

# Forced migration, sexual and gender-based violence and health: findings from the SEREDA project

The SEREDA project is a multi-country research initiative which has worked to understand the nature and extent of sexual and gender-based violence (SGBV) experienced by forced migrants throughout the journey from displacement to settlement in countries of refuge. The project seeks to make recommendations to reduce its incidence and mitigate its consequences. SEREDA is funded by Riksbankens Jubileumsfond, as part of the Europe and Global Challenges programme, with additional support from Lanson. SEREDA runs from 2018 to 2022 and is led by the University of Birmingham with the University of Melbourne, and Bilkent and Uppsala Universities and NGO partners. This briefing outlines the health specific findings based on in-depth interviews with 68 forced migrant victims and 26 service providers. Interviews were conducted between 2018 and 2020 by multilingual researchers in English or in the respondents' chosen language. The project gained ethical approval from the University of Birmingham.

Sexual and gender-based violence (SGBV) is acknowledged to be a serious public health issue requiring urgent attention. Health systems have potential to respond positively to forced migrant SGBV experience or to exacerbate it through untreated SGBV consequences and lack of medical care for victims. The vast majority of SEREDA respondents experienced repeated and intersecting forms of SGBV that occurred at the hands of different perpetrators over time and place, pointing to a continuum of violence experienced before, during and after conflict. Many respondents experienced both intimate-partner and family violence and other forms of SGBV by non-partners such as militia, officials, smugglers, traffickers and other forced migrants.

Violence occurred at all stages in the migrant journey:

- **Pre-displacement:** physical, psychological and sexual interpersonal violence, early and forced marriage, family violence, rape, female genital mutilation/cutting and intimate-partner violence (IPV).
- **In conflict:** torture, rape, physical violence, forced marriage and sexual violence.
- **In flight and transit:** sexual and physical violence in camps, and at borders in urban and unsettled areas, transactional sex in exchange for food, hygiene items and/or travel passes. Enslavement and kidnapping across migratory



pathways. LGBTQIA+ participants subjected to conversion/corrective rape.

- **In the UK:** IPV intensified and immigration status used to control victims. Racist attacks, prolonged waiting for asylum decisions and destitution, lengthy and aggressive asylum interviews, mixed gender housing and detention exacerbated traumas. SGBV experienced in Home Office housing and when homeless, trafficked and/or in forced prostitution.

## Health impacts of SGBV

The combined effects of the continuum of violence resulted in high levels of trauma resulting in both physical and psychological harms. Some physical impacts of SGBV were clearly visible, e.g. through scarring and bruising. Respondents talked about bleeding following attacks, while some were hospitalised and others contracted sexually transmitted diseases (STDs). Some physical injuries generated permanent health problems including gynaecological and urinary problems. Some respondents were caring for children born of rape. Most respondents reported psychological health problems. Table 1 summarises the health impacts of SGBV.

Female, male and LGBTQIA+ victims of torture suffered from long-term health issues such as loss of hearing, torture marks, and neurological damage. Victims reported experiencing a range of psychological effects including episodes of anxiety, depression, sadness, flashbacks, panic attacks, sleep disruption and eating disorders which affected their physical health. The physical impact of SGBV for some led to psychological problems. The distress experienced by victims was said to extend vicariously to victims' children and family members. Male victims reported feeling psychological pain when unable to protect

fellow refugees, especially women and children.

SGBV impacts were compounded by ongoing stress associated with uncertain legal status or the process of applying for asylum. The need to repeatedly recount distressing experiences of SGBV and torture to provide evidence of an asylum claim often left victims feeling re-traumatised but without the support generally offered to non-migrant victims around such disclosures. Respondents reported being treated as 'liars' and 'criminals'. Several respondents were left feeling hopeless with the Home Office paying little or no attention to their SGBV experiences in their asylum decision-making.

Victims felt that they needed to stay busy to take their minds off past traumas, but this could be difficult when they spent months or years awaiting a decision without psychological support. Detention was particularly problematic as many respondents complained about inhumane treatment. Those who were detained had access to very few resources including medication or counselling and found detention exacerbated the effects of their prior trauma. Women victims, in particular, reported that experiences of SGBV had undermined their confidence with long-lasting impact on their self-image, self-esteem and self-worth. Some women reported feelings of guilt and self-hatred, others anger, sadness and loss. Many outlined changes in their attitudes toward men, including a loss of sexual desire. Victims tended to avoid socialising due to fears of being judged by others if their experiences of SGBV became known. Women who survived abusive and controlling relationships spoke of isolation and loneliness, sometimes associated with being kept away from others over extended periods. Feelings of despair, exacerbated by isolation and loneliness, often manifested in mental health disorders, culminating at worst in suicidal ideation. Several respondents described having attempted suicide.

**Table 1** Health impacts of SGBV

Psychological	Physical
<ul style="list-style-type: none"> <li>• Post-traumatic stress</li> <li>• Suicide ideation and attempts, self-harm</li> <li>• Flashbacks</li> <li>• Sleep disorders</li> <li>• Depression with associated memory and concentration losses, hopelessness</li> <li>• Eating disorders</li> <li>• Self-isolation and agoraphobia</li> <li>• Intense anxiety, panic attacks</li> </ul>	<ul style="list-style-type: none"> <li>• Broken bones, burns and scarring</li> <li>• Chronic pain</li> <li>• Reproductive and gynaecological problems</li> <li>• Sexually transmitted infections, e.g. HIV</li> <li>• Urinary difficulties</li> <li>• Permanent physical disability</li> <li>• Forced pregnancy (from rape) with no access to medically supervised termination</li> </ul>

## SGBV, health systems and forced migration

The forced migrants interviewed for the SEREDA project were asked about the healthcare they had received. Service providers and victims often referred to health systems as inaccessible and discriminatory. Lack of access to healthcare were said to hinder recovery and exacerbate traumas. Health, SGBV and immigration intersected in the complex ways outlined below.

### 1. Avoiding healthcare due to migration-related stressors

Although some respondents had been able to access the health and psychological treatments they needed through General Practitioners (GPs) or civil society organisations, the majority received no support. Individuals who were refused asylum seekers or undocumented migrants were too fearful to seek medical assistance or report SGBV experience to the police due to concerns of being reported to immigration (e.g. as part of NHS data sharing). Some victims were prevented from accessing healthcare by controlling spouses or families. For others, concerns about NHS medical charges deterred them from accessing healthcare and support. Service providers talked about health professionals missing opportunity to identify and support SGBV victims. Other key findings included:

- Fear of having to pay or having no entitlement to free healthcare
- Lack of awareness and application of NHS healthcare charging exemptions
- Lack of trust in “foreign” institutions and health systems
- Lack of knowledge that a clinician of a chosen gender could be requested
- Language barriers and lack of awareness that interpretation was available on request
- Concerns about lack of confidentiality
- Fear and shame of disclosure.

### 2. Restricted access to health services post-SGBV exposure

Scant health interventions were provided for SGBV victims as they fled their country of origin. On the rare occasions that mobile services were provided, access was severely restricted due to geographical and physical barriers. Fear of authorities and of being stigmatised also restricted access. The majority of respondents reported receiving no help after attacks, nowhere to report or to seek emergency contraception or post-exposure prophylaxis to prevent HIV or other STDs.

In the UK, service providers reported that forced migrants struggled to access primary healthcare with GP practices rejecting registration without provision of identification and proof of address. Some NGOs supported forced migrants to register at the GP. Restricted access to primary healthcare led victims to seek help from Accident and Emergency (A&E) services. Many victims continued their lives with untreated SGBV effects mentioned above.

### 3. Limited capacity of health professionals to assist forced migrant victims

Health professionals reported a number of issues affecting their ability to support victims. The importance of confidentiality, informed consent and of enabling a victim to disclose in their own time were emphasised. Yet, in order to access specialist service provision and gain protection within the asylum system and the National Referral Mechanism process, victims were expected to share their experiences in detail early in their engagement with the system, regardless of a victim’s preparedness to disclose at that stage. The impact of trauma could undermine individuals’ ability to provide a detailed account of their symptoms and experiences. The opportunity to disclose SGBV experience and other traumas in GP appointments was restricted due to limited duration of such appointments. In the allocated ten minutes it was often impossible for GPs to build sufficient rapport to facilitate disclosure. Joint GP appointments for spouses also curtailed disclosure.

GP respondents emphasised that they did not receive training about how to communicate with SGBV victims in time sensitive situations. Victims were sometimes requested to repeat potentially re-traumatising details when completing lengthy referral forms. Clinicians required ample time to create the right space for completing these detailed forms with their patients. Despite referral efforts, the acceptance of referrals to NGOs and other services was said to take a long time without a guarantee of success. Other findings indicated:

- Limited capacity of clinicians to identify victims of SGBV and their needs
- Clinicians had limited understanding that psychological pain can be expressed somatically
- Clinicians not trained in gender sensitivity or forced migrant health issues
- Services not equipped to deal with complex trauma
- Lack of detailed psychological or physical health assessments for victims
- Lack of health services integrated into immigration services
- Dispersal and re-dispersal policies undermining

victims' connections with healthcare services

- Lack of digital competency limited access to healthcare services especially during the pandemic.

#### 4. Limited specialised services for migrant health needs

Specialised and trauma-informed services for forced migrant health were uncommon and unevenly spread geographically. Insufficient specialist services for victims meant lack of treatment for SGBV-related health conditions. Trauma and poor mental health affected victims' cognitive reactions and undermined short and long-term memory, hindering their ability to self-disclose and recall traumatic memories during asylum interviews. Most were unaware of the availability of counselling services with service providers highlighting that building sufficient trust, to enable disclosure and then encourage access to healthcare, was a lengthy process. Moreover, despite high demand for mental health services among forced migrant SGBV victims, there was limited provision for, and capacity of, mental health support. Practitioners lacked awareness of conflict and displacement trauma-related psychological conditions.

known about or used

- Office for Health Improvement and Disparities (OHID), NHS England and NHS Improvement to produce guidance for healthcare professionals about how to support victims and good practice to integrate trauma-informed practice into training and education at different levels
- Ensure GP registration policies do not exclude asylum seekers and that GP frontline and clinical staff understand asylum seekers' entitlement to primary and secondary care and the possibility they may lack proof of address or ID or immigration documents
- Royal Colleges to provide support and guidance on SGBV and migrant health to enable their members to work effectively with SGBV victims
- Department of Health and Social Care, OHID, NICE and Royal Colleges and Faculties to develop guidelines for good practice to integrate trauma-informed practice into training and education at different levels, building on the online Migrant Health Guide
- Increase NHS capacity to offer specialist mental health support to forced migrant victims.

## Recommendations:

### Health Policy and Guidance

- Ensure all asylum seekers, including those in initial accommodation and hotels, receive timely information and support to access healthcare and are registered with a GP as soon as possible
- Strengthen healthcare provision for forced migrant SGBV victims and support practitioners to develop capacities to recognise and respond to SGBV
- Home Office, Department of Health and Social Care and Office for Health Improvement and Disparities to ensure firewall between health data and the Home Office and continue improving transparency of communications to refugee and asylum seeker populations about the limited circumstances in which personal data can be shared between Home Office and the NHS
- Department of Health and Social Care to review communication about the exemption from NHS charging for victims of violence as it is not widely

### Frontline healthcare provision

- Implement training for health professionals and support personnel to enable them to identify and support SGBV victims and to raise awareness of referral pathways
- Ensure clinical training covers the specific vulnerabilities and needs of forced migrants and especially SGBV victims
- Inform all patients about their right to request female clinicians, and to request an interpreter.

## Further reading:

WHO, UN Women, UNFPA (2014) Health care for women subjected to intimate partner violence or sexual violence. Luxemburg: WHO.

WHO (2017) Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence. Geneva: WHO.

SEREDA Project website: <https://www.birmingham.ac.uk/research/superdiversity-institute/sereda/index.aspx>

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Link to full report: <https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/iris/2021/sereda-full-report.pdf>