

STUDY

Requested by the FEMM committee



The traumas endured by refugee women and their consequences for integration and participation in the EU host country



Policy Department for Citizens' Rights and Constitutional Affairs
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Abstract

This study was commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the FEMM Committee. The study focuses on the trauma that refugee and asylum-seeking women suffer when reaching their host country. Drawing on an extensive survey of scientific literature, international organisations' reports, websites, press, and discussions with relevant experts, it highlights survivors' different needs and the structural, cultural and psychological barriers to their resettlement in the EU. It argues for coordinated, gender- and culture-sensitive policies, EU collective responsibility in managing the refugee crisis and multi-level interventions from an intersectionality perspective.

This document was requested by the European Parliament's Committee on Women's Rights and Gender Equality (FEMM).

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LIST OF ABBREVIATIONS

CEAS	Common European Asylum System
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
EU	European Union
FGM	Female Genital Mutilation
FRONTEX	European Border Agency
GUE/NGL	European United Left – Nordic Green Left
IOM	International Organisation on Migration
LGBTI	Lesbian, Gay, Bisexual, Trans and Intersex
MEP	Member of the European Parliament
MPM	Multiphase Model
NGO	Non-Governmental Organisation
PICUM	Platform for International Cooperation on Undocumented Migrants
PTSD	Post-traumatic stress disorder
UCHA	United Nations Office for the Coordination of Humanitarian Affairs
UN	United Nations
UNHCR	United Nations High Committee on Refugees
UNODC	United Nations Office on Drugs and Crime
UNICEF	United Nations International Children’s Emergency Fund
VAW	Violence Against Women
WRC	Women’s Refugee Commission

EXECUTIVE SUMMARY

Migration has been part of human history and an ever-growing phenomenon. The number of displaced people worldwide in 2019 was about 79.5 million. Most of them were displaced within their own country (internally displaced persons). Over 30 million are refugees (26 million) and asylum seekers (4.2 million). In the end of same year the number of refugees in the EU was 6,570,500 (this figure does not include migration within the EU).¹ Nearly half of them are estimated to be women. Refugee women flee their countries due to war, abuse of their human rights, poverty and seek refuge in Europe. The common themes in millions of stories and different experiences are loss and violence: loss of loved ones, loss of freedom, status, social and cultural identity, loss of physical and mental health, loss of community and support networks.

Refugee and asylum-seeking women and LGBTI people escape situations of abuse of their human rights (e.g., sexual torture, rape and other forms of gender-based violence). They are exposed to hardships and different types of extreme violence throughout the migration process and in the context of the destination countries. Although migration for women is more difficult due to their lack of means and traditional care duties, the number of refugee women is rising. The trauma generated by such experiences has long-lasting damaging effects on their lives, physical and mental health, and impedes their integration in the destination country.

The fate of refugees in the EU often depends on the constellation of political parties and their attitude to the refugee question. An increasing number of Member States' governments either close their borders (Hungary²) or are opposed to the EU relocation quotas (Hungary, Poland, Czechia and Slovakia)³. At the same time, the EU Member States, which serve as entry points (Italy, Greece, Malta, Spain), have been overwhelmed with the influx of refugees and unable to provide adequate support measures.⁴ The recent European Commission New Pact on Migration and Asylum does not seem that it is going to improve the situation, as shown in the sections 4.2 and 5.2 of this study.

The 'refugee crisis' is instrumentalised by the media that portray refugees as 'illegal' and distinguish between regular and irregular ones for electoral purposes, thus rendering them prey to xenophobic rhetoric.

Gender is a central dimension that merits attention. Women and the LGBTI community are more prone to be victims of violent incidents due to patriarchal structures, cultural factors, and their socio-economic status, while in their countries of origin, as well as during the migration journey and in the post-migration periods.

Race, socio-economic status, and culture intersect with gender and lead to compound discrimination. An **intersectionality approach**, combined with feminist, trauma, and post-colonial analyses, will help understand and capture the multitude of effects traumatic experiences cause for refugee and asylum-seeking women.

Health issues are part of the vulnerabilities of migrant populations because of diseases endemic in the countries of origin, inadequate health care received, and health complications during the migration journey, together with often insufficient health facilities in transit camps and accommodation centres.

¹ UNHCR (2020) Global trends: Forced displacement in 2019. UNHCR Global Data Service. Copenhagen: Denmark.

² <https://www.infomigrants.net/en/post/30148/how-hungary-is-violating-eu-law-on-refugees>

³ Kriesi, H, et al. (2021) Debordering and re-bordering in the refugee crisis: a case of 'defensive integration'. *Journal of European Public Policy*. 28(3):331-349.

⁴ Robbers, G., Lazdane, G. and Sethi, D. (2016) Sexual violence against refugee women on the move to and within Europe. *Entre Nous*. 84.

Besides, traumatic experiences at all migration stages exacerbate physical problems and cause many mental health issues, not least psychiatric disorders, such as post-traumatic stress disorder and depression.⁵ Psychotherapeutic interventions are usually based on European cultural elements and understanding of therapy and do not incorporate different senses of self. As a result, they often act as an impediment to refugee and asylum-seeking women's smooth adjustment to their new reality and acculturation process.

Trauma is correlated with physical and psychological problems. Victims of sexual violence often flee their country of origin and seek refuge in the destination country.⁶ Mental health issues (mainly PTSD, depression, and anxiety) act as significant barriers to seeking treatment, care and support.⁷ Their increased vulnerabilities in the host country, often combined with structural impediments, such as lack of education and literacy, contribute to their poverty and isolation.⁸ Recovery from trauma occurs within a social context that involves reconnection with family, and engagement in everyday, routine activities and integration into the local community.

Gender inequalities and different women's expectations require gender-sensitive responses by the European Member States and all relevant authorities.⁹ In the last decades, a growing body of research has investigated refugees' needs and informed policies designed to meet their needs in the EU Member States. A review of the literature shows that, despite the increasing number of studies, the approaches of data collection do not capture the different needs of refugee women or their diversity. Much more research into the intersectionality of refugee women's disadvantage must be complemented by gender-disaggregated data and more qualitative studies to reveal cultural differences toward effective policies and services.

This study, through a survey of existing evidence (i.e., scientific literature, international organisations and NGO websites, statistics, press articles), seeks to:

- better understand trauma (at all stages of the migration process) through an intersectional lens, and identify refugee and asylum-seeking women's and LGBTI people's needs and areas of intervention;
- look into the interrelation of their lived experience with structural and cultural circumstances in the destination country, which often intensify their trauma and social disadvantage; and
- highlight how policies can simultaneously address structural and cultural barriers, provide trauma relief, and facilitate smooth resettlement through gender-sensitive and multi-level approaches.

Evidence and best practices across the EU and other destination countries inform a set of policy recommendations to this end.

More **interdisciplinary research**, both qualitative and quantitative, into the diverse and complex circumstances of refugee and asylum-seeking women and LGBTI people is required; standard definitions and gender-specific data collection methods throughout the EU should be the starting point of debate on the EU level.

⁵ Robertson, C.L. et al. (2006) Somali and Oromo refugee women: trauma and associated factors. *J Adv Nurs*. 56(6):577-87.

⁶ Robbers, G., Lazdane, G. and Sethi, D. (2016) Sexual violence against refugee women on the move to and within Europe. *Entre Nous*. 84.

⁷ Robertson, C.L. et al. (2006) Somali and Oromo refugee women: trauma and associated factors. *J Adv Nurs*. 56(6):577-87.

⁸ Ibid.

⁹ Robbers, G., Lazdane, G. and Sethi, D. (2016) Sexual violence against refugee women on the move to and within Europe. *Entre Nous*. 84.

A **holistic approach to addressing refugee women's needs is a priority**. Interventions must be multi-level and multi-phased both within the national and the EU context. They must target individuals and groups to improve their physical and mental health and address structural social, economic, and cultural impediments to integration.

Interventions should draw on cultural diversity and harness cultural beliefs and attitudes to enhance healing potential. A better understanding of the specific nature of refugee women's lived experiences will lead to a more **gender-sensitive policy design and services** that meet their needs. Their experience, marked by the prevalence of gender-based violence, is different and must be acknowledged as such.

Health and psychological support **services should be integrated** with housing, employment and education/training policies and welfare provisions to help refugee women regain their self-esteem, confidence, and optimism to make a new start.

Granting asylum and facilitating integration helps coping with trauma experiences. Raising awareness of both the locals and the refugee and asylum-seeking women will **promote a genuine cultural dialogue and lead to a mutually beneficial and harmonious co-existence**.

Policy-making should include bottom-up elements, (i.e., involve migrant women and girls) as well as relevant civil society organisations, all of which can provide useful input regarding migration, asylum and integration policies and risks. **Coordination of all relevant stakeholders and strong political will are indispensable**.

Europe can be the safe haven where traumatised refugee and asylum-seeking women are offered opportunities to recover and thrive. Respecting and celebrating their differences, while building on their shared experiences and common goals through an honest cultural dialogue, refugee and European women can weave together a brighter future for all.

1. INTRODUCTION: CONCEPTS AND ISSUES

KEY FINDINGS

Refugee and asylum-seeking women and LGBTI people face situations in which violation of their rights results in traumatic experiences in their countries of origin, the transition, as well as during integration into the destination EU countries.

Research needs to identify the multifarious factors that generate violence and trauma for these women, while paying attention to the individuality of experience using an intersectional lens of analysis.

Lack of common definitions of all related issues as well as lack of disaggregated data obscure the magnitude and the severity of the problems in areas requiring policy interventions. Data can be interpreted in ways which depend on political priorities.

***“When home turns into hell,
you, too, will run
with tears in your eyes screaming rescue me!
and then you’ll know for certain:
you’ve always been a refugee.”
Kamand Kojouri***

Migration flows have acquired gigantic dimensions in the first two decades of the 21st century. The year 2019 marked the highest recorded number of displaced people, 79.5 million worldwide, who lived in internal or external displacement situations. According to the United Nations High Commissioner for Refugees (UNHCR) at the end of 2019, the number of refugees among the displaced was 26 million.¹⁰ Women form almost half of the migrant population; in 2019, their share was 48%.¹¹

Refugee and asylum-seekers decide to leave their countries because of political, economic, social, and religious reasons, such as war, threats to their life, terror, and gender-based violence by strangers (armed conflict) or family members (forced marriage, sexual assault, honour killings). Their journey may last years. Migrants and refugees experience various forms of violation of their rights and traumatic experiences in their country of origin, during the journey, and after they arrive in the host country. Besides, women, girls, and LGBTI people are often involved in circumstances that are unique to their gender.

Migration takes its toll on migrants’ health, physical and mental. However, refugee women are the most vulnerable. The prevalence rates of mental health disorder are twice as high as those of labour migrants.¹²

This study focuses on the traumatic experiences refugee and asylum-seeking women suffer while reaching, or within their host country. The methods used are a survey of the relevant literature (i.e., academic papers, reports, press articles, and grey literature) on refugees, trauma and related policies

¹⁰ UNHCR (2020) Global trends: Forced displacement in 2019. UNHCR Global Data Service. Copenhagen: Denmark.

¹¹ IOM (2019). *World Migration Report 2020*. Geneva: International Organisation for Migration, p.3.

¹² Rometsch-Ogioun El Sount, C. et al. (2018) Psychological burden in female Iraqi refugees who suffered extreme violence by the 'Islamic State'. The perspective of care providers. *Front Psychiatry*. 9:562.

in Western countries (EU and beyond); data collected by the websites of international organisations, NGOs, and feminist organisations with the most recent indicative figures; finally, some discussions with professionals and policy-makers which provide insight into procedural and practical impediments to implementation.¹³ Numerical data, especially gender-disaggregated ones, are scarce. This paper's aim, limited in its scope, is to focus on the ways in which existing services, or the lack of them, fail to break the cycle of violence, from the country of origin to the destination countries and protect traumatised refugee and asylum-seeking women. Based on research on trauma, policies, and services, it aims to present the interlinked factors that act as barriers to resettlement and call for a holistic approach and multi-level policies. Showing the intersecting causes of disadvantage and the effects of trauma together with several best practices both in the EU and elsewhere leads to some policy recommendations that could contribute to safer and smoother resettlement of refugee survivors of violence in EU countries by addressing their diverse needs.

1.1. Concepts and definitions

In this paper, we adopt the following definitions:¹⁴

Migrant – An umbrella term refers to a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for various reasons. The term includes several well-defined legal categories of people, such as migrant workers, persons whose particular types of movements are legally defined, such as smuggled migrants, and those whose status or means of movement are not explicitly defined under international law, such as international students.

Refugee – A person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of their nationality and unable or unwilling to avail themselves of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.¹⁵

Asylum seeker - A person who seeks safety from persecution or serious harm in a country other than their own, and awaits a decision on applying refugee status under relevant international and national instruments. In case of an unfavourable decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds.

Female asylum seekers who are recognised as refugees in the relevant determination process will be granted refugee status.¹⁶ This category must also include LGBTI people who are equally and often more vulnerable.

According to the 1954 Convention relating to the Status of Stateless Persons, a **stateless person** is a 'person who is not considered a national by any State under its law's operation'. UNHCR estimated that 4.2 million stateless people reported in 76 countries at the end of 2019. Statelessness is an essential issue in the discussion of migration, as it means denial of fundamental rights to those who are not

¹³ Interviews with a migration lawyer, a WHO official, a NGO consultant and a MEP were conducted by the author to verify some of the conclusions and have the actors' insights on processes and practical impediments.

¹⁴ IOM, Key Migration Terms. <https://www.iom.int/key-migration-terms>

¹⁵ UN General Assembly, *Convention Relating to the Status of Refugees*. 28 July 1951, UN Treaty Series. 187:137, <<http://www.unhcr.org/refworld/docid/3be01b964.html>>.

¹⁶ Alam, A. et al. (2019). *Migrant, refugee and asylum-seeking women and girls in Europe*. Strasbourg: Institute of Political Studies.

citizens of the state. Disaggregated data from 28 of the 76 countries showed that in 2019, 51% of stateless people were women, and 48% were children.¹⁷

However, such categorisations are artificial and are used by governments for political purposes. In this paper, the term 'refugee' will be used most of the time, as trauma is a shared experience and official labels are largely irrelevant. The distinction between 'refugee' and 'asylum-seeker' will only be made to demarcate the procedural stage and the part of their journey to the destination country, and entitlement to the services available, if any.

According to Article 3 of the Council of Europe Istanbul Convention on preventing violence against women, **gender** refers to 'socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men'. LGBTI people's traumatic experiences are very similar to those of refugee women; given the limited scope of this study, specific references will only be made when they call for different responses.

Considering differences among refugees contributes to a better understanding of their attitudes, needs and circumstances. Kunz's *kinetic model of refugee theory* differentiates between **anticipatory** and **acute** refugees.¹⁸ The former can anticipate problems and prepare to leave in an orderly manner. The latter leave because of an event that strikes immediately and has no time to prepare for their departure. Although all refugees may have experienced trauma, acute refugees are particularly prone to such experiences. This distinction is helpful in policy formation and implementation of services. Kunz categorisation refers also to **majority-identified**, **event-related** and **self-isolated** refugees, according to whether they left their country because they oppose political or social events, suffer active discrimination of their particular group, or have different personal reasons. The last two types of refugees are usually undocumented, which adds to their difficulty in obtaining the right to remain; most of the times, they are deported.

Trauma

Refugee and asylum-seeking women may experience different traumatic experiences than undocumented immigrant women whose social status is lower. Usually, the former flee from their countries due to war or persecution, and they may be exposed to violence during the journey and to violence in refugee camps and in the country they settle.

Trauma is often confused with **Post-Traumatic Stress Disorder (PTSD)**¹⁹ caused by exposure to a life-threatening injury or situation, or witnessing death during the war, but this is a very narrow way of viewing it.

Trauma is not a disorder but a reaction to a kind of wound caused by actual life events and harmful situations which may happen once or repeatedly.²⁰ It is caused by expressions of violence, such as sexual abuse, racism, discrimination, and can be **complex** or **cumulative**. In the host country, such effects are often exacerbated by structural factors (e.g., poverty, barriers in communication and access to services, education, or employment) and situational factors (e.g., family separation, lack of community support, perceived xenophobia, racism). This multi-dimensional definition of trauma is more comprehensive. It allows us to understand the range of traumatic experiences, their complex

¹⁷ UNHCR (2020) Global trends: Forced displacement in 2019. UNHCR Global Data Service. Copenhagen: Denmark.

¹⁸ Kunz, E. (1981). Exile and resettlement: Refugee theory. *International Migration Review*. 15:42-51.

¹⁹ American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th edition). Arlington, VA: Author.

²⁰ Burstow, B. (2003). Toward a radical understanding of trauma and trauma world. *Violence Against Women*. 9, 1293-1317.

causes (individual or systemic), and effects on migrant women's mental health before, during and after migration.

Trauma in women's experience is often the result of gender-based violence; this is understood as a violation of human rights and a form of discrimination against women because of their gender and shall mean all acts that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.²¹ GREVIO is a group of independent experts²² monitoring the Convention's implementation,²³ which calls for the recognition of gender-based violence as grounds for prosecution of the perpetrators - though this is seldom the practice. Violence against women (VAW) is based on gender inequality, and gender relations affect women at different stages of their lives and generate traumatic experiences. All people who identify as women are prone to VAW.

The WHO codifies gender-based violence as including (but not limited to) the following manifestations: violence by intimate partners and by family members; sexual violence (including rape) by non-partners (e.g. acquaintances, friends, teachers and strangers); trafficking, including for sexual and economic exploitation; femicide (murder of a woman), which takes many forms, among which are intimate partner femicide, honour killings, murder because of dowry and financial matters, murders involving sexual violence; acid throwing; sexual harassment in schools, workplaces and public places, and increasingly also online through the Internet or social media. All the above apply to refugee and asylum-seeking women.²⁴ Although definitions of violence against women and gender roles vary depending on the context, research has demonstrated a pervasive trend of violence across nations and cultures.²⁵

The UN (1984) defines **torture** as 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.'²⁶

The **UN Trafficking in Persons Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children** defines **trafficking in persons** as 'the recruitment, transport, transfer, harbouring or receipt of a person by such means as threat or use of force or other forms of coercion, abduction, fraud or deception for exploitation.'²⁷ Trafficking is often related to sexual and physical violence experiences before during the trafficking process and severe restrictions on personal freedom.²⁸ The trafficking of women and girls for forced prostitution is well-recognised.

²¹ <https://www.coe.int/en/web/gender-matters/council-of-europe-convention-on-preventing-and-combating-violence-against-women-and-domestic-violence>

²² Hossain, M., Zimmerman, C., Abas, M., Light, M., and Watts, C. (2010) The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. *American Journal of Public Health*. 100(12) 2242-49.

²³ Alam et al. (2019). Migrant, refugee and asylum-seeking women and girls in Europe. Strasburg: Institute of Political Studies.

²⁴ WHO (2016a) *Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children*. Geneva: World Health Organisation.

²⁵ Guruge, S., Roche, B. and Catalo, C. (2012) Violence against women: An exploration of the physical and mental health trends among immigrant and refugee women in Canada. *Nursing Research and Practice*. Vol.2012. Article ID 43592, 15 pp. doi:10.1155/2012/434552,

²⁶ <https://www.ohchr.org/en/professionalinterest/pages/cat.aspx>

²⁷ <https://www.ohchr.org/en/professionalinterest/pages/protocoltraffickinginpersons.aspx>

²⁸ Zimmerman, C. et al. (2008) The health of trafficked women: a survey of women entering post trafficking services in Europe. *American Journal of Public Health*, 98(1), 55-59.

This study pays particular attention to **intersectionality** issues. Women are on the receiving end of discrimination based on gender and other dimensions, such as race, ethnicity, sexuality, age, patriarchy, social and economic status. Intersectionality is the theory that examines how all these different socially and culturally constructed categories interact and contribute to perpetuating social inequalities. It argues that forms of oppression (e.g. racism, sexism, disablism) overlap, defining unique social groups, and thus posits that the consequences of disability, race/ethnicity and gender cannot be understood sufficiently by studying these phenomena separately; their overall effects need to be examined by looking into how disability, gender and race/ethnicity structurally interrelate to establish access to resources (both material and relational) or lead to risks for the groups in question.²⁹

The often extreme physical and psychological trauma features are experienced and expressed in culturally unique ways; they start in the refugee and asylum-seeking women's country of origin and continue during the journey and in the host countries.³⁰ Gender-based violence experiences include forced marriages (even of children), child labour, exclusion from education - more generally, various instances whereby women and girls have their bodies controlled and their liberties limited. Women increasingly engage in migration, notably towards Europe from war-torn contexts and oppression zones. They face economic and social difficulties as they are often financially dependent on men and have care responsibilities.

Many of these different factors are not captured by the ways data are collected, and their nuanced outcomes cannot be addressed through routine interventions. Coping with such traumatic experiences can often generate unique strengths. It is part of human nature to adapt to ever-changing situations. Refugee women are not just victims of their circumstances. Through resilience, which comprises the notions of courage, adaptability, and hope, they can be empowered to transform their life. **Resilience**, however, is not a status but a dynamic **process** influenced by circumstances, culture, and individual traits.³¹ Research in the last decades has brought about a paradigm shift in viewing refugee women's resilience. The ability to cope depends on external and internal processes.³² Internal processes comprise existing external support and ways to access it: for instance, location, services, family circumstances, network, and immigration status. External ones relate to women's beliefs and factors such as religion, which help them interpret their experience and reframe it within the specific context each time.

Resilience must thus be treated with caution. There are risks involved when it is seen in isolation from the necessary external support, its provision and responsibility for that support.³³ Most importantly, it should not be taken for granted that severely traumatised women who have endured the journey would always be resilient to cumulative trauma.³⁴ Ideological arguments about individual responsibility can shift the blame to refugees while introducing cuts in state services.³⁵ Refugee women are not a uniform category and must be viewed from an intersectional lens. The importance of community and family is paramount, and there are cultural differences that must be considered when

²⁹ European Parliament (2013) *Discrimination Generated by the Intersection of Gender and Disability. A Study*, Directorate General for Internal Policies, Policies Department C: Citizens' Rights and Constitutional Affairs, Gender Equality, European Parliament, Brussels).

³⁰ Zimmerman, C. et al. (2008) The health of trafficked women: a survey of women entering post trafficking services in Europe. *American Journal of Public Health*, 98(1), 55-59.

³¹ Masten, A.S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56, 227-238.

³² Burstow, B. (2003). Toward a radical understanding of trauma and trauma world. *Violence Against Women*. 9, 1293-1317

³³ Pulvirenti, M. and Mason, G. (2011) Resilience and survival: Refugee women and violence. *Current Issues in Criminal Justice*. 23(1):37-52

³⁴ According to Australian research, refugee women of African background show greater determination to overcome traumatic experiences and exhibit stronger will and better survival skills. See Australian Human Rights Commission (2009) *African Australians: A Report on Human Rights and Social Inclusion Issues*. Discussion paper. Human Rights and Equal Opportunity Commission. Sydney.

³⁵ Pulvirenti, M. and Mason, G. (2011) Resilience and survival: Refugee women and violence. *Current Issues in Criminal Justice*. 23(1):37-52

interventions and policies are being designed. Availability of the relevant infrastructure is essential for resilience-building.

Globalisation and post-colonialism theories contribute significantly to placing migration movements in the bigger picture and highlighting their interrelation with economic and political factors that shaped poorer nations' history and shaped their internal governance.³⁶

1.2. Indicative recent figures

Official statistics distinguish between two groups of forcibly displaced persons: a) refugees and asylum seekers who, according to the 1951 Refugee Convention are defined, as people who have crossed international borders to find safety due to fear of prosecution and b) internally displaced persons (IDPs) who are displaced within their own country.³⁷

According to UNHCR, 79.5 million people were displaced at the end of 2019 because of persecution, conflict, violence, or events seriously affecting public order (e.g., natural disasters).³⁸ It is worth noting that often such factors act in combination. Asylum seekers submitted 2 million new claims worldwide, the majority in the US (301,000 applications), while in the EU, it was Germany (142,500), France (123,900) and Spain (118,300) that received most applications.³⁹

An estimated 123,663 refugees and migrants arrived in Europe via countries of the Mediterranean Sea in 2019.⁴⁰ This figure is lower than the respective figures of 373,650 in 2017 and 185,130 in 2018. In 2019, almost 740,000 applications for asylum were lodged in EU+ countries⁴¹, an increase of 11% compared to 2018. Significantly, top receiving countries, such as France, Italy, Greece and Spain, received more applications in 2019 than during the migration crisis of 2015.⁴²

The International Organisation on Migration (IOM) has since 2002 developed a central management database with information on over 55,000 cases (as of 2019) of trafficking, which contains both quantitative and qualitative data. A significant part of this effort has been the launch of the Counter-Trafficking Data Collaborative (CTDC) in 2017, in partnership with NGOs Polaris and Liberty Shared, which is the first global data hub on human trafficking, with a centralised dataset of over 90,000 cases. In 2016 and 2017, 40,190 victims of trafficking registered were from 147 countries and were exploited in 107 countries. Most of them were women (54%), while 20% were girls, 22% were men, and 5% were boys. Nearly 30% were trafficked into forced labour, while 47% were trafficked for sexual exploitation.⁴³ The United Nations Office on Drugs and Crime (UNODC) has been systematically collecting and analysing data on trafficking for more than a decade.

Over the last decade, more than one million refugees were resettled (with or without UNHCR assistance) from countries that could not provide them with the necessary support; particularly

³⁶ Crosby, A. (2006) The boundaries of belonging: Reflections on migration policies into the 21st century. *Inter Pares Occasional Paper*. No 7. June.

³⁷ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

³⁸ UNHCR (2020) *Global trends: Forced displacement in 2019*. UNHCR Global Data Service. Copenhagen: Denmark.

³⁹ *Ibid.*

⁴⁰ Includes sea arrivals to Italy, Cyprus, Malta, and sea/land arrivals to Greece and Spain (including the Canary Islands). <https://data2.unhcr.org/en/situations/mediterranean>

⁴¹ EU countries plus Iceland, Liechtenstein, Norway and Switzerland.

⁴² EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office, p.57.

⁴³ IOM (2019). *World Migration Report 2020*. Geneva: International Organisation for Migration,

vulnerable women and girls have been part of resettlement.⁴⁴ Lack of disaggregated data does not enable valid conclusions about the percentage of migrant, asylum-seeking and refugee women, as these categories are often conflated.

Europe has been the primary destination for refugees from central Asian and African countries prepared to risk their lives to flee from their countries of origin. In the past few years, most of these refugees enter through Spain, Greece and Italy's shores and come from ten countries – Syria and Afghanistan being the leading countries of origin.

The decision of whether refugees and asylum seekers will stay in a Member State depends on its immigration policy and attitude to refugee and asylum seekers. Despite the efforts to standardise definitions and inform the coordination of policies at an EU level, insufficient implementation at the national level is at the root of the growing abuse of human rights for displaced people. Border controls are linked with population control and minimisation of irregular migration by countries—the stricter the measures, the greater the number of people attempting illegal entry. How much in line are such practices with the EU founding principles?⁴⁵

More and more Member States close their borders due to having disproportionate numbers of refugees and asylum seekers blocked in the entry countries, without moving toward relocation to their destination Member States. Many European states resist settlement of migrants within their territory by introducing strict standards of proof, which often leads to rejection of the asylum claim. Except for Spain, the number of asylum-granting decisions on applications for international protection in the EU+ countries dropped by 11% in 2019 compared to 2018.⁴⁶ The EU has been criticised for focusing on tackling 'illegal migration' instead of protecting human rights.

The first inter-governmentally negotiated agreement to cover all aspects of international migration in a holistic manner was the Global Compact for Migration in 2018.

The United Nations General Assembly mentions: 'We commit to respond to the needs of migrants who face situations of vulnerability, which may arise from the circumstances in which they travel or the conditions they face in countries of origin, transit and destination, by assisting them and protecting their human rights, following our obligations under international law.'⁴⁷

Table 1 below outlines the objectives set out by the UN in terms of migration governance⁴⁸.

⁴⁴ UNHCR (2020) Global trends: Forced displacement in 2019. UNHCR Global Data Service. Copenhagen: Denmark.

⁴⁵ Carrera, S., Blockmans, S., Gros, D and Guild, E. (2015) The EU's response to the refugee crisis – Taking stock and setting policy priorities, CEPS Essay No. 20, CEPS, Brussels, December; Hyndman, J. (2000) Managing differences: Gender and culture in humanitarian emergencies. In J. Hyndman (Ed). *Managing displacement: Refugees and the Politics of Humanitarianism*. Minneapolis. University of Minnesota Press. See also <https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:12016P/TXT&from=EN>

⁴⁶ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

⁴⁷ UNGA (2018). Draft outcome document of the Conference, Intergovernmental Conference to Adopt the Global Compact for Safe, Orderly and Regular Migration. Note by the President of the General Assembly. 30 July. [A/CONF.231/3](#), p.23.

⁴⁸ https://refugeesmigrants.un.org/sites/default/files/180713_agreed_outcome_global_compact_for_migration.pdf

Table 1: Migration objectives

Table 1. Global Compact for Migration objectives by category

1. Specific and relatively straightforward measures	2. Specific but contested issues	3. Very broad and aspirational goals
Improving migration data and research (Objective 1)	Opening wider legal pathways for migrants (Objective 5)	Reducing the negative drivers of migration (Objective 2)
Providing accurate and timely information at all stages of migration (Objective 3)	Managing borders in an integrated, secure and coordinated manner (Objective 11)	Addressing and reducing vulnerabilities in migration (Objective 7)
Ensuring that migrants have proof of their legal identity (Objective 4)	Using detention only as a last resort, and seeking alternatives (Objective 13)	Empowering migrants and societies for full social inclusion and cohesion (Objective 16)
Facilitating fair and ethical recruitment and conditions for decent work (Objective 6)	Providing access to basic services for migrants (Objective 15)	Eliminating all forms of discrimination and promoting evidence-based public discourse (Objective 17)
Saving lives and coordinating efforts on missing migrants (Objective 8)	Investing in skills development and mutual recognition (Objective 18)	Creating conditions for migrants and diasporas to fully contribute to sustainable development (Objective 19)
Strengthening the transnational response to smuggling (Objective 9)	Facilitating return and reintegration (Objective 21)	Strengthening international cooperation and global partnerships (Objective 23)
Preventing, combating and eradicating trafficking in persons (Objective 10)		
Strengthening migration procedures (Objective 12)		
Enhancing consular services for migrants (Objective 14)		
Facilitating remittance transfers (Objective 20)		
Supporting portability of social security entitlements and earned benefits (Objective 22)		

Source: IOM (2019, p.298).

Some of the table's objectives are overlapping and involve both short- and long-term policy responses. For example, Objective 10 on trafficking (a short-term specific goal) can also be seen as part of Objective 7 (an aspirational goal). It is important to note that as a widespread problem, vulnerabilities are seen as broad and aspirational, which translates into more long-term and coordinated policy actions or a policy umbrella, rather than a short-term priority.

It took a long time for refugee women's gendered experience to be recognised. Many legal documents remain gender-blind because recognition of structural gender inequalities by international law is tricky territory.⁴⁹ Gender issues are often ignored or understudied in research into migration. However, the intensification of migrant flows has augmented refugee and migrant women and girls' vulnerability to exploitation, trafficking, discrimination, and different forms of violence.⁵⁰

Despite the above official declarations and careful phrasing, and the increasing share of women refugees coming to Europe in recent years, policies are still lagging in addressing their vulnerabilities and specific needs. There is a pressing necessity to protect women's human rights in their particular circumstances.

⁴⁹ Charlesworth, H. and Chinkin, C. (2000) *The Boundaries of International Law. A Feminist Analysis*. Manchester Juris Publishing, Manchester University Press.
⁵⁰ Alam, A. et al. (2019). *Migrant, refugee and asylum-seeking women and girls in Europe*. Strasburg: Institute of Political Studies.

2. TRAUMATIC EXPERIENCES BEFORE, DURING AND AFTER MIGRATION

KEY FINDINGS

Refugee women encounter traumatic experiences due to extreme circumstances in their countries of origin, treacherous migration journeys, challenging asylum procedures and difficulties of integration in the destination countries.

Women and girls are exposed to particular forms of violence related to their gender, their cultural and socio-economic position and the legal status among other factors.

War, poverty, domestic violence, rape, forced marriage and female genital mutilation are the most common sources of trauma in the countries of origin.

Physical and sexual violence, financial exploitation, threats and hardship increase their vulnerabilities during the migration journey.

Challenges such as settlement, housing, access to employment, health care and education, adjusting to a new culture, language difficulties and xenophobic attitudes are stress-generating factors which combined with higher risk of violence aggravate the existing traumas.

The journey to 'safety' is literal and metaphorical, travel through space and time with strong emotional connotations. Those women escape war, terror, famine and sexual violence to encounter more traumatic experiences during their transit to a place they are seen as aliens. This situation can be overwhelming in every respect.⁵¹

Women are less likely to be subjected to torture than men. At the same time, there is a lack of studies focusing specifically on women's torture experience.⁵²

While there is a host of studies on particular categories of migrant, refugee and asylum-seeking women, there is a dearth of systematic reviews addressing health issues among refugee and asylum seekers.⁵³

While women are less likely to be subjected to torture than men but much more prone to other traumatic events and more associated psychological problems.⁵⁴ The UNHCR Executive Committee states that 'women and girls *can be* exposed to particular protection problems related to their gender, their cultural and socio-economic position, and their legal status, which mean they *may be* less likely than men and boys to be able to exercise their rights and therefore that specific action in favour of

⁵¹ Munt, S.R. (2012) Journeys of resilience: the emotional geographies of refugee women. *Gender, Place and Culture*. 19(5):555-577.; Shishehgar, S., Gholizadeh, L., DiGiacomo, M. and Green, A. (2017) Health and socio-cultural experiences of refugee women: An integrative view. *J Immigrant Minority Health*. 19: 959-973.

⁵² Robertson, C.L. et al. (2006) Somali and Oromo refugee women: trauma and associated factors. *J Adv Nurs*. 56(6):577-87.

⁵³ Heslehurst, N. et al. (2018) Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med* 16(1):89; Asgary, R. and Segar, N. (2011) Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved* 22(2): 506-522. *Project MUSE*.

⁵⁴ Robertson, C.L. et al. (2006) Somali and Oromo refugee women: trauma and associated factors. *J Adv Nurs*. 56(6):577-87.

women and girls *may be* necessary to ensure they can enjoy protection and assistance on an equal basis with men and boys'.⁵⁵

Higher levels of trauma reported in the destination country are caused by a combination of low language skills and education or lack of family and social support and child care.⁵⁶ Attitudes of the local population and dominant beliefs or xenophobic attitudes are also very relevant. Qualitative studies based on in-depth interviews with refugee women in the EU have shown that percentages as high as up to 70% of female migrants and refugees have experienced incidents of sexual violence in certain Member States, compared to 11% prevalence of violence against European women and girls over 15.⁵⁷ Taking into account that gender-based violence incidents are underreported, figures may be even higher.

Studies have suggested that older women with family responsibilities and fewer resources and connections are more vulnerable to violence in the destination country.⁵⁸

Violence against women has been designated a 'global pandemic' by the UN and WHO, with numerous human rights violations and significant repercussions for physical and mental health.⁵⁹ The exacerbation of this phenomenon by the Covid-19 crisis is alarming, and the continuation of lockdown policies will deteriorate the situation.⁶⁰

Violence against women takes many forms in the context of migration. In the case of refugee and asylum seeking-women, it includes manifestations in the country of origin, the journey to the destination country, and the circumstances, processes and attitudes faced after arrival.

2.1. Violence in the country of origin

According to UNICEF, about 650 million women alive today were married before the age of 18, with about 250 million being younger than 15 years of age.⁶¹ 70,000 adolescent girls worldwide die from complications resulting from child and teenage pregnancy. 120 million girls under 20 years of age have been exposed to sexual violence.⁶² 200 million girls in 30 countries have been subjected to genital mutilation, a practice common in some countries in Africa, the Middle East and Asia, which is carried out mainly on girls between infancy and the age of 15 years.⁶³

Girls and women are disproportionately affected by armed conflicts, a problem recognised by the UN in the Security Resolution 1325, which calls for a gender-sensitive approach to conflict resolution. According to UN data, at least 1 in 5 refugees or displaced women are estimated to have experienced

⁵⁵ <https://www.unhcr.org/45339d922.html>, emphasis added.

⁵⁶ Robertson, C.L. et al. (2006) Somali and Oromo refugee women: trauma and associated factors. *J Adv Nurs*. 56(6):577-87.

⁵⁷ Keygnaert I, Vettenburg N., and Temmerman M. Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *Cult Health Sex*. 2012;14(5):505-520; Robbers, G., Lazdane, G. and Sethi, D. (2016) Sexual violence against refugee women on the move to and within Europe. *Entre Nous*. 84.

⁵⁸ Robertson, C.L. et al. (2006) Somali and Oromo refugee women: trauma and associated factors. *J Adv Nurs*. 56(6):577-87.

⁵⁹ <https://www.unwomen.org/en/what-we-do/ending-violence-against-women>

⁶⁰ Domestic violence in France increased by 32% during the first week of the lockdown, in Lithuania by 20% in the first three weeks. Ireland saw a five-fold increase in domestic violence orders and Spanish authorities reported an 18% rise in calls during the first fortnight of confinement see European Commission (2021b) International Women's Day 2021: Covid-19 pandemic is a major challenge for gender equality. Press release. 5. March 2021. https://ec.europa.eu/commission/presscorner/detail/en/ip_21_1011

⁶¹ <https://www.unicef.org/stories/child-marriage-around-world>

⁶² <https://www.unicef.org/mena/press-releases/nearly-one-in-four-adolescent-girls-experience-physical-violence>

⁶³ <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>.

sexual violence.⁶⁴ A WHO report published in March 2021⁶⁵ acknowledges that violence against women is much more prevalent. One in three women has experienced violence. The report does not include refugees, asylum-seekers, undocumented migrants or indigenous women, as it relies on official data. Hence it underestimates the magnitude of the phenomenon. Measuring violence in connection with disability and gender is particularly challenging.⁶⁶

Near-death experiences, homelessness, hunger and thirst and trauma related to family members' violence or unnatural deaths of their loved ones are the main factors impacting refugee women's health before leaving their countries.⁶⁷

Rape is standard practice afflicting women in armed conflict situations in the homeland. It can also be the case in a domestic context in patriarchal societies together with other forms of sexual abuse such as genital mutilation or child marriage. It is also inextricably linked to the 'journey to freedom.'⁶⁸ Qualitative research findings suggest that often rape is planned and systematic and a way of keeping control. It was not until 1998 that rape and sexual torture were recognised as crimes against humanity, war crimes or reasons for granting refugee status.⁶⁹

There is an increased risk of mental ill-health for refugee women due to trauma, especially with depression and PTSD.⁷⁰ Although there are apparent gender differences in mental health conditions, differentiating between pre- and post-migration effects is more complex because of socio-economic backgrounds.⁷¹

2.2. The transition stage

The strengthening of the European borders in 2015 has led migrants from developing countries to resort to illegal routes and pathways to Europe. Smugglers have created additional conditions of gender-based violence during the transition process. Women have reported increased **vulnerabilities related to the migration journey**, including physical and sexual violence, or financial exploitation or threats. Sex has been used as a bargaining chip in migration processes if money is not available.⁷²

The journey for migrant women is an experience that generates fear: fear for women's own life and safety as well as that of their children. Hunger and all types of exposure to the elements, rape, assaults, theft, threats, make the passage traumatic, even for those who had not been traumatised in their

⁶⁴ <https://www.unwomen.org/en/news/in-focus/women-refugees-and-migrants>.

⁶⁵ <https://who.canto.global/b/QR99R>

⁶⁶ Interview with a senior WHO official, 17 March 2021. Consent not given to disclose the name of the source and the source stays with the author.

⁶⁷ Jesuthasan, J. et al. (2018) Near-death experiences, attacks by family members, and absence of health care in their home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study. *BMC Medicine*. 16:15

⁶⁸ It is reported that smugglers and traffickers set use of contraceptives as a condition before the transport.

⁶⁹ Pittaway, E., and Bartolomei, L. (2001) Refugees, race, and gender: The multiple discrimination against refugee women. *Refuge: Canada's Journal on Refugees*. 19(6):21-32.

⁷⁰ Steel, J.L et al. (2017) The psychological consequences of pre emigration trauma and post migration stress in refugees and immigrants from Africa. *J Immigrant Minority Health*. 19:523-32

⁷¹ Hollander, A.C. et al. (2011). Gender-related mental health differences between refugees and non-refugee immigrants: A cross-sectional register-based study. *BMC Public Health* 11, 180.

⁷² Alam, A. et al. (2019) Migrant, refugee and asylum-seeking women and girls in Europe. Strasburg: Institute of Political Studies; Freedman, J. (2016) Sexual and gender-based violence against refugee women: a hidden aspect of the refugee 'crisis'. *Reproductive Health Matters*. 24(47):18-26.

countries of origin. Women and girls travelling alone are particularly vulnerable.⁷³ Survival sex is often the only option to access food for themselves and their children.⁷⁴ Support by non-governmental organisations (NGOs) is not always guaranteed.⁷⁵

Furthermore, after arriving in the host country, they remain at risk of gender-based violence by members of their own family/community and xenophobic strangers. Traumatized male family members may become violent at home and mirror their country of origin's patriarchal relations and cultural beliefs.⁷⁶ There is evidence that refugee women are more exposed to domestic violence than other women, as it is seen as 'normal' in some cultures, and access to services or help is much more difficult.

Amnesty International research in 2016 based on interviews with 40 refugee women and girls who have travelled from Turkey to Greece and the Balkans has shown that they had felt threatened throughout the journey and had experienced physical abuse, sexual exploitation and pressures to have sex by smugglers, security staff or other refugees, as well as financial exploitation.⁷⁷

Females are particularly affected by **trafficking**. In 2018, women accounted for about 50% of victims of trafficking detected globally, with girls accounting for about 19%.⁷⁸ Trafficked women and girls in forced labour or sex work need mental health support, as, like victims of torture, they have no control over their health and mental health. As a result, they are prone to post-traumatic stress disorder (PTSD), depression and several sexually transmitted diseases.⁷⁹ There is scarcity of data on trafficked women. According to the findings of some qualitative studies conducted with women receiving post-trafficking services, the interviewees had experienced sexual violence, threats to their life and restriction of freedom before and during the trafficking period. Sexual violence was also combined with physical violence. The longer the trafficking period, the greater the risk of continuous abuse of women.⁸⁰

Asylum applications can involve lengthy procedures and extended stays in accommodation centres or camps, which increases the vulnerability of female refugees. Transit refugee camps and accommodation centres often do not provide adequate protection from exploitation and violence. There is a high risk for gender-based violence by border guards⁸¹, community members, fellow refugees and even UN peacekeeping forces who are supposed to protect them, as research in relevant Greek and French camps has shown.⁸² Blackmail is often used in refugee camps and practised by security, police officers and other male personnel in exchange for favours, food, documents and the satisfaction of needs. Refugee women are prone to sexual and physical abuse by their husbands while

⁷³ Robbers, G., Lazdane, G. and Sethi, D. (2016) Sexual violence against refugee women on the move to and within Europe. *Entre Nous*. 84.

⁷⁴ Bartolomei, L., Eckert, R. and Pittaway, E. (2014) "What happens there...follows us here": Resettled but still at risk: Refugee women and girls in Australia. *Refugee*. 2:45-56.

⁷⁵ A study of refugee women in Germany reports that women of Syria and Iraq reported receiving help but no other refugees. See Jesuthasan, J. et al. (2018) Near-death experiences, attacks by family members, and absence of health care in their home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study. *BMC Medicine*. 16:15 <https://doi.org/10.1186/s12916-017-1003-5>

⁷⁶ Pittaway, E., and Rees, S. (2006) Multiple jeopardy: Domestic violence and the notion of cumulative risk in refugee camps. *Women against Violence*. 18:18-25.

⁷⁷ <https://www.amnesty.org/en/latest/news/2016/01/female-refugees-face-physical-assault-exploitation-and-sexual-harassment-on-their-journey-through-europe/>

⁷⁸ UNODC (2020). Global report on trafficking in persons. Vienna: United Office on Drugs and Crime.

⁷⁹ Antonopoulou, C. (2006) Symptoms of post-traumatic stress disorder in victims of sex-related trafficking. *Int Psychol Bull*. 10(4):32-37

⁸⁰ Hossain, M., Zimmerman, C., Abas, M., Light, M., and Watts, C. (2010) The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. *American Journal of Public Health*. 100(12) 2242-49.

⁸¹ Pittaway, E., and Bartolomei, L. (2001) Refugees, race, and gender: The multiple discrimination against refugee women. *Refugee: Canada's Journal on Refugees*. 19(6):21-32.

⁸² Freedman, J. (2016) Sexual and gender-based violence against refugee women: a hidden aspect of the refugee 'crisis'. *Reproductive Health Matters*. 24(47)18-26; Freedman, J. (2019). Grand challenges. Refugees and conflict. *Frontiers in Human Dynamics*. <https://www.frontiersin.org/articles/10.3389/fhumd.2019.00001/>

temporarily residing in camps. To avoid incidents of sexual harassment, families often decide to sleep outside camps without any facilities.⁸³

The WRC has found that **lack of adequate information** (including translation and interpretation by female interpreters) is a barrier to women's and girls' ability to express themselves, understand their rights and locate appropriate services to protect themselves.⁸⁴

While Member States recognise gender-based violence as grounds for asylum (Finland, France, Sweden, Portugal even in the form of codified law), implementation is insufficient.⁸⁵ Such experiences are challenging to communicate and prove in practice. In cases where families apply for asylum, female voices are often in the background, and their possible experience of violence can be concealed.⁸⁶

The mainstreaming of gender equality guidelines in both the FRONTEX (European Border Agency) and the Common European Asylum System (CEAS, discussed later) is a positive step. The former has also included gender guidelines in its Fundamental Rights training to increase the gender sensitivity of border guards and improve refugee women's protection.

2.3. Post-migration violence and stressors in the destination country

Destination countries are far from being safety havens for immigrant women.

The long-lasting period as asylum-seekers has a significant psychological impact on women. Moreover, they are exposed to traumatic experiences. The usual stressors of worrying about their families back home and the uncertainty of their future, feelings of guilt, practical everyday problems and access to services exacerbate existing mental health issues.⁸⁷

The first years in the host country is when refugee women must find new coping skills, learn the language, familiarise themselves with the culture and meet basic needs, such as employment, housing, and education. Acquaintance with a new culture often clashes with their own identity and traditional roles, which may cause tension with their community. Relocation comes with the acceptance of new norms.

These are all challenges that lead to frustration and high stress levels, as the path to fundamental human rights is long and full of obstacles. In addition to their pre-migration traumatic experiences, frustration and everyday difficulties cause further stress.

Affordable and good quality housing makes adaptation and acculturation easier.⁸⁸ The necessity for **individual residence** permits has often been highlighted in the literature as shared permits link women with their husbands or partners' situation and create conditions of dependence that usually entail violence and difficulties in reporting violence incidents. A recent report by the Platform for International Cooperation on Undocumented Migrants (PICUM) highlights that the Council of Europe's Anti-Trafficking Convention and the Istanbul Convention require EU states to make available residence

⁸³ Freedman, J. (2016) Sexual and gender-based violence against refugee women: a hidden aspect of the refugee 'crisis'. *Reproductive Health Matters*. 24(47)18-26

⁸⁴ WRC (2016). No safety for refugee women on the European route. Report from the Balkans. New York, NY: Women's Refugee Commission.

⁸⁵ <https://www.coe.int/en/web/istanbul-convention/country-monitoring-work>

⁸⁶ Alam, A. et al. (2019). Migrant, refugee and asylum-seeking women and girls in Europe. Strasburg: Institute of Political Studies.

⁸⁷ A recent study involving care providers to Iraqi refugees in Germany revealed that anxiety about family back home and inability to reunite is the dominant source of stress. See Rometsch-Ogioun El Sount, C. et al. (2018) Psychological burden in female Iraqi refugees who suffered extreme violence by the 'Islamic State'. The perspective of care providers. *Front Psychiatry*. 9:562.

⁸⁸ Shishehgar, S., Gholizadeh, L., DiGiacomo, M. and Green, A. (2017) Health and socio-cultural experiences of refugee women: An integrative view. *J Immigrant Minority Health*. 19:959-973.

permits if this is necessary for protection-related reasons and cooperation with the authorities for law enforcement.⁸⁹

Administrative limitations often impede the implementation of relevant legislation. For instance, some federal states in Germany have introduced residence legislation (regulations) in the form of the decrees to reduce violence risks for migrants. However, criticism has been expressed for the applicability of the procedure, which involves officials not competent in assessing the psychological and long-term consequences of incidents and reluctance on the victims.⁹⁰

Racism and xenophobia in the destination societies are challenges with their own complexities. The impact of immigration on the host countries' demographics makes social integration harder because of the blame of racist and xenophobic shift to refugees who are seen as responsible for unemployment and a burden on the health system. The current Covid-19 pandemic has brought to light such attitudes.

Loss of culture in the host country was seen as positively correlated with post-migration depression. Research from Sweden among African refugees showed that higher levels of depression were positively associated with lack of employment and a bidirectional relationship between traumatic experiences and employment.⁹¹ A significant factor of refugee women's psychological burden is worrying about family back home and reunion prospects.⁹²

⁸⁹ PICUM (2020) *Insecure Justice? Residence permits for victims of crime in Europe*. Brussels: Platform for International Cooperation on Undocumented Migrants.

⁹⁰ PICUM (2020) *Insecure Justice? Residence permits for victims of crime in Europe*. Brussels: Platform for International Cooperation on Undocumented Migrants.

⁹¹ Steel, J.L., Dunlavy, A.C., Harding, C.E. and Theorell, T. (2017) The psychological consequences of pre emigration trauma and post migration stress in refugees and immigrants from Africa. *J Immigrant Minority Health*. 19:523-32.

⁹² Rometsch-Ogioun El Sount, C. et al. (2018) Psychological burden in female Iraqi refugees who suffered extreme violence by the 'Islamic State'. The perspective of care providers. *Front Psychiatry*. 9:562; Gangamma, R. (2017) A phenomenological study of family experiences of resettled Iraqi refugees. *J Marit Fam Ther*. 44:323-35.

3. REFUGEE WOMEN'S HEALTH ISSUES

KEY FINDINGS

Health issues are inextricably related to the process and circumstances of migration. They are part of the vulnerabilities of migrant populations.

Refugee women are prone to diseases endemic in their countries of origin, as well as health complications during the migration journey, together with often insufficient health facilities in transit camps and accommodation centres.

Traumatic experiences in the pre-migration, migration and post-migration stages result in exacerbation of physical and mental health conditions which are often interrelated.

There is a need for more research into the interplay between ill health and context, as well as disaggregated data specific to refugee and asylum-seeking women and the effectiveness of interventions.

The IOM uses terms such as **health vulnerability** and **health resilience** to analyse the health status of migrants and that of refugee and asylum-seeking women more specifically. **Health vulnerability** captures the degree to which an individual is 'unable to anticipate, cope with, resist and recover from the impacts of diseases or epidemics.' It is related mainly to low socio-economic status and other factors, such as trauma and stress, isolation, and insecurity, all associated with the conditions before, during and after the migration journey. **Health resilience** is an individual attribute or skill and a determinant of having access to resources (physical facilities and intangible resources such as social networks).⁹³

The effects of trauma can be physical and psychological. Common symptoms are headaches, dizzy spells, fainting, memory and breathing problems.⁹⁴ Experience of loss, specifically, is related to depression symptoms.⁹⁵ Women often report more substantial health impact due to rape, such as feelings of shame, depression, lack of vitality, loss of sexual interest, breathing problems, feelings of pins and needles.⁹⁶

Circumstances in the destination country aggravate refugee women's health problems.

Poor working conditions, low pay, and mobility restrictions (e.g. in the case of undocumented migrant women) create extreme conditions of health vulnerability. They are related to psychological distress and mental health issues since many migrant women who work in the invisible domestic sector

⁹³ IOM (2019). World Migration Report 2020. Geneva: International Organisation for Migration, p.214.

⁹⁴ Guruge, S., Roche, B. and Catallo, C. (2012) Violence against women: An exploration of the physical and mental health trends among immigrant and refugee women in Canada. *Nursing Research and Practice*. Vol.2012. Article ID 43592.

⁹⁵ Schmidt, M., Kravic, N., Ehlert, U. (2008). Adjustment to trauma exposure in refugee, displaced, and non-displaced Bosnian women. *Arch Womens Ment Health*. 11(4):269-76.

⁹⁶ Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

as carers, for instance, have limited access to sexual and reproductive health services.⁹⁷ The risk of **sexually transmitted diseases** naturally increases with forced sexual intercourse.⁹⁸

Pregnancy-related matters also present migrant women with health vulnerabilities. Reviews have shown that they are at risk of worse pregnancy outcomes in the destination country either because they are not integrated or because they are reluctant or ignorant of services available.⁹⁹

Refugee and asylum seekers are a particularly vulnerable group in **perinatal health**. A systematic review of systematic reviews on the issue found that in addition to adversary pregnancy outcomes among refugee and asylum-seeking women, adverse perinatal outcomes such as maternal mortality, pre-term birth and congenital anomalies) to be more prevalent amongst migrant women than native ones.¹⁰⁰

Risk factors in perinatal mental health issues include stress, lack of adequate social and family support, lack of emotional support from their spouse, adjustment and language difficulties in the host country, as well as inadequate proper pregnancy care support.¹⁰¹ Some systematic reviews have demonstrated a higher prevalence of perinatal mental health disorders, such as postnatal depression and PTSD in asylum-seeking and refugee women.¹⁰²

A body of research has investigated the link between type 2 diabetes mellitus (T2DM) and PTSD. Diabetes is prevalent among ethnic minorities residing in Western countries. Traumatic experiences cause physical conditions, and high-stress levels may lead to inflammation and insulin resistance.¹⁰³ Women were overrepresented among patients with diagnosed type 2 diabetes. Unhealthy lifestyle and enormous pressure during the waiting period and lack of resources to adapt to the new reality are the leading causes.

A systematic review of studies on migrant domestic workers has shown that common health problems, such as musculoskeletal strain, deriving from care giving tasks or respiratory difficulties are caused by exposure to chemicals and infections are related to **sexual abuse in the workplace**.¹⁰⁴ Evidence suggests that other health problems, such as coronary heart disease, arthritis, vaginal bleeding, urinary tract infection, neonatal death, miscarriage, and pre-term delivery, are due to their hardships experienced in their home countries and the journey.¹⁰⁵

⁹⁷ Malhotra, R. et al. (2013). Health issues of female foreign domestic workers: A systematic review of the scientific and gray literature. *International Journal of Occupational and Environmental Health* 19(4):261–277.

⁹⁸ <https://www.unwomen.org/en/news/in-focus/women-refugees-and-migrants>

⁹⁹ Benach, J. et al. (2011). Migration and 'low-skilled' workers in destination countries. *PLoS Medicine* 8(6):e1001043.

¹⁰⁰ Heslehurst, N. et al. (2018) Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med*, 16(1): 89. Nonetheless, the review points out its own limitations – out of the 29 systematic reviews it used, only one focused exclusively on asylum seekers -the rest grouped asylum seekers and refugees with other migrant populations. Additionally, the review emphasised inconsistent use of definitions and limited availability of data.

¹⁰¹ Ibid.

¹⁰² Two systematic reviews, using data from original European studies, have indicated that women who were registered refugees or originated from Africa, Romania, Kosovo and Russia had a significant higher risk of stillbirth, early neonatal mortality and perinatal mortality, compared to native women in the host countries of Norway, Sweden, Ireland and the Netherlands. Female asylum seekers and refugees also demonstrated more incidents of sexual assault, unwanted pregnancies, induced abortion and higher offspring mortality. See Heslehurst, N. et al. (2018) Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med*. 16(1):89.

¹⁰³ Research among asylum seekers in the Netherlands attempted to evaluate the relationship between T2DM and PTSD and confirmed that there is a link. Agyemang, C. et al. (2011) Relationship between post-traumatic stress disorder and diabetes among 105 180 asylum seekers in the Netherlands. *European Journal of Public Health*. 22(5): 658-662.

¹⁰⁴ Malhotra, R. et al. (2013). Health issues of female foreign domestic workers: A systematic review of the scientific and gray literature. *International Journal of Occupational and Environmental Health*, 19(4):261–277.

¹⁰⁵ Kalt, A., Hossain, M., Kiss, L. and Zimmerman, C. (2013) Asylum seekers, violence and health: A systematic review of research in high-income host countries. *American Journal of Public Health*. 103(3):30-42.

Mental health impairments are prevalent in refugee populations.¹⁰⁶ For instance, PTSD is estimated to be ten times more likely than in the general population.¹⁰⁷ PTSD is ubiquitous in refugees -the reasons are threefold: a) experience of severe trauma (mainly accumulated), such as torture, imprisonment, loss of family and friends; b) the asylum process itself, which is often associated with the long wait, the uncertainty of outcome, and adversarial living conditions; c) the difficulties and stress of settling within a new culture, which entails periods of isolation, exclusion, discrimination and racist behaviour.¹⁰⁸ Patients suffer from intrusive thoughts and hyper arousal, expressed as nervousness, difficulty concentrating, and sleep disorders.¹⁰⁹ Asylum seekers whose application is under evaluation more often than not have very stressful life situations which prevent them from benefiting from any treatment.¹¹⁰ Some research has questioned even the possibility of treating severely traumatised refugees, and studies have presented varied outcomes.¹¹¹

The term **bodily distress syndrome** is used to explain somatic symptoms encountered in migrant populations with psychiatric causes.¹¹²

There is an identifiable need for developing methods appropriate for assessing refugees' mental health status. Early health screening and intervention can improve the mental health of refugees. One such screening tool is the 13-item Refugee Health Screener, which has been designed as a brief and culturally sensitive first screener; it assesses symptoms of common refugee disorders, including anxiety, depression and PTSD. The screener has been translated into 17 languages, has been tested with several different refugee groups and is considered widely applicable in refugee populations.¹¹³

The increased rates of mental health issues of refugee women, such as PTSD, anxiety, depression and psychoses¹¹⁴, can be attributed to the pre- and post-migration stress conditions and the asylum-seeking process itself.¹¹⁵ Near-death experiences have been shown to cause long-lasting trauma.¹¹⁶

PTSD is a significant issue highlighted by researchers, with women found to be more likely than men to develop PTSD because of trauma.¹¹⁷ Women asylum seekers and refugees exhibit higher PTSD and

¹⁰⁶ Schmidt, M., Kravic, N., Ehlert, U. (2008). Adjustment to trauma exposure in refugee, displaced, and non-displaced Bosnian women. *Arch Womens Ment Health*. 11(4):269-76.

¹⁰⁷ Fazel, M., Wheeler, J. and Danesh, J. (2005) Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet* 365(9467):1309-1314.

¹⁰⁸ Pfortmueller, C.A. et al. (2016) Adult asylum seekers from the Middle East including Syria in Central Europe: What are their health care problems? *PLoS ONE* 11(2): e0148196.

¹⁰⁹ Rometsch-Ogioun El Sount, C. et al. (2018) Psychological burden in female Iraqi refugees who suffered extreme violence by the 'Islamic State'. The perspective of care providers. *Front Psychiatry*. 9:562.

¹¹⁰ A study of refugees and asylum seekers in Norway has demonstrated that females improved more from PTSD treatment than males, which is in line with other studies. Those who have been violent offenders in a previous extreme situation (conflict, war etc.) responded less well to treatment. See Stenmark, H et al. (2014) Gender and offender status predicting treatment success in refugees and asylum seekers with PTSD. *Eur J Psychotraumatol* 30(5).

¹¹¹ Stenmark, H et al. (2014) Gender and offender status predicting treatment success in refugees and asylum seekers with PTSD. *Eur J Psychotraumatol* 30(5).

¹¹² Buhmann, C. et al. (2015) Follow-up study of the treatment outcomes at a psychiatric trauma clinic for refugees. *Torture* 25(1): 1-16.

¹¹³ Bjärtå, A. et al. (2018) Assessing severity of psychological distress among refugees with the refugee health screener, 13-item version. *Journal of Nervous and Mental Disease* 206(11): 834-839.

¹¹⁴ Thompson, C., Vidgen, A. and Roberts, N. (2018) Psychological interventions for post-traumatic stress disorder in refugees and asylum-seekers: A systematic review and meta-analysis. *Clinical Psychology Review*. 63: 66-79.

¹¹⁵ Evidence from Sweden and the Netherlands in Hollander, AC. et al. (2011). Gender-related mental health differences between refugees and non-refugee immigrants: A cross-sectional register-based study. *BMC Public Health* 11: 180.

¹¹⁶ Jesuthasan, J. et al. (2018) Near-death experiences, attacks by family members, and absence of health care in their home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study. *BMC Medicine*. 16:15.

¹¹⁷ Studies of Bosnian and Kosovar refugee victims of the Yugoslav war have found prevalence of PTSD at 23.5 and 26.3% respectively, while research into Iraqi Kurdish refugees in Sweden showed prevalence at 37%. See Alpak, G. et al. (2015). Post-traumatic stress disorder among Syrian refugees in Turkey: A cross-sectional study. *Int J Psychiatry Clin Pract*. 19(1):45-50; Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

depression compared to men.¹¹⁸ It often takes the form of physical symptoms, such as blurred vision, tinnitus, pain in the stomach, legs and arms, shortness of breath, and there is a strong association with chronic pain.¹¹⁹

According to a systematic review and meta-analysis of 161 articles and the results of 181 surveys involving 81,866 conflict-afflicted people from 40 countries, traumatic events (including pre-migration stress) are associated with depression and PTSD.¹²⁰

Studies have found that up to 50% of asylum seekers have PTSD after surviving combat, torture, rape or mutilation.¹²¹ Methods used in relevant research include self-reported scales for participants to rate their symptoms, psychiatric interviews, or a combination of both.¹²²

Gender-specific aspects are evident in studies, such as Kosovar and African refugees, showing a higher prevalence of PTSD and loneliness in women than men.¹²³ Experience of political violence and internal displacement presents a strong positive correlation with the severity of PTSD symptoms.¹²⁴ War is crucial as a cause of PTSD, with 66% of the women in this study having lived in war conditions. A survey of Syrian refugees in Turkey has found that PTSD is a significant mental health problem in refugee camps, with a higher impact on women exposed to two or more traumatic events and had a history of psychiatric disorder.¹²⁵

Moreover, the complexity generated by different socio-economic, educational and cultural backgrounds of refugees and other migrant groups and the terms through which they have been accepted in the destination country make it difficult to disentangle the consequences of pre-migration and post-migration stress.¹²⁶

Studies have also explored the relationship between PTSD and host country integration. The available evidence suggests that long-waiting asylum granting periods and acculturation difficulties create additional stress conditions.¹²⁷

Most interventions focus on single conditions disregarding the complexity of trauma and the importance of socio-economic factors.¹²⁸ Dealing with the psychological aspects will be impeded by multiple security and employment needs. Nevertheless, the existing evidence is not enough. More

¹¹⁸ Hollander, AC. et al. (2011). Gender-related mental health differences between refugees and non-refugee immigrants: A cross-sectional register-based study. *BMC Public Health* 11, 180.

¹¹⁹ Rometsch-Ogioun El Sount, C. et al. (2018) Psychological burden in female Iraqi refugees who suffered extreme violence by the 'Islamic State'. The perspective of care providers. *Front Psychiatry*. 9:562.

¹²⁰ Steel, Z. et al. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA*. 302(5):537-49.

¹²¹ Summarised in Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

¹²² Alpak, G. et al. (2015). Post-traumatic stress disorder among Syrian refugees in Turkey: A cross-sectional study. *Int J Psychiatry Clin Pract*. 19(1):45-50.

¹²³ Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

¹²⁴ Schmidt, M., Kravic, N., Ehlert, U. (2008). Adjustment to trauma exposure in refugee, displaced, and non-displaced Bosnian women. *Arch Womens Ment Health*. 11(4):269-76.

¹²⁵ Alpak, G. et al. (2015). Post-traumatic stress disorder among Syrian refugees in Turkey: A cross-sectional study. *Int J Psychiatry Clin Pract*. 19(1):45-50.

¹²⁶ A point made by Hollander, AC. et al. (2011) in their discussion of refugee and non-refugee immigrants in Sweden.

¹²⁷ Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

¹²⁸ Successful innovative interventions include trauma-focused psychotherapy (TFP), eye movement desensitisation and reprocessing (EMDR), narrative exposure therapy (NET) and individual cognitive behavioural therapy (CBT). See Thompson, C., Vidgen, A. and Roberts, N. (2018) Psychological interventions for post-traumatic stress disorder in refugees and asylum-seekers: A systematic review and meta-analysis. *Clinical Psychology Review*. 63: 66-79.

comparative research is required to generate robust and disaggregated data on interventions to treat PTSD and the impact of different migration stages on refugee and asylum-seeking women's health.

4. STRUCTURAL AND PSYCHOLOGICAL BARRIERS IN RESETTLEMENT

KEY FINDINGS

Refugee and asylum-seeking women's resettlement and access to services are affected by structural and psychological impediments whose interplay leads to intersectional discrimination which aggravates the effects of their traumatic experiences.

The asylum-seeking process is particularly taxing for women and all professionals involved. Women's stress and their reluctance to reveal their experience of violence meets with professionals' coping mechanisms to deal with the psychological aspect of their work. Cultural bias and reduced empathy and understanding of refugee women's position and often lead to unfair decisions.

Psychological factors and cultural factors, such as trauma, isolation, mental health problems, mistrust and fear interact with structural barriers. Access to essential services such as housing, education, health care, employment is limited by lack of information, acculturation problems, and xenophobia in the local community.

Despite the existing legislation, there is not enough political will to facilitate resettlement and to respect human rights, through co-ordinated efforts and gender-sensitive policies on both the national and EU levels.

Carswell et al. (2011) classify post-migration problems into five main categories: residency determination, health care, welfare and asylum, a threat to the family, adaptation difficulties and loss of culture and support. Access to services is, in theory, granted to refugee women, but services are not uniform in terms of quality and duration and depend on many factors. Navigating the system is not easy in a country with a different culture.¹²⁹

Barriers to access are related to language, lack of information, cultural, social, economic and psychological factors. Violence survivors are reluctant to resort to services, as their vulnerable position may lead to failure of their asylum claims and stigmatisation of themselves and their families among their communities.

4.1. Under-reporting and the culture of silence

¹²⁹ Carswell, K., Blackburn, P. and Barker, C. (2011) The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *International Journal of Social Psychiatry*. 57(2): 107-19.

Under-reporting is a significant issue in different forms of sexual assault and violence. Sex is a taboo subject in many cultures.

Many migrants prefer not to report for several reasons:¹³⁰ fear of stigmatisation, reluctance to relive the traumatic experience when dealing with authorities, lack of trust in authorities, or fear of the impact on their migration status. These conditions are exacerbated in women (including undocumented migrants), as they often live under dependence on their spouses and face economic precarity and employment exploitation.

Under-reporting perpetuates a cycle of violence and exploitation¹³¹ and creates a 'conspiracy of silence' which obscures the degree of prevalence of gender-based violence and the magnitude of the need for services to deal with the conditions which emanate from it: fear, depression, PTSD, insomnia, feeling 'dirty'.¹³² Fear of losing their social networks makes survivors reluctant to report violent incidents, so they suffer in silence.¹³³ Any reaction could cause their excommunication and social isolation in a foreign land. Somatisation is also a very common reaction to violence. Early interventions are needed; healthcare professionals should ask about violence and adopt a holistic approach to treatment.¹³⁴

Severely traumatised people do not want to speak about their dehumanising experiences, especially when they are in another country and culture and even more so if they expect a decision on their status. They, understandably, feel that their asylum-granting process will be affected if they reveal their vulnerability.

For refugee and asylum-seeking women, talking about gender-based violence is even more problematic due to the cruel and debasing nature of rape, trafficking, or torture. They are afraid to talk about it because of the stigmatising effect on them and their family members. Moreover, fear of this appearing on their medical records in the host country can be a deterrent.¹³⁵

Racism is another source of fear which affects all refugees, and silence is cultivated within their communities. Fear of losing community support forces women to adopt traditional roles, and the vicious circle is perpetuated.¹³⁶ Limited access to employment and education impedes refugee women's empowerment to break free.

Single refugee women and mothers are particularly disadvantaged and over-represented in failed asylum cases, as they are perceived as a drain to the host nation's economy.¹³⁷ This group is particularly vulnerable and stigmatised. They become targets for forced marriage and often enter which prove to

¹³⁰ Tankirk, M. and Richters, A. (2007) Silence as a coping strategy: the case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war. In B. Drozdek and J.P. Wilson (Eds). *Voices of Trauma: Treating Survivors across Cultures*. New York. N.Y.: Springer, pp. 191-210.

¹³¹ PICUM (2020). *Insecure Justice? Residence permits for victims of crime in Europe*. Brussels: Platform for International Cooperation on Undocumented Migrants.

¹³² Pittaway, E., and Bartolomei, L. (2001) Refugees, race, and gender: The multiple discrimination against refugee women. *Refuge: Canada's Journal on Refugees*. 19(6):21-32.

¹³³ Tankirk, M. and Richters, A. (2007) Silence as a coping strategy: the case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war. In B. Drozdek and J.P. Wilson (Eds). *Voices of Trauma: Treating Survivors across Cultures*. New York. N.Y.: Springer, pp. 191-210.

¹³⁴ Guruge, S., Roche, B. and Catallo, C. (2012) Violence against women: An exploration of the physical and mental health trends among immigrant and refugee women in Canada. *Nursing Research and Practice*. Vol.2012. Article ID 43592.

¹³⁵ Tankirk, M. and Richters, A. (2007) Silence as a coping strategy: the case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war. In B. Drozdek and J.P. Wilson (Eds). *Voices of Trauma: Treating Survivors across Cultures*. New York. N.Y.: Springer, pp. 191-210.

¹³⁶ Pittaway, E., and Bartolomei, L. (2001) Refugees, race, and gender: The multiple discrimination against refugee women. *Refuge: Canada's Journal on Refugees*. 19(6):21-32.

¹³⁷ Most single refugee women in Europe are from Africa. Asian women usually travel with their husbands. Jesuthasan, J. et al. (2018) Near-death experiences, attacks by family members, and absence of health care in their home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study. *BMC Medicine*. 16:15.

be violent. Others may have fallen pregnant following rape and are ostracised because of the shame they bring to themselves and their families.¹³⁸

Domestic violence in the destination country is on the rise; qualitative research has highlighted different causes. Separation of couples during the journey (often long) and suspicion often triggers husbands' violent behaviour. Loss of status and property leads many people to alcohol abuse and more outbursts of violence. Research has shown that refugee women's adoption of the Western lifestyle can be one of the leading causes of domestic violence because it is perceived as a rejection of their tradition and culture. When divorce is not an easy option because it is not culturally acceptable and may lead to contempt by their community, expressing different views becomes very difficult and risky for refugee women.¹³⁹

Cultural groups have their master narratives related to their history and dominant ideas about gender identity, sexuality, and gender relations, helping them make meaning out of life events. Master narratives are not fixed but dynamic, depending on the context. When women and girls form counter-narratives in the host country, they usually keep them secret and engage in 'cultural censorship'. Survivors of sexual violence adopt this attitude.¹⁴⁰ Group therapy, involving an all-women group of the same or similar culture with a female interpreter, social workers and psychotherapists, seems to be an environment in which women may feel at ease to talk.

4.2. The asylum decision-making process

The **Common European Asylum System (CEAS)** is a legal and policy framework intended to harmonise standards for refugees seeking protection in the EU. It outlines a clear and functional process for applications for protection, a set of common standards for fair and efficient asylum procedures, a set of conditions for a dignified reception of applicants and a set of criteria for granting protection status. After 2005, improvements were implemented and resulted in Directives on asylum procedures, reception conditions, qualifications of third-party nationals requiring protection and criteria for determining the Member State responsible for international protection.¹⁴¹ Proposals for reform of the relevant Directives were made by the European Commission but led to disagreements. In theory, the underlying principle of CEAS is that the EU is an open border zone where countries share the same human values and implement uniform and standard procedures, which are transparent, effective, and equitable.¹⁴² This idealised view is not reflected in the situation's current management. Member States' responses are fragmented and diverse.¹⁴³ There is a tendency of responsibility shifting, culminating in the EU-Turkey Statement¹⁴⁴ as the blueprint for 'managing' refugee displacement.¹⁴⁵ The

¹³⁸ Bartolomei, L., Eckert, R. and Pittaway, E. (2014) 'What happens there...follows us here': Resettled but still at risk: Refugee women and girls in Australia. *Refugee*. 2:45-56.

¹³⁹ Tankirk, M. and Richters, A. (2007) Silence as a coping strategy: the case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war. In B. Drozdek and J.P. Wilson (Eds). *Voices of Trauma: Treating Survivors across Cultures*. New York. N.Y: Springer, pp. 191-210.

¹⁴⁰ For a detailed analysis, see Tankirk, M. and Richters, A. (2007) Silence as a coping strategy: the case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war. In B. Drozdek and J.P. Wilson (Eds). *Voices of Trauma: Treating Survivors across Cultures*. New York. N.Y: Springer, pp. 191-210.

¹⁴¹ Directives:: 1) Recast Asylum Procedure Directive (2013), 2) Recast Reception Conditions Directive (2013), 3) Recast Qualification Directive (2011), 4) Recast Dublin III Regulation (2013) and 5) Recast Eurodac Regulation (2013).

¹⁴² EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

¹⁴³ Ibid. Chapter 5. For case law: <https://caselaw.easo.europa.eu/Pages/default.aspx>

¹⁴⁴ European Council. (2016, March 18). *EU-Turkey statement, 18 March 2016*. <http://www.consilium.europa.eu/en/press/press-releases/2016/03/18/eu-turkey-statement/>

¹⁴⁵ ECRE (2017) Principles for Fair and Sustainable Refugee Protection in Europe. ECRE's vision of Europe's role in the Global Refugee Protection Regime: Policy Paper 2. Brussels: European Council on Refugees and Exiles.

recent (September 2020) **European Commission Proposal for a New Pact on Migration and Asylum**¹⁴⁶ arguably gives the Member States free rein to exhibit selective/flexible solidarity, which enhances division and does not lead to consensus, as it legitimises different Member State responses.¹⁴⁷

The EC Pact claims that it aims to establish transparent, fair, and faster border procedures, accompanied by monitoring and legal safeguards, to assess each individual case in a mutually beneficial way for both applicants and the asylum system. Although it is early days, as the Pact is still under legislative procedure, there are concerns about the impact that fast-track processing of asylum applications might have on a fair and in substance assessment of individual cases. Consequently, possible violence and trauma experiences might be ignored, as applicants are under pressure to provide quick evidence and the rights of appeal are curtailed. Fears have been expressed regarding possible deportations and increased risks for returns to unsafe countries.¹⁴⁸ It might not facilitate quick relocation and reunification with refugee families, particularly in the case of vulnerable groups. Instead, it seems to offer the Member States the option of absolving themselves from their duties by 'sponsoring' capacity-building in the other Member States. This eventually might increase pressure on the entry countries, causing inefficiency in meeting the refugees' needs and exacerbating xenophobia in the local communities on the EU's edges.

The asylum decision-making process's centrality in determining asylum-seeking women's future is a major stress-generating factor that merits special attention. It can be flawed and traumatic for refugee women. All professionals involved are not immune to 'vicarious trauma', the emotional residue that professionals have from working with trauma survivors when they hear their stories and feel the pain, and fear they have experienced. Vicarious trauma leads to stress and task inefficiency.¹⁴⁹ The degree of empathy of the professionals also is affected after some years of service. Research shows that interpreters and NGO staff are more prepared to reflect on their role's emotional demands than immigration judges and legal representatives.¹⁵⁰

One of the main parts of asylum decision-making is the applicant's narration of her story of trauma and fear, which led her to flee her country and seek refuge. There are many procedural stages and numerous actors involved and the process involves certain challenges. The applicant must convince decision-makers of the severe risks of a possible rejection of her claim and not treating the application fairly. Due to the high number of claims and in specific contexts of political rhetoric and ideological or cultural bias, all professionals operate under pressure. From the first interviewers, case workers, NGO representatives, interpreters to the judges, all are prone to making mistakes without feeling accountable.¹⁵¹

Different coping mechanisms on the part of professionals lead to 'case hardening', which means that professionals' detachment grows with time and stories become routine and mundane and are not

¹⁴⁶ European Commission (2020) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and The Committee of the Regions on a New Pact on Migration and Asylum. COM/2020/609 final.

¹⁴⁷ De Bruycker, P. (2020) The New Pact on Migration and Asylum: What it is not and what it could have been. 15 December. Odysseus Network. Special Series of posts on the New Migration Pact. <https://eumigrationlawblog.eu/the-new-pact-on-migration-and-asylum-what-it-is-not-and-what-it-could-have-been/>; Carrera, S. et al. (2015) The EU's response to the refugee crisis – Taking stock and setting policy priorities, CEPS Essay No. 20, CEPS, Brussels, December.

¹⁴⁸ GUE/NGL (2020) The Migration and Asylum Pact. Challenging the European Commission's narrative from the Left. Brussels.

¹⁴⁹ Surawski, N., Pedersen, A. and Briskman, L. (2008) Resisting refugee policy: Stress and coping of refugee advocates. *The Australian Community Psychologist*. 20 (2):16-29. For a thorough investigation of professionals' coping mechanisms see Baillot, H., Cowan, S. and Munro, V.E. (2013). Second-hand emotion? Exploring the contagion and impact of trauma and distress in the asylum law context. *Journal of Law and Society*. 40(4):509-40.

¹⁵⁰ Baillot, H., Cowan, S. and Munro, V.E. (2013). Second-hand emotion? Exploring the contagion and impact of trauma and distress in the asylum law context. *Journal of Law and Society*. 40(4):509-40.

¹⁵¹ Sagy, T (2006) Even heroes need to talk: Psycho-legal soft spots in the field of asylum lawyering. Bepress Legal Series working paper 1014. Available at: <http://law.bepress.com/expresso/eps/1014>.

treated afresh. Moreover, denial lies in the conviction of professionals that they are part of a well-functioning system and that showing emotion is unprofessional. Discussing with peers can consolidate handling cases and lead to embedded trauma within organisations. For some judges, refuge becomes a 'faceless formality of legal principle'.¹⁵²

Moreover, it is presumed that applicants have received advice and guidance from NGOs and legal professionals to base their claim. There is evidence that this is not the case, especially when it comes to legal aid in austerity times.¹⁵³ Moreover, advice by NGOs differs significantly.¹⁵⁴ When it comes to appeals, legal representation is essential. Without it, appellants are bound to be unsuccessful. Several countries, such as Germany, Switzerland and Czechia, have amended their legislation to include free legal advice, counselling and legal representation.

Long periods for registration and lodging have been observed in many Member States; e.g., in Spain and Greece, NGOs have observed bureaucratic delays in registering and lodging an application.¹⁵⁵ The applicant's legal status remains unclear during this period. In Belgium, Fedasil improved the arrival path, making registration and lodging of the asylum application procedures quicker and more efficient; in France and Lithuania, legislation passed in 2019 to improve the asylum procedure, while Germany and Sweden also amended their legislation.¹⁵⁶

Access to information related to the procedure is fundamental; the Asylum Procedures Directive (2013/32/EU) stipulates that the applicant should be informed in a language that they can reasonably understand -this information should be available both at border crossing points and in detention facilities. Information has been insufficient in Hungary and Malta, among other cases. In Belgium, Fedasil has launched a multi-lingual information platform in 12 languages; in Lithuania, recordings were introduced during the initial interview. Interpretation and translation are seen as essential in the asylum procedure. For example, Croatia and Czechia have produced guides for refugees' integration in different languages. Some initiatives have been undertaken to streamline administrative processes, e.g. by integrating information held by various public entities (Germany XAVIA project, or the Asylum Seekers' Register in Latvia).¹⁵⁷

The asylum-granting process is an unequal battle which not only often fails displaced women but also adds to their pre-existing trauma through the complexity of its processes and the vicarious trauma of all professionals involved.

4.3. Dealing with trauma

Starting with some valuable conclusions generated by research on war veterans and arguing for a public health model is insufficient. In refugee and asylum-seeking women, there is a need to incorporate cultural elements and forms of oppression to capture the multidimensional nature of their

¹⁵² Baillot, H., Cowan, S. and Munro, V.E. (2013). Second-hand emotion? Exploring the contagion and impact of trauma and distress in the asylum law context. *Journal of Law and Society*. 40(4):509-40, p. 536.

¹⁵³ Ibid.

¹⁵⁴ Interview with an NGO representative, 20 March 2021. Consent not given to disclose the name of the source and the source stays with the author.

¹⁵⁵ Fundación Cepaim. (2020). *Input to "EASO Asylum Report 2020: Annual Report on the Situation of Asylum in the European Union"*. <https://www.easo.europa.eu/sites/default/files/easo-annual-report-2019-Fundacion-Cepaim-contribution.pdf>; Cyprus Refugee Council. (2020). *Input to "EASO Asylum Report 2020: Annual Report on the Situation of Asylum in the European Union"*. <https://www.easo.europa.eu/sites/default/files/easo-annual-report-2019-Cyprus-Council-for-Refugees-contribution.pdf>; Danish Refugee Council Greece. (2020). *Input to "EASO Asylum Report 2020: Annual Report on the Situation of Asylum in the European Union"*. <https://www.easo.europa.eu/sites/default/files/easo-annual-report-2019-Danish-Refugee-Council-contribution.pdf>

¹⁵⁶ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

¹⁵⁷ Ibid.

trauma and feminist approaches to healing, which consider that the world is not a safe place for women.¹⁵⁸

A **multi-level understanding** of the historical, cultural, political, social, and economic context will provide beneficial insights to policy makers, health and mental health professionals regarding the unique and poly-traumatic lived experiences of refugee women. This knowledge will bridge the 'discord between refugee traumatic migration experiences and available government settlement policies'.¹⁵⁹

Arrival in a foreign country after having left behind family, friends, property, or status, to start a new life is not for the faint-hearted, especially when it is owing to an emergency. The journey enhances trauma, impacting physical and mental health. Long waiting periods to have asylum claims examined contributes to anxiety and depression. A failed asylum claim may mean either return to the country of origin or living in the host country without any support as undocumented immigrants. Often asylum claims are unsuccessful because the advice offered to refugees is not sufficient¹⁶⁰.

Healing can only be the outcome of coordinated efforts by health and mental health professionals. Emphasis should be placed on culturally appropriate mental health services by trained practitioners.¹⁶¹ There is growing acknowledgement of the contribution that victims of trauma themselves can have in the healing process and not rely solely on medication. This tremendous **potential for self-healing** can be harnessed through innovative methods such as physical exercise, relaxation techniques, spirituality,¹⁶² or story narration, to mention but a few.

4.3.1. Psychological interventions

Therapists are faced with many challenges when they work with refugees and asylum seekers because of trauma and the numerous practical problems their patients encounter. Having the possibility to talk about their physical or psychological pain in their cultural frame, using their cultural representations and symbols and female interpreters from their community is crucial for refugee and asylum-seeking women and increase the possibility of effective intervention.

Storytelling has been part of most cultures since ancient times and a method of dealing with trauma. Through narrating their story repeatedly, victims of sexual violence, torture or trafficking view the incident from another perspective and 'edit' it in space and time, which has a desensitising effect that helps the healing process.¹⁶³ Cultural representations are central in psychotherapy, as are 'translation and shifting between cultural universes'.¹⁶⁴ Talking therapies can be problematic because they are based on Western values. Bridges between cultures must be sought through therapeutic interventions.

¹⁵⁸ See George, M. (2010). A theoretical understanding of refugee trauma. *Clinical Social Work Journal*. 38:379-387.

¹⁵⁹ Ibid. p.385.

¹⁶⁰ Interview with migration lawyer, 22 March 2021. Consent not given to disclose the name of the source and the source stays with the author.

¹⁶¹ Steel, J.L. et al. (2017) The psychological consequences of pre emigration trauma and post migration stress in refugees and immigrants from Africa. *J Immigrant Minority Health*. 19:523-32.

¹⁶² *Spirituality* can be seen as non-religious, which is the ability to cope with new situations and shocking experiences or religious, belief in a higher power. See Shishehgar, S et al. (2017) Health and socio-cultural experiences of refugee women: An integrative view. *J Immigrant Minority Health*. 19:959-973.

¹⁶³ Munt, S.R. (2012) Journeys of resilience: the emotional geographies of refugee women. *Gender, Place and Culture*. 19(5): 555-577.

¹⁶⁴ The French ethno-psychoanalysis approach can be an appropriate and innovative method. It uses multicultural group settings and invites the client or the family. Some of the group members have common experiences and one becomes the main interlocutor of the client, while the other members listen and intervene at times. Group settings help in cases of extreme trauma which has caused splitting processes. The harmful effects of the administrative asylum processes must also be dealt with during the therapy sessions. A holding which will allow the reactivation of positive experience is required to reintegrate the self. See Sturm, G., Baubet, T. and Moro (2007)

Moreover, cultural narratives can play a crucial role in creating dissociated parts of the self and help women create spaces in the past, present, and future and retell their story to reintegrate the self in a climate of uncertainty and immense pressure during the asylum-seeking process.¹⁶⁵ This process can be empowering in the right circumstances but not in an environment of racism and social exclusion.

Embracing difference means being prepared to critically approach stereotypical and Western representations of diversity and learn about other cultures. Moreover, in some cultures, the sense of self is collective: it is based on the family and not on the individual.

A warm and welcoming environment contributes to women's willingness to open up and talk about their experiences. A space that feels like a home with refreshments is more inviting and conducive to women's desire to open up during their interviews or therapy sessions. Therapists and interpreters must be women. Similarly, soundscapes and singing can build bridges and create a sense of community¹⁶⁶ to encourage women to focus on the positive aspects of their journey and the future, building on similarities between different cultures.

4.4. Access to services

Article 14 of the European Convention of Human Rights states: "The enjoyment of the rights and freedoms outlined in this Convention shall be secured without discrimination on any ground such as sex, race colour, language, religion, political or another opinion, national or social origin, association with a national minority, property, birth or another status".¹⁶⁷ The rights of refugees are recognised and protected, and so is their access to services.

4.4.1. Housing and accommodation

Having a 'home' is a significant factor for refugee women's smooth resettlement. Accommodation centres in destination countries leave a lot to be desired in facilities and living conditions. They often lack security measures that increase women's vulnerability.¹⁶⁸

Finding suitable housing is a struggle for refugees. Facilitating access to decent housing is crucial in enabling refugee women to settle in the host country. Success depends on their employment situation and lack of prejudice within the local community, as stigma and poverty are the major impediments. Not all Member States have adequate and sufficient social housing.¹⁶⁹

There are plenty of cases where temporary accommodation has reached its limits (e.g. Luxembourg, Malta, Slovenia, Lithuania, Greece, Romania). Efforts to increase capacity have taken place in France, Belgium, Ireland, Cyprus, Czechia, Portugal and the Netherlands. Other initiatives have included municipalities' funding to encourage rentals for international protection individuals (Luxembourg), the

Mobilising social and symbolic resources in transcultural therapies with refugees and asylum seekers: The story of Mr Diallo. In B. Drozdek and J.P. Wilson. *Voices of Trauma: Treating Survivors across Cultures*. New York. N.Y: Springer, pp. 211-31.

¹⁶⁵ Munt, S.R. (2012) Journeys of resilience: the emotional geographies of refugee women. *Gender, Place and Culture*. 19(5): 555-577

¹⁶⁶ Munt, S.R. (2012) Journeys of resilience: the emotional geographies of refugee women. *Gender, Place and Culture*. 19(5): 555-577

¹⁶⁷ Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14*, 4 November 1950, ETS 5, available at: <https://www.refworld.org/docid/3ae6b3b04.html> [accessed 12 March 2021]

¹⁶⁸ Robbers, G., Lazdane, G. and Sethi, D. (2016) Sexual violence against refugee women on the move to and within Europe. *Entre Nous*. 84.

¹⁶⁹ Shisheghar, S., Gholizadeh, L., DiGiacomo, M. and Green, A. (2017) Health and socio-cultural experiences of refugee women: An integrative view. *J Immigrant Minority Health*. 19:959-973.

extension of the stay period for those without adequate financial means, or the provision of financial support (Romania).¹⁷⁰

NGOs in Cyprus, Greece, Poland and Spain have highlighted that recognised beneficiaries are still at risk of homelessness and inadequate living conditions. In addition to discriminatory attitudes in Spain, strict contract requirements in the private market put international protection beneficiaries at a disadvantageous position. Other barriers include requirements for a city or census registration before getting access to social housing, which creates dire circumstances for refugees seeking accommodation.¹⁷¹

4.4.2. Employment and education

Employment and access to education help refugee women transform themselves and adjust to the host country.

Becoming financially independent and economically active in occupations that match the training they had received in their countries of origin is challenging. Failure to do so leads to heightened depression and feelings of helplessness.¹⁷² In addition to improving their income, supporting them to access employment or education/training boosts their self-respect and self-confidence. Community support is vital and is mainly provided by refugee communities, religious institutions and voluntary organisations.¹⁷³

Difficulties of **integration in employment** are also significant and can be seen as 'economic violence' for migrant and refugee women, who are often in precarious occupations in the informal economy. Undocumented migrant women are at a more significant disadvantage, as they are likely to be both dependents on their spouses and exploited in the workplace. They are often in domestic work, which is invisible and does not enable them to be protected by the destination country's labour legislation. Generally, work in private spaces provides circumstances favourable for sexual and economic exploitation and gender, ethnic, racial and other forms of discrimination.¹⁷⁴

Refugee women in the informal economy can also become trapped into smuggling, beggary or servitude by migration agents, criminal organisations, or sex traffickers.¹⁷⁵ Racism and xenophobia permeate all spheres of life. Refugee women undergo discrimination in the labour market and are often treated as second-class citizens. Undocumented migrant women are the most disadvantaged category, with domestic and sex work as the main areas of their labour market activities. The links between the migration process, trafficking and sex work must be further explored and addressed. Their invisibility caused by their 'illegal' existence deprives them of access to health, education and support services. Statelessness generates all sorts of discriminatory and racist practices, as refugee women and their families are the 'other' due to religious, ethnic and cultural differences.¹⁷⁶ Moreover, their over-representation in very low-paid occupations makes it easier for them to find work before their

¹⁷⁰ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

¹⁷¹ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

¹⁷² Bemak, F. and Chung, R.C.-Y. (2017) Refugee trauma: Culturally responsive counseling interventions. *Journal of Counseling & Development*. 95:299-308.

¹⁷³ Allsopp, J., Sigona, N. and Phillimore, J. (2014) *Poverty among refugees and asylum seekers in the UK: An evidence and policy review*, IRiS Working Paper Series, No. 1/2014. Birmingham: Institute for Research into Superdiversity.

¹⁷⁴ https://www.ilo.org/wcmsp5/groups/public/@dgreports/@gender/documents/publication/wcms_101118.pdf.

¹⁷⁵ Benach, J. et al. (2011). Migration and 'low-skilled' workers in destination countries. *PLoS Medicine*, 8(6):e1001043. 3

¹⁷⁶ Pittaway, E., and Bartolomei, L. (2001) Refugees, race, and gender: The multiple discrimination against refugee women. *Refuge: Canada's Journal on Refugees*. 19(6):21-32.

husbands do, which challenges their traditional gender roles. Further erosion of conventional values is brought about by the rapid acculturation of girls who are exposed to two very different cultures.¹⁷⁷ All these lead to tension conducive to domestic violence and re-living of trauma.

The recent Covid-19 pandemic has led to significant job losses; 40% of the 2.2 million women who lost their jobs during the first wave were in low-paid occupations.¹⁷⁸ If one adds the informal economy the figures will be higher, and integration of these vulnerable women will be harder, as was shown by the lower percentage of women who re-entered the labour market in the last two quarters of 2020.¹⁷⁹ The pandemic caused an increase in caring responsibilities for all genders but, due to their traditional roles, refugee women may be affected disproportionately.¹⁸⁰

In 2019, several Member States introduced measures to facilitate asylum applicants' access to the labour market. Examples include Lithuania (right to work if the decision on the application has not been taken within six months), France (access to labour market allowed after six months), Belgium (applicants get the right to work on their residence permit).¹⁸¹ These are positive steps that must be adopted across the EU.

4.4.3. Access to health care

The right to health is a universal human right. The Covid-19 pandemic has revealed the importance of the national health systems, which had been at the centre of political disagreement for decades. Some governments still do not prioritise people's health over economic interests. Right after it acceded to power in July 2019, the Greek conservative government deprived refugees, asylum seekers and undocumented migrants of access to the national health system, except for emergency treatment.¹⁸²

Health care experiences of migrant, refugee and asylum seeker women suffer from: a) negative communication and discrimination issues, which involve insensitive communication, stereotypes, racist beliefs, misunderstandings, and lack of connection with health professionals with an ensuing lack of confidence to express concerns; b) cultural clashes related to lack of understanding of Western medicine and associated pressures (e.g., to take medication inappropriate to their religion); c) limitations in clinical perinatal practice and healthcare, with too much focus on Western technological and procedural approaches and less on the particularities of the patient (e.g., in cases of FGM pregnant migrants.)¹⁸³ Access to psychological support to deal with violence and other traumatic experiences is also critical, yet often lacking.

Barriers to accessing health care among refugees and asylum seekers have been identified in the literature. Barriers that are common among female asylum seekers and refugees include a) organisational barriers, such as language and information access, lack of familiarity with the healthcare

¹⁷⁷ Bemak, F. and Chung, R.C-Y. (2017) Refugee trauma: Culturally responsive counseling interventions. *Journal of Counseling & Development*. 95:299-308.

¹⁷⁸ EIGE (2021) Covid-19 derails gender equality gains. Press release. 5 March 2021. <https://eige.europa.eu/news/covid-19-derails-gender-equality-gains>.

¹⁷⁹ European Commission (2021b) International Women's Day 2021: Covid-19 pandemic is a major challenge for gender equality. Press release. 5. March 2021. https://ec.europa.eu/commission/presscorner/detail/en/ip_21_1011

¹⁸⁰ Ibid.

¹⁸¹ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

¹⁸² The previous left-wing government of Syriza had offered to all people residing in Greece universal coverage of their health needs.

¹⁸³ Heslehurst, N. et al. (2018) Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med* 16(1):89.

system and availability of support services, including entitlements to free health care b) social barriers, such as lack of finance, transport, resettlement problems (e.g., housing, food and employment) combined with social isolation and c) personal and cultural barriers, such as failure to identify symptoms, fatalism, mistrust, absence of female health care professionals, discrimination, stigma and stereotyping.¹⁸⁴

Health concerns have arisen from research into refugee transit accommodation sites. Camps should be seen as temporary and unsuitable for pregnant women and new mothers, survivors of violence due to their gender or sexual orientation. Hygiene conditions are inadequate (e.g., not having separate male and female toilets). Notably, access to reproductive care is limited, with pregnant women often being reluctant to resort to local hospitals for services such as ultrasound. Medication and contraception should be available.¹⁸⁵

Provision of health services differs according to needs. Health screening of people in transit is different from that of permanent residents regarding the range of services and health professionals' availability. Failure to relocate refugees quickly leads to more significant service provision's inefficiency to stranded people.¹⁸⁶ Increasing efforts to relocate them to safer accommodation while improving water quality, hygiene in cramped accommodation facilities is necessary to protect residents' safety.

4.4.4. Integration into the community

In 2019, several EU countries organised initiatives to enhance refugees' integration into communities through various activities, such as open day events and training on discrimination, taking place in schools, police academies and offices.

Information initiatives focus on raising awareness of the rights and obligations of asylum seekers in everyday life of the reception country: France, for instance, published in 2019 information on the functioning of temporary accommodation centres; Lithuania and Czechia organised lectures and seminars for refugees and asylum seekers; Latvia developed video tutorials, while Croatia updated its guide for integration of foreigners.¹⁸⁷

The lack of swift and fair relocation of refugees in all Member States impedes integration into local societies and exacerbates xenophobic and racist tendencies. It also renders it impossible to respect their human rights. As an MEP said: *'Refugees are here to stay, and we must do something to help them settle. Leaving people without access to the local society can cause more deviant and anti-social behaviour. Women are the weakest link in the migrant population and on the receiving end of different types of pressure, especially mothers and young ones'*.¹⁸⁸

¹⁸⁴ Heslehurst, N. et al. (2018) Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med* 16(1):89; Asgary, R. and Segar, N. (2011) Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved* 22(2): 506-522. *Project MUSE*.

¹⁸⁵ WRC (2016). No safety for refugee women on the European route. Report from the Balkans. New York, NY: Women's Refugee Commission.

¹⁸⁶ 'We used to see people only briefly for quick health checks; they didn't want to stop for health services because Greece was just a transit point for them – a place from which they hoped to move on quickly. Now we need to start looking at existing medical conditions, such as depression, anxiety, post-traumatic stress disorder and other mental health-related symptoms, along with pregnancy and disability'. Apostolos Veizis: On the front line of the refugee and migrant crisis in Greece. <https://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/multimedia/articles/apostolos-veizis-on-the-front-line-of-the-refugee-and-migrant-crisis-in-greece>

¹⁸⁷ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

¹⁸⁸ Interview with MEP, 17 March 2021. Consent not given to disclose the name of the source and the source stays with the author.

4.4.5. Identification of vulnerabilities

Identification of vulnerabilities remains challenging, not least when it comes to non-visible vulnerabilities (e.g., psychological consequences of trauma, human trafficking, sexual orientation and gender identity issues, disability). NGOs have repeatedly stressed the need for standard identification procedures in countries such as Austria, Portugal, Switzerland, Ireland and Croatia. UNHCR has also launched a consultation process on the protection of LGBTI refugees.¹⁸⁹

Belgium made significant efforts in 2019 to improve its identification system. In France, special working groups have been set up to elaborate an action plan (to be put into practice in 2020/2021) to detect vulnerabilities and address them during the entire asylum process. The AMIF project has involved a psychosocial team's setup to identify Malta's mental health-related vulnerabilities. In Cyprus, authorities in cooperation with UNHCR and the NGO Cyprus Refugee Council have developed vulnerability screening methods. Vulnerabilities are increasingly recognised, albeit dealt with in a limited way. There have been a few cases (e.g., France and Switzerland) acknowledging FGM and forced marriage practices as a reason for granting asylum.¹⁹⁰

Only a few Member States have taken measures for applicants with special needs, such as minors, cases of FGM-risk girls, trafficking and domestic violence victims, or LGBTI individuals. The Swedish Migration Agency, for instance, introduced new standards for handling forcibly married child applicants; while in France, provisions for the protection of girls at risk of FGM were set in 2019, and the Equality Council commended the sensitivity and professionalism in dealing with women's applications. Finland has published a guide on domestic violence and FGM guidelines for caseworkers. UNHCR praised a report by the Federal Council in Switzerland, highlighting the need for more staff training and increased support for victims of sexual violence.¹⁹¹ Collaboration between UNHCR, the IOM, Médecins du Monde and the Croatian authorities has led to the development of procedures and roles for service providers regarding the prevention and response to sexual and gender-based violence at reception centres. Sweden, the Netherlands, and Belgium have taken steps to produce instructions and monitor the assessment of gender- and sexual orientation-related cases.

¹⁸⁹ <https://www.unhcr.org/news/press/2019/5/5cdd901b7/idahot-unhcr-launching-consultations-lgbti-refugees-rights.html>.

¹⁹⁰ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

¹⁹¹ <https://www.unhcr.org/dach/ch-fr/35280-rapports-feri-un-premier-pas-en-faveur-de-la-protection-des-femmes-refugiees-en-suisse.html>.

5. BEST PRACTICES AND RECOMMENDATIONS

KEY FINDINGS

A number of best practices have been identified at the national level, often involving state and civil society authorities.

Research is needed using both quantitative and qualitative studies to inform policy and individualised coping strategies.

Granting asylum and facilitating integration helps coping with trauma experiences. Raising awareness of both the locals and the refugee and asylum-seeking women will promote a genuine cultural dialogue and lead to a mutually beneficial and harmonious co-existence.

Policy-making should include bottom-up elements, (i.e., involve migrant women and girls) as well as relevant organisations from civil society, all of which can provide useful input regarding migration, asylum and integration policies and risks.

A gender-sensitive and holistic approach is vital to achieve effective policies. Coordination of all relevant stakeholders and strong political will are indispensable.

5.1. Best practices

The Council of Europe Expert Group on Action against Violence against Women and Domestic Violence (GREVIO) has published several baseline reports on implementing the Istanbul Convention, which also covers violence and discrimination against migrant and refugee women. These reports (e.g., on Malta, Belgium and the Netherlands) often identify a lack of gender emphasis on addressing violence (notwithstanding some promising initiatives, such as information provision and awareness-raising).

Many initiatives focus on addressing more explicitly the effects of gender-based violence.¹⁹² In this section, a collection of some best practices is presented in thematic order. Others feature in the relevant sections of this paper. They include initiatives and measures at the Member State level that can be replicated and coordinated joint efforts.

5.1.1. Combating gender-based violence

The project **Equality55**, funded under the EU 'Rights, Equality and Citizenship programme', supports local authorities to include and protect migrant survivors of violence or women classified as being at risk.¹⁹³ Equality is piloted in four partner cities: Brussels, Luxembourg, Rome and Gothenburg, with

¹⁹² <https://ec.europa.eu/migrant-integration/feature/integration-of-migrant-women?lang=fr>

¹⁹³ European Commission (2021a) 2021 Report on gender equality. https://ec.europa.eu/info/sites/info/files/aid_development_cooperation_fundamental_rights/annual_report_ge_2021_en.pdf

each partner city focusing on one topic and developing one specific toolbox (e.g., practical training tools and awareness-raising material on SGBV). The project tools will be disseminated through national and EU city networks with the active support of about 30 'trainee' cities.

Since 2018, the **SURVIVOR Project** in Greece, co-financed by the EU's Rights, Equality and Citizenship Programme, has focused on improving services for refugee and migrant survivors of gender-based violence.¹⁹⁴ The circumstances in which such women and girls live in, and the barriers mentioned above often lead to lack of awareness regarding their rights to services and access to them. The Survivor Website provides toolkits and other resources for agencies and practitioners in Europe supporting the integration and resettlement of refugees.

The Portuguese legal framework recognises acts of torture, rape or other severe forms of physical, sexual or psychological violence as grounds for asylum. It is sensitive to the applicants who are victims of domestic violence, forced marriage and female genital mutilation. Moreover, gender-sensitive reception facilities are also part of the law's provisions to prevent violence.¹⁹⁵

France provides **shelter services for women victims of violence**, managed by specialist organisations, and accommodation for periods ranging from months to several years in dedicated buildings and specialist support. Such practices promote autonomy and the long-term rehabilitation of women. However, GREVIO has called for an extension of these and other care services for migrant women.¹⁹⁶

Austria has had a long history of welcoming asylum seekers. The **Traiskirchen federal refugee reception centre** has been used since the end of WWII and now hosts a unique "women's house" with an all-female staff, including security personnel.¹⁹⁷ Other measures include a women's telephone line with consultations in Arabic, Turkish, Romanian, Bosnian/Croatian/Serbian, German, Hungarian and English.

Denmark has also demonstrated high standards of provision at the Sandholm reception facility. Housing units, medical care, and psychological support are available for all asylum seekers, together with childcare, educational courses, and work placements of short duration. Facility staff are trained in domestic violence. Simultaneously, the asylum procedures address the needs of specific categories of refugees, such as LGBTI and victims of trafficking and identify the necessary support.¹⁹⁸

A recent PICUM report has outlined measures that ten European countries (Germany, Belgium, France, the Netherlands, Spain, Poland, Greece, Italy, Switzerland and the UK) have adopted regarding residence permits. All ten countries except for the UK are part of the Council of Europe's Anti-Trafficking Convention and Council of Europe's Istanbul Convention. Additionally, all are party to the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which guarantees access to justice for all women regardless of residence status. According to the report, all ten countries have legislation to grant residence permits to domestic violence victims on spouse-dependent visas. Simultaneously, in five of them (France, Greece, Italy, the Netherlands and Spain) visas are extended to undocumented survivors, not on a spouse-dependent visa. Moreover, all ten countries have legislation on residence permits for victims of human trafficking. Except for France, the

¹⁹⁴ Ibid.

¹⁹⁵ GREVIO (2019b). GREVIO baseline evaluation report- Portugal. Strasbourg: Council of Europe.

¹⁹⁶ GREVIO (2019a). GREVIO baseline evaluation report- France. Strasbourg: Council of Europe.

¹⁹⁷ GREVIO (2017a). GREVIO baseline evaluation report- Austria. Strasbourg: Council of Europe.

¹⁹⁸ GREVIO (2017b). GREVIO baseline evaluation report- Denmark. Strasbourg: Council of Europe.

Netherlands, and Switzerland, specific legislation is making available residence permits for labour exploitation victims with legal penalties in the remaining countries.¹⁹⁹

European countries have joined forces to work against trafficking. In October 2019, the European Crime Prevention Network (EUCPN) and European countries launched a long-term campaign to address people who may have become victims of trafficking who need support, assistance and protection.²⁰⁰

5.1.2. Health and mental health initiatives

The Swiss government provides mandatory health coverage for all asylum seekers that can register with a general practitioner free of charge.²⁰¹ The previous Greek government (2015-19) offered access to the National Health System to all migrants.

The EU authorities developed the **ORAMMA** project to address the maternal health needs of migrant women during the increasing influx of migrant population, which reached its height of 1,015,000 people in the period 2014-19. It responded to evidence that migrant women showed poor health outcomes during the perinatal period by developing an innovative inter-professional approach, including recruiting volunteer maternity assistants to help migrant pregnant women.²⁰² Such initiatives must be replicated in all Member States.

Confronting cumulative trauma, especially during the asylum-seeking process, is particularly challenging for therapists.²⁰³ Transcultural therapies have shown to be beneficial. Different cultural symbols and frames can help traumatised women renegotiate their position in a new social, cultural and religious setting.

The **Migrant Women Association Malta (MWAM)** is a civic and advocacy organisation for the social and economic promotion of asylum seekers, migrants and refugee women in the Maltese Islands. Their 18-month project 'Better Future' has implemented a mental health framework to support refugees and migrant women victims of violence; this is based on the victim's perspective and involves training interpreters and practitioners to provide support.²⁰⁴

The **Multiphase Model (MPM)** of Psychotherapy, Counselling, Social Justice and Human Rights is a culturally responsive model of affective, cognitive and behavioural intervention specifically designed for refugees to meet their needs, including those related to trauma. Awareness and understanding of the culture and value system of their clients' experiences and beliefs, and political countertransference, are necessary for the successful implementation of MPM. It comprises five phases: mental health education, individual/group/family psychotherapy, cultural empowerment, indigenous healing and social justice and human rights.²⁰⁵

¹⁹⁹ PICUM (2020) *Insecure Justice? Residence permits for victims of crime in Europe*. Brussels: Platform for International Cooperation on Undocumented Migrants.

²⁰⁰ <https://eucpn.org/preventhumantrafficking>

²⁰¹ Pfortmueller, CA. et al. (2016) Adult asylum seekers from the Middle East including Syria in Central Europe: What are their health care problems? *PLoS ONE* 11(2): e0148196.

²⁰² ORAMMA (2017) *Approach to Integrated Perinatal Healthcare for Migrant and Refugee Women*. Operational Refugee and Migrant Maternal Approach., deliverable D4.2.

²⁰³ Sturm, G., Baubet, T. and Moro (2007) Mobilising social and symbolic resources in transcultural therapies with refugees and asylum seekers: The story of Mr Diallo. In B. Drozdek and J.P. Wilson (Eds). *Voices of Trauma. Treating Survivors across Cultures*. New York. N.Y: Springer, pp. 211-31.

²⁰⁴ <https://migrantwomenmalta.org>.

²⁰⁵ Bemak, F. and Chung, R.C-Y. (2017) Refugee trauma: Culturally responsive counseling interventions. *Journal of Counseling & Development*. 95:299-308.

5.1.3. Training and employment

The Swedish project **Mirjam**, also funded by the ESF, aims at empowering refugee women with job-related support; through small coaching groups and visits to workplaces, newly-arrived refugee women learn about the Swedish labour market, opportunities and financial support for studies, work/life balance and relevant issues.²⁰⁶

The Slovenian programme **Razkrite roke 3**, funded by the ESF, brings together immigrant women, mainly from former Yugoslavia, to improve their employability and language skills.²⁰⁷

The European Social Fund for Germany programme '**Strong in the workplace – Migrant mothers get on board**' helps immigrant mothers' labour market integration. Many projects aim to support them, improving access to the labour market and raising awareness of businesses that might not appreciate their qualifications and potential.²⁰⁸

A noteworthy initiative is the **Employer Tailored Chain Cooperation**, which brings together organisations from seven countries (Belgium, Cyprus, France, Germany, Italy, the Netherlands and the United Kingdom), applicants and individuals who enjoy international protection. The project, funded by the Asylum, Migration and Integration Fund (AMIF) seeks to tailor the skills of applicants and the needs of employers and create long-term, sustainable employment.²⁰⁹

The project **Participation and Language** in the Netherlands informs applicants about possibilities for language learning, volunteering, social networks and acquaintance with the Dutch culture. Other initiatives for information provision and training have taken place in Cyprus, Latvia, Malta, Croatia and France. Initiatives in Sweden for labour market integration and mentoring programmes in Austria were explicitly designed for migrant women. Still, barriers are significant and include limited language training and lengthy bureaucratic procedures.²¹⁰

Generation 2.0 in Greece provides legal counselling and intercultural mediation, career counselling, non-formal education and advocacy to migrants, refugees and asylum seekers. In partnership with the humanitarian organisation International Rescue Committee, they have launched the programme '**Facilitating Access to Work for Vulnerable Populations in Athens**'. This empowers refugees and asylum seekers to enter the Greek and European labour markets by mobilising employers and offering job opportunities. To raise awareness about the challenges related to lawful residence, they designed an interactive map that displays the gaps and challenges in a digestible way and could serve as a model for similar awareness campaigns²¹¹ (see Figure1).

²⁰⁶ <https://ec.europa.eu/esf/main.jsp?catId=46&langId=en&projectId=2799>

²⁰⁷ <https://ec.europa.eu/esf/main.jsp?catId=67&langId=en&newsId=2657>

²⁰⁸ <https://www.esf.de/portal/EN/Funding-period-2014-2020/ESF-Programmes/bmfsfj/strong-in-the-work-place.html>

²⁰⁹ <https://www.fedasil.be/en/news/awareness/launch-european-project-employment-applicants-international-protection>

²¹⁰ EASO (2020) *Annual Report on the Situation of Asylum in the European Union 2020*. Luxembourg: European Asylum Support Office.

²¹¹ <https://g2red.org>

Figure 1 Mapping of the challenges in lawful residence. Interactive map



Source: <https://g2red.org/mapping-of-challenges-in-lawful-residence/>

The **RAJFIRE (Network for the Autonomy of Women Immigrants and Refugees)** in France provides migrant women with information and support on administrative, legal and social issues. They organise their activities using the Maison des Femmes de Paris, a space where feminist associations (including the ADFEM collective for exiled and migrant women) come together.²¹²

The **Lighthouse** in Spain assists migrant women in their social and economic integration through training and contacts with educational, health and social services.²¹³

5.2. Policy Recommendations

'We, as Europeans, need to move beyond political frustrations and bargaining and work towards minimizing barriers for people who have fled some of the most violent conflicts, persecution and extreme forms of poverty of our time'. Apostolos Veizis²¹⁴

The problem of trauma in refugee populations and the necessity of addressing it is widely acknowledged, albeit usually in a gender-blind manner. There are some coordinated actions on EU and global levels.

The **Strategy and Action Plan for refugee and migrant health in the WHO European Region** addresses refugees' exposure to violence and stigmatisation. It suggests the systematic elimination of discrimination and the deployment of health assessment to identify violent incidents and address the health needs related to sexual and reproductive health, gender-based violence, rape management,

²¹² <http://rajfire.free.fr>

²¹³ <https://www.fundaciosalutalta.org/que-fem/proyecto/proyecto-far>

²¹⁴ Apostolos Veizis, Director of the Medical Operational Support Unit for Médecins Sans Frontières (MSF) in Greece. See Apostolos Veizis: On the front line of the refugee and migrant crisis in Greece. <https://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/multimedia/articles/apostolos-veizis-on-the-front-line-of-the-refugee-and-migrant-crisis-in-greece>

forced marriage, adolescent pregnancy and mental health.²¹⁵ It highlights the need to prevent and manage physical and psychological trauma among refugees, which happens both in the countries of origin and during the migration journey.²¹⁶

The **WHO Global Plan of Action to strengthen the role of the health system within a national multisectoral response to interpersonal violence, in particular against women and girls and children**, recommends the strengthening of intersectoral coordination, including coordination within the health system.²¹⁷

The **WHO Action Plan for sexual and reproductive health** makes several recommendations:

- to adopt legislation that safeguards reproductive health choices free from coercion and violence;
- to amend legislation and adopt broad definitions of sexual assault, sexual violence and rape that cover such incidents in all forms of relationships;
- to raise awareness as to the role of the health system and of society overall in preventing sexual violence;
- to address the root causes of sexual violence, such as gender inequality and socio-cultural norms that tolerate violence and empower women and young people, ensuring adequate sexuality education, and combating negative male gender roles and stereotypes linked to the use of violence;
- to enhance the capacity of health care providers to detect and address intimate partner violence against pregnant women.²¹⁸

In public debates of recent years, migration has been a **topic of discussion for electoral purposes** rather than a constructive enquiry into the lives of migrants and the adoption of effective policies.²¹⁹ Often the increasing number of refugees and asylum-seekers are viewed by governments as a threat they must deter using measures such as immediate detention and regionalisation of solutions at Member State level. Rising xenophobia in the population is even more worrying and calls for measures aiming at raising public awareness.

Violation of human rights during the entire migration process, including the journey and while in refugee camps, deserves special attention, and impunity should cease for the responsible parties. The only approach which is adequate and appropriate would be the **human rights approach**, adopted in this study because it goes beyond legal categories, divisions and a dichotomous logic.

The following sections outline the pillars of such an approach making policy recommendations that can act simultaneously at different levels to deal with intersectional discrimination of refugee and asylum-seeking women and LGBTI people.

²¹⁵ https://www.euro.who.int/__data/assets/pdf_file/0004/314725/66wd08e_MigrantHealthStrategyActionPlan_160424.pdf

²¹⁶ Ibid.

²¹⁷ WHO (2016a) Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneva: World Health Organisation.

²¹⁸ WHO (2016b) Action Plan for sexual and reproductive health. Copenhagen: WHO Regional Office for Europe.

²¹⁹ Alam, A. et al. (2019) Migrant, refugee and asylum-seeking women and girls in Europe. Strasburg: Institute of Political Studies.

5.2.1. Research and Data

'The data are very silent when it comes to refugee and asylum-seeking women'.²²⁰

Data are often conflating the different categories of female asylum seekers and refugees with female migrants - with resulting limitations of research outcomes and obfuscating gender vulnerabilities. Policy-makers must urgently disentangle the different categories conceptually and identify specificities to develop targeted interventions. **Data need to be disaggregated** by age and gender to provide more utility and more information for policy responses and relevant practices.²²¹

There is currently limited **research** into how trauma experiences affect health outcomes. More research (both quantitative and qualitative) into correlations between trauma (including those that are trafficking-related)²²² and health is necessary. More specifically identification of the mechanisms through which traumatic experiences are translated into negative health outcomes, as well as the intermediary factors that come into play should be pursued. Such research is crucial for intervening in the right way to address and prevent undesired health outcomes.

Research methods could be a) quantitative measures of post-traumatic and somatic symptoms, together with a questionnaire of social adaptation in the host country and b) qualitative semi-structured interviews to address differential needs and develop comprehensive and customised recommendations for social-psychiatric assistance.²²³ Appropriate methodologies are to be developed to collect data about health and violence among this vulnerable population.²²⁴ They could contribute to the study of association (if any) of symptoms with types of violence.²²⁵

Refugee and asylum-seeking women constitute a highly vulnerable group. In order to capture the experience of their traumatic, physical, emotional, and metaphorical journey, there is a clear need for **interdisciplinary** large-scale studies that can lead to reliable data and inform effective policies. More research into vulnerable groups, such as undocumented migrant women, is required.

Recognition of gender-based violence and **standard definitions** are indispensable for a coordinated range of policy measures for traumatised refugee women. Definitions must be accepted internationally and inform policies at both the EU and global levels. They cannot be left to the discretion of individuals from different backgrounds, with diverse experiences, views, and attitudes regarding gender.

²²⁰ Interview with a senior WHO official, 17 March 2021. Consent not given to disclose the name of the source and the source stays with the author.

²²¹ Kalt, A. et al. (2013) Asylum seekers, violence and health: A systematic review of research in high-income host countries. *American Journal of Public Health*. 103(3): 30-42; Shishegar, S. et al. (2017) Health and socio-cultural experiences of refugee women: An integrative view. *J Immigrant Minority Health*. 19:959-973.

²²² Zimmerman, C. et al. (2008) The health of trafficked women: a survey of women entering posttrafficking services in Europe. *American Journal of Public Health*, 98(1), 55-59.

²²³ Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

²²⁴ Kalt, A., Hossain, M., Kiss, L. and Zimmerman, C. (2013) Asylum seekers, violence and health: A systematic review of research in high-income host countries. *American Journal of Public Health*. 103(3):30-42.

²²⁵ Guruge, S., Roche, B. and Catallo, C. (2012) Violence against women: An exploration of the physical and mental health trends among immigrant and refugee women in Canada. *Nursing Research and Practice*. Vol.2012. Article ID 43592.

5.2.2. A holistic, culturally- and gender-sensitive approach

It is imperative to stop treating refugee and asylum-seeking women in international organisations reports and documents as a uniform category and adopt approaches that **acknowledge their diversity** in terms of traumatic experiences and needs.²²⁶

Migrant and refugee girls must be recognised as a separate group rather than as part of the children group, which risks making the gender-specific aspects of violence less visible. Simultaneously, they should be seen as a homogeneous group and individuals with diverse experiences.²²⁷

These interventions must go beyond the generic needs of the group of female refugees or asylum seekers and address the **individual's circumstances** in question. Providers should therefore receive relevant training.²²⁸

Studies have often indicated the significance of an early and holistic psychiatric assessment to identify more vulnerable and in need of treatment, using criteria such as age, need of access to health care, the experience of near-death incidents and violent family members.²²⁹ Such provision should be part of medical and care service delivery, bearing in mind that it is not a matter that can be addressed with one-size-fits-all policies.²³⁰ Universal **diagnostic** tools, such as those used in the Australian project WaR (Women at Risk)²³¹, would enable a more uniform assessment of traumatised women's needs in terms of services and understand the compounding effect on risk due to their reluctance to be open about the extent of their trauma.

Refugee health must be at the centre of a range of physical and mental health policies. Their nutrition in camps and accommodation centres deserves attention. Psychosomatic or physical conditions which can deteriorate because of stress and poverty should be investigated. To prevent deterioration of physical and mental health, the UNHRC should remain responsible for refugee women's health and not just oversee and facilitate the implementation of resettlement in host countries.

Access to health care has caused political controversy between supporters of the rhetoric of individual responsibility and those in favour of universal health care. It seems that the current Covid-19 pandemic has revealed the importance of universal health care and national health systems, which is not enough to convince their opponents. Some Member States remain ambivalent when it comes to the vaccination of refugees against Covid-19, either by not including them in their vaccination campaigns or by not encouraging undocumented migrants to safely access vaccines.²³²

²²⁶ As an example, the issue of being an offender has shown to have an impact on the success and response to PTSD treatment and should be taken into consideration. See Stenmark, H et al. (2014) Gender and offender status predicting treatment success in refugees and asylum seekers with PTSD. *Eur J Psychotraumatol* 30(5).

²²⁷ Alam, A. et al. (2019). Migrant, refugee and asylum-seeking women and girls in Europe. Strasburg: Institute of Political Studies.

²²⁸ Asgary, R. and Segar, N. (2011) Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved* 22(2): 506-522. *Project MUSE*

²²⁹ Jesuthasan, J. et al. (2018) Near-death experiences, attacks by family members, and absence of health care in their home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study. *BMC Medicine*. 16:15.

²³⁰ Schweitzer, R.D. et al. (2018) Recently resettled refugee women-at-risk in Australia evidence high levels of psychiatric symptoms: individual, trauma and post-migration factors predict outcomes. *BMC Med* 16:149.

²³¹ Bartolomei, L., Eckert, R. and Pittaway, E. (2014) "What happens there... follows us here": Resettled but still at risk: Refugee women and girls in Australia. *Refuge*. 2: 45-56; Zimmerman, C. et al. (2008) The health of trafficked women: a survey of women entering posttrafficking services in Europe. *American Journal of Public Health*, 98(1): 55-59.

²³² <https://www.dw.com/en/refugees-and-undocumented-migrants-must-be-vaccinated-be-warn/a-56664623>

Barriers to health access have been identified, and strategies to overcome them are urgently needed.²³³ It is also crucial for users and providers alike to clarify the differences between the health system and its immigration system. Information about the health system should be provided upon arrival. NGOs can be deployed and engaged more to assist in navigating the complex health and social systems.²³⁴

Screening of female refugees and asylum seekers is essential to obtain the first idea of their life stories and their traumatic experiences. Doctors should be further trained to recognise signs and symptoms of trauma and torture.²³⁵

Granting asylum plays a significant role in dealing with trauma.²³⁶ Being granted asylum reduces some uncertainties and may encourage the refugee to enter the health care system.

Most **importantly, interventions must be introduced simultaneously on different levels** to minimise the stress factors which exacerbate mental health problems in the post-migration period. Such factors are access to employment and health care, family reunification, combined with addressing mental health symptoms.²³⁷

Acculturation and resettlement are among the main contributors to high-stress levels and related diseases, such as depression or type 2 diabetes mellitus.²³⁸ Some Member States, such as Germany, offer only acute care services and no counselling.²³⁹ Lack of psychiatric care can lead to re-traumatisation and worsening existing medical conditions. Such services must be provided to refugee women free of charge.

Studies have emphasised nurses' role in developing a **holistic understanding** of the uniqueness of refugee women's traumatic experiences and the range of their needs in the post-migration phase. They go beyond the biomedical model and promote reconnection with family and community and strategies to integrate them into daily life.²⁴⁰

The efficiency of **innovative therapeutic interventions** to deal with traumatic experiences has not been investigated enough across countries and different refugee groups. It is imperative to collect robust cross-national data and implement such interventions more.

Overemphasis on the impact traumatic experiences have on survivors' mental health can often divert attention from their other vital needs. Focusing on the latter from an intersectionality perspective is necessary to decide on the measures required. Research has shown that interventions worldwide often do not consider the particular needs according to the severity of trauma and age group.²⁴¹

²³³ Heslehurst, N. et al. (2018) Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med* 16(1):89.

²³⁴ Asgary, R. and Segar, N. (2011) Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved* 22(2): 506-522. *Project MUSE*.

²³⁵ *ibid*.

²³⁶ Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

²³⁷ Carswell, K., Blackburn, P. and Barker, C. (2011) The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *International Journal of Social Psychiatry*. 57(2): 107-19.

²³⁸ Agyemang, C. , Goosen, S., Anujo, K, and Ogedegbe, G. (2011) Relationship between post-traumatic stress disorder and diabetes among 105 180 asylum seekers in the Netherlands. *European Journal of Public Health*. 22(5): 658-662.

²³⁹ Jesuthasan, J. et al. (2018) Near-death experiences, attacks by family members, and absence of health care in their home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study. *BMC Medicine*. 16:15 <https://doi.org/10.1186/s12916-017-1003-5>

²⁴⁰ Robertson, C.L. et al. (2006) Somali and Oromo refugee women: trauma and associated factors. *J Adv Nurs*. 56(6):577-87.

²⁴¹ Hossain, M., Zimmerman, C., Abas, M., Light, M, and Watts, C. (2010) The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. *American Journal of Public Health*. 100(12) 2242-49.

Trauma has culture-specific dimensions and triggers different **coping strategies** among different ethnic groups.²⁴² Counsellors must understand the impact of trauma and adopt a multifocal approach that will consider the socio-economic stressors and barriers in the destination country.

Counselling must be done in the clients' language and be **culture-centred** to achieve better results. Counsellors must try to interpret their clients' fears and traumatic experiences in the context of the culture of their country of origin. Only culturally responsive mental health services can encourage refugee women to seek help.²⁴³ Enabling them to speak in private to female professionals (e.g., doctors, psychiatrists, psychotherapists, and counsellors) provides them with a safe space where they can be open and does not expose them to their community. Helped by female interpreters, women overcome language barriers and feel at ease to share their stories. A welcoming and friendly place is vital.²⁴⁴ Cultural references such as books in different languages and artefacts or pictures on the walls from refugee women's countries of origin could bring up memories and create a multicultural environment. Over time counsellors can empower refugee women to develop the necessary skills to adjust successfully to the new culture.

5.2.3. Integration into society through multi-level, co-ordinated policies

Research has shown that long-term mental health and psychological problems in war refugees can be **influenced by the context** in which they are placed. This suggests that **policies related to asylum provision and subsequent integration are significant**, and there is a need for more (better used?) resources to support refugee populations.²⁴⁵

Integration and security in the destination country have been reported to help women deal with previous trauma. Aspects such as language learning, contact with families back home and doing handicrafts seem to have positive impact.²⁴⁶ Language proficiency accelerates employment, education, vocational training and personal autonomy.²⁴⁷ It can also enable them to seek medical and specialist help to mitigate the effects of trauma without risking exposure to their community.

Social support groups and networking play a vital role in accessing health resources and the treatment and healing processes.²⁴⁸ Community-run groups to share experiences and coping strategies contribute to integration more generally. Using community resources and grassroots networks in resettlement contexts can empower and lead to better services for vulnerable people.²⁴⁹

²⁴² Such ethnic variations examined in Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

²⁴³ Bemak, F. and Chung, R.C-Y. (2017) Refugee trauma: Culturally responsive counseling interventions. *Journal of Counseling & Development*. 95:299-308.

²⁴⁴ Shishehgar, S. et al. (2017) Health and socio-cultural experiences of refugee women: An integrative view. *J Immigrant Minority Health*. 19:959-973.

²⁴⁵ Schmidt, M., Kravic, N., Ehlert, U. (2008). Adjustment to trauma exposure in refugee, displaced, and non-displaced Bosnian women. *Arch Womens Ment Health*. 11(4):269-76.

²⁴⁶ Renner, W. and Salem I. (2009). Post-traumatic stress in asylum seekers and refugees from Chechnya, Afghanistan, and West Africa: Gender differences in symptomatology and coping. *International Journal of Social Psychiatry*. 55(2):99-108.

²⁴⁷ Shishehgar, S. et al. (2017) Health and socio-cultural experiences of refugee women: An integrative view. *J Immigrant Minority Health*. 19:959-973.

²⁴⁸ Robbers, G., Lazdane, G. and Sethi, D. (2016) Sexual violence against refugee women on the move to and within Europe. *Entre Nous*. 84; Heslehurst, N. et al. (2018) Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med* 16(1):89.

²⁴⁹ Asgary, R. and Segar, N. (2011) Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved* 22(2): 506-522. *Project MUSE*.

There is room for **more participatory research** into different communities **and building links and trust** with community leaders and natural healers to ensure services' alignment with the recipients' culture.²⁵⁰ Building **trust** is the first step toward effective interventions.

Furthermore, **counsellors** can be instrumental in empowering women to communicate with other communities and learn how to navigate the system. They can also inform policymakers about differences in basic definitions, such as 'family', which may mean 'extended family'. Such differences are significant when it comes to reunification and support programmes.²⁵¹

Respect for **religion** as a vehicle for connectedness for many refugee women can be empowering, as their faith represents the 'grounding principle'²⁵² and part of many refugee women's identity and master narrative. Their faith helps them endure suffering and deal with events they cannot explain.²⁵³

Raising awareness among the refugee community about services and culture should be a priority. Art can be a vehicle; through painting, photography, music and films, the process of acculturation could start in accommodation centres during the long wait for the outcome of asylum claims. In the current political climate on the EU level, when refugee camps often look like 'warehouses of souls', such suggestions sound wholly detached from reality. Circumstances, however, can quickly improve in a climate of political will and collaboration between the Member States.

In parallel with professionals, **campaigns to raise awareness of the wider public** must be prioritised. **Political countertransference** is an adverse reaction toward migrant and refugees. It is a risk for the general public that is exposed to overt and covert political messages.²⁵⁴

Funding specific programmes is indispensable to catering for female refugees and asylum seekers' needs.²⁵⁵ As traumatic **experiences associated with gender-based violence**, e.g., trafficking, also happen in the destination states and involve Member State citizens, national governments must put in place support services to facilitate the integration of survivors into the mainstream of society.²⁵⁶

5.2.4. Multi-level and coordinated policies

Research evidence²⁵⁷ suggests that the **EU policy fails to protect refugee women** and decrease their vulnerabilities.

²⁵⁰ Burstow, B. (2003). Toward a radical understanding of trauma and trauma world. *Violence Against Women*. 9, 1293-1317,

²⁵¹ Shishehgar, S. et al. (2017) Health and socio-cultural experiences of refugee women: An integrative view. *J Immigrant Minority Health*. 19:959-973.

²⁵² Munt, S.R. (2012) Journeys of resilience: the emotional geographies of refugee women. *Gender, Place and Culture*. 19(5): 555-577

²⁵³ Tankirk, M. and Richters, A. (2007) Silence as a coping strategy: the case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war. In B. Drozdek and J.P. Wilson (Eds). *Voices of Trauma: Treating Survivors across Cultures*. New York. N.Y.: Springer, pp. 191-210.

²⁵⁴ Bemak, F. and Chung, R.C-Y. (2017) Refugee trauma: Culturally responsive counseling interventions. *Journal of Counseling & Development*. 95:299-308.

²⁵⁵ Asgary, R. and Segar, N. (2011) Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved* 22(2): 506-522. *Project MUSE*.

²⁵⁶ Zimmerman, C. et al. (2008) The health of trafficked women: a survey of women entering posttrafficking services in Europe. *American Journal of Public Health*, 98(1), 55-59.

²⁵⁷ Freedman, J. (2016) Sexual and gender-based violence against refugee women: a hidden aspect of the refugee 'crisis'. *Reproductive Health Matters*. 24(47)18-26

The legal basis for better policies is present **at the EU level**. The political debate on EU refugee policy must continue in light of the recent New Pact of the European Commission and agree on a fair relocation of refugees concerning human rights law and relevant conventions. Prompt relocation and respect for family reunification for the most vulnerable are essential, even in the current situation of 'flexible' or 'à la carte' solidarity. EU bodies must monitor procedures. Joint funding and implementation with a common notion of solidarity can eventually lead to coordinated policies.²⁵⁸

Standards are set but are not met. There must be sanctions for the Member States which do not comply with the guidelines.

Outsourcing of asylum processing and EU border management must be reversed, as such practices render the EU an accomplice in the infringement of human rights by third countries.²⁵⁹ When states decide to return asylum seekers to their countries of origin, they must ensure that the refugee women's health and safety are protected. Their health problems and trauma are often aggravated during the asylum process and the refugee camps' inhumane conditions.²⁶⁰ Governments and international organisations must collaborate on finding alternatives to the encampment system and funding programmes for particularly vulnerable people, such as victims of violence or torture, unaccompanied minors and those with pre-existing medical conditions.

Policies should be coordinated and designed with local associations and agencies. It is essential that special funding be provided on an international level, allocated equitably to the refugee population, independently of gender, race, ethnicity or other categorisations. Allocation in terms of resettlement must also be fair.

On the authorities' level, concerns have been expressed regarding **poor decision-making on asylum applications** and unnecessary detention. Existing policies require adaptation and revision to allow for a fair and efficient process of asylum applications, without being either unnecessarily long or fast-track, as the New Pact suggests. Legal procedures and **competent personnel** should support victims of trafficking, easing the administrative processes involved in asylum and evaluating their needs.²⁶¹

Policy-makers must agree on refugee women and LGBTI people's entitlements and design standard, evidence-based EU policies to be implemented uniformly by the Member States. Actions should be **holistic** and target structural barriers. Moreover, each case's particularities should be considered from an intersectional perspective of discrimination.

Policy-making should have **bottom-up elements** such as involving migrant women and girls and relevant advocacy organisations, which can provide constructive input regarding migration, asylum and integration policies and risks.²⁶²

Technology should be deployed to facilitate and make administrative processes more accessible and user-friendly and also as a tool to monitor and prevent incidents of violence in circumstances of social isolation. There are applications and devices which could be used to this end.

²⁵⁸ De Bruycker, P. (2020) The New Pact on Migration and Asylum: What it is not and what it could have been. 15 December. Odysseus Network. Special Series of posts on the New Migration Pact. <https://eumigrationlawblog.eu/the-new-pact-on-migration-and-asylum-what-it-is-not-and-what-it-could-have-been/>

²⁵⁹ GUE/NGL (2020) The Migration and Asylum Pact. Challenging the European Commission's narrative from the Left. Brussels.

²⁶⁰ Kalt, A., Hossain, M., Kiss, L. and Zimmerman, C. (2013) Asylum seekers, violence and health: A systematic review of research in high-income host countries. *American Journal of Public Health*. 103(3):30-42.

²⁶¹ Zimmerman, C. et al. (2008) The health of trafficked women: a survey of women entering posttrafficking services in Europe. *American Journal of Public Health*, 98(1), 55–59.

²⁶² GREVIO, for instance, has recommended greater inclusion of women's NGOs, community-based and grassroots activist groups to address the integration of refugee and migrant women in Denmark GREVIO (2017b). GREVIO baseline evaluation report- Denmark. Strasbourg: Council of Europe.

Service providers during resettlement often operate in silos with limited communication and coordination. **Raising awareness and training** of the entire spectrum of staff involved (including officers, border control staff, refugee accommodation sites' personnel, professionals involved in refugee-status-granting processes, policy-makers and medical and psychiatric staff) must be coordinated and continuous. This can be achieved through seminars and online materials, highlighting both similarities and differences and sensitising professionals. In this way, all the above will become better informed about refugee and asylum-seeking women and LGBTI people's lived experiences, together with the intersecting factors that increase their vulnerability.

Such measures will counteract the desensitisation caused by focusing on similarities and disregarding differences. In a similar vein, immigration judges and legal representatives can be trained to acknowledge the emotional demands of their roles, which is essential for them to reach fair judgements.²⁶³ Offering psychological assessment and support to all professionals may improve the process's fairness. Special cultural competency training is required for staff and adjudicators to give them the qualifications and resources to deal with LGBTI cases and improve the LGBTI refugee determination process.²⁶⁴ Consultation with human experts on domestic violence, conflict or trafficking, to design appropriate services is critical. Measures must be complemented with broader advocacy in favour of a more equitable system for all LGBTI refugees.

The **length of entitlement to services for the highest risk categories of refugee women must be extended** and gradually phased out and replaced by access to services and welfare benefits. Professionals must help refugees navigate the complex mechanisms of welfare states and receive the help they are entitled to.

It is essential to go beyond the stereotypical representation of women migrants as dependent and victims and address the "global" common factors that generate vulnerability conditions beyond cultural contexts.²⁶⁵ **Resilience** is a concept which must be handled with care, as it can have both positive and negative impacts on refugee women who are survivors of violence. They are resilient and fragile at the same time, and with the right interventions they can be helped to retain positive experiences and build a future for themselves and their families in the host country. Viewing resilience as a dynamic process in the context of state services is a safer and fairer option. On the one hand, it helps avoid 'dichotomous distinctions between resilient and non-resilient people',²⁶⁶ and on the other hand, it better recognizes and acknowledges the trauma generated by gender-based violence.²⁶⁷

Policies must also be consistent in all domains. It seems that this is not always the case due to a lack of standard criteria and coordination. *'Different committees in the EU pass contradictory legislation. On the one hand, we introduce policies that aim to better employment conditions for migrant workers and the other policies favouring pushbacks. These committees co-exist in the same building and have common members. This verges on hypocrisy.'*²⁶⁸

²⁶³ Baillot, H., Cowan, S. and Munro, V.E. (2013). Second-hand emotion? Exploring the contagion and impact of trauma and distress in the asylum law context. *Journal of Law and Society*. 40(4):509-40.

²⁶⁴ La Violette, N. (2013) Overcoming Problems with Sexual Minority Refugee Claims: is LGBT Cultural Competency Training the Solution? In Spijkerboe, T. (ed.), *Fleeing Homophobia. Sexual Orientation, Gender Identity and Asylum*. Oxon: Taylor & Francis Books.

²⁶⁵ Alam, A. et al. (2019). Migrant, refugee and asylum-seeking women and girls in Europe. Strasbourg: Institute of Political Studies.

²⁶⁶ Bottrell, D. (2009) Resistance, resilience and social identities: Reframing 'Problem Youth' and the 'Problem of Schooling'. *Journal of Youth Studies*. 10(5):597-616.

²⁶⁷ Pulvirenti, M. and Mason, G. (2011) Resilience and survival: Refugee women and violence. *Current Issues in Criminal Justice*. 23(1):37-52

²⁶⁸ Interview of the author with a MEP, 17 March 2021. Consent not given to disclose the name of the source and the source stays with the author

Implementation of Directives and adoption of best practices is essential.²⁶⁹ A **gender-equality perspective** must be a policy against violence and humanitarian responses to the refugee question. Nevertheless, there is the **risk of gender washing**. *'With all those gender issues...I think there is gender-washing. It appears that we address gender issues, but in reality, nothing changes within the organisations. It is like window-dressing. It is the reality for all gender issues that people express their commitment to equality, but then there is no money and nothing changes'*.²⁷⁰

²⁶⁹ Robbers, G., Lazdane, G. and Sethi, D. (2016) Sexual violence against refugee women on the move to and within Europe. *Entre Nous*. 84.

²⁷⁰ Interview with a senior WHO official, 17 March 2021. Consent not given to disclose the name of the source and the source stays with the author.

6. CONCLUDING REMARKS

“The new migrants from the dust bowl are here to stay. They are the best American stock, intelligent, resourceful, and, if given a chance, socially responsible. To attempt to force them into a peonage of starvation and intimidated despair will be unsuccessful. They can be citizens of the highest type, or they can be an army driven by suffering to take what they need. On their future treatment will depend the course they will be forced to take.” — John Steinbeck, The Harvest Gypsies: On the Road to The Grapes of Wrath

Refugee and asylum-seeking women’s odyssey to the destination country is full of hurdles, and Ithaca is often not the promised land they were hoping to find.

Pre-existing traumatic experiences are compounded during the journey with new gender-based violence, patriarchy, racism, xenophobia, lack of respect for a different culture, religion or sexuality. All these factors intersect with administrative delays and uncertainties in the asylum process, structural barriers to services and support, leading to poverty and the deterioration of their physical and mental health after they arrive at their destination.

Poverty is an extra barrier to the challenges of the asylum process. The appalling conditions in some refugee camps and accommodation centres require immediate action. Poverty reduction among refugee and asylum-seeking women is a central area of intervention and a highly politicised one.

Refugee, asylum-seeking women and LGBTI people are not a homogeneous group, nor are their health needs uniform. Moreover, socio-economic status and culture are interlinked with gender and deserve attention. An intersectionality approach is the most appropriate way to understand and capture the factors and facets.

Different stakeholders must join forces to combat intersectional discrimination consistently and in the right spirit. *‘We suffer from a mentality of scarcity. There is little funding, little this and the other, and we end up competing with each other rather than building bridges and collaborating. It is a problem in our field. We do not always find a way to collaborate and join forces.’*²⁷¹

Unless the European Union ensures that this is achieved in all Member States, policies will remain fragmented and ineffective. Consequently, the needs of refugee women, girls and vulnerable groups will not be met. On the contrary, their physical and mental health problems due to trauma will deteriorate. Gender is a central dimension and needs to be analysed and addressed with gender-sensitive measures.

To enable a common and consistent approach to the refugee and asylum-seeking question, the perspective of policy- and decision-makers must focus on the EU as a unit, with external borders and responsibility for all refugee-related policies. Standard definitions, values, attitudes to diversity, awareness of the intersections of EU and national policies, increased emphasis on understanding otherness and diversity are the essential tools to appropriate policies based on human rights, law and shared humanity.

²⁷¹ Interview with a senior WHO official, 17 March 2021. Consent not given to disclose the name of the source and the source stays with the author.

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ANNEX

FOCUSING ON THE BRIGHT SIDE

Ilhan Omar

Ilhan Omar is the first Somali-American ever elected to the U.S. Congress. Born in Mogadishu, she arrived in the U.S. as a refugee when she was 12. Omar was born the youngest of seven siblings in 1981. Her mother died when she was just two years old. She was eight when Somalia's civil war broke out. Her family fled to Kenya, where they spent four years in a refugee camp before moving to the U.S. in 1995. Omar **tweeted** on the eve of her swearing-in this January: **'23 years ago, from a refugee camp in Kenya, my father and I arrived at an airport in Washington, DC. Today, we return to that same airport on the eve of swearing-in as the first Somali-American in Congress.'**

Zohre Esmaeli

'It takes time, patience and mutual understanding to build respect and a peaceful, happy communal life amongst people of different backgrounds... Integration is indeed a two-way street.'

Born and raised in Afghanistan's capital Kabul, Zohre Esmaeli fled with her family to Germany in 1998 when she was 13 to escape the war and the Taliban regime. She became a model, designer and author. She is based in Berlin.

Outside of the fashion world, she has devoted her energy towards helping other newcomers integrate into life in Germany. Having experienced the confusion and challenge of straddling two vastly different ways of life within and outside of home, she conceptualized and founded "Culture Coaches" in 2015. The project's objective is to offer newcomers, as well as Germans insights into each other's cultures, countries and value systems. Gender equality is key in this project.

Source: <https://www.dw.com/en/afghan-model-zohre-esmaeli-women-are-likely-to-integrate-faster-than-men/a-37662674>

Maya Youssef

Speaker, composer and virtuoso of the qanun: disseminating peace through the healing power of music.

Born in Damascus and now based in the UK, Maya Youssef is hailed as 'queen of the qanun,' the 78-stringed Middle Eastern plucked zither. Maya's intense and thoughtful music is rooted in the Arabic classical tradition but forges pathways into jazz, Western classical and Latin styles. For her, the act of playing music is the opposite of death and destruction; it is a life- and hope-affirming act and an antidote to what is happening, not only in Syria, but in the whole world.

Her debut album Syrian Dreams, produced by the legendary Joe Boyd, was highly-acclaimed in music press around the world and has led to many awards, performances on prestigious stages, and recognition from the British government of her status as an exceptional artistic talent. In perhaps her highest honour, the Year 6 class of Dalmain Primary School in London is named 'Youssef' in recognition of her inspirational work.

Source: *The Guardian* 21 May 2019 'Prominent Refugees and their contribution to the UK- in pictures', <https://mayayoussef.com/about/>

Jasmin Akter

UK-BangladeshCricketer

Jasmin is Rohingya, described by the UN as one of the most persecuted minorities in the world. She was born in a refugee camp in Bangladesh just after her father died.

Since arriving in the UK as a refugee, she has excelled at cricket, and together with her friends, started an all-Asian girls' cricket team in Bradford.

Jasmin said, ***'All I know is the feeling, the sheer pleasure of the motion feels greater when every breath blows with liberation.'***

Source: <https://www.observerbd.com/news.php?id=223188>

Lena Gorelik

Lena Gorelik is a German writer. She was born in 1981 in St. Petersburg. In 1992 she came to Germany with her Russian-Jewish family as a "Kontingentfluchtling" (quota refugee).

She studied at the German School of Journalism in Munich and then took a course in Eastern European studies at Ludwig-Maximilians-Universität in Munich. Her first novel, *Meine weißen Nächte* (My White Nights) was published in the autumn of 2004, and was acclaimed by *Bücher* as "the best new book about Germany - an absolutely charming book", while the *Süddeutsche Zeitung* wrote that "My White Nights' proves that new German literature can possess both levity and gravitas." In 2005, the book won the Bavarian Culture Prize in the category of literature. Her second novel *Hochzeit in Jerusalem* (Wedding in Jerusalem) was published in spring 2007, and was nominated for the German Book Prize 2007. She was honored for her work with the Ernst-Hoferichter Prize in 2009 and a series of other awards.

https://en.wikipedia.org/wiki/Lena_Gorelik

Waris Dirie

'I am a human rights activist, supermodel, mother, a Bond girl & always a nomad.'

Dirie was one of 12 children born into a large nomadic family in Somalia. At about age 13 she ran away from home to avoid an arranged marriage with a much older man and went to London to serve as a maid. She was illiterate, but took classes to learn to read and write English.

In 1983, at age 18, she became a model. She appeared on the runways of Paris, Milan, and New York, on adverts of Revlon and Chanel and on the covers of leading fashion magazines.

Dirie, who had undergone FGM at about age five, overcame personal and cultural barriers to speak openly about it, and in 1997 she was appointed as the United Nations Population Fund's special ambassador for the elimination of FGM. She recounted her experience with FGM, as well as her dramatic transformation from nomad to fashion model, in her autobiography *Desert Flower: The Extraordinary Journey of a Desert Nomad* (1998).

Source: <https://www.britannica.com/biography/Waris-Dirie>.

Enissa Amani

German-Iranian comedian Enissa Amani was born in 1985 in Teheran, Iran. Her parents fled to Germany in 1987 as politically persecuted persons. Her second name Sahar was her mother's pseudonym during the days when her parents met as political revolutionaries.

She studied literature in Frankfurt, the city where she grew up. Initially, she wanted to write a book with short stories but ended up only blogging her short texts. When she noticed that people liked her jokes, she started presenting them as a stand-up comedian on small stages.

She became famous in Germany in 2013 through her stand up comedy appearances in shows like TV total or StandUpMigranten. In 2016, she had her own show called Studio Amani which was rather negatively received by the audience. She received the German Comedy Award as best newcomer in 2015. In 2018, Netflix released a comedy special with Anissa Amani, the first one with a woman from Germany.

Source: <https://famousgermans.com/enissa-amani-german-iranian-comedian-facts>

Shafika Qias

From the Moria camp to Athens catwalks

Born in Afghanistan, one of ten children, Shafi and her family fled to Iran when she was six months old. Their life in Iran was hard: poverty and mistrust by the locals. They fled again to Greece in 2017 and lived in the Moria refugee camp for a while before settling in Athens.

In Iran she discovered her passion for fashion design and was taught how to sew. When they moved to Athens a friend from Germany sent her a sewing machine as a gift. She started designing and sewing her own clothes at first and then approached quite a few organisations but the doors were closed. Her luck changed when she spoke to Kasia Maciejowska, founder of DILA, an organisation promoting art projects of young refugee women, who urged her to try crowdfunding for her first fashion show. The funds were raised in no time with the support of fashion professionals. She took part in Athens Fashion Film Festival with the collection 'Flame' standing for Feminine, Loving, Artistic, Modern and Elegant, principles governing her design, bridging Europe and Asia. ***'Bringing together elements of different countries, cultures and aesthetic codes does not just influence the way I see the world; I believe they can be the foundation of a better future.'***

Source: Από το προσφυγικό καμπ της Μόριας στα δικά της Fashion Shows στην Αθήνα! | VOGUE.GR

Dina Nayeri

'It is the obligation of every person born in a safer room to open the door when someone in danger knocks.'

The writer Dina Nayeri fled Iran with her family at the age of eight, after her mother converted to Christianity. They spent two years as asylum seekers before settling in the US as refugees. She is US and French citizen and lives in London. Her most recent book, *The Ungrateful Refugee*, looks at the refugee experience from both a personal and journalistic perspective. ***'Still, I want to show those kids whose very limbs apologise for the space they occupy, and my own daughter, who has yet to feel any shame or remorse, that a grateful face isn't the one they should assume at times like these. Instead they should tune their voices and polish their stories, because the world is duller without them – even more so if they arrived as refugees. Because a person's life is never a bad investment, and so there are no***

The traumas endured by refugee women and their consequences for integration and participation in the EU host country

creditors at the door, no debt to repay. Now there's just the rest of life, the stories left to create, all the messy, greedy, ordinary days that are theirs to squander.'

Source: *The Guardian* 21 May 2019 'Prominent Refugees and their contribution to the UK- in pictures'.

This study was commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the FEMM Committee. The study focuses on the trauma that refugee and asylum-seeking women suffer when reaching their host country. Drawing on an extensive survey of scientific literature, international organisations' reports, websites, press, and discussions with relevant experts, it highlights survivors' different needs and the structural, cultural and psychological barriers to their resettlement in the EU. It argues for coordinated, gender- and culture-sensitive policies, EU collective responsibility in managing the refugee crisis and multi-level interventions from an intersectionality perspective.

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