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Sexual and gender-based violence and refugees

The impacts of and on integration domains

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Abstract

In considering the state of knowledge around sexual violence and war Skjelsbaek notes the reluctance of researchers to “look into how this crime affects the victims” (2001:212). Given the prevalence of SGBV across the refugee journey, experiences need to be conceptualised as an ongoing and multi-faceted experience of trauma, with both immediate and long-term consequences. Pulling together the piecemeal evidence in the literature on SGBV, we describe distal impacts of SGBV on integration, wherein traumatic but largely sporadic events impact on integration. We also describe the proximal impacts of integration domains on SGBV survivors’ lives, whereby refugees’ exposure to, and ability to recover from, SGBV is shaped by experience within the integration domains. We conclude that the experience of SGBV can hamper survivors’ attempts to resettle and integrate into a new life through a number of distal impacts *on* and proximal impacts *of* integration, and embedded within these structural inequalities.

Citation

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Introduction

The number of refugees in the world in 2016 reached the highest point since records began (United Nations High Commission for Refugees, UNHCR, 2016) as conflicts across the globe but particularly in the Middle East and the Levant region forced millions of people to flee their homes in search of sanctuary. The estimated numbers of refugees arriving by boat to European shores exceeded one million in 2015 (UNHCR, 2016). Greece and Italy were the main focus of these arrivals and tens of thousands of people are known to have died en route. While data indicates that more men have fled crisis areas than women, it is now evident that increasing numbers of women and children are fleeing conflict and seeking sanctuary using routes which involve multiple risks (UNHCR, 2016).

Evidence indicates that refugees fleeing to Europe may become vulnerable in result of the interplay of contextual factors including the securitization of Europe's borders, with many forced to use the services of smugglers to get beyond closed borders. While refugees seek to escape violence in their countries of origin, and such violence can include sexual and gender-based violence (SGBV), there is evidence that they, and particularly women and children, continue to be vulnerable to SGBV across the refugee journey. Such threats can come from multiple directions: police and security services; smugglers, other refugees and even family members and partners. SGBV is defined by UNHCR as *"any harmful act that is perpetrated against one person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life"* (UNHCR, 2011, p. 6). Women and children become particularly vulnerable to SGBV but such experiences are common for men too (Johnson et. al 2010), although the full scale of SGBV prevalence is not established.

There is no data available reporting the full extent of SGBV against refugees. It is well acknowledged that many people do not disclose their experiences but also there is no common recording mechanism. Looking at region or country specific studies gives us some sense of the scale of incidence. Sipsma, Falb et al. (2015) looking at refugee women in Rwanda suggested that about half of refugee women experienced some form of SGBV. Experiences of violence among these women frequently occurred during the conflict with about half experiencing some form of violence compared to a quarter of those fleeing the conflict. Experiences of Intimate Partner Violence (IPV) have been extensively reported in precarious settings, for example among women in the ongoing armed conflict in Democratic Republic of Congo and during crisis in Cote d'Ivoire in 2008 (Peterman et al., 2011; Hossain et al., 2014). Freedman (2016) showed that the closing of EU borders to refugees has coincided with increased levels of recorded sexual violence, for example as some refugees were forced to cover smuggling costs with transactional sex. Norredam et al. (2005) notes some asylum seekers in the EU are harassed and abused by strangers, people in authority and those allocated to their protection in camps, detention centres and host countries. Tankink and Richters (2007) report in a study of South Sudanese refugee women in the Netherlands, many women were not only raped by soldiers as a theft of male and family honour, but also by their husbands and other male family members.

Given the estimated prevalence of SGBV across the refugee journey¹, experiences need to be conceptualised as an ongoing and multi-faceted experience of trauma, with both immediate and long-term consequences. Understanding such experiences must focus on the perspectives of survivors and the events and actions, which they classify as harmful. The aim of this working paper is to identify firstly the state of knowledge about the impacts of refugees' experiences of SGBV on their integration into countries of resettlement and secondly upon the ways that different integration domains can influence vulnerability to, and recovery from, SGBV within such countries. This approach moves us beyond the focus of SGBV in conflict or flight, with the implicit assumption that asylum applications will solve all ills, to think critically about what happens in resettlement. While other SEREDA working papers consider the nature of interventions to aid survivors' recovery, we look at how wider contextual and policy factors offer scope for recovery or conversely can exacerbate survivors' suffering. In order to provide a structure for the paper to frame our analysis we utilise Ager and Strang's (2004) integration indicators framework, considering evidence across all their integration domains. Pulling together information about integration which features in papers and reports about SGBV experiences more broadly, rather than specific work on survivors' integration outcomes, we are able to identify the ways that SGBV can shape integration outcomes and that integration experiences shape vulnerability to, and recovery from, SGBV. The paper begins with a short discussion of methods before moving on to consider in detail the health impacts of SGBV and how these, and related socio-cultural factors connect with the integration domains.

Method

The review undertaken for this working paper focused on the experiences of forced migrants which can include asylum seekers, refugees, the family or spouse of refugees, undocumented migrants who have had an asylum claim refused and internally displaced people. Research was conducted using these databases; PsycARTICLES Full Text, Embase (Classic), HMIC Health Management Information Consortium, Journals@Ovid Full Text, Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R), PsycINFO, Social Policy and Practice. Further searches were made on Web of Science and Scopus. Key terms used included the following search words: experience, violence, sexual violence, gender-based violence, internally displaced person*, refugee*, immigrant*, or asylum seeker*, impact of SGBV, SGBV experience, trauma, weapon of war, well-being, and integration.

Broad and narrow search methods were deployed to assure inclusion of a wide spectrum of research enquiry. We reviewed articles that met the inclusion criteria such as sexual and gender-based violence, integration, health, employment, housing, education, language, safety, citizenship and rights. A backward (reference) search was further made with the identified articles to identify papers that might have been omitted. A forward (citation) search was also done to identify any new articles that might have been omitted during the initial search. Some 93 articles were included in this review from almost two decades, between 2000 and 2018. It is important to note that no studies have

¹ The estimates of SGBV prevalence in the refugee journey differ. For example, one study found that up to 28.6% of male and 69.3% of female migrants have experienced sexual and gender-based violence (SGBV) since their arrival to Europe (Keygnaert and Guieu, 2015). Another study reported that one in five refugees or displaced women in complex humanitarian situation is subject to violence (Vu et al., 2014).

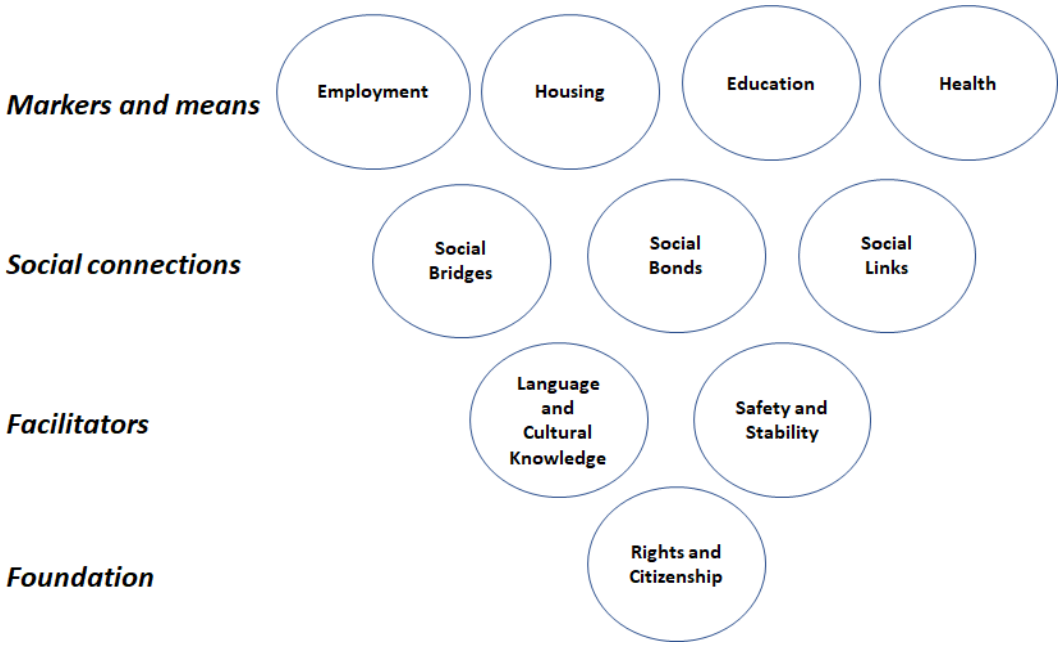
focused directly upon SGBV and integration so the information we have collated has been gleaned from papers largely focuses on forced migrants' SGBV experiences.

SGBV and refugee integration

In this section we explore the impact of SGBV on refugee integration and the resources refugees employ for survival and resettlement. Integration is a multidimensional process, and a range of stakeholders have a role; individuals, refugee community organizations, institutions and society (Ager and Strang, 2004). In the UK integration is considered to have been achieved "*when refugees are empowered to achieve their full potential, contribute to the community and access services to which they are entitled*" (Home Office 2005 in Phillimore, 2012). SGBV experience, combined with other personal, cultural and experiential factors and local opportunity structures, can be considered one of the factors influencing the pace and direction of integration processes and refugee experiences. Whilst analysing the evolving relationship between SGBV and refugee integration in countries of refuge, we deploy Ager and Strang's conceptual framework of integration (2008), developed as part of the *Indicators of Integration* study commissioned by the UK Home Office in 2002. This framework provides an analytical structure in which we can examine the relationship between SGBV and integration.

The framework consists of four integrative domains; means and markers, social connections, facilitators and foundation (Ager and Strang, 2008) (see Figure 1). Each of these domains is based on indicators, in the respective order; 1) Employment, health, housing, education; 2) Social bonds, bridges and links; 3) Language and cultural knowledge, safety and stability; 4) Rights and citizenship. The framework has been used extensively in the Global North but also in China, South America and Australia. While there has been little critique of the model it has its shortcomings. The main focus is upon social policy domains rather than sociological factors such as belonging and identity and psychological factors such as individual characteristics. Nonetheless, it forms a useful framework for our analysis which enables us to pull findings together from across multiple disciplines and organise them in a way which makes them accessible to scholars of integration.

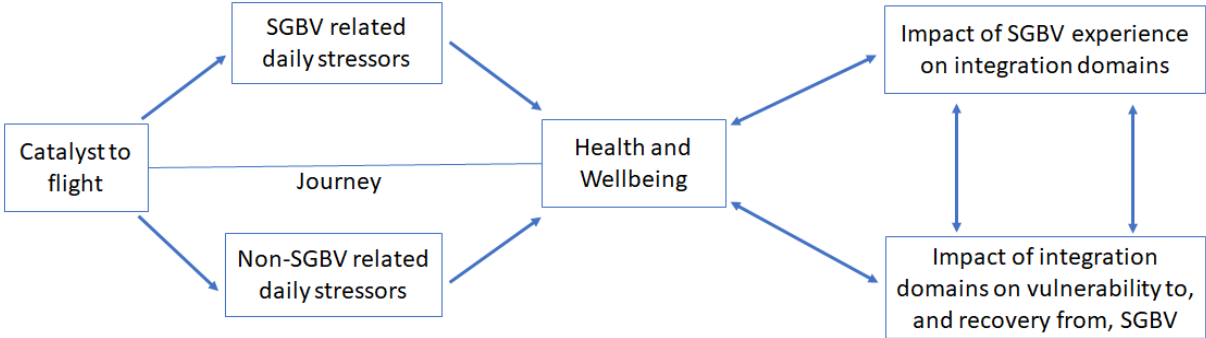
Figure 1: Integration indicators framework (Ager & Strang 2008)



We recognize that experiences of SGBV can shape individuals’ ability to integrate and will use the findings from our literature review to examine the impacts of such experiences on refugees’ ability to integrate across the domains. We might describe these as distal impacts – wherein traumatic but largely sporadic events impact on integration. However, the literature review also revealed that refugees’ exposure to, and ability to recover from, SGBV is shaped by experience within the integration domains. We might describe these as the proximal impacts of integration domains on SGBV survivors’ lives.

We deploy a person-centred approach, where we place the wellbeing of refugee SGBV survivors at the heart of our analysis. We examine the literature offering empirical evidence around refugees’ subjective experiences of violence and the relevance of social and cultural norms and socio-economic status. We begin by highlighting the importance of health in influencing all other integration domains before discussing domain by domain the impacts of SGBV on refugees’ ability to integrate and the impact of the domains on their susceptibility to, or prevention of, continued SGBV and upon their ability to recover from SGBV. We finish the paper with a short conclusion outlining the current state of knowledge on SGBV and integration and how research around SGBV might progress to fill gaps in the existing knowledge base. A diagrammatic representation of the focus of the study can be found in Figure 2.

Figure 2: SGBV and refugee integration model (authors, adapted from Miller and Rasmussen, 2010 and Fernando, 2010)



Means and markers: employment, health, housing and education

Health

Health and wellbeing are perhaps the fundamental factors shaping SGBV survivors’ ability to integrate, while factors undermining ability to recover health, or exacerbating physical and/or psychological wellbeing will also shape integration opportunities hence the highlighting of the role of wellbeing in Figure 2. Health interacts with many of the other indicators as we will see later in the paper. As such being healthy, as Ager and Strang (2004) argue, is a key *means* to integration. Miller and Rasmussen (2010) highlight the importance of proximal and distal factors in influencing refugee health: proximal being everyday/daily stressors (poverty, social exclusion, inadequate housing, being in a controlling relationship), whilst distal factors refer to events that happened occasionally such as conflicts wherein attacks happen sporadically.

Distal impacts

We examine the clinical impacts of SGBV on refugees in a separate working paper, so only briefly outline these here. SGBV can comprise sexual, emotional, psychological, physical, and harmful cultural practices (UNHCR, 2003). Keygnaert et al. (2012) state that physical and psychological violence were the most prevalent types of violence reported amongst refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands, followed by socio-economic and sexual violence. Women from poor communities, living in shelters or detention and camps, younger/teenage children from a low socio-economic background or single parent families are said to be most vulnerable (Bonewit and Shreeves 2016; UNHCR, 2016). People who have been survivors of SGBV or have witnessed SGBV in a family setting, when they were younger, are also at an increased risk of trauma (Brown et al. 2005, Keygnaert, Vettenburg & Temmerman 2012).

Trauma may result in physical, psychological, social and spiritual consequences either in the long or short term (Tavara, 2006) and can have distal impacts on survivors’ ability to integrate. Thomas (2013) classifies health impacts as physical, psychological, reproductive, and behavioural. Psychological problems can include anxiety, depression, and sleep difficulties, which could develop into long-term psychological problems such as Post-traumatic Stress Disorder (PTSD) or self-harm. A study by Fisher and Regan (2006) which investigated abuse in older women found that women who

have suffered abuse of any kind were twice as likely to experience depression and anxiety compared to those without such a history. Women also reported poorer physical health and higher medication usage than women without trauma. The physical consequences of sexual violence range from physical injuries, infections, and disability. Keygnaert et al. (2012) looking at SGBV in refugees, asylum seekers and undocumented migrants in the Netherlands and Belgium found that around half of survivors interviewed reported bruises, bleeding, exhaustion, unconsciousness, heart or gastrointestinal problems, weight loss and other physical complaints. Several survivors had permanent injuries. Others either died of the immediate consequence of the violence or by committing suicide shortly after (Keygnaert, 2012).

Reproductive health consequences included STIs, HIV, symptoms of sexual disorders, unwanted pregnancy, miscarriage, forced abortion, fistulas and maternal and neonatal deaths. A study of Iraqi women survivors of domestic violence in Detroit, USA (Barkho, 2011) reported associations with breathing problems and exposure to physical violence with muscle pain. Research has also shown that the trauma involved in the experience of sexual violence can result in survivors engaging in unhealthy behaviours such as smoking, alcohol and drug abuse, eating disorders and risky sexual activity (Thomas, 2013). Christian et al. (2011), looking at SGBV against men in the Democratic Republic of Congo, highlighted that men were raped as a way of punishing them through destroying their masculine identities. While extensive physical health consequences, such as body weakness and infections are reported to result from male rape, health care professionals noted that male survivors hardly reported or sought treatment for symptoms of SGBV because of associated shame, stigma and isolation (Penge 2012).

Persons who have experienced the death of close family members as a result of trauma are likely not to talk about sexual violence against them (Tankink, 2004). Thoughts and actions of past trauma may be suppressed (Herman, 2001). After periods of war and displacement, sexual violence often goes unreported for the sake of peace. Whilst some researchers argue that retelling of sexual violence might help with the healing process (Herman, 2001) others believe that retelling could lead to reliving the experience and might result in other psychological problems such as anxiety (Tankink & Richters, 2007). Herman (2001) argues that disclosure helps survivors reconstruct their prior experience to suit their present needs and future goals, enabling them to develop counter narratives on healing and giving them control over past experiences. In the long term such approaches may help prevent further psychological distress such as PTSD. As we will see later in the paper, PTSD and other physical and psychological conditions resulting from SGBV have profound distal impacts on people's ability to engage in integrative activity. Further, the support and treatment available to survivors impacts on their ability to recover and resettle effectively.

Proximal impacts

Social and cultural structures imported from refugees' country of origin can affect ability to recover and contribute to proximal impacts on lives of SGBV survivors within integration domains. While evidence about the importance of disclosing SGBV experiences for recovery is inconclusive, there are a number of factors known to prevent women from seeking help. Patriarchal gender norms, poverty and cultural expectations are influential. Discussing anything of a sexual nature is taboo in some societies: survivors may feel guilt and shame (Tankink and Richters 2007). This is particularly the case where there is stigma attached to being known to be a victim. If these norms continue within host

societies, they can exacerbate mental and physical health problems (Keygnaert et al., 2012).

The circumstances surrounding resettlement may adversely affect the health of refugee SGBV survivors. Being unable to access treatment for psychological health problems increases the risk of SGBV and, because having psychological problems have been associated with having 'no self-confidence', can affect ongoing vulnerability to further violence (Keygnaert et al., 2012).

Miller and Rasmussen (2010) argue that daily stressors have the most overall influence on refugee health and recovery from SGBV. Survivors of traumatic experiences become more resilient to depression than the national average (Bonanno, 2008), and these survivors who have experienced the distal factors (exposure to war related violence) are more likely to gain psychological equilibrium if given the necessary support (Foa & Rothbaum, 2001). High rates of psychological distress among refugee SGBV survivors are exacerbated by every-day stressors in destination countries (Miller and Rasmussen, 2010). Studies highlight that the cumulative effect of unemployment and inadequate housing and uncertain legal status, can be more harmful than addressing the original trauma (see Miller and Rasmussen, 2010). These stressful conditions impede recovery processes, perpetuating the cycle of exclusion and disadvantage. Poverty and debt have been found to exacerbate SGBV survivors' mental health, prompting reoccurring memories of their SGBV experiences (Tankink & Richters, 2007).

Understanding how and where to seek help with SGBV is also important. Byrskog et al., (2016) show that female Somali-born SGBV survivors in Sweden with low levels of literacy often relied on informal sources for medical support and did not seek clinical support. Midwifery encounters and childbirth were not perceived as the appropriate place to discuss past or ongoing violence. Women were hesitant about midwives asking SGBV related questions, but saw them as valuable sources of information and access to support services. Byrskog et al. (2016) suggested that the links between violence and health need to be better explained to enable patients to build trust and encourage help-seeking behaviour. In some settings, e.g. in the emergency room, signs of domestic abuse are often given insufficient attention by clinicians because many hospitals lack appropriate referral systems. Collaborations between refugee communities, maternity care and social service providers were found to support families in transition and bridge gaps in service provision (Byrskog et al., 2016). Kulwicki et al. (2010), argue that the continuity of care is important for building trust.

Employment

Fyvie et al. (2003) argue that individuals need to make progress in functional dimensions of integration such as education and training, employment, and housing is necessary for integration to begin. There is limited evidence regarding the impact of SGBV experiences on refugees' ability to integrate in these functional aspects. Mainstream integration scholarship focuses on the general refugee and migrant populations rather than those who have experienced SGBV. The evidence that is available suggests that SGBV experiences influence survivors in multiple ways, affecting overall wellbeing. Wellbeing, according to Williamson and Robinson (2006), encompasses multiple domains: biological, material, social, mental, emotional, cultural and spiritual. The most researched impacts of

SGBV are mental and physical health consequences and it is these that invariably shape refugees' access to other integration domains.

Distal impacts

SGBV survivors score significantly higher on PTSD scales and face more major obstacles to treatment and care, e.g. stigma than refugees who have not experienced SGBV (Amone-P'Olak et al., 2018). Refugees, who have had repeated or continued experiences of SGBV, are yet more susceptible to PTSD (Vyssoki & Schürmann-Emanuel, 2008). Untreated mental health conditions generate distal impacts on survivors' capacity to integrate through contributing to memory problems, poor wellbeing, socio-economic exclusion and hinders learning and the development of language skills which are necessary to gain access to the labour market (Gušić et al., 2017).

The continued mental and physical aftermath of SGBV results in a restricted ability to work, implying long-term economic consequences of SGBV for individuals, families and broader society. Numerous studies have demonstrated that people recovering from SGBV take more sick days from work and have decreased productivity in various countries.² In the Congo, Christian et al. (2011) found that the productive abilities of male survivors were severely diminished due to physical and mental symptoms, but also because of exclusion from social and commercial networks. Experiences of SGBV affects women's capacities to engage in productive activities, perpetuating poverty and reinforcing existing gender inequities (Gurman et al., 2014).

The cultural context of SGBV survivors often influences economic participation. Patriarchal cultures impose social and cultural norms that contribute to women's marginalisation even in countries of resettlement (Sakyiwah, 2016). Some SGBV survivors are unable to engage in employment because their agency and movement is controlled. They may be expected to remain segregated or to rely on a male breadwinner. Association with SGBV can impact on family honour undermining the economic integration of an entire family where a member is known to be sexually abused, leaving all members facing exclusion from commercial interactions (Jesuthasan et al., 2018). Thus both the physical and psychological impacts and the social impacts of SGBV can reduce access, or ability, to work, undermining social status and compounding poverty – therein distal impacts are connected to proximate impacts perhaps perpetuating a vicious cycle from whence it is difficult for refugees to break.

Proximal impacts

Accessing employment is known to be problematic for refugees. Many refugees cannot find a job, qualifications are not recognised, conversion courses are not readily available, and so if they wish to attempt to return to their former career they have to retrain (Stewart et al., 2008). Refugees' social status reduces through immigration and inability to regain their pre-migration status. Some are not permitted to work while others can access jobs but are under-employed, unable to find opportunities commensurate with their skills, qualifications and experience (Phillimore & Goodson 2006). Such economic hardships are one of the key risk factors and proximal impacts on exposure to SGBV. Without permission to work and other means of support, some refugees resort to work in the informal economy where they were exposed to increased risks of labour and sexual exploitation

² The overall domestic violence cost for all population in England and Wales equals yearly to \$32.9 billion (UN Women, 2016).

(Keygnaert et al., 2012). Others, especially women, when unable to find work are forced to engage in sex work for survival with transactional sex expected by employers or landlords (Samari, 2017).

Unemployment and poverty, as well as undermining the ability to recover from SGBV, can also increase women refugees' exposure to interpersonal violence (IPV) while financial dependency hampers the ability to leave abusive relationships. Dependency and controlling relationships prevent some SGBV survivors recognizing that verbal and financial abuse are forms of gender-based violence (Ogunsiji, 2012). Economic independence can help women escape abuse, but access to work is difficult for women as there is frequently inadequate access to childcare and few opportunities to engage in vocational training. In some countries, for example in the USA as part of 'Coordinated Community Response', support services have worked with local businesses to find survivors a short term job which it is hoped may eventually lead to economic independence (Shorey et al., 2014), although we have been unable to identify any evaluations of this initiative.

Long-term changes in gender roles, from being a provider to undertaking domestic labour, can challenge traditional gender norms (Linos 2009). Unemployment amongst male refugees has been found to undermine self-esteem, impact upon their sense of belonging and reduce their wellbeing, all of which have been associated with increased perpetration of IPV (Christian, 2011). Penge (2012) showed that male survivors were not able to contribute to household income because of physical and mental health problems. Several studies have reported increased marital tensions related to gender-power shifts and changes in the traditional division of labour, which increase risks of psychological, sexual and physical violence (Rezazadeh & Hoover, 2018, Tankink & Richters, 2007).

Housing

Proximal impacts

We were unable to find any evidence outlining the impact of SGBV on refugees' access to safe and secure housing in countries of resettlement. However, there is ample evidence showing that such housing improves the functioning and well-being of SGBV survivors and their children regardless of their legal status (Cesario et al., 2014). Safety and security of housing is also an important factor determining refugees' feeling 'at home'. Findings indicate that refugee SGBV survivors mainly rely on public housing and shelters often segregated from mainstream communities making it difficult for them to make connections with the local population. Daoud et al. (2012) found that foreign-born women living in low income and high immigrant neighbourhoods reported lower rates of IPV. They speculated that IPV rates might be lower because refugees had ready access to informal community support.

The nature of housing can influence both refugees' ability to recover and the likelihood of being subject to further GBV. The importance of housing in determining vulnerability is evidenced in the European Asylum Support Office (EASO) "*guidance on reception conditions: operational standards and indicators*" aimed at improving asylum seekers' living conditions and services (EASO, 2016). European Directive 2013/33/EU has laid down standards for the reception of applicants for international protection, recommending that "*EU Member States should implement specific measures addressing SGBV, including sexual assault and harassment, and that adequate medical and psychological care for vulnerable groups should be guaranteed*" (Oliveira et al., 2018). Nevertheless,

even European asylum reception facilities where high numbers of cases of SGBV have been reported (highest in Belgium, Malta, Ireland and Hungary) have been found to be unsafe (Oliveira et al., 2018). The high rates of reported SGBV incidents are not necessarily a reflection of a higher prevalence than in countries of low reporting. Conversely high reporting figures can be a reflection of effective systems in place allowing to record the SGBV incidents, contrary to settings of low reporting which may be an implication of a restricted environment to report SGBV.

Housing insecurity proximately effects lives of refugees and is a major barrier among women wishing to escape domestic violence, and the main reason that they return to abusers (Thurston et al., 2013). Good quality shelters can respond to SGBV survivors' immediate housing needs but are often useful only on a short-term basis. Immigrant women from Mexico and Central America in Houston (USA) in safe shelters reported large effect size improvements in their mental health and levels of resilience (Cesario et al., 2014). However, placing SGBV survivors in shelters can undermine their status in their communities, because of the stigma associated with such spaces (Jesuthasan et al., 2018). Those who access emergency accommodation can find themselves unable to return to their family or community. Shelters for domestic violence survivors from Arab immigrant communities in Detroit (USA) were found to be often insensitive to women's cultural needs, for example serving non-halal meat, and failing to offer interpretation (Kulwicki, 2010).

Overcrowded housing and lack of privacy in German asylum reception facilities may increase SGBV survivors' vulnerability and exposure to violence because they involve sharing with unknown men (Oliveira et al., 2018). Women refugees and asylum seekers SGBV survivors living in such inadequate conditions experienced a deterioration in their mental health (Bonewit and Shreeves, 2016). Frequent disputes and fights were reported, resulting from conflicts about access to food, sanitary facilities, alleged theft and high levels of boredom (Bonewit and Shreeves, 2016, p. 24). Sexual harassment in European reception centres has been reported as occurring on a daily basis (Bonewit and Shreeves, 2016, p. 27). Problems included staring, comments, unwanted touching and rape. Women who reported abuse felt that they were not taken seriously and rather than action being taken against the perpetrators, the women were advised to stay in their rooms. In addition, perpetrators after completing a prison sentence for sexual assault were returned to the same reception or accommodation centres (Bonewit and Shreeves, 2016, p. 27). Single women felt more vulnerable to sexual assault than married women because they lacked male protection, with single mothers the most vulnerable. SGBV incidents were perpetuated by staff, guards, persons in authority and volunteers. Most interpreters were male making it difficult for women to report harassment or sensitive medical information (Bonewit and Shreeves, 2016, p. 11, 25). Sexual assaults against children have also been reported in reception centres in Germany. Some rooms lacked locks and toilets were located some distance from rooms which could jeopardise refugees' privacy and safety (Bonewit and Shreeves, 2016, p. 25).

Education

Several studies (Gesemann, 2006; Ouald Chaib, 2011 in Akua-Sakyiwah, 2015) have emphasised the importance of education in assisting migrants' integration. There are few studies examining the interaction between SGBV, refugees and education in destination countries.

Distal impacts

Work by Phillimore et al. (2007 and 2011a) showed that experience of SGBV and associated trauma was associated with poor levels of concentration which undermined individuals' ability to study. Also, women across post-conflict settings (including Liberia, Rwanda, South Sudan, Uganda, Thailand) who are expected to marry young and have children as teenagers have little or no access to education (Gurman, Trappler et al. 2014). Early marriage and consequent limited education impacts upon their ability to become independent, making them reliant on their spouse in abusive relationships.

Proximal impacts

Education can build preventive capacities of people vulnerable to SGBV. Keygnaert et al. (2012, p. 513) found one third of respondents with refugee, asylum seeking or undocumented migrant backgrounds identified lack of knowledge and information as a risk factor. This included 'not knowing the language and culture of the host country' and lack of 'sexual knowledge' and 'self-defence skills'.

Acquiring education is particularly challenging for SGBV survivors who are economically dependent on their spouses, and not able to pay for their own education (Shabbar, 2012). Further, many facilities are not suitable for women with child-rearing responsibilities. In German reception centres, some SGBV survivors could not attend language classes because of a lack of childcare (Bonewit and Shreeves, 2016, p. 25). This was also a problem in the UK (Phillimore et al., 2007). Cultural expectations as discussed above can be an important factor determining whether or not refugee women are permitted to attend classes (Akua-Sakyiwah, 2015).

Social connections: social bonds, social bridges and social links

Social networks are often thought to be the connective tissue between public outcomes and rights. They include social bonds with family and co-ethnic, co-national and co-religious groups; social bridges with other communities and social links with the structures of the state (Putnam, 1993 and Woolcock, 1998). Development of social relations and a sense of belonging in a new country are instrumental to integration processes (Ager and Strang, 2008; Cheung and Phillimore 2017). Wessendorf and Phillimore (2018) show that migrants in super diverse contexts are facilitated to integrate through establishing social relations of differing affective and functional depths³. Lack of networks and high levels of isolation have been shown to be detrimental to refugees' resettlement experiences (Cheung and Phillimore 2017).

Social bonds

Proximal impacts

The social context of SGBV survivors is instrumental in determining the level of their social engagement. Social and family support and cohesiveness has been reported as a protective factor for many refugees in Europe (Gorman et al. 2003), increasing their psychological wellbeing (Sherwood and Kalifani, 2012). Refugees who established social networks are better able to access social and material support and tended to suffer less psychological distress (McMichael and Manderson, 2004; Cheung & Phillimore 2017). Social support provides hope, an escape from distress and an opportunity to form relationships that resembled family bonds (Thommessen et al., 2017). The risk

³ Contrary to dominant discourses that assume integration with the majority society as instrumental means to integrate.

of depression and other psychological problems appears to increase with length of time away from close relatives (Keygnaert et al. 2012).

Distal impacts

However, victimization places a strain on family life and socialising, with survivors tending to withdraw from social activities (Hossain, Zimmerman et al. 2014). As noted above many SGBV survivors suffer from trauma and PTSD which have social implications (Gušić et al., 2017). In many, but not all, socio-cultural settings, SGBV survivors reported that they wanted to keep their experience secret to avoid shame and stigma. However, disclosure has been noted by some to be a prerequisite for recovery meaning those who keep quiet may struggle unaided with physical and psychological problems (Tankink & Richters, 2007). Others argue that rehearsing trauma compounds the suffering of survivors. Thus more research is required to ascertain in which conditions 'retelling' stories can have a positive or negative effect on long-term integration.

The emotional and psychological pain of SGBV have been reported to have direct implications for social isolation and can be described as a distal impact on the ability to integrate. Keygnaert et al. (2012), found that around two thirds of respondents who had experienced SGBV described themselves as being 'depressed', 'a psychological wreck', 'dispirited' or 'very insecure'. They often isolated themselves from others not trusting anybody. Survivors kept silent about their abuse avoiding disclosure to family and friends to prevent condemnation (Tankink, 2013). The social consequences of SGBV can be particularly severe for children born of sexual violence who can face stigmatization from their communities (Josse, 2010). Such isolation can exacerbate SGBV survivors' feelings of anxiety, shame, anger, frustration and hatred (Josse, 2010).

Feelings of guilt led to another distal impact of SGBV as it prevented survivors from disclosing their stories and seeking support from service providers (Tankink & Richters, 2007; Keygnaert et al., 2012). The majority of SGBV respondents from diverse backgrounds described in research deployed 'silence' as a coping strategy. Byrskog et al. (2016) found Somali-born women living in Sweden feared that community gossip would reveal their experiences of non-partner sexual violence. The risk of a backlash from their community restricted their willingness to interact within that community. These women adopted a "moving on" strategy using alternative resources to social networks in order to try to forget their past (Byrskog et al., 2016).

Proximal impacts

However, some SGBV survivors coped with distress through social interactions with their close relatives and friends, whether in person or by phone. In particular, they confided in others who had similar experiences (Tankink and Richters, 2007). In these relations they found social and emotional support, increased self-esteem, and strengthened identity. They regained a sense of control, trust and shared purpose (Keygnaert et al., 2012). Such coping strategies offered new opportunities to participate in society and build social capital. Nevertheless, being a refugee meant for many SGBV survivors leaving their family behind and having no one to turn to. They missed informal networks and extended family members. Loneliness and feeling of exclusion triggered the memories of

traumatic pre-flight experiences (Tankink and Richters, 2007). Forced migrant SGBV survivors described having poor social networks to build on with the lack of networks impeding their social functioning;

"I have no hope for the future. I live in a reception centre without any contact with other people. I have no money, no work and no contact with girls (Zoran, 23, Kurdish asylum seeker)" (Keygnaert et al., 2012). Sometimes, the SGBV incident itself would cause fragmentation of survivors' social networks. For example, separation from a partner or children, condemnation and expulsion from their family or community, or being forced to change reception centre, escaping perpetrators at the same time as breaking important social networks (Keygnaert et al., 2012).

Contact with family and ethnic networks can prevent SGBV survivors seeking help (Rezazadeh and Hoover, 2018). Hassan et al. (2016) argued that *"women and girls often fear or actually face social repercussions, including rejection, divorce, abuse and ostracism. In a minority of cases they may suffer from 'honour' crimes at the hands of family members"*. Families sometimes blamed SGBV survivors for the abuse and demanded their silence (Hyman et al., 2011), preventing them seeking support (Tankink & Richters, 2007). Sometimes husbands left wives who admitted experiences of rape, *"because if a relative does something wrong, all family members are held responsible for it"* (account of SGBV survivor in Tankink & Richters, 2007, p. 195). In communities where pregnancy outside of marriage is socially unacceptable, women impregnated through rape must choose between forced abortion or ostracism.

Distal impacts

Men and boys who experience sexual abuse also struggle socially (Christian et al., 2011, Hassan et al., 2016). They experienced fear, ridicule, disrespect and marginalisation, forcing them to separate from their communities and sometimes their families (Christian et al., 2011). Sturm et al. (2007) show how male asylum seekers' traumatic memories can overwhelm and destabilise them, diminishing their capacity *"to represent his experiences and to maintain or create social bonds"* (Sturm et al., 2007, p. 216). The social isolation of SGBV survivors can mean they lack networks to support their recovery or access to services.

Spousal refugees escaping conflict are often separated from their partners for extended periods. While living apart they develop survival strategies which can permanently disrupt gender norms. Once reunited often immigrant women were unable or unprepared to conform to traditional gender roles (e.g. Tankink & Richters, 2007). Such disruption could result in disagreements and tensions escalating to domestic violence and forced isolation. SGBV survivors living with abusive spouses have been found to be socially restricted with their social interactions strictly controlled by their husbands (Shabbar et al, 2012).

SGBV had a distal impact upon individuals' ability and willingness to form social networks with peers, but there is evidence that the presence of social networks was critical to aid recovery. Social networks with other refugees and people from their ethnic community contributed to a sense of well-being and helping refugees to develop understanding of their new society and access support services (Byrskog et al., 2016). Social support encouraged refugee SGBV survivors to engage socially,

improve social capital and exchange information and knowledge, including health information, and awareness raising (Keygnaert et al., 2012).

Proximal impacts

One study in Hong Kong found that female marriage migrants were more vulnerable to spousal violence and more socially isolated, compared with local women (Choi et al., 2012). Seeking advice and intervention from extended family, and from community elders or from religious leaders were the first steps taken to resolve IPV in the West African community in the USA (Kalunta-Crumpton, 2017). Only when support from social networks failed, did survivors turn to public services.

Family and friends in some contexts act as bridges and encourage survivors to seek support, whilst in others try to prevent them from seeking external support (Tamkink & Richters, 2007, Byrskog et al., 2016). The generational conflict between parents and daughters has sometimes been shown to contribute to increased violence against women where structural changes are not followed by ideological shifts (Grzyb, 2016). Newly arrived Afghan girls in Sweden reported familial abuse and oppression as their worst traumas, and faced higher levels of dissociative experience than settled students, affecting their mental health and social interactions (Gušić, 2017).

Religious actors often act as bridges having an important role in advising and resolving conflict in cases of family violence (Kalunta-Crumpton, 2017). Survivors of domestic abuse seek support and consult religious leaders for intervention, especially among faith communities where they are the first point of contact. However, religious leaders sometimes hold patriarchal views encouraging women to submit to their husbands and endure abuse (Kulwicki et al., 2010). In some communities, a wife leaving her husband is stigmatised and reporting IPV triggers repercussions. Yet, faith networks have been crucial in offering continuity for SGBV survivors after flight (Byrskog et al., 2016, Parsitau, 2011).

Social bridges

Distal impacts

Relationships outside of refugees' own communities have been little studied in relation to recovery from SGBV. 'Outsiders' (of ethnic communities) were perceived by some refugees as easier and safer to disclose to than survivors within their own communities in Australia and in the Netherlands (Ogunsiji et al., 2012, Tankink & Richters, 2007).

Proximal impacts

One of the proximal impacts of social bridges was that SGBV survivors built friendships with local women from host communities and broke 'silence' by confiding their experiences. Trusted local women acted as social bridges guiding survivors to support services. Engagement with host communities can also have a bridging effect on survivors' reporting; *"Several women suggested that their reluctance to report their IPV experience might be due to their low level of integration into the Western culture"* (Ogunsiji et al., 2012). Ogunsiji et al. (2012) describe the case of a woman experiencing continued domestic abuse receiving encouragement to leave her husband from an

Australian friend, who told her that she would receive government support. Practical assistance from Swedish society such as organising residence permits and providing housing and maternity care contributed to feelings of stability for SGBV survivors and their recovery (Byrskog et al., 2016).

Many SGBV survivors have weak social networks and suffer in silence in countries of refuge because they lack knowledge about the availability of, and how to use, social and health resources in countries of refuge (Hyman et al., 2006b, 2009, Ogunsiyi et al.). This lack of awareness prolonged victimisation and reduced access to protection or encouragement to escape from abuse (Roy et al., 2012). Lack of proficiency in local languages reduce refugee women's chances of sharing experiences and burdens, increasing the risk of low self-esteem, loneliness, and depression (Shishehgar et al., 2017). Often refugee women were not aware of, or informed about, their rights: for example women from the West African community in the USA were unaware of 'non-law enforcement' resources available to survivors of domestic abuse such as counselling and hospital treatment (Kalunta-Crumpton, 2017).

Social links

Distal impacts

Although there is evidence that access to treatments in state or non-state organisations can be beneficial, many SGBV survivors were reluctant to make such links as they associated seeking mental health care with stigma. They believed that turning to an outside organisation would undermine their inner strength. Some rape survivors were reluctant to disclose sexual violence to medical practitioners in fear of having their family's name in the medical records (Tankink and Richters, 2007).

Proximal impacts

Sometimes connections with support services offered hope that women could reunite with their families. For example, SGBV survivors are referred for sexually transmitted disease testing which has been observed as the first step for their re-integration into their communities. Medical evidence illustrating the absence of disease can be presented to a husband who may then accept his wife (Kelly, 2011).

Some host countries offer a variety of support services for SGBV survivors. For example, in Spain social workers help refugee women to access employment, housing, education, and tackle social exclusion through referrals to health centres, hospitals, local social services, emergency care services, subsidised housing, and the courts (Martinez-Roman, 2017). A wide range of NGOs assist refugees who are at increased risk of violence and social exclusion (Martinez-Roman, 2017). Additionally, migrant organisations can play a significant role in providing context specific counter-SGBV initiatives. Despite efforts to prevent and respond to SGBV, there remains insufficient support services for survivors. Often existing services, especially provided by refugee/immigrant community organisations, fall short in protecting confidentiality of service users and are not trusted because they are perceived to lack professionalism (Kulwicki, 2010). Established non-specialist services may not be accessible. Refugee women in Australia experienced language and logistical barriers in

accessing SGBV support services, as well as fearing the police and worrying about breaking up their family (Vaughan et al., 2015). Reluctance to seek help is often related to local services being inadequately equipped or culturally insensitive when responding to refugee women's needs (Rossiter et al., 2018).

Facilitators: Language and cultural knowledge, safety and stability

Language and cultural knowledge

Competency in the language of the country of resettlement is fundamental for integration (Shishehgar, 2018). Language skills enable survivors of SGBV to understand and access information about their rights, to access services, employment and become self-reliant.

Proximal impacts

Language barriers can prevent survivors from seeking support and have proximal impacts on refugees' lives. Thurston et al. (2013) found that refugee IPV survivors were vulnerable to homelessness because information about domestic violence shelters was not available in their language. Language and cultural knowledge to some extent determines SGBV survivors' degree of engagement with host communities, which we show above are important to facilitate access to services. Individuals, coming from different cultural contexts, often face culture shock upon their arrival to countries of refuge. Penge (2012), a refugee SGBV survivor, outlines how initially she was afraid to go outside in the UK, because she was nervous about cultural differences.

Distal impacts

Some abusive partners do not permit their spouses to attend language classes because they wish to ensure they remain isolated and unable to interact with the host community and seek help (Kalunta-Crumpton, 2018). For example, a South-Sudanese SGBV survivor living in the Netherlands, was forbidden by her husband to take Dutch classes (Tankink & Richters, 2007). After her divorce she was able to attend lessons to improve her language and literacy skills. Low local language competency also reduces access to training and employment prospects (Thurston, 2013; Kapai, 2012).

Proximal impacts

Communication difficulties between officials and refugees create further proximal impacts and have serious consequences for both survivors and perpetrators of SGBV, for example inappropriate arrests or release of a perpetrator by the police (Kulwicki, 2017). Participants in European Asylum Reception Centres emphasized the need for improving communication between staff and residents as a preventive measure to mitigate SGBV (Oliveira et al., 2018). Interpreting for refugee SGBV survivors is challenging, with inconsistent interpretations risking inappropriate or inadequate services (Alaggia et al., 2017). When official interpreters were not available, online services have been used (such as 'Google Translate') or interpreters of other cases (Alaggia et al., 2017), but survivors were unable to build a relationship with constantly changing interpreters so did not feel comfortable disclosing. Female survivors found it difficult to work with male interpreters (Alaggia et al., 2017). Some

interpreters refused to translate sexually explicit terms (Alaggia et al., 2017). The behaviour of interpreters can increase women's vulnerability, for example, when interpretation is poor or personal opinions are offered ('How can you leave your husband?') (Martinez Roman et al., 2017).

Agnew (1998) found that refugee women who experienced IPV were more likely to seek support from those service providers that spoke their mother tongue and were from their cultural community. However subsequent studies have indicated that foreign born survivors often prefer to access support outside of their communities (Tankink & Richters, 2007, Ogunsiji, 2012). Survivors with communication disabilities whose needs, such as sign language, are not adequately met, face further safety issues (Hyman et al., 2006, Peta, 2017). Individuals with speech impairments were found to be vulnerable to SGBV because they cannot scream for assistance (Hyman et al., 2006, Peta, 2017). There is evidence that poverty, gender and disability intersect to create vulnerabilities to SGBV for girls and women with disabilities (Hyman et al., 2006, Peta, 2017). They are at increased risk of sexual abuse, especially if they are financially, emotionally or physically dependent on the perpetrator (Peta, 2017, Hyman et al., 2006).

Lack of mutual cultural understanding between refugees and hosts has been shown to lead some refugee families to fearing that women will become too integrated if they speak local languages and adopt social and cultural norms, and thus become "too Canadian" (Rezazadeh and Hoover, 2018), or "too Dutch" (Tankink & Richters, 2007). Some outreach programmes have been developed to address SGBV in refugee communities, for example the RISE (Refugee and Immigrant Safety and Empowerment) programme in Detroit, USA, which promotes cultural competencies and the linguistic capacity of local communities (Barkho et al., 2011).

Safety and stability

Proximal impacts

Feeling unsafe can undermine refugee recovery from trauma. Sturm et al. (2007, p. 216) found that *"a lot of severely traumatised persons avoid talking about particularly dehumanizing or humiliating experiences they have been through because they do not really feel safe in the environment where they have to make their testimony"*. The safety and stability of refugees is often compromised by terrible living conditions in which they feel unsafe or unwell and unable to focus on recovery. Survivors may feel unable to develop social networks locally if they are made to feel unsafe because of racism or discrimination. Anti-migrant discourse can make them feel unwelcome and fearful of further attack (Phillimore, 2011b). Insecurity can be exacerbated by stereotyping of refugee communities as perpetuating honour-based violence or FGM, stigmatising such communities and perhaps being used to justify exclusionary immigration policies (Jesuthasan et al., 2018). The lack of safety and stability proximally effect survivors' lives by increasing vulnerability to SGBV and reducing ability to recover.

Service providers sometimes lack cultural knowledge and do not know how to effectively and sensitively challenge stigma, taboo and shame associated with SGBV. In family conflicts, in extreme circumstances, risks escalated to honour-based violence and even murder (Jesuthasan et al., 2018).

Service providers can fail to understand various phases of SGBV from experiences of refugees in their home countries, in war and conflict, in transit and in the resettlement struggling to conceptualise refugee SGBV experience in all its complexities (Kapur et al., 2017). Support workers may lack competence in engaging with cultural norms and values that abusers use to justify violence.

Foundation: Rights and citizenship

There is considerable evidence indicating that refugees have received insufficient knowledge about their rights, suggesting that much more could be done by authorities to inform and educate refugees about their entitlements. Such knowledge often depends on refugees being able to access services providing information in their mother tongue. Even when aware of their rights refugees may not act. For example, Keygnaert et al. (2012) reported that, in reception centres in Germany, women weighing up the risks chose not to report some incidences of SGBV, because they feared a backlash from their communities.

Distal impacts

Experience of SGBV can have a distal impact on survivors' ability to deal with their asylum or immigration claim. SGBV related mental health conditions, in particular untreated trauma-related complications, can result in memory problems or engaging in tactics to avoid discussing traumatic events. Yet a positive outcome from an asylum claim is frequently predicated on being able to offer a consistent and coherent self-narrative (Gušić et al., 2017). Some refugees also feel high levels of shame about their experiences and struggle to reveal the full extent of SGBV despite its importance to their claim.

Proximal impacts

Arguably, successful integration means that refugees are empowered to access the services to which they are entitled and able to exercise their rights. However, proximal impacts of access or limitations in access, to rights, entitlements and citizenship can hamper the recovery of refugees who have experienced SGBV or restrict their access to support services. A number of studies have found that SGBV survivors were not aware of their legal rights and were less likely to use social services (Hyman, 2006, Vaughan et al., 2015, Martinez Roman, 2017), partly because of language problems. In the recent study on asylum-reception centres, the majority of residents (72%) were unaware of SGBV preventive measures (Oliveira et al., 2018). Women asylum seekers in Germany, who were identified as vulnerable, were not aware of their entitlements to separate living spaces, therapy, medical support and legal representation (Bonewit and Shreeves, 2016). Such lack of awareness might have contributed to low levels of SGBV reporting. Often those in precarious immigration positions (for example no legal residence permit or unprotected status) are unable to exercise rights and are subject to increased residence-related risk factors and vulnerability to SGBV (Oliveira et al., 2018, Keygnaert et al., 2012). In many countries, only refugees with an official residence permit are assured access to healthcare services, depriving irregular immigrants of basic services.

The proximal impact of asylum determination processes has been found to decrease levels of resilience and coping for SGBV survivors; *"Fear of being sent back to their country of origin and*

uncertainties about their future in the UK were mentioned by all women as well as being unable to work whilst waiting for asylum applications to process” (Sherwood and Liebling-Kalifani, 2012). Frustration and stress related to immigration procedures, especially the length of time spent waiting for a decision, has been found to increase rates of SGBV (Oliveira et. al, 2018).

Conditions tied to spousal visas can leave women vulnerable to abuse. Undocumented or illegal immigrants are often trapped in abusive relationships, whereby they fear deportation if they contact the police (Kulwicki et al., 2010, Martinez Roman et al., 2017). This is because immigration laws in many countries ties women’s presence to dependency on sponsoring spouses, perpetuating cycles of violence (e.g. Kapur et al., 2017); *“several women were sponsored to migrate by their husbands, and they had a sense of obligation to endure their violent experiences for fear of being returned to Africa”* (Ogunsiji et al., 2012, p. 1663).

Some legal exemptions have been introduced to mitigate the harmful effect of laws on women subjected to SGBV. For example, in Spain the Organic Law 10/2011 of July 27, 2011, allows an abused woman and her children to request permission to reside and work under exceptional circumstances (Martinez Roman et al., 2017). In addition, the Istanbul Convention, Article 59 allows survivors of SGBV some exceptions in relation to immigration control (see Stoyanova, 2018). Yet, exemptions do not necessarily apply to all women. For example, the USA Violence Against Women Act (VAWA, 1994) does not protect women married to non-citizens or non-residents (Clark 2007). In the USA, survivors must meet strict requirements regarding proof of abuse before the application can be made. Law enforcement agencies often struggle with communication and lack cultural sensitivity, making it difficult for women to report abuse and subsequently produce evidence from those authorities. In addition, there can be a requirement to prove that a marriage was conducted in good faith which can be difficult for arranged marriages (Kapur et al., 2017). People with religious marriages who did not register their union with the state are required to first prove their marriage is genuine in court (Kapur et al., 2017).

In general, states in the Global North are responsible for the protection of refugee women under the principle of universality in international human rights. Somali women refugees in Sweden have expressed appreciation for the freedom women are mandated by Swedish law (Byrskog et al., 2016). In Spain, Moroccan women appreciated women’s rights and that male violence against women is a crime, but nonetheless for a range of reasons found exercising their rights more difficult than Spanish women (Martinez Roman et al., 2017). Barriers included the requirement to file a formal complaint in order to access services and benefits, as many are reluctant to officially report abuse because they fear losing their children or because they are dependent on their partner for money or immigration status (Martinez Roman et al., 2017). In the USA, legislation around divorce and child custody discouraged refugee survivors of domestic violence from seeking separation (Kalunta-Crumpton, 2017).

Coping and resilience

It is important to understand the social and cultural strategies that refugee SGBV survivors adopt to cope with trauma based on the resources available to them. Spirituality has been identified as a key

coping strategy for traumatized people (Bryant-Davis and Wong, 2013). Bryant-Davis, Cooper et al. (2011) found that in the absence of clinical professionals, religious ministers in Liberia supported and assisted SGBV survivors to cope and recover after the civil war. Emotional support was offered in the form of prayers and bible studies. Zraly and Nyirazinyoye (2010) looking at Rwandan rape survivors found that survivors' coping strategies and healing processes focused upon their approaches to resilience including drawing strength from within the "self" to overcome different situations, and the belief that while there is life, there is power to overcome all challenges.

Using faith as a coping strategy has frequently been reported in relation to refugee SGBV survivors. *"Without my religion I wouldn't be able to continue my life. God has made me strong. I am a very healthy and strong woman. I am never ill. God gives me power. God helps me to forget"*. (Tankink & Richters, 2007). Some attended regular religious congregations where they drew strength and a feeling of belonging. However, many do not disclose their SGBV experiences in fear of ridicule or rejection. Parsitau (2011) studying internally displaced people in Kenya argued that faith played a critical role in assisting integration in the camps, and a motivating factor for change. *"...We have lost everything we had,...God is all we have now ..."* (Parsitau, 2011). Pastoral care, collective prayers, religious study groups can support SGBV survivors emotionally and socially (Parsitau, 2011). Ritual practices helped refugees to engage in new roles, whilst traumatic experience restricted abilities to take on new social roles and engage in host communities (Sturm et al., 2007).

Logie, Daniel et al. (2017) argue that the cumulative proximal effects of experiences of SGBV can affect future coping skills. A study by Frazier, Conlon et al. (2006) examined longitudinal post-traumatic life change in a sample of sexual assault survivors. They found that sixteen years after the incident many survivors acknowledged positive changes in their lives which had resulted from their recovery. These included increased assertiveness, spirituality and empathy. Positive changes were associated with fewer symptoms of depression, anxiety and PTSD and greater levels of life satisfaction. Negative changes included beliefs about the unfairness and lack of safety in the world.

Conclusions

This working paper has discussed how the experience of SGBV influences refugee's mental and physical health and their ability to integrate and achieve equality of socio-economic outcomes in countries of refuge. Pulling together the piecemeal evidence in the literature on SGBV we are able to draw some tentative conclusions about the relationship between SGBV and integration. We have summarised these distal and proximal effects in Table 1. The experience of SGBV clearly can and does hamper survivors' attempts to resettle and integrate into a new life through a number of distal impacts. In addition, integration domains, and embedded within these structural inequalities, can expose women in particular to further abuse or undermine their recovery, whilst support received through various functional areas of integration can protect them from abuse and facilitate recovery. These interactions, as observed throughout the paper, can generate numerous proximal impacts on the lives of refugee SGBV survivors.

Survivors can experience disadvantage across integration domains largely because of the ongoing and multi-faceted experience of trauma, a distal stressor, with its immediate and long-term health

and socio-economic implications. Lack of appropriate support to address trauma and continued traumas once in countries of refuge, such as IPV, can be exacerbated by the combined proximal non-SGBV and SGBV related stressors such as immigration status or structural violence. Significant barriers remain to refugee SGBV survivors' ability to access health provision, employment, education and housing. The interplay between distal and proximal influences throughout the refugee journey and resettlement across different integration domains, can have a cumulatively detrimental effect on the possibilities of integration.

The SGBV experiences of refugees should be recognised as spatially and temporally complex. Trauma could occur pre-conflict, during conflict, in flight and in refuge. Daily stressors related to life in a new country with uncertain status and lack of socio-economic resources can have a compounding effect on vulnerable refugees' psychological wellbeing (see more Miller and Rasmussen, 2010). There is growing body of evidence that daily stressors, for example poverty, destitution and/or domestic violence, are greater predictors of one's mental health condition, than 'big' life changing traumatic events, such as exposure to political violence (e.g. Al-Krenawi et al., 2007).⁴ There is also evidence that daily stressors decrease people's resilience to cope with potentially traumatic life events (Kubiak, 2005). Therefore, addressing the impacts of SGBV experiences on refugees requires consideration and mitigation of all potential proximal and distal stressors in addition to those associated with trauma, while strengthening refugees' inherent capacities and resources to recover (Betancourt & Williams, 2008; Boothby et al., 2006, in Miller and Rasmussen, 2010).

Table 1: The relationship between SGBV and integration

Integration indicator	Distal impacts of SGBV on ability to integrate	Proximate impacts of integration indicator on vulnerability to SGBV or on ability to recover
Health	Sexual, emotional, psychological, physical, reproductive, behavioural effects which impact all areas of integration	Lack of support impacts on ability to recover Lack of awareness by clinicians and no continuity of care limits access to support
Employment	Impairment caused by PTSD impact ability to work, decrease productivity Exclusion of survivors and their families from work for honour related reasons	Unemployment and economic hardship increase vulnerability to SGBV Financially dependent women more likely to face IPV Marital tensions associated with changed gender dynamics and loss of male esteem
Housing		Safe and secure to housing reduces vulnerability and enhances recovery Housing insecurity locks women into abusive relationships Overcrowding and poor security in centres and camps increases vulnerability
Education	SGBV experiences reduce ability to concentrate and sustain learning	Dependent women unable to pay for education Education builds preventative capacities

⁴ This study found that spousal violence and parental violence against children greater predicted mental health of children than exposure to political violence in the West Bank.

		Lack of knowledge and information SGBV risk factor
Social bonds	Survivors often withdraw because they lack trust Stigmatisation can lead to withdrawal or exclusion Loss of networks impairs social functioning and recovery	Strong bonding relationships help recovery Bonding relations can act as bridge to help-seeking Bonds and/or controlling relationships can prevent help-seeking Separation from family can increase susceptibility to psychological disorders Disruptions in relationships can increase levels of IPV
Social bridges	Survivors may be more willing to build bridges than bonds	Can raise awareness about unacceptable nature of SGBV and reduce vulnerability “Outsiders” as key bridges to support and intervention
Social links	Fear of shame associated with sharing family name	NGOs key to countering SGBV initiatives Mainstream services can lack cultural sensitivity and competences around confidentiality
Language and cultural knowledge	Trauma and instability reduce access to language classes and lack of competency to SGBV services Abusive partners restrict language learning to maintain control	Survivors unable to communicate needs or access treatment Interpreting inconsistent, lack competency and professionalism Poor communication in centres increases SGBV vulnerability
Safety and stability		Poor safety and stability reduces ability to recover and increases vulnerability Anti-refugee discourse can increase isolation Support workers may lack cultural competency
Rights and citizenship	Trauma and associated memory problems can make retelling of stories for asylum assessors appear to lack credibility	Lack of knowledge of rights and entitlements can increase vulnerability Refugees in precarious positions unlikely to report SGBV Conditions tied to spousal visas problematic Services dependent on formal complaints are avoided for fear about status Knowledge of rights and entitlements can empower

There is a lack of systematic analysis of the impacts of SGBV experiences on refugees’ ability to integrate. We have pieced together a picture from many sources, most of which just cover one or two aspects of integration. It is unsurprising that most attention focuses upon refugees’ mental and physical health. What is surprising is the lack of knowledge about how these health problems shape short and long term life chances. While there are numerous possible effects, without additional

research it is not possible to know which effects are experienced in what circumstances and how those effects might be reduced.

In this review some contradictions have emerged that should be considered in future studies including: the dual positive and negative role of faith leaders in addressing SGBV, the appropriateness of existing solutions for refugee women experiencing domestic violence in the context of limited familiar support in new countries of residence, the suitability of using Western-based psychotherapies and diagnoses for individuals from diverse backgrounds, as well as the extent of commitment to a survivor-centred approach and respecting survivor's own choices. Further research is needed to examine how SGBV experiences affect refugees' integration, especially in education, housing, employment and the development of social capital. More knowledge is needed about the ways in which experiences of the asylum process, with its associated expectation of retelling trauma, can re-traumatise refugees and impact upon ability to resettle. Longitudinal studies would be particularly helpful in developing understanding of short and long term impacts as well as the effectiveness of different interventions. Finally, studies should integrate gender sensitivity and adopt a gender analysis to understand the differences in needs, outcomes and experiences of refugees of all genders and ages regardless of their background.

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