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Forced migration and sexual and gender-based violence: findings from the SEREDA project in the UK

Over 82 million people were forcibly displaced in 2020, around half of whom were female. Women and girls face specific vulnerabilities when forced to migrate including to sexual and gender-based violence (SGBV). Data is lacking about the numbers of forced migrants experiencing SGBV but it is thought to exceed 50%. Men, boys and LGBTQIA+ people can also be victims. The SEREDA project brings new understanding about the nature and incidence of SGBV experienced by forced migrants in England. The project interviewed 68 forced migrant SGBV victims, and 26 service providers working with victims, between 2018-2020. Three online workshops were organised with practitioners to co-produce recommendations seeking to improve resettlement experiences for SGBV victims in the UK.

Different kinds of violence were evident at different stages of forced migration along a continuum of violence. Some respondents experienced SGBV at all these stages, including restriction of movement, physical and verbal abuse, humiliation, torture, starvation, human organ trafficking and slavery, sexual violence, labour exploitation, blackmailing, being thrown into the sea (or threat of), deprivation of possessions including medicines and official papers, or being left in the desert. Incidents of SGBV took place in the country of origin, transit countries, during the journey and/or in the UK. The majority of perpetrators were men, frequently connected to the state security apparatus or smuggling gangs or as partners or family. LGBTQIA+ respondents gave extensive accounts of violence committed by family, officials, smugglers, other forced migrants and co-ethnics including conversion/ corrective rape.

SGBV and resettlement in the UK

Some victims reported interpersonal violence (IPV) perpetration in the domestic sphere following arrival in the UK. IPV included emotional, physical, economic, and psychological abuse as well as a lack of support and encouragement. Victims spoke of how they feared or were discouraged from reporting SGBV incidents. Women's precarious immigration status which in some cases was dependent on their remaining in an abusive marriage, and their lack of knowledge of the Domestic Violence Rule meant men were able to abuse, control and exploit them using the threat of ending relations and associated destitution, detention and deportation if they did not obey.

Service providers and victims generally referred to

SEREDA: Sexual & Gender Based Violence against Refugees from Displacement to Arrival

immigration and asylum policies and practices as harmful. Systems were said to exacerbate existing trauma, generate new trauma or increase victims' likelihood of experiencing SGBV. The engagement with lengthy UK asylum determination processes and fear of detention and deportation contributed to victims' poor mental health. Without legal status, they could not work, study or apply for family reunion and lived in fear of return to persecution.

There were three main ways in which systems interacted with SGBV:

1. Encouraging violent dependency

- Forced migrant women who joined husbands with refugee status on a spousal visa had No Recourse to Public Funds (NRPF) and lived with the threat of deportation if the marriage broke down
- Women were scared to report IPV and if they fled, being NRPF meant they had few housing and support options leaving them open to further exploitation by friends and strangers
- Refused asylum seekers not in receipt of housing or support relied on exploitative relationships for survival while others engaged in transactional sex to survive
- LGBTQIA+ victims were said to rely heavily on transactional sex for survival
- Asylum seekers, spouses and refused asylum seekers were not permitted to work or study, and had to survive on no or very low levels of income
- Claimants without support and social connections sometimes got trapped into exploitative relationships in order to access basic necessities.

2. Traumatic asylum processes:

- Lengthy waits for a decision on their asylum case and inability to work or study while waiting exacerbated psychological distress with some respondents lacking day to day distractions which could reduce the effects of living in fear of being returned to persecution
- Shifts between being "in" and "out" of systems when refused asylum seekers were between appeals resulted in destitution, undermining wellbeing and increasing risks of SGBV
- Gender insensitive asylum interviews by male caseworkers and with male interpreters prevented women victims from disclosing SGBV experiences
- Some groups were reported increased risks of vulnerability and discrimination during asylum interviews, for example LGBTQIA+ victims.

3. Unstable and risky housing:

- Given that many victims had experienced SGBV at the hands of men being housed in mixed gender accommodation was problematic
- Many spoke of bathrooms and bedrooms without locks, abusive staff who walked in unannounced, and sexual harassment
- Dispersal and re-dispersal away from support networks undermined psychological wellbeing and important connections with friends, NGOs and/or healthcare providers
- Detention generated flashbacks to imprisonment and enslavement
- Respondents were exposed to racist abuse and homophobia in dispersal neighbourhoods and housing
- Victims of Muslim background reported feeling stigmatised and discriminated against for wearing religious attire
- Those newly granted leave to remain were evicted from their asylum housing with many experiencing long waits for welfare payments or not knowing how to access Universal Credit and thus becoming destitute
- Forced migrants, who were destitute, were vulnerable to further exploitation and violence.

Health impacts of SGBV

The combined effects of the continuum of violence and interactions between SGBV, immigration and asylum systems were reported to generate high levels of trauma resulting in physical and psychological harms. Experiences of SGBV resulted in physical injury, with some injuries resulting in permanent health problems. Women talked of bruising and bleeding following attacks, while some were hospitalised. Longer-term problems included scarring, gynaecological and urinary problems. Respondents talked about injuries and sexually transmitted diseases sustained during their journeys wherein they were unable to access post-rape prophylaxis with some respondents giving birth to children of rape. Some women reported feelings of guilt and self-hatred, others anger, sadness and loss. Feelings of despair, exacerbated by isolation and loneliness, often manifested in mental health disorders, culminating at worst in suicidal ideation.

Healthcare

Although some respondents had been able to access health and psychological treatments they needed, either through GPs or civil society organisations, the majority received no support. Individuals who were refused asylum seekers and undocumented migrants were too fearful to seek medical assistance or report violent incidents to the police. Some GP practices rejected registration without victims producing what they deemed to be appropriate identification. Some respondents suggested that health professionals lacked knowledge of lived experiences of forced migrant

victims and the barriers they faced accessing services such as frequent changes of address, language barriers and having No Recourse to Public Funds (NRPF). Respondents highlighted that NHS medical charges for overseas visitors deterred migrant populations from seeking healthcare and support, while opportunity to identify and support SGBV victims were missed. GP respondents emphasised that they did not receive SGBV training about how to communicate in time limited situations with victims. Referral processes were said to be problematic as victims were sometimes requested to repeat potentially traumatising details when completing lengthy referral forms. There was limited provision for, and capacity of, mental health support and lack of awareness among practitioners about the mental health consequences of conflict-exposure among forced migrant populations.

Barriers to SGBV disclosure and accessing support

Service providers said that the process whereby victims disclosed SGBV experiences could take years. Language barriers were a major barrier preventing victims from seeking help and accessing support services. Reliance on community-based interpreters contributed to users feeling unsafe to self-disclose and lack of trained interpreters could restrict their ability to offer outreach services to forced migrant users. Reasons for non-disclosure included self-blame, stigma, shame, guilt, not knowing that experiences "counted" as violence, the normalisation of violence, fear of authority, and experiences of impunity. Women were sometimes told by others in their communities to remain in abusive relationships and/or keep quiet about abuse. Some did not disclose because of their precarious immigration status (on spousal visas or undocumented individuals).

Resilience and integration

Despite the accounts of severe vulnerability to SGBV and long-lasting SGBV effects on health and wellbeing, many respondents exhibited high levels of resilience. Victims attributed their ability to survive to their faith and to their desire to ensure a better life for their children. Language and communication, cultural knowledge, possession of digital skills, and feeling safe and secure all had a role in helping respondents to settle in the UK. Mutual help and support groups as well as volunteer and advocacy opportunities were all cited as resilience building. Friendships with other victims and local residents, faith communities and access to support networks were all integral to building resilience and facilitating integration.

Immigration status was a significant influencing factor on resilience and ability to integrate. Lack of secure status was reported to prevent women seeking access to support and justice. Women victims without legal status were less likely to reach out for support and were reported to often 'suffer in silence', because they believed they were not entitled to access welfare services. Awaiting refugee status served as a constant reminder of victims' 'foreignness'. Gaining leave to remain was the biggest boost to victims' resilience and overall wellbeing as it opened up opportunities to work, study and access language classes and through those facilitated access to wider social networks and feelings of safety and security. Family reunion was also considered a significant factor for successful settlement and integration. Victims' separation from family, including sometimes dependent children, often undermined their ability to integrate even after receiving a positive decision.

SGBV could undercut attempts to integrate across the Home Office's Integration Indicators (Ndofor-Tah et al. 2019). However actions across the integration domains could also provide opportunities for protection or recovery from SGBV. A complete lack of women-specific and SGBV victim specific integration support was noted by service providers although some victims had accessed help from small grassroots community organisations or neighbours. Access to work, language training and education offered distraction from past traumas and hope for the future.

Recommendations and way forward

To protect and support SGBV victims, the way forward requires multi-stakeholder collaborations to take action and mainstream SGBV and trauma sensitivity into the asylum and immigration systems and migrant service delivery. SGBV experiences are widespread and greater commitments are needed to tackle violence against forced migrants and support their recovery. Improved coordination between sectors is necessary to strengthen people-centred service delivery among forced migrants in the interest of public health and protecting human rights. It is important that the harm occasioned to SGBV victims in the UK's asylum and immigration system is not normalised but seen as a serious problem requiring an urgent response. The interests and vulnerabilities of forced migrant women and girls need to be recognised, integrated and supported within the national strategy for tackling violence against women and girls (HM Government, 2021).

We outline four key guiding principles for way forward:

1. Mainstream SGBV responsibility - appoint an entity to oversee gender sensitivity in the UK

immigration and asylum systems.

2. SGBV and trauma sensitisation - SGBV training and trauma awareness provision for professionals working with victims.

3. Victim-centred and inclusive service delivery - ensure services address forced migrant victims' needs.

4. Non-discriminatory approach to forced migrant SGBV victims - ensure fair and humane treatment for all.

We propose a number of key recommendations:

To Home Office

- Integrate gender and trauma sensitivity into the asylum and immigration systems to strengthen intersectoral capacities to support SGBV victims in the UK.

To Department of Health and Social Care and Home Office

- Home Office, Office for Health Improvement and Disparities and NHS England and NHS Improvement to ensure the specific needs of forced migrant victims are integrated into the guidance and implementation of the UK Violence Against Women and Girls Strategy (HM Government, 2021) through Integrated Care Systems (ICS), recognising forced migrant specific risks and the role of the state in exacerbating or addressing the risk of harm.

To Home Office and housing contractors

- Ensure that accommodation and service contracts mandate the delivery of gender-sensitive services and that there are mechanisms to ensure these are implemented
- Ensure single sex housing for uncoupled women at all points in the asylum process
- Make sure all individuals working in asylum accommodation receive gender sensitivity training, and employ women to work in female only housing
- Improve safety, safeguarding and wellbeing in accommodation
- Review dispersal policies making decisions based on continuity of care, access to services and maintenance of support networks for victims.

To Home Office, Ministry of Housing, Communities and Local Government and NGOs

- Allow asylum seekers to engage with work, volunteering and training to enable them to provide distraction from trauma and the opportunity to rebuild their lives
- Ensure all asylum seekers receive timely information and support to access healthcare and are registered with a GP as soon as possible.

To Department of Health and Social Care, NHS England and NHS Improvement

- Office for Health Improvement and Disparities, NHS England and NHS Improvement to produce guidance for healthcare professionals about how to support forced migrant SGBV victims
- 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.

To NHS England and NHS Improvement, Integrated Care Systems, Royal Colleges and Faculties, NHS hospital and primary care services

- Implement training for health professionals and personnel to support them to identify and work with SGBV victims
- Ensure clinical training covers the vulnerabilities and needs of forced migrants and SGBV victims
- Inform all patients about their right to request female clinicians, and to request an interpreter
- Home Office, NHS England and NHS Improvement, Police, NGOs and Local Government to improve coordination within and between mainstream and migrant organisations by strengthening referral pathways.

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

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