings showed that while, legally, undocumented immigrants were entitled to health care rights in France, the consequences of their social stigmatization and of their precarious living conditions, and the climate of fear and suspicion generated by increasingly restrictive immigration policies in practice hindered many from feeling entitled to those rights.

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Author, Year/Country/Reference	Study Objective	Design, Sample, and Method of Analysis	Conceptualization of Structural Violence (SV)	Health-Related Outcome (s)	Findings
Pursch et al., 2020/France/[26]	To explore the provision of health services to migrants in Calais and La Linière in northern France, to contribute to the discourse on the effects of SV on non-governmental service providers and migrants in precarious conditions, and to inform service provision policies.	Qualitative (semi-structured interviews)/20 key interviewees—Non-governmental organization (NGO) representatives/thematic analysis.	Immigrant status	Health care access	Structural violence negatively affected migrant well-being through restricted services, intentional chaos, and related disempowerment. The NGOs were required to shift service delivery to adhere to boundaries set by the government, such as limiting distribution points and constantly changing distribution locations to ensure that individuals living on the streets had difficulties to access services.
Owczarzak et al., 2021/Ukraine/[27]	To explore paperwork as a form of SV through its production of legitimate citizens, often through enforcement of gender stereotypes and moral narratives of deservingness. In addition, the study examined the relationship between the government and NGOs in the provision of services to women who used drugs.	Qualitative study including 78 participants (41 medical and social service providers and 37 women who used drugs)/grounded theory.	Paperwork bureaucracy	Health and social care provision	Documentation requirements were enacted as a form of SV towards already marginalized women through use of coding for marginalized, stigmatized, ill, or disabled identities, and prevented the women from accessing the services and resources they needed.
Hamed et al., 2020/Sweden, Germany and Portugal/[29]	To study access to health care in several neighbourhoods by interviewing local health care users.	Qualitative study (semi-structured interviews)/11 interviewees (health care users)/thematic analysis.	Discrimination (racism, racial inequalities)	Health care access	Findings were that users felt that medical staff viewed these patients' narratives as illegitimate, and regarded the patients as unworthy of treatment, which often resulted in a delay in treatment.

Author, Year/Country/Reference	Study Objective	Design, Sample, and Method of Analysis	Conceptualization of Structural Violence (SV)	Health-Related Outcome (s)	Findings
Lewis and Russel, 2013/United Kingdom/[30]	To understand the issues faced by young smokers—and those trying to quit smoking—in a deprived community.	Qualitative study (ethnographic study with participant observation) including 5 members of a youth club located in a disadvantaged neighbourhood.	Neighbourhood deprivation	Smoking /quitting smoking	The study found that young people were somewhat caught between three competing domains (economic and political structures, media structures, and organized crime). These domains together conspired to provide young people with means of consumption from which they were excluded through legitimate structures.
Sarang et al., 2010/Russia/[28]	To explore accounts of HIV and health risks among injection drug users.	Mixed-method study including a qualitative (semi-structured interviews) and quantitative (descriptive) design and a sample of 209 injection drug users. Qualitative data analysed using thematic analysis.	Drug policing strategies	Drug use/risk of physical violence	The study found that policing practices violated the rights of drug users directly, but also indirectly, through inflicting social suffering. Extrajudicial policing practices introduced fear and terror into the day-to-day lives of drug injectors, and ranged from the mundane (arrest without legal justification or evidence in order to expedite arrest or detainment; and extortion of money or drugs for police gain) to the extreme (physical violence as a means of facilitating confession, and as an act of "moral punishment" without legal cause or rationale, as well as torture and rape).

Human immunodeficiency virus (HIV); Non-governmental organization (NGO); Structural violence (SV).

The results indicate that there was criminalization and stigmatization associated with addiction, and that the women experienced multi-layered social barriers when seeking rehabilitation services [24].

Rodriguez-Martinez and Cuenca-Piqueras investigated how sexual harassment in the workplace intersected with other forms of direct and indirect violence among undocumented migrant women who were domestic and sex workers. The results indicate that the interviewed women did not consider verbal abuse as sexual harassment and attributed the abuse to their work. The study also indicated that sexual harassment had fewer negative consequences for women compared with intimate partner violence [23].

In France, Pursch and colleagues studied how non-state providers' policies affected health service provision to migrants The study found that the role of non-governmental organizations (NGOs) in providing migrant health services in northern France was complex and contested. There were indications that SV negatively affected migrant's well-being through restricted services, intentional chaos, and related disempowerment. In addition, NGOs were required to adapt service delivery to fit within the boundaries set by the government, such as limiting distribution points to one hour and constantly changing their location to ensure that individuals living on the streets were less able to access services [26].

In Ukraine, Owczarzak et al. investigated how red-tape bureaucracy and paperwork were a form of SV in the provision of health services for female drug abusers The study indicated that documentation requirements were enacted as a form of SV towards already marginalized women (through use of coding for marginalized, stigmatized, ill and/or disabled identities) and prevented them from accessing the services and resources they needed. In addition, despite the benefits that official status could confer, both clients and providers criticized the system because it often excluded the very women who needed help the most [27].

The study by Hamed et al. (n= 11) was carried out in Germany, Portugal and Sweden and used racial discrimination as an analytical lens. It investigated accessibility to health care among users in the three countries. The included health care users felt that medical staff regarded their narratives as illegitimate and viewed them as unworthy of treatment; the study concluded that this was a form of SV [29].

In the UK, the Lewis and Russel study investigated the experiences of young smokers (n= 5)—both active smokers and those who were trying to quit smoking—at a youth club in alow-income neighbourhood [30]. The findings indicate that young people were somewhat caught between three competing domains: economic and political structures, media structures, and organized crime. These three domains together conspired to provide young people with means of consumption from which they were excluded through legitimate structures. The authors pointed out that, rather than expecting young people to act in accordance with the health risk advice, interventions were needed to bridge issues of agency and critical consciousness that could otherwise be eroded by SV [30].

The study by Sarang and colleagues investigated accounts of HIV risk and other health risks among drug users in Russia The study found that policing practices violated rights of drug users directly, but also indirectly, through inflicting social suffering. In addition, the study indicated that extrajudicial policing practices introduced fear and terror into the day-to-day lives of drug injectors. The fear and terror experiences ranged from the mundane (arrest without legal justification or evidence, in order to expedite arrest or detainment; extortion of money or drugs for police gain) to the extreme (physical violence as a means of facilitating confession, or as an act of "moral punishment" without legal cause or rationale; as well as torture and rape) [28].

3. Conclusions

This review sought to describe studies using an SV framework to investigate health-related outcomes in Europe in terms of: the country where they were carried out; the design; and how SV was operationalized. We found two studies each from Spain and France, one each from the UK, Ukraine, and Russia, and one final study performed in Sweden, Portugal and Germany. Furthermore, the eight studies in the review used very different conceptualizations of SV, which indicates the complexity of using SV as a concept in public health in the European context. Future research is needed to identify and standardize measures of SV, which will be essential to inform appropriate interventions aiming to reduce the effects of SV on population health.