

Forced migration and sexual and gender-based violence

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Document Version

Publisher's PDF, also known as Version of record

Citation for published version (Harvard):

Pertek, S, Phillimore, J, Goodson, L, Stevens, A, Thomas, S, Hassan, P, Darkal, H, Taal, S & Altaweel, R 2021, *Forced migration and sexual and gender-based violence: findings from the SEREDA project in the UK*. University of Birmingham. <<https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/iris/2021/sereda-full-report.pdf>>

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

November 2021



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

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Report information:

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Citation: Pertek, S., Phillimore, J. and Goodson, L. with Stevens, A., Thomas, S., Hassan, P., Darkal, H., Taal, S. and Altaweel, R. (2021) Forced migration and sexual and gender-based violence: findings from the SEREDA project in the UK. Research Report. University of Birmingham.

Funding: Riksbankens Jubileumsfond as part of the Europe and Global Challenges programme with philanthropic support from Lansons.

Front cover photograph: Philippa James

Back cover artwork: Dr Penelope Mendonça, penmendonca.com

Design: evansgraphic.co.uk

Acknowledgements: SEREDA Team wishes to thank the victims and service providers who participated in this study, as well as project partners and collaborators listed above. Thanks are also due to professionals and clinicians who contributed to the co-production of recommendations during multi-stakeholder workshops. Special thanks to Claire Zhang from Office for Health Improvement and Disparities (formerly Public Health England) for extensive comments on recommendations.



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Terminology

We use the term victims in this report to refer to forced migrants who are, or have been, subject to SGBV. However it is important to note that they may be considered victims/survivors in that they are engaged in acts of recovery often in the face of circumstances which render them vulnerable to continued SGBV.

Acronyms

| | |
|---|--|
| DHSC - Department of Health and Social Care | NHS - National Health Service |
| FGM/C - Female genital mutilation/cutting | NRPF - No recourse to public funds |
| HO - Home Office | OHID - Office for Health Improvement and Disparities |
| ICS - Integrated Care Systems | PHE - Public Health England |
| IPV - Intimate partner violence | RTOF - Refugee Transitions Outcomes Fund |
| MENA - Middle-East and North Africa Region | SGBV - Sexual and gender-based violence |
| NGO - Non-governmental organisation | |

Short summary

Over 82 million people were forcibly displaced in 2020, around half being female. Women and girls face specific vulnerabilities in forced migration including sexual and gender-based violence (SGBV). The exact proportion of forced migrants experiencing SGBV is unknown but thought to exceed 50%. Men, boys and LGBTQIA+ people can also be victims. The SEREDA project sheds light upon forced migrants' experiences of SGBV. The project interviewed in the UK 68 forced migrant SGBV victims, and 26 service providers working with victims, between 2018 and 2020. Three online workshops were organised with practitioners to co-produce recommendations focussing on improving the lives of 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, often connected to state security apparatus or in smuggling gangs or as partners or family. Some respondents reported an intensification of intimate partner violence (IPV) post-conflict.

Asylum and immigration systems exacerbated existing trauma, generated new trauma or increased victims' vulnerability to further SGBV. Lengthy UK asylum determination processes and fear of detention and deportation intensified victims' mental health conditions. Immigration systems encouraged violent dependency of victims on perpetrators who threatened them with deportation if they were not obedient. Lengthy, gender-insensitive, asylum interviews compounded trauma associated with pre-arrival SGBV. Unstable and unsafe mixed-gender housing, and lack of, and inappropriate, shelter increased risks of SGBV.

The combined effects of the continuum of violence and interactions between SGBV, immigration and asylum generated high levels of trauma resulting in physical and psychological harms. The majority of victims received no health and psychological support. Refused asylum seekers and undocumented migrants, fearing detention or deportation, were too fearful to seek medical assistance or report experiences of violence to the police. Some GP practices

rejected victims' registration if they lacked what was deemed appropriate identification. Victims often did not disclose experiences of SGBV because of self-blame, stigma, shame, guilt, not knowing that experiences "counted" as violence, the normalisation of violence, inadequate interpreters, fear of authority, and past experiences of impunity. Integration across social policy domains could provide opportunities for protection or recovery from SGBV. However, a complete lack of women and SGBV victim specific integration support was noted. Some victims found help from grassroots community organisations or neighbours while others found themselves isolated and alone without access to help or care.

The report sets out 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 - incorporate SGBV training and trauma awareness among professionals working with victims.
3. Victim-centred and inclusive service delivery - ensure services focus on the needs of forced migrant victims.
4. Non-discriminatory approach to forced migrant SGBV victims - ensure fair and humane treatment for all.

Key recommendations, among others, include to:

1. Recognise that violence extends beyond conflict into flight and refuge and introduce appropriate actions.
2. Integrate gender and trauma sensitivity into the asylum and health systems to strengthen intersectoral capacities to support SGBV victims.

Executive summary

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 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 focus on the needs of forced migrant victims.
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 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.

Introduction

Forced migration is gendered – women and men experience displacement in different ways (Freedman, 2010). Over 82 million people were forcibly displaced in 2020, around half of whom are female (UNHCR, 2021). Although women and girls face specific vulnerabilities when forced to migrate (Rohwerder, 2016), increasing evidence suggests that men and sexual minorities are also vulnerable (WRC, 2020). Risks include heightened vulnerability to sexual and gender-based violence (SGBV). The Women's Refugee Commission (WRC, 2019) have highlighted extraordinary levels of SGBV experienced by refugees during recent conflicts, throughout refugees' flight, in temporary camps and in immigration detention centres (WRC, 2016). There is clear evidence that forced migrants experience high levels of structural and interpersonal violence across their migration pathways (Friedman, 1992; Freedman, 2016). The exact proportion reporting such experiences remains unknown although generally exceeding 50% of all women and with under-reporting the norm (Dorling et al., 2012; Dudhia, 2020). Sexual and gender-based violence (SGBV) includes rape and sexual assault, as well as physical, psychological or emotional violence; forced marriage; forced sex work; and denial of resources, opportunities, services and freedom of movement on the basis of socially ascribed gender roles and norms (UNHCR, 2011).

The SEREDA project sought to understand the nature and incidence of SGBV experienced by refugees who have fled conflict and are residing in countries of refuge. Funded by Riksbankens Jubileumsfond as part of the Europe and Global Challenges programme, with additional philanthropic support from Lansons, the project runs from 2018 to 2022 and is led by the University of Birmingham in conjunction with the University of Melbourne and Bilkent and Uppsala Universities. The project works closely with NGO partners and has collected data from victims and stakeholders in the UK, Australia, Turkey, Tunisia, and Sweden. The study in the UK was undertaken with the support of Doctors of the World UK.

The purpose of this report is to outline the findings from the UK interviews with victims and service providers. We begin by outlining the methods used to collect data before summarising key findings around the nature and impact of SGBV. We continue by outlining the barriers to disclosure and accessing services and identify three main ways in which UK immigration systems interacted with SGBV. We then share findings around resilience and integration of SGBV victims before setting out recommendations.

Methods

Semi-structured interviews were undertaken in England with 68 forced migrant¹ SGBV victims, and 26 service providers who worked with SGBV victims, between 2018-2020. Victims interviewed included men, women and LGBTQIA+ forced migrants from the Middle-East and North Africa (MENA region) and Sub-Saharan Africa. The 26 service provider respondents included clinicians, project workers and managers from public sector bodies and local, national and international non-governmental organisations. The victim sample details can be found at the Table 1. Most victim respondents were female reflecting the reality

the majority of SGBV victims are female. Our recruitment methods, detailed below, enabled us to reach women respondents. In addition our interviewers were female, essential in a project focusing on such sensitive topics. However, we also engaged with several male victims and believe that further research with men and boys is necessary employing male researchers as it can be challenging to ask men to share their experiences with women researchers because of the stigma male victims' experience.

All respondents were over the age of 18. All interviews were carried out in English or the chosen language of victims by multilingual researchers and community researchers, eliminating the need for interpreters. Victim respondents came from 20 different countries in the MENA and Sub-Saharan Africa regions and were identified through contacting agencies and organisations working with forced migrants. These included national charities and small co-ethnic organisations. We also used a snow-balling approach wherein victims could identify other potential interviewees. Respondents were recruited from across England but given our partnerships with NGOs based in the West Midlands and South East and London, a large proportion of respondents came from these regions. Respondents self-identified as experiencing SGBV when answering broad screening questions. Interviews explored experiences of SGBV, identity of perpetrators, support received, factors shaping vulnerability and resilience, help needed and the effects of SGBV on resettlement. Service providers from across the UK were approached having been identified as having contact with victims. They included six organisations working nationally, two globally and 18 locally or regionally (London and South East, West Midlands and Yorkshire). Interviews were undertaken with individuals working with forced migrants in charities, health

¹ We use the term forced migrant to denote individuals who have experienced some form of involuntary displacement. It is used to shift attention away from legal definitions to individual experiences.

services, and local authorities. They were asked to give an overview of victims' experiences, vulnerabilities and resilience factors, the services they provided, data and monitoring, and treatments and interventions as well as to reflect on the impact of SGBV on victims' integration processes.

Ethical approval was received from the University of Birmingham Ethical Review Committee. All interviews were undertaken with informed consent with interviewees assured of anonymity in subsequent reports, discussions and publications. Interviews were recorded, transcribed and verified by multilingual peer researchers. Steps were taken to reduce the potential for re-traumatisation, and respondents in need of support were referred to the appropriate agencies.

In addition, in 2021 three online workshops with NGO representatives, healthcare professionals and representatives of public institutions, who were in positions to influence and inform policy, were organised to share the SEREDA research findings and co-produce recommendations to improve resettlement experiences for SGBV victims in the UK. In total 50 professionals attended the workshops with details provided in Table 2. The report was also shared for consultation with the Home Office, Public Health England (now renamed to Office for Health Improvement and Disparities - OHID) and the

National Health Service (formerly PHE) and National Asylum Seeker Health Steering Group (NASHG).

Representatives came from charities and networks that work with forced migrants and victims of SGBV and trafficking, provide essential services, welfare support and shelters, as well as specialists in asylum support, domestic violence, LGBTQIA+ and forced migrant women's outreach and advocacy. Health practitioners included clinicians (e.g. nurses, midwives and mental health therapists) working with forced migrant populations with an interest in migrant health and inclusion. Consultants and representatives from OHID (formerly PHE), Public Health Scotland, Scottish Human Rights Commission, GPs, public health professionals and safeguarding leads also participated, as well as researchers in SGBV and migrant health and wellbeing. During workshops attendees commented on research findings and suggested recommendations to improve policy and practice in participatory and consultative group discussions. To ensure feedback from participants was incorporated into the SEREDA recommendations, detailed notes were taken during workshops which were coded using NVivo 12 software and analysed using thematic analysis. Recommendations from the workshops and recommendations raised earlier by research respondents have been triangulated and integrated. We expand on recommendations in section 7.1.

Table 1 Profile of victim interviewees

| Category | | MENA (n=30) | Sub-Saharan Africa (n=36) |
|--------------------|-----------------------|----------------|------------------------------|
| Gender | Male | 9 | 4 |
| | Female | 22 | 32 |
| | Other | 1 | - |
| Marital Status | Married or partnered | 9 | 12 |
| | Single | 13 | 16 |
| | Divorced or separated | 10 | 4 |
| | Not stated | - | 4 |
| Immigration status | Asylum seeker | 12 | 15 |
| | Refused asylum seeker | - | 8 |
| | Undocumented | 1 | - |
| | Refugee | 9 | 13 |
| | Dependent spouse | 10 | - |

Table 2 Profile of workshop participants

| Workshop type | Number of participants |
|--|------------------------|
| Workshop with NGOs | 26 |
| Workshop with healthcare professionals | 10 |
| Workshop with individuals and organisation representatives in a position to influence or inform policy | 14 |

Findings: Experiences of SGBV

Forced migrant respondents were asked about their experiences of SGBV. While a very small number had experienced one discrete incident, the vast majority experienced repeated occurrences often at the hands of different perpetrators over time and place (Phillimore, 2021). Some researchers have used the term continuum of violence to describe the ongoing violence experienced by women before, during and after conflict (Cockburn, 2004; Kostovicova et al., 2020). Some respondents experienced both interpersonal violence (IPV) and other forms of SGBV. In line with much of the evidence around the cycle of violence (see WRC, 2019) respondents reported an intensification of IPV post-conflict and upon arrival in the UK. LGBTQIA+ respondents gave extensive accounts of violence committed by family, officials, smugglers, other forced migrants and co-ethnics including conversion/corrective rape.

Table 3 Experiences of violence at different stages of migration reported by respondents

Violence pre-displacement

- Forced marriage (women and LGBTQIA+) and child marriage
- Violence and SGBV within families
- Imprisonment and control
- Rape and expectation of marrying rapist
- Female genital mutilation/cutting (FGM/C) (Sub-Saharan Africa)
- Normalisation of violence and impunity for abusers
- Intimate partner violence (IPV) by husband and his family (MENA)
- Stigma associated with divorce and expectation of remaining in abusive situations (MENA)

Violence in conflict

- Torture, including sexual torture, of men and women (MENA)
- Men forced to watch family and strangers raped
- Forced marriage (MENA)
- Forced conscription of men (Sub-Saharan Africa)

Violence in flight

- Camps loci for rape of young men, LGBTQIA+, women and girls
- Physical violence and SGBV by authorities, local people and employers (MENA)
- Transactional sex and rape by traffickers
- Women and girls separated from families and attacked (MENA)
- Enslavement and kidnapping (Sub-Saharan Africa)

Violence in the UK

- Intensification of IPV and use of immigration status to control (MENA)
- Discrimination and racist attack (MENA)
- Aggressive and lengthy asylum interviews
- Relationship between waiting, destitution and psychological disorders
- PTSD from asylum interviews, detention and shared housing
- SGBV in Home Office housing and when homeless
- Prostitution and trafficking (Sub-Saharan Africa)
- Economic abuse and deprivation of resources
- Lack of safe spaces for IPV and LGBTQI victims
- Insufficient specialist services for victims – lack of treatment exacerbates conditions

Different kinds of violence were evident at different stages in the continuum with some respondents, as noted above, experiencing SGBV at all these stages. Some types of violence reported were more specific to victims from particular regions although this does not mean that other respondents had not experienced these same types of violence. Some forms of

violence were structural, that is occasioned by social structures which fail to meet their basic needs or even exacerbate vulnerability to SGBV. Respondents reported having experienced and/or witnessed a wide range of human rights violations, including restriction of movement, physical and verbal abuse, humiliation, torture, starvation, human organ trafficking, 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 were said to have taken place either in the country of origin, transit countries and/or the UK. The majority of perpetrators reported were men, frequently connected to state security apparatuses or smuggling gangs or as partners or family. The violence experienced by respondents at different stages of migration is summarised in Table 3 and discussed in the next section.

SGBV pre-displacement and in conflict

Victims experienced personal violence that was socially and culturally embedded in the domestic sphere and manifested as physical, emotional, verbal, financial and sexual violence and, in Sub-Saharan Africa, included female genital mutilation (Goodson et al., 2020). Female victims described denial of their agency and were subjected to shame and stigma on disclosure of sexual assault or after divorcing an abusive partner (Goodson et al., 2021). Perpetrators included family and community members. In households where women experienced domestic violence, children were also reported to experience abusive behaviour.

“ Yeah there’s a lot of memories of violence, hitting, the most one I see is hitting, the one I see is my dad hitting his wife, things like that, its normal. ”
(Ethiopia, female, refused asylum seeker)

“ He raped me but when I told my mom, her first reaction was to slap me saying that I brought disgrace to the family. ”
(Algeria, female, asylum seeker)

LGBTQIA+ respondents recalled sexual, domestic, and emotional violence from their families, community, and state actors. Victims spoke of how discriminatory LGTBQIA+ legislation in countries of the MENA region enabled and facilitated (indirect) state induced physical violence (Goodson et al., 2021). SGBV was used as a way of enforcing community norms, notably in the case of corrective rape, perpetrated by members of the local community against people who were believed to be gay or lesbian.

“ We definitely faced problem regarding people’s attitude. When we walked in some bad neighbourhoods, we were verbally abused. Some people even beat me. ”
(Syria, man, asylum seeker)

Victims also reported ways gender is deployed as a ‘weapon’ by the authorities in order to spread fear, silence any resistance and assert dominance (ibid). Women and children were said to be tortured and humiliated as a way to inflict indirectly violence to, and control over, their husbands and fathers.

“ During the war in Sierra Leone the woman we were raped, they cut their arm, they cut their feet, because when I was coming from there, when I took the bus, nearly everybody was killed there... ”
(Guinea, female, asylum seeker)

“ In prison, all prisoners are blindfolded. [...] During questioning, they’d force us to strip naked, and they’d hang us from our hands, using chains, while the rest of our body is left dangling Then they’d start different ways of torture; burning you with flame and torture with electricity...They used more than 100 torture methods. [...] They’d insert stakes in males and there were rapes. They’d sometimes force prisoners to rape each other. It happened many times. ”
(Syria, male, refugee)

Conflict related threats and violence, forced conscription and religious and political persecution were also given examples of structural violence experienced by respondents at the hands of the state.

SGBV during the journey

In transit, experiences of and exposure to violence were more prevalent among those undertaking long journeys travelling over land and sea and spending time in encampments (Goodson et al., 2021). Poverty, powerlessness, lack of legal protection and dependency on smugglers and aid workers during the journey and in formal camps increased vulnerability to SGBV.

Though most common in females, sexual violence and exploitation was also experienced by heterosexual, gay and non-binary men and boys. Rape by exploitative smugglers and sometimes in return for basic necessities, money, or onward travel in camps was said to be common.

“ It used to happen a lot there. They'd come to the place where they kept us and then people from different places, Nigeria, Eritrea, Ethiopia, the smugglers came with guns and then they'd pick the one lady that he or they liked. They'd just take her somewhere and they'd do whatever they want to with her. ”

(Ethiopia, female, asylum seeker)

Victims reported experiencing beatings, imprisonment, torture, sexual assault, rape, harassment, blackmail, threats, human trafficking and modern slavery at the hands of smugglers, local people and authorities.

“ ...I remember one of my friends, my best friend when we are coming, because she got killed there. Because they wanted to have sex with her, she refused, and they cut her throat with knife. Nobody say anything...A lot of women didn't make it. In our own group we were like nine of us, but only three of us that make it. All the rest they die, they kill them there.”

(Guinea, female, asylum seeker)

Forced migrants, because of their 'illegal' presence in various countries, felt unable to report human rights violations to law enforcement agencies, believing that they would be punished for being

in the country (ibid). Experiences of police brutality, lack of state protection and third party (physical) violence led victims to have little faith in authorities and their willingness or ability to safeguard forced migrants in transit. Victims felt that this lack of protection rendered them more vulnerable to SGBV, racial discrimination and faith-based persecution in transit countries and particularly at border zones. Furthermore despite all the above experiences there was no provision of humanitarian or medical support for forced migrants on the move so they were left to deal with the physical consequences of SGBV unaided and could not access emergency contraception or post-exposure prophylaxis to prevent HIV infection. Some of our respondents reported being infected with STDs or becoming pregnant as a result of SGBV en route and having no access to services.

SGBV and resettlement in the UK

Victims reported a range of interpersonal violence perpetration in the domestic sphere after arrival in the UK. This included emotional, physical, economic, and psychological abuse as well as a lack of support and encouragement (Goodson et al., 2021). Some women reported that the physical and sexual violence they suffered in the domestic sphere intensified during resettlement, especially for those on spousal visas.

“ A woman married to a British man, so her salary enters his account! And he is always reminding her: 'I signed your papers; without me, you would not have papers, and I can ring the Home Office right now, and they will send you back home.' which is painful. ”

(Zimbabwe, female, refugee)

Victims spoke of how they feared or were discouraged from reporting SGBV incidents. The fear of 'honour killings' was a threat for some women from the MENA region (ibid). Stakeholder respondents noted that building support networks, engaging with local communities and taking part in education or training could be difficult for those living with trauma.

Forced migrant women's precarious immigration status and lack of knowledge about their rights and entitlements meant men were able to exploit them for financial gain but also used emotional blackmail with the threat of ending relations if they did not obey (Goodson et al., 2020).

The experience of being brought up in a highly patriarchal culture that undervalues women, and confines them to private spaces, discouraging them from engaging in the public sphere, left women vulnerable in the host countries too, as they sometimes lacked skills to navigate public spaces (ibid).

The engagement with lengthy UK asylum determination processes and fear of detention and deportation contributed to poor mental health of victims, and is described in detail below. Without legal status, they could not work or apply for family reunion and lived life in a distressing state of limbo.

Interaction between SGBV and Immigration and Asylum systems

Service providers and victims generally referred to immigration and asylum policies and practices as harmful. Systems were said to exacerbate existing trauma, generate new trauma or increase victims' vulnerability to SGBV. There were three main ways in which systems interacted with SGBV (Phillimore, 2021).

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 their marriage broke down. They feared return to a dangerous country of origin, being shamed because of marital failure and the possibility of family violence perpetrated as a punishment. We encountered stories of marital breakdown followed by return that resulted in familial violence. Women would not report IPV and if they escaped being NRPF meant they had few housing and support options (i.e. hostel places were dependent on access to welfare) leaving them open to further exploitation by friends and strangers. Some Sub-Saharan African respondents were lured to the UK with promises of a new life by husbands who turned out to be pimps or who enslaved them. They were too frightened to report their situation as they had been told they would be arrested for breaking the law. Refused asylum seekers not in receipt of housing or support sometimes entered exploitative relationships for survival while others engaged in transactional sex to survive. LGBTQIA+ victims were said to rely heavily on transactional sex for survival. Some husbands used their wives' dependent status for control purposes, taking all their earnings and reporting them to the Home Office to try to get them deported if they were not obedient.

“...I didn't even expect it was a brothel...so I thought it was cleaning or restaurant or whatever she knew people that she could connect me to and all that, she was asking me if I have moves, if I know how to fix condom, I was really you know kind of confused, but I didn't really say anything to her at the end of the day, and we went back home with my boyfriend... he was like you see all those girls there, and all that, that's the only thing you can do at the moment. It's not that I'm going to leave you there, but just to raise some money!”
(Nigeria, female, refugee)

As asylum seekers, spouses and refused asylum seekers were not permitted to work or study they had to survive on very low levels of income. We were told that claimants without support and social connections during prolonged waiting for asylum sometimes got trapped in exploitative relationships in order to access basic necessities².

Traumatic asylum processes

The length of time awaiting a decision and inability to work or study (and thus be distracted from traumatic memories) while waiting was described by many as highly problematic exacerbating psychological distress with some respondents living in terror of being returned to persecution. The uncertainty associated with waiting in fear for many years undermined integration after a positive decision (see also Phillimore and Cheung, 2021). Many respondents had experienced periods of destitution associated with bureaucratic errors or with failed claims (later going to, and sometimes overturned, in appeal) which increased vulnerability to SGBV. Lengthy waiting for asylum decisions undermined wellbeing and increased risks of SGBV.

Victims and service providers reported that inhumane treatment and especially the presence of a culture of disbelief was the norm throughout the asylum system. The culture of disbelief, invasive interviewing techniques, lack of safe spaces and of trained interpreters

² We were told that some asylum seekers got trapped in the vicious cycle of exploitation and trafficking e.g. from pregnancy from sexual trafficking to seeking funds for abortion in continued trafficking situations.

Table 4 Victim interview experiences

- Lengthy interviews without a break (several examples of over 5 hours), forced to return quickly if break requested regardless of levels of distress
- Aggressive interviewing techniques – shouting, laughing, accusations and threats of detention
- Insensitive handling of SGBV disclosure generating great distress
- Re-traumatising effect of being asked to repeat the same information about SGBV repeatedly
- No post-interview counselling
- Interpreters “untrustworthy”, not competent and sometimes critical, sometimes making threats
- Confidentiality concerns around disclosing SGBV to an interpreter who may share that knowledge with co-ethnics causing respondent to be shamed
- Disclosure not facilitated or supported with cultural sensitivities around SGBV, gender or sexual identity not understood
- Delays in disclosure assumed to be associated with dishonesty
- Use of male interviewers even when female requested
- Presumptions of criminality rather than victimhood for rape and trafficking victims
- Insistence on the production of evidence of historical SGBV that was impossible to access
- LGBTQIA+ sexuality questioned

made sharing traumatic stories even more difficult. Asylum interviews were particularly problematic with service providers highlighting the lack of caseworker knowledge about difficulties associated with SGBV disclosure, lack of awareness of gender sensitivities and vulnerabilities and the absence of after-care, potentially increasing risks of retraumatising claimants. Asylum applicants were expected to provide evidence of SGBV at early stages in their claim which was often unavailable. Gender insensitive and male dominated environments could prevent women victims from disclosure during interviews. Also, LGBTQIA+ minorities were reported to be at increased risk of vulnerability and discrimination during asylum interviews. Throughout our interviews with over thirty respondents who had passed through the asylum system only two talked about an interviewer who was “kind” such experiences were very much the exception.

In Table 4 we summarise victims’ experiences of asylum interviews.

Unstable and risky housing

The issue of housing was raised frequently. Given that many victims had experienced SGBV at the hands of males in authority or other migrants (including refugees) 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. Women stayed in their rooms unless they had to use the bathroom. In COVID conditions women spoke of a complete absence of social distancing and hygiene measures. The key housing issues highlighted were:

- Mixed housing and hostels unsafe for women, girls and LGBTQIA+
- Dispersal and re-dispersal away from support networks undermines psychological wellbeing

and connections with healthcare

- Detention generated flashbacks to imprisonment and enslavement
- Enforced homelessness if claims fail or are successful, with one woman stuck in hospital after becoming homeless while in labour and others sexually abused while homeless
- LGBTQIA+ victims housed in areas with homophobic communities
- Sexual harassment in Home Office accommodation hard to report and not taken seriously
- Women returning to abusive relationships after becoming homeless or being placed in risky housing
- NRPF respondents unable to access housing and hostels

Respondents were also exposed to racist abuse and transphobia in dispersal locations and lack of control over location of residence prevented respondents from living near friends and support networks. Other victims reported feeling stigmatised and discriminated against for wearing religious attire. The ability to build positive and meaningful social relationships was undermined when victims were housed in areas where as ‘outsiders’ they experienced discrimination.

Those newly granted leave to remain were evicted from their asylum housing with many experiencing long waits for access to welfare or not knowing how to access Universal Credit. Becoming destitute or at risk of destitution, some forced migrants were again left vulnerable to exploitation and violence.

The three different types of interactions between systems and SGBV that we set out above are not mutually exclusive with many respondents having multiple negative experiences. We now move to outline the health impacts of SGBV in forced migration experiences.

Health impacts of SGBV

The combined effects of the continuum of violence and interactions between SGBV, immigration and asylum resulted in high levels of trauma culminating in physical and psychological harms (Goodson et al., 2020 and 2021). Victims reported physical impacts of SGBV, some of which were clearly visible by the marks remaining on their bodies, while others related to psychological and other health problems. Some injuries resulted in permanent health problems. Women talked of bruising and bleeding following attacks, while some were hospitalised. In the longer run, women talked of scarring, gynaecological and urinary problems. Other respondents talked about injuries sustained during their journeys and sexually transmitted diseases. Some respondents were caring for the children of rape. We summarise the health impacts of SGBV below in Table 5.

Table 5 Health impacts of SGBV

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

Both female, male and transgender victims of torture suffered from long-term health issues such as loss of hearing, torture marks, and neurological damage.

“*And till now, I’m under treatment for nerves damage. This is all because of what happened to me years ago. Today, I went to doctor and was prescribed five drugs for my headaches and pain*”
(Syria, male, refugee).

Victims discussed the somatic impacts of SGBV and recognised that one type of impact can act as a driver for another. 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 (ibid). The physical impact of SGBV for some led to psychological problems.

“*I am so tired, psychologically, and physically. I see nightmares every night. I get panic attacks I can’t stop shivering every time I think I might be deported to be killed back home. I am not*”

eating well, but still I am gaining weight.”
(Jordan, female, asylum seeker).

Distress not only affected those who went through the experience, but also their children and extended to family members.

“*So now, it’s not for us, even the children, seven years old, you know, they are thinking about it and they were scared. It’s very difficult, very difficult.*”
(Eritrea, female, asylum seeker)

Male victims reported feeling immense psychological pain when they were unable to protect fellow refugees, especially women and children (Goodson et al., 2021).

At times, the SGBV impacts were compounded by ongoing stress associated with uncertain status for those awaiting the outcome of their asylum application. The need to repeatedly recount distressing experiences of SGBV and torture to evidence their asylum case often left victims feeling re-traumatised but without the support that is generally offered to non-migrant victims of SGBV during and after disclosure.

“*I talked about the torture I faced in Egypt to the Home Office, and I was asked so*”

many times, it really hurts to go into details...

(Egypt, female, refugee)

Respondents reported being routinely treated as 'liars' and 'criminals' (ibid). Several respondents said that the Home Office paid little or no attention to their experiences of SGBV and would not take these into account in decision-making, leaving them feeling helpless.

It was stressful...I think at the end of the interview she was shouting that you're lying that you're this...I was so scared, I was so nervous...I was so scared I was just crying, crying; stressed, everything was on my head at that time...

(Sierra Leone, female, refugee)

Victims needed to stay busy to take their minds off the past but this could be difficult when they spent months or years awaiting a decision and received no psychological support.

Detention was particularly problematic as many respondents complained about inhumane treatment while in detention. Those who were detained had access to very few resources including medication or counselling and found detention exacerbated existing trauma as they had too much time to reflect on terrible experiences.

When I came here, they took me to detention and I spent almost two months [there] and I kept on remembering what happened, what had happened to me in Libya. So, I couldn't forget completely about it because I went into detention.

(Ethiopia, female, refused asylum seeker)

Women victims, in particular, reported that experiences of SGBV had undermined their confidence and had long-lasting impact on their self-image, self-esteem and self-worth, in some cases perpetuating incidents of SGBV (ibid).

To be honest I'm not, I don't have any confidence... because I can't do the thing that I want to do. I'm not

allowed to travel, 15 years in one place. It's hard life. I'm not allowed to do anything.

(Guinea, female, asylum seeker)

Some women reported feelings of guilt and self-hatred, others anger, sadness and loss. Many reported changes in their attitudes toward men, including a loss of sexual desire (ibid). Lack of self-confidence also meant women tended to avoid socialising due to fears of how they might be judged by others. Women who had survived abusive and controlling relationships spoke of isolation and loneliness sometimes related to not being allowed to associate with others for years. On the whole, women tried to stay away from other people because they were either afraid of further attacks or worried that people may find out about their past, leaving them without the extended support networks which are so important for recovery and for integration in a new country (Goodson et al., 2020). Feelings of despair, exacerbated by isolation and loneliness, often manifested in mental health disorders, culminating at worst in suicidal ideation. Several respondents talked of having attempted suicide. In the following section we discuss the barriers to accessing support and SGBV disclosure.

Access to 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 abuse to the police in case they were detained and/or deported.

Service providers reported institutional barriers among forced migrants seeking to access GPs with GP practices rejecting registration without identification, despite the NHS remit to promote universal access to healthcare. We were told that restricted access to healthcare pushed migrants to seek help from Accident and Emergency services, instead of GPs. In case of dispersed migrant SGBV victims, some respondents suggested that health professionals were ill prepared to understand their lived experiences and barriers to accessing services such as moving addresses, language barriers and NRPF.

The importance of confidentiality, informed consent and enabling a victim to disclose in their own time were emphasised by stakeholder respondents. However, in order to access specialist service provision and gain protection within the asylum system and the National Referral Mechanism process, victims needed to share their experiences in detail to demonstrate their eligibility for support. The impact of trauma and lack of awareness among professionals

of how trauma can affect interview processes often undermined claimants' ability to provide the detailed and linear accounts expected by caseworkers.

Similarly, the opportunity to disclose SGBV experience and other traumas to clinicians was often restricted due to the limited duration of medical appointments, with the allocated times insufficient for GPs to build adequate rapport to enable SGBV disclosure. Joint GP appointments for spouses were also considered as limiting opportunities for disclosure. Respondents highlighted that NHS medical charges for overseas visitors deterred migrant populations from seeking healthcare and support, meaning they missed opportunities to identify and support SGBV victims.

In addition, GP respondents reported that they did not receive training about how to communicate with SGBV victims in time sensitive situations. Referral processes were said to be problematic involving the collection of potentially traumatising details and completion of lengthy referral forms. Clinicians required sufficient time to complete these detailed forms with their patients. Despite referral efforts, the acceptance of referrals to NGOs and other services was said to take long time without a guarantee of success. Moreover, we were told about limited provision for, and capacity of mental health support, and lack of awareness among practitioners about the mental health consequences of war-exposure among forced migrant populations.

Barriers to SGBV disclosure and support

We identified a range of barriers to SGBV disclosure and accessing support/help-seeking at individual, organisational and policy levels, as summarised in Table 6. In asking about disclosure, we learned from service providers that the process of disclosing could take years. Language barriers were reported as a major individual barrier preventing people from seeking help and accessing support services (Goodson et al., 2020 and 2021). In addition, reliance on community-based interpreters contributed to users feeling unsafe to disclose and lack of trained interpreters could restrict providers' ability to offer outreach services to forced migrant users.

Table 6 Barriers to accessing support for forced migrant SGBV in the UK

| Individual | Organisational | Policy |
|--|--|---|
| <ul style="list-style-type: none"> • Language barriers • Travel costs • Lack of awareness of rights and entitlements • Lack of knowledge of available services and how to access them • Re-traumatisation associated with intimate examinations • Distrust of service providers • Fear of being ostracised by co-ethnic community or abandoned by their partner • Fear that children will be removed by social services if disclose SGBV • Other immediate priorities such as accessing support with finances, housing and legal status • Unable to meaningfully engage with SGBV support services while continuing to feel unsafe e.g. unsecure immigration status. | <ul style="list-style-type: none"> • Lack of will and/or SGBV awareness among health and asylum professionals • Lack of awareness and application of NHS healthcare charging exemptions • GPs rejecting registrations without proof of address • Lack of knowledge about LGBTQIA+ issues and other forms of discrimination and violence • Limited inter-agency and cross-sectoral coordination • Lengthy referral processes • Lack of funding or restricted resources • Faith spaces welcoming and alienating forced migrant SGBV victims. | <ul style="list-style-type: none"> • Prolonged wait for decision on asylum application • Home Office staff, lawyers and judges involved in decision-making process not adequately informed on the particular needs and experiences of victims of SGBV, including homophobic violence • Lack of gender and trauma sensitivity in asylum interviews • Policies in place to protect vulnerable people from the impact of violence and detention are often inadequately implemented or lack scope • Dispersal policy impacting continuity of care and established relationships with service-providers • Limited access to specialist services in some dispersal locations • Individuals without status unable to access secondary care and counselling. |

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. Individuals residing in the UK were told by abusers that if they reported abuse they would be deported, their children could be taken into care, or they would lose custody. Some said they had not realised what happened to them could be classified as violence, that they were too embarrassed to admit what had happened and they felt disclosure would only make their lives harder especially if co-ethnic people found out about their experiences. 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 (spousal visas or undocumented). Similarly, 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. Most were unaware of counselling services with service providers highlighting that building sufficient trust to enable disclosure and then encourage access to healthcare was an extremely lengthy process.

Workshop participants spoke also about limited inter-agency and cross-sectoral coordination affecting migrant SGBV victims’ access to support, and suggested the importance of increased multi-stakeholder collaboration to draw on specialist skills, avoid duplication and increase the impact of advocacy work, including campaigning for legal and policy change. In particular, the relationship between service providers, Home Office and NGOs was reported as urgently needing improvement so that they could work together to improve safeguarding policies through better coordination. NGO respondents told us that they were not informed of housing decisions by safeguarding hubs³. Moreover, we heard accounts of pressure placed on women to leave their abusive husbands and of inadequate and hasty responses to FGM/C which subsequently separated and traumatised families.

Finally, although faith spaces were said to be both welcoming and a lifeline to welfare support and integration opportunities, they were also described as alienating to victims of SGBV, with some users experiencing shame and lack of acceptance from faith leaders and faith communities. We move on to discuss policy related barriers manifested in the interaction of SGBV and immigration and asylum systems.

Resilience and integration

Despite the accounts of severe vulnerability to SGBV and long-lasting SGBV effects, many respondents exhibited high levels of resilience. Respondents repeatedly outlined the ways that the structural environment undermined their resilience. They pointed to the importance of changing external conditions to maximise their capacity to be resilient. Many attributed their ability to survive to their faith, religious beliefs 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 integrate in the UK (Goodson et al., 2020 and 2021). 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 (ibid). These social networks enabled victims to develop the knowledge about, and the confidence to, access support.

Building bonding relationships, social ties and links with people and organisations, in particular NGOs, were pivotal in creating a sense of security and stability. For some respondents support organisations were critical to victims’ material and psychological survival. Those respondents who had fled to the UK following persecution because of their sexuality struggled to socialise with their wider ethno-national communities, partly because they had lost trust in people. However, they found that LGBTQIA+ support groups and charities

were helpful for rebuilding confidence and social networks.

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 ‘suffer in silence’, because they believed they were not entitled to access welfare services.

³ For instance, we were told about the Home Office not informing NGOs about change of address of their clients/users, in result undermining their welfare and protection. Also, decisions of police without coordination with NGOs on specific cases of their users could lead to rehousing victims with perpetrators.

The 'peculiarity' of awaiting asylum served as a constant reminder of victims' 'foreignness'. Victims described how the process of 'othering', at community and institutional levels, over time led victims to embody an 'outsider' identity that prevented them from feeling a part of UK society (Goodson et al., 2021). Temporary housing and being moved around the country was destabilising for those in the asylum system.

Gaining leave to remain was the biggest boost to victims' resilience and overall wellbeing as opportunities to work, study and access language classes increased their hope for the future and enabled access to social networks (ibid). No longer subject to government dispersal policies respondents with the right to remain in the UK could register with a GP and build a relationship wherein they felt able to disclose their experiences and access a referral to psychological support services, and their children could go to school without fear of being moved away from their friends.

Family reunion was also considered a significant factor for successful settlement and integration (Goodson et al., 2020). While refugees could apply for family reunion and for marriage visas, getting permission for family reunion was both difficult and expensive and dependent on income. Being separated from their family was said to have a significant negative impact on respondents' mental and psychological health.

In terms of integration experiences SGBV could undermine attempts to integrate across the Home Office's Integration Indicators (Ndofor-Tah et al., 2019). The indicator areas could also provide opportunities for protection or recovery from SGBV. Victims talked about poor physical and mental health impacting on ability to integrate. Psychological trauma, for example, affected victims' ability to concentrate and their confidence levels, whilst PTSD meant some respondents were fearful of authority figures

or even males in general. These could prevent victims being able to work and learn. However, access to work, language training and education were also found to offer distraction from past traumas offering hope for the future. Intimate partner violence (IPV) could lead to homelessness and fear of rooflessness sometimes convinced victims to remain with abusers. Good housing provision in safe areas enabled women to leave abuse. Safe houses were needed for trafficked women. Social connections with peers, local people and agencies helped facilitate victims' access to resources needed to move on with their lives and importantly friendships with those who shared experiences could enable empowerment. However, some connections were anti-integrative if peers were controlling and judgemental, stigmatising victims or those individuals who left abusive partners. Connections with LGBTQIA+ communities and acceptance into these networks was profoundly healing for some respondents who had experienced abuse most of their adult lives. Learning language, about UK culture and norms and digital skills helped respondents to integrate but lack of such knowledge and skills could have the opposite effect meaning respondents could not easily communicate with others. Victims found knowing their rights, that they did not have to accept violence and would not be deported for reporting it, was life changing and also sought to know their responsibilities in terms of laws and child rearing as they feared "getting into trouble" with the possibility of deportation. Throughout the UK project we identified low levels of support with integration. Many of the organisations working with victims were "fire-fighting" around immigration cases, access to healthcare and destitution. A complete lack of women specific and SGBV victim specific integration support was noted although some victims had found help through small community organisations or the aid of neighbours.

Way forward

This report has summarised the SEREDA project findings from the research undertaken in the UK. We have outlined the nature of SGBV across migration experience, from pre-displacement, during transit and in resettlement in what we identify as a continuum of violence. Our findings shed light on the specific vulnerabilities associated with the UK asylum and immigration system which was described as trauma and gender insensitive. To improve integration and settlement experiences for 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 among forced migrants is widespread and greater commitments are needed to tackle such violence and support victims' 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. Asylum housing and support contracts must mandate provision of gender-sensitive services and checks must be made to ensure that contractors deliver appropriate services. 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). In the final part of this report we set out recommendations for change identifying key stakeholders who we believe should work to take these forward.

Service providers and victims were asked to suggest recommendations for actions to be taken to reduce/prevent exposure to SGBV and to aid recovery. Victims tended to focus on the situation in their country of origin and the measures that might be taken to prevent the necessity of fleeing. They stressed that people arrived in Europe because they were escaping abuse and that the best way forward would be to prevent the abuse so that people could remain in their home countries. They wanted to see patriarchal gender norms challenged, the end of impunity for abusers and in-country safe havens for victims. Service providers focused more on improved funding and service provision in the UK to meet the needs of victims.

Below we outline recommendations of relevance to stakeholders including the Home Office, Office for Health Improvement and Disparities and the National Health Service suggested by research respondents and participants from the three co-production workshops (introduced in section 2), and generated by the research team in response to findings. We prioritised implementable recommendations organised into areas of responsibility. We begin by outlining the key guiding principles followed by priority actions for improving resettlement experiences for SGBV victims and ensuring that they enjoy genuine refuge in the UK without being exposed to further harms.

Key guiding principles

- 1. Mainstreaming SGBV:** There is a need to appoint an organisation or network with responsibility for the safety of SGBV victims and for gender mainstreaming within the UK immigration and asylum systems.
- 2. SGBV and trauma sensitisation:** Limited SGBV and trauma sensitisation were described within the NHS, Home Office and other statutory services. SGBV training and trauma awareness is needed to improve protection and safeguarding practices.
- 3. Victim-centred and inclusive service delivery:** Victims must be at the centre of service delivery. Services need to ensure availability of trained interpreters, accessible information in multiple languages and access to trauma-sensitive support and asylum services.
- 4. Non-discriminatory approach to forced migrant SGBV victims:** There is a need for fair, humane and non-discriminatory treatment of forced migrant SGBV victims which prioritises the safety and recovery of victims regardless of their legal status. Forced migrant victims must be treated with the same levels of care and compassion as any other SGBV victim.

Recommendations

Asylum and immigration systems and practices

Interviews (Home Office)

- Integrate gender and trauma sensitivity into the asylum system
 - Resource pre-interview support with disclosure, commissioning NGOs to sensitively explain how the system works and the importance of disclosure during interviews
 - Throughout asylum processes review opportunities for identifying health problems and vulnerabilities and ensure correct referral processes are in place
 - Provide training and best practice examples for case workers in trauma sensitivity to support disclosure and discussion of SGBV experiences within interviews
 - Match women claimants with women case workers and interpreters as a default
 - Move away from a culture of disbelief around asylum claimant testimonies by recognising that poor memory and inconsistency are indicators of trauma
 - Identify sensitive and realistic ways in which victims can evidence SGBV experiences
 - Manage the length and frequency of interviews, ensure regular breaks and avoid (repeatedly) asking questions that retraumatise
 - Interview as geographically close to victims as possible and ensure provision of appropriate and trusted childcare
 - Fund post interview counselling for SGBV victims by specialist providers
 - Ensure asylum decision making is undertaken in a timely and transparent manner to avoid claimants turning to negative coping strategies and facing risks of exploitation
 - Regularly check compliance to the guidelines set out in Gender issues in the asylum claim (Home Office, 2018) by undertaking audits
 - Implement an advocacy system wherein independent advocates are permitted to sit in on interviews with potential SGBV victims (subject to victims' consent)
 - Ensure there are safety nets and full access to health services for women refused asylum seekers breaking the relationship between NRPF and exploitation.

Protection from Interpersonal Violence (Department of Health and Social Care, Home Office and NHS England and NHS Improvement)

- 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
- Home Office to provide materials explaining IPV and SGBV to new arrivals in required languages, stating where to get help, and the potential consequences for perpetrators
- Home Office to recognise and minimise the vulnerabilities of women on spousal visas identifying clear routes out of abusive relationships that do not expose victims to risks of deportation
- Recognise that using someone's immigration status as a mechanism of control is coercive behaviour
- Department of Health and Social Care, Office for Health Improvement and Disparities and Home Office to introduce, and raise awareness of, a firewall between statutory services, the Police and UK Visa and Immigration so victims feel sufficiently safe to access services.

Housing and dispersal policies (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
 - Recognise that exploitation may continue in asylum accommodation, identify safety risks and introduce mitigation strategies
 - Adopt a zero-tolerance policy against racism, harassment, homophobia and violence in asylum housing. Penalise providers who do not address these problems
 - Implement safety audits of asylum accommodation which attend to gender sensitivity and implement accountability mechanisms to ensure post-inspection improvements
 - Provide safe houses for the most vulnerable asylum applicants such as LGBTQIA+, trafficked and single mother asylum seekers
 - Ensure face to face welfare support is available in asylum accommodation
- Review dispersal policies making decisions based on continuity of care, access to services and maintenance of support networks for victims
 - Minimise re-dispersal of SGBV victims enabling them to maintain support networks and services
 - Consult victims about dispersal locations and give 28 days' notice to allow preparation including informing support organisations so they can connect victims to services in new locations
 - Avoid lengthy stays in temporary accommodation
 - Ensure that housing providers work to connect victims with local support services
- Ensure that all residents in initial accommodation (IA) and hotels are signposted to their nearest GP and asylum seekers are provided with information in required languages on their right to NHS services, how to register with a GP, how to use NHS services and how to access COVID-19 information and testing services
- Provide direct support to all residents in IA and hotels with pre-existing medical conditions who require a provider to assist a service user to register with a GP.

Integration support (Home Office, Ministry of Housing, Communities and Local Government, 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
- Empower victims through awareness raising on women's rights and support initiatives that promote gender equality in forced migrant communities
- Build the capacity of forced migrant communities to recognise interpersonal violence and utilise reporting mechanisms
- Provide gender sensitive integration support for SGBV victims within Refugee Transitions Outcomes Fund (RTOF) and other integration initiatives
- Encourage initiatives to strengthen victims' social connections and foster trust through social, leisure and educational spaces and networks
- Encourage faith organisations to introduce measures to enable discussions on SGBV, challenge stigma and offer safe spaces to victims
- Ensure all asylum seekers receive timely information and support to access healthcare and are registered with a GP as soon as possible.

Health and social care

Health Policy and Guidance (Department of Health and Social Care, Home Office and NHS England and NHS Improvement, NICE and Royal Colleges and Faculties)

- 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 known about or used
- 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
- UK Health Security Agency to support the development of guidance on identification and treatment of STDs among forced migrant populations and support inclusive access to health
- Office for Health Improvement and Disparities to develop pathways between mainstream support and healthcare services and forced migrant support groups
- National and regional migrant health leads of the Office for Health Improvement and Disparities in partnership with third sector organisations to build on the Asylum Seeker Mental Health and Wellbeing – Contracts Finder to create a resource hub of services at regional and local levels and ensure information updated regularly
- Ensure that the new cross-government National Asylum Seeker Health Steering Group (NASHSG) establishes a forced migrant SGBV task group to review existing policy and practice and identify ways of improving services
- Royal Colleges to provide support and guidance on SGBV and migrant health to enable their members to work effectively with SGBV victims
- Office for Health Improvement and Disparities, Mental Health teams in Department of Health and Social Care, 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. NHS Leadership to implement trauma-informed guidelines
- Office for Health Improvement and Disparities to expand its Migrant Health Guide to provide information about the lived realities of forced migration (i.e. low income and destitution) and SGBV vulnerabilities and set out guidance on how to offer support
- Establish a national language interpreting and translation policy for health and social care in England perhaps adapting the NHS Scotland's strategy
- Increase NHS capacity to offer specialist mental health support to forced migrant victims
- Ensure health concerns are represented at the National Asylum Forum.

Frontline healthcare provision (NHS England and NHS Improvement, Integrated Care Systems, Royal Colleges and Faculties, NHS hospital and primary care services)

- Implement training for health professionals and support personnel to enable them to identify and work with SGBV victims
- Ensure clinical training covers the specific vulnerabilities and needs of forced migrants and especially 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
- Inform all patients about their right to request female clinicians, and to request an interpreter
- Engage interpreters, from outside of the patient's own community, and ensure they are trained to work with SGBV victims
- Develop mechanisms to prevent victims having to make multiple disclosures to different stakeholders and consider safe data sharing protocols to minimise risks of re-traumatisation.

Safeguarding, service development and coordination (NHS, Home Office, Police, NGOs and Local Government)

- NHS England and NHS Improvement to develop safeguarding procedures to facilitate improved communication between stakeholders including: the Home Office, housing providers, local authorities, law enforcement and supporting VCSE/NGO organisations, and to respond to the specific needs of SGBV victims
- 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
- Develop mechanisms to address harmful traditional practices (e.g. FGM/C) in ways that safeguard the wellbeing of families and children
- Provide rehabilitation programmes for perpetrators of SGBV with group and individual therapeutic work focusing on prevention and de-escalation
- Provide sustainable funding for NGOs to support the work they do with SGBV victims
- Develop networks to enable sharing of good practice, expertise, and to foster trust and collaboration between service providers.

Further information

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"Everywhere I go I am 'illegal'."



Governments make it like this."

FORCED MIGRANTS FACE VIOLENCE/MULTIPLE RISKS OVER TIME & PLACE

I HAVE BEEN TREATED LIKE AN ANIMAL
BUT HAVE NO PROOF OF MY EXPERIENCES.



THE MAN ASKS ME 500 QUESTIONS.
I DON'T TRUST THE INTERPRETER.
THEY LAUGH AT ME & I CRY.

UNITED
KINGDOM



ASYLUM SEEKERS



GET RAPED HERE TOO.

I HAVE CHILDREN NOW.
WE LIVE IN HOSTELS.



THE MONEY ISN'T ENOUGH.
I WORRY ABOUT GETTING MY PAPERS.
I HAVE BEEN WAITING FOR FIVE YEARS.

My body
goes white
I nearly die.

I have pain everywhere in my body. I remember what happened to me



MY HUSBAND SAID WE HAD TO LEAVE
I DIDN'T HAVE A CHOICE

He promised
to get me
to Canada.
But he put
me in a
freezer
to the U.K.



UNITED
KINGDOM

I had no ID,
no work,
I exchanged
for sex.

FRANCE

Borders closed.
'Mafia Man' raped
me for 3 days.

THEY NAMED ME 'BLACK'.
A TOURIST FOUND ME.
SOME PEOPLE HELPED ME
TO GET TO FRANCE.

GREECE

I hid in the forest. I had no ID, no food, no sanitary products.
The boys came I couldn't stop them.



SMUGGLERS MADE ME
TAKE THE DINGY.
I SWAM AT NIGHT.
PEOPLE DROWNED.

TURKEY

I had no money.
no status,
I worked in a
beauty salon,
a brothel.
Women were
gang raped.

MY HUSBAND PAID
FOR ME TO GO TO TURKEY
BUT HE KEPT MY BABY.

SUDAN

We hid so
they can't
send us back.
The rapist
came for
my baby.

ERITREA
WAS MY HOME

My father had problems
with the government.

We had to hide from the police.

A family friend raped me.
I bled,
couldn't tell
anyone.

ACTIONS WITHIN COUNTRIES OF REFUGE
& GENDER INSENSITIVE ASYLUM SYSTEMS
CAN PERPETUATE, REINFORCE &
EVEN INTRODUCE NEW HARMS

The
SEREDA
Project

UNIVERSITY OF
BIRMINGHAM

IRIS

HOW CAN HUMANITARIAN
AGENCIES & GOVERNMENTS
MAKE PEOPLE SAFER & OFFER CARE
WHEN THEY ARE MOBILE?