Migrant women's experiences of sexual and gender-based violence and help-seeking journeys: Focus on Coventry, England.

AUTHORS

Lorna O'Doherty,

Claire Pillinger,

Erica Bowen

Co-funded by the Rights Equality and Citizenship Programme of the European Union

Authors and affiliations
Dr Lorna O'Doherty, Centre for Advances in Behaviour Science, Coventry University, UK
Claire Pillinger, Centre for Advances in Behaviour Science, Coventry University, UK
Prof Erica Bowen, Centre for Violence Prevention, University of Worcester

This research was supported by a European Commission grant
CAPTIVE/Just/2015/RDAP/AG/VICT/9243

This publication has been produced with the financial support of the Rights, Equality and Citizenship (REC) Programme of the European Union. The contents of this publication are the sole responsibility of the CAPTIVE Project partners and can in no way be taken to reflect the views of the European Commission.

Summary

Background

The current report shares findings on issues identified by migrant and refugee women in the UK in relation to their experiences of violence in their country of origin, over the course of their journey and in the UK. We also examined help-seeking and perspectives of service providers. The research comprised a comprehensive review of the extant UK literature, followed by interviews with survivors based in Coventry, UK.

Methods

For the literature review, we searched several electronic bibliographic databases using comprehensive criteria. Reference lists of identified studies and grey literature were also searched. Searches generated 2327 papers with 10 meeting the criteria for inclusion. The studies explored women's exposure to violence and experiences of support services in the UK using interview, survey and clinical questionnaires. Five of these studies gathered professionals' perceptions in relation to women using their services; 3 explored the experiences of service professionals working with migrant women. An additional 13 reports, mostly published by charities and NGOs, were included. Nine women living in the UK were identified through a specialist service for migrant women survivors of rape and sexual assault and through links within a local migrant community. Participants (23-54 years) came from Tanzania (2), DRC (1), Pakistan (2), India (2), Sri Lanka (1), and Uganda (1). An interview schedule was used to guide the interview and the story-telling approach was adopted. Interviews were transcribed and thematically analysed. In coding data, we commenced with first-order categories of (i) reasons for leaving (ii) migration journeys (iii) experience of violence in the UK and (iv) help-seeking journeys. We tracked major exposures to violence over participants' lives to enable analysis of how these exposures interacted with migration decisions, experiences and consequences in terms of mobility and health.

Findings

Across both stages of the research, we identified major themes in the following categories:

- Violence and oppression as triggers for mobility
- Mental health crisis as a turning point
- Interconnections between domestic servitude and domestic violence
- SV/GBV as having far-reaching effects on women's lives across the lifespan
- Inadequate service provision

Conclusion

The reviews, supported by the primary study, highlight the multiple, overlapping, and enduring nature of violence and vulnerabilities that migrant women face. The enormous impact of SV/GBV in terms of mental and physical health was also clear. The burden of violence exceeds that of abused native women owing to added challenges of instability and vulnerability relating to discrimination, economic disadvantage, immigration status, unemployment, poor living conditions, isolation, and multiple victimisation. A key message arising from this research is the need to increase awareness of frontline professionals and

service providers about the complex and protracted experiences of violence and vulnerability among migrant women. Services need to have specialist reach including staff that share language and cultural backgrounds; capability around responding to disclosure and referral; cultural competence and confidence to challenge harmful community norms; access to trained interpreters; options for migrant/women to exercise choice (e.g. request female interviewer for police/immigration interviews); and trauma-informed practice across contexts in which migrant people/women present. To end this cycle of violence and vulnerability, it is essential that we utilise multiple pathways to inform newly arrived and current migrants (e.g. access to information on risks, rights, and services via multiple avenues to community groups). Only by bringing these threads to our policies, practice and research work with non-UK survivors can we begin address the toxic and perpetuating mix of marginalisation and violence in the lives of so many.

Background and aims

Gender-based violence including sexual violence persists in the UK and around the world, and the risks of these forms of violence in the lives of women and girls increase during times of conflict, instability and mass movements of people. This is especially prominent in 2017 when the numbers of people on the move are at their highest since World War II. The research reported herein was undertaken in the UK as part of a project funded by the European Commission aimed at addressing sexual and gender-based violence among migrant and refugee women in Europe. The project, known as CAPTIVE, consists of a research component (Workstream I) and a set of actions related to cross sector best practice sharing and training (Workstreams II-IV). We are a partnership across six countries: Malta, Spain, France, Germany, Italy and the UK. For the purposes of the project, we have adopted the Council of Europe definition of gender based violence:

"[G]ender-based violence [GBV] against women" shall mean violence that is directed against a woman because she is a woman or that affects women disproportionately[.]

Article 3d, Council of Europe Convention on preventing and combating violence against women and domestic violence.

We have used UN definition of migrant
"any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country."

(Refugee Convention, 1951)

and the UN definition of refugee:
"a person who has fled from and/or cannot return to their country due to a well-founded fear of persecution, including war or civil conflict"

(Refugee Convention, 1951).

The WHO (2013) has highlighted that one in three women and girls experience sexual and/or domestic violence across the lifespan. Migrant women face higher levels of violence than native born-women and are more prone to becoming trapped in a cycle of abuse (Burchill, 2011). Reduction in risk of violence may be the reason, or part of the reason, for women's decisions to migrate. Many women who enter the UK on their partner's visa rely on their partners (as primary applicants) for leave to remain in the UK. This coupled with financial dependence puts them in a very vulnerable situation. However, increased awareness of the potential difficulties for dependent migrants and risks of abuse means that UK Visas and Immigration (formerly, the UK Border Agency) will consider independent applications for LTR from people who have been victims of domestic violence sooner than would otherwise be permitted (Home Office, 2015). Though significant, the risks that migrant women face go well beyond their immigration status. They often arrive in the UK at a young age; they may be poor, lack language skills or understanding of their rights; and they may be isolated and consequently develop social relationships with people with potential to exploit them. They may have been exposed to recent or non-recent physical and psychological trauma

(including sexual violence) and experience serious mental and physical health issues associated with this trauma.

A systematic review of 23 studies to understand the health concerns of asylum seekers in high-income host countries revealed that most studies linked GBV to mental health problems such as depression, emotional distress, suicidality as well as to physical health problems ranging from injuries and pain syndromes to arthritis and coronary heart disease (Kalt, Hossain, Kiss, & Zimmerman, 2013). Sexual violence was also found to increase risk for health problems such as STI's, urinary tract infections, miscarriage, pre-term delivery and neo-natal death. Torture exposure amongst migrant women was associated with depression, PTSD and political violence to poorer health-related quality of life. Selkirk, Quayle & Rothwell (2014) conducted a systematic review of 24 reports that explored the factors associated with attitudes towards seeking psychological help among working age migrants. Three main themes emerged from the review: logistical barriers, cultural mismatch and preference for assistance from alternative sources. Service providers were often said to lack sensitivity and understanding of pertinent cultural and religious issues. For instance some women from eastern cultures expressed discomfort at the direct style of communication adopted by western providers, with some women reporting direct experiences of discrimination and being belittled by service providers (Selkirk et al. 2014). For many of the migrant women, seeking help from formal services was associated with shame and stigma, and so they preferred to cope with problems independently or seek help from informal sources of support or traditional healers (Selkirk et al. 2014). Culturally incongruent provisions increase the risk of alienating migrant women. For example a migrant woman's expectations may be contrary to Western culture, they may wish to form a close relationship with a professional before disclosing or help seeking but in western cultures this is discouraged and so could lead to feelings of rejection and humiliation (Selkirk et al. 2014). More recently, Sudbury & Robinson (2016) conducted a literature review examining barriers to sexual and reproductive health care for refugee and asylum-seeking women. The main findings from the review were that many refugee and asylum-seeking women are not aware of the services and support that are available for them, what they are entitled to and how to navigate the new system which in turn discourages them from engaging with services.

In the context of changing landscape with respect to UK policy, service provision and migration patterns, the current report shares UK findings from Workstream I on issues identified by migrant and refugee women in the UK in relation to their experiences of violence in their country of origin, over the course of their journey and in the UK as the destination/receiving nation. We also examined help-seeking and perspectives of service providers from different sectors. The research was split into two stages. In the first stage, a comprehensive review of the extant UK literature was undertaken, the findings of which are outlined in the first section of this report. The second stage of the report shares the primary research with survivors.

Literature review: experiences of migrant women survivors of GBV and professionals who work with them

Search strategy

Relevant publications were sourced by searching the following electronic bibliographic databases:

- Psycinfo
- Academic Search Complete
- CINAHL
- Medline
- PsychArt
- PubMed
- Web of Science
- EBSCO

Initial searches were conducted in January 2017 and repeated in June 2017 to identify any additional recently published articles. No additional articles were identified with the second search. Reference lists of included studies were searched and considered in line with the inclusion/exclusion criteria (see below). We also searched the British grey literature on the topic of GBV and migration. To ensure the most comprehensive review of the literature, a combination of the following search terms were used:

Migrant women survivors:

• Violence • Violence against women • Female genital mutilation • Exploitation • Hono* killing • Intimate partner violen* • Domestic Violen* • Abus* • Forced marriage • Mental health • Wellbeing • Trauma	AND	• Women • Female • Girls	AND	• *migrant • Refugee • Asylum seeker • Minority ethnic	AND	United Kingdom

Professionals working with migrant women:

• Violence • Violence against women • Female genital mutilation • Exploitation • Hono* killing • Intimate partner violen* • Domestic Violen* • Abus* • Forced marriage • Mental health • Wellbeing • Trauma	AND	• Women • Female • Girls	AND	• *migrant • Refugee • Asylum seeker • Minority ethnic	AND	United Kingdom	AND	Service provider Professional Advoca* Provider

Inclusion/exclusion criteria for review

The following inclusion criteria were used:

- Original empirical studies with samples of individuals from the UK
- The study includes migrant women and/or girls who have experienced any form of gender-base violence
- Studies published in English in peer review journals.
- The study reports research with service providers or professionals working with female members of migrant and refugee communities for issues related to mental health or violence exposure.

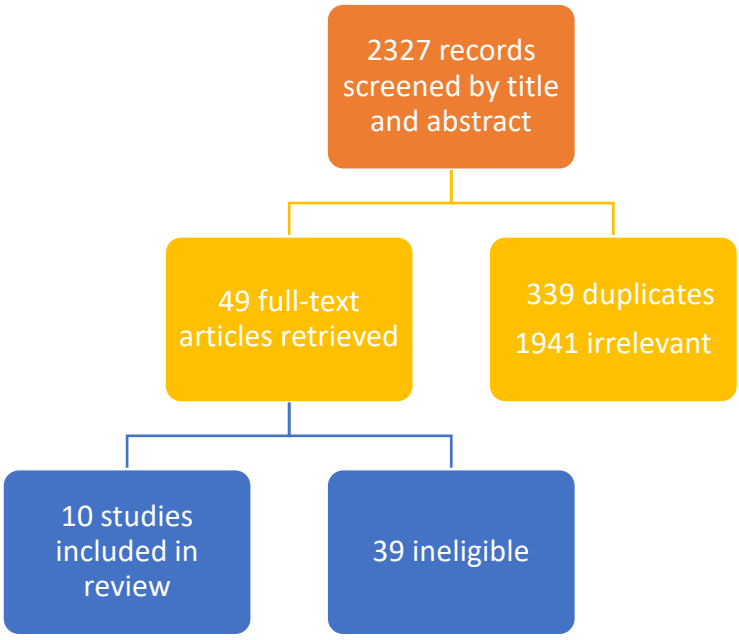
Results & key findings

Searches generated 2327 papers with 10 meeting the criteria for inclusion. Figure 1 shows the number of papers initially identified then rejected or retained. Five studies explored migrant women survivor experiences. The studies including 154 female asylum seekers from 14 countries in Europe, Africa, the Middle East and Latin America (Bogner et al., Herlihy & Brewin, 2007), 24 Portuguese migrant women (Graca, 2014), 43 asylum seekers including Black African, Black Other, Asian, Caucasian females (Rogstad & Dale, 2004) and 30 South Asian migrant women (Anitha, 2008; 2010), explored women's exposure to violence and experiences of support services in the UK using a range of methods including interview, survey and clinical questionnaires.

Five studies exploring migrant women's experiences involved service providers (N=278) (Baillot, 2009; 2012; Burchill, 2011; Caning, 2013; Lavender et al., Baker & Richens, 2006). These were 154 heads of midwifery 14 health visitors, 20 immigration judges, 24 UK border control personnel, 25 legal representatives, 13 rape support professionals, 21 NGO personnel, 1 translator, 1 asylum adjudicator, 4 asylum support workers. Studies gathered professionals' views in relation to women using their services through interview and survey methods.

The three studies that explored the experiences of service professionals working with migrant women consisted of 2 papers involving direct interview with service providers (Baillot, 2012; Burchill, 2011) and 1 survey (Lavender et al., 2006). The sample of service professionals working with migrant women therefore comprised 297 service providers from a range of different sectors including 177 heads of midwifery, 20 immigration judges, 24 UKBA officials, 25 legal reps, 21 NGO personnel, 16 interpreters, 14 health visitors.

Figure 1 Search Strategy for experiences of migrant women and the professionals working with them



To summarise the research, the findings are grouped in to the following four categories:

- Effects of SV/GBV
- Barriers to disclosure and help-seeking
- Inadequate service provision
- Service providers require specialist training to meet needs of migrant women

Effects of sexual violence/gender-based violence

Two studies explored the effects of GBV for migrant women. The effects of GBV for migrant women in the UK were extensive and covered physical, emotional and psychological and

social effects. Canning (2013) explored the effects of conflict-related sexual violence amongst women seeking asylum in Merseyside through interviews with 13 professionals and one rape survivor. In this study the professionals indicated that the most prevalent effects amongst this group of women were psychological trauma, depression, anxiety, insomnia, dissociation and flashbacks. Physical effects included sexually transmitted infections and reproductive problems whilst social effects included relationship breakdown, social isolation, and separation from children. The study by Anitha (2010) which explored the experiences of 30 South Asian women who had experienced DV, revealed the majority of women experienced a range of mental health problems including depression, extreme stress, suicidal ideation, self-harm, eating and sleeping difficulties and extreme fear which they attributed to the abuse they faced and their ongoing financial difficulties and worries about deportation.

Barriers to disclosure & help seeking

Women faced multiple barriers to disclosure and help-seeking. Through tribunal observations, case file analysis and interviews with 104 professionals/service providers in the UK asylum process, Baillot (2012) identified 4 mitigating factors that were repeatedly identified as barriers to disclosure. These included culture and shame, trauma and stress, vocabulary and narration, and a lack of understanding and or engagement in the asylum process. An additional four studies provided evidence in support of the barriers identified by Baillot (2012) and will be discussed below.

In regard to **culture and shame**, many migrant women were from cultures where marital rape was not recognised and as a consequence were unlikely to label their experience in this way, or to consider what had been done to them as abusive. Similarly, if violence was perpetrated outside the home, women were reluctant to report it as they often feared their husband would leave them and they would be ostracised by the community particularly in cultures where there are taboos around sex and gender, and sexual purity is of high importance. There is evidence that these cultural norms transfer across national and cultural contexts. Reluctance to report is also compounded by perceived low conviction rates for GBV and SV amongst victims in high-income/destination countries and other negative consequences from reporting. Moreover, in cases where women did disclose violence to family and friends, their behaviour was scrutinised and they were told to preserve with the relationship with their husband in order to protect the honour of the family (Anitha, 2008).

Service providers lack of cultural awareness was also identified as a significant barrier. Following interviews with 14 health visitors to explore how they deal with the complexities of working with refugees, Burchill (2011) found that the main challenge the health visitors faced was a lack of cultural understanding. This lack of cultural understanding has the potential to manifest in a lack of cultural sensitivity which serves to further alienate women wishing to seek help. Professionals also experienced difficulty meeting the women on their own as members of their husbands family would chaperone them to appointments. Another challenge for professionals was reported to be working with women from cultures that valued patriarchy in which the Father, as head of family, has the right to beat and rape

his wife. As a consequence women from such cultures did not acknowledge there was a problem with the abuse and violence they experienced. Professionals stated that it was particularly challenging providing help and support to women whose religious and cultural beliefs are at odds with legal system of the UK, and especially for women who have experienced FGM (Lavender et al., 2006). Professionals also reported that it was difficult to for women to leave their husband as they feared the stigma they would face from their community and being disowned by their family and community for doing so.

The second barrier to disclosure identified by Baillot (2012) was **trauma and stress.** Migrant women experienced significant trauma and stress following GBV and SV (as discussed above) manifesting in a range of physical and psychological conditions including extreme stress, anxiety, PTSD, memory loss. Disclosing and recounting experiences to professionals increased stress and so to protect themselves from re-traumatisation the women would avoid disclosure. This was supported by research by Bognor (2007) who interviewed 27 asylum seekers from 14 countries in Europe, Africa, the Middle East and Latin America who had a history of pre-migration trauma to determine whether and how sexual violence affects asylum seekers' disclosure of personal information during Home Office interviews. The study found that asylum seekers were very reluctant to disclose for a variety of reasons including the impact of past traumatic events, confusion, shock, flashbacks, feeling they would not be believed, shame, being a burden to the family or because in their culture it is considered wrong to talk about such things.

The third barrier identified was that of **vocabulary and narrative** (Baillot, 2009, 2012). Use of terminology was found to be particularly important; women do not always possess language skills to make disclosures and even where they do, they may avoid talking openly about SV and GBV, preferring to use euphemisms or emotional expressions which have no direct equivalent in English (Baillot, 2012). This frequently lead to misunderstandings and disclosures being overlooked by officials and other professionals (Baillot, 2009) Communicating about sensitive emotional matters was particularly challenging for the women, their understanding of emotional difficulties did not necessarily conform to Western models and they reported feeling shame and discomfort when recounting events to others (Baillot, 2012).

The final barrier identified by Baillot (2012) was **engagement with and understanding of the asylum process.** Across the included studies (Baillot, 2009; Bogner et al., 2007), the traumatic experience of the UK asylum process was a significant barrier to disclosure in addition to an engrained distrust of state officials. Asylum assessment interviews were reported to be traumatic, stressful experiences being conducted in unfamiliar and intimidating environments (Baillot, 2009). Coupled with women's distrust of authority, there were heightened concerns over confidentiality which undermined the disclosure process (Baillot, 2012; Bogner et al., 2007). UK Visa and Immigration officials and immigration judges' approach to asylum seeking women was also described by professionals as aggressive, confrontational and unprofessional, displaying lack of sympathy, sensitivity and/or appreciation of the difficulties women disclosed and lack understanding of pertinent cultural and religious issues (Baillot, 2009; 2012). Bogner et al.'s (2007) study also

highlighted the importance of cultural factors in the interview process. As one of Bogner et al.'s participant's noted:

At home you are not allowed to talk to other men you are not related to, you are not allowed to look any men in the eyes. So how could I have to look any men in the eyes? So how could I have looked him [male Home Office official] in the eyes and told him what happened to me? It's a different culture.

It was noted that women would rarely be interviewed alone, but in the presence of children or their husband or other family members which would act as a further deterrent to disclosure (Baillot, 2009). Baillot (2009) explored women's disclosures of rape during asylum seeking process, the help and barriers they encountered through a series of semi-structured interviews with 6 legal representatives, 1 asylum adjudicator, 1 translator, 4 workers from asylum support sector. In this study the issue of interpreters was also identified as a barrier to disclosure. In a number of instances officials failed to book interpreters or if they did, they were often unsuitable due to gender, age or ability to articulate sensitive topics using the appropriate vocabulary. Concerns about confidentiality within certain communities also acted as a barrier to disclosure and there were reports of interview transcripts being purposely modified to avoid using the word rape and to protect the culture of the victim.

In addition to cultural and personal/social factors in the interview process, Baillot (2012) identified logistical barriers including a lack of privacy, chaotic and noisy environments and lack of time which all served to minimise opportunities for disclosure. The UK asylum officials in this study acknowledged that poor staff practice and interview style formed a significant barrier. In most cases professionals would avoid asking questions about GBV even when it was clear this had occurred and demonstrated preference for closed questions which stifled free flowing narration by the women. Failure to provide an interpreter, minimisation of women's experiences of GBV all served to further reduce opportunity for disclosure.

In addition to the 4 barriers identified by Baillot (2009; 2012), **fear** was consistently reported as a barrier to disclosure. For migrant women, fear permeated a number of domains of their lives, was experienced on a number of levels and for a variety of reasons. Many of the women were scared to report the violence because they would not be believed. They feared seeking help and support in case their immigration status was discovered leading to being reported and deported. They fear being separated from their children and they fear that if they did stay within the UK they would be traced and subjected to further violence, or if they leave the perpetrator and go home they would be subject to honor-based crimes, ostracised from wider kinship networks and disowned by family (Bogner et al., 2007; Anitha 2008; 2010). For example, Anitha (2008) interviewed 30 South Asian recent marriage migrants living in the North West and Yorkshire regions of England about the nature of domestic violence they face, their patterns of help-seeking, pathways out of the abusive relationship and their experience of service provision. The women reported that their husband and/or his family would monitor their movements to minimise the possibility of disclosure and in some cases would keep them imprisoned in their own homes. Their status

as newly-arrived marriage migrants in the UK, often unable to speak English and being unaware of the laws in the UK also contributed to their vulnerability as the perpetrators threatened them with deportation, arrest and even being sectioned if they disclosed the violence or approached the police.

Lack of awareness of rights in the UK and support services available was another notable barrier to disclosure. The most commonly cited barrier to accessing support services was women's lack of knowledge and access to information about the services and support available to them. Graca (2015) interviewed 24 Portuguese women living in London and Reading who had experienced DVA to explore their relationship with the English justice system and in particular, with service providers when experiencing DVA. It was found that most of the women only demonstrated generic awareness of the services available. For the London-based women, the majority believed that the services available did not have much to offer them. They were seen as a place where they could find someone to talk to but not find a solution to their problems. As a result, the women opted to go to the police or a family member rather than use dedicated services. The Reading-based women showed greater awareness of the services available in the local area and regarded the services provided there as useful due. The women stated that having practical support services was most helpful and that having Portuguese-speaking support workers and information about the services in Portuguese would likely increase uptake. This is supported by the work of Rogstad & Dale (2004) who surveyed 43 asylum seekers attending a Hallamshire GUM clinic to determine whether or not their needs are different to British patients attending the clinic. Rogstad & Dale found that the asylum seekers required more appointments, but often missed more appointments than British women and despite free access to services, different languages, lack of appropriate information on the services available created a significant barrier to seeking help.

Inadequate service provision

It was evident in the literature, women's experiences of services were highly variable with the majority of the women reporting dissatisfaction with services due to a failure to deal with the causes of their symptoms, failure to take women's disclosures seriously and poor referral mechanisms (Anitha 2008, 2010). It was also clear that services for migrant women experiencing GBV are haphazard. Where services do exist, few offer support tailored to the specific needs of the women (Lavender et al., 2006). Indeed, it was noted that it took most women several contacts with services to receive the help they needed.

For example, Anitha (2010) interviewed 30 south Asian women to explore the nature of the abuse they experienced, the process of leaving the abusive relationship and their experience of health, welfare and legal services. In this study, it was found that on average the women contacted four services to finally receive help for the DV that they endured. In addition, although the majority of women with children who left the abusive relationship received support, the support they received often fell short of their needs; women that didn't receive help faced additional hardships due to child-care responsibilities. Moreover in Baillot's (2012) study, UK Visa and Immigration professionals acknowledged that the quality of advice

and support provided to asylum seekers is highly variable and that restrictions on legal aid and funding often make it difficult for them to devote the time required to develop the effective relationships of communication and trust with the women.

Service providers require specialist training to meet needs of migrant women

Throughout the literature it was evident that service providers were aware that the needs of refugees are multiple, complex, overlapping & require specialist knowledge & understanding (Burchill, 2011) and that GBV was part and parcel of a package of abuses that migrant women experienced (Baillot, 2012). Professionals consistently reported that there was limited training available and a gross lack of awareness of the many forms of GBV refugee women may experience, insufficient knowledge of consequences of GBV and lack of cultural understanding (Canning, 2013). Emphasis was placed on the need for specialised training for professionals who have contact with migrants, refugees and asylum seekers. Specifically, it was recommended that professionals undertake specialised culturally sensitive training to help increase awareness of the various forms of GBV that migrant women may experience so that they will have the confidence, skills and specialist knowledge to effectively and sympathetically help and support this particular group of women (Lavender et al., 2006)

Grey literature

Methods

Using similar search terms and inclusion criteria as for the academic literature, we searched several websites to identify reports about migrant women's experiences of GBV and help-seeking in the UK between 2006 and 2016.

Key findings

We identified 13 reports from the grey literature that met inclusion criteria and were published between 2006 and 2016. These reports included 1188 migrant women and girls who were survivors of GBV. These 13 studies were mostly reported by charities and NGOs that work with women and/or migrants (Christie & Goodwin, 2009 ; Girma, Radice, Tsangarides, Walter, Sands, Stevenson & Besong, 2014; Girma, Kershaw, Lousley, Radice & Walter, 2015; Hubbard, Payton & Robinson, 2013; Imkaan, 2016; Larasi, Roy & Tweedale, 2014; Marsh & Sharma, 2016; Psarros, 2014; Refugee Council, 2009, 2012; Social Perspectives Network, 2006; Scottish Refugee Council, 2009; Thiara & Roy, 2012).

Synthesis of reports generated the following key findings:

- 50-80% of migrant women had a lifetime experience of physical or sexual violence
- 57-76% of women reported exposure to GBV in their country of origin
- There was greater variation in the rates of violence experience since arrived in the UK or Europe (10-70%) which may reflect different timeframes of the studies
- Between 4,000 and 10,000 women and girls are sexually exploited at any one time in the UK (Refugee Council, 2009)
- 37-50% of migrant women in the 13 reports had experienced mental health problems, with 25% reporting major deterioration since arriving in UK (SPN, 2006)

- Detention centres pose substantial risks to women's safety and wellbeing (Women for Refugee Women, 2015)
- Most services were rated by participants as unhelpful (Imkaan, 2012)

Primary study

Rationale

Our review of the academic and grey literature together with mapping different services in the UK has demonstrated that the landscape of migrant women's experiences is constantly shifting in response to macro events such as geopolitical developments and Britain's decision to withdraw from the EU; changes in national and regional social and health policy; changes in funding models for public services and the third/charity sector; and changes to legislation and policy around immigration. Therefore, there is a need to continue to capture women and girls' perspectives on their exposure to violence and how this is being addressed in the context of their experiences as migrants.

Participants and setting

We involved migrant women living in the UK who self-identified as having experienced some form of GBV. In order to recruit participants into the research, the researcher (LOD) used links within a local migrant community where three women were identified through 'snowballing.' Six additional women were invited to participate through a specialist service for migrant women survivors of rape and sexual assault.

Data collection and analysis

Ethical approval was granted by Coventry University Ethics to conduct this work. Our research was trauma-informed and intersectionality (Crenshaw, 1989) was used as a theoretical framework. Nine women were interviewed in two service settings to ensure the availability of post interview support. Women were provided with information (verbal and written) and asked to sign consent forms. Interviews were conducted in English except for one Pakistani woman who had a preference for speaking in Urdu, which was facilitated by involving a researcher with language skills in Urdu. With women's consent, interviews were audio-recorded and transcribed and anonymised prior to analysis. Women were given a £20 shopping voucher as an honorarium. We collected some basic socio-demographic information at the conclusion of the interview.

It was explained to women that we were hoping to understand better women's experiences of getting help in the UK for experiences of violence in their lives. We emphasised that they were free to share as much or as little as they felt comfortable to discuss. An interview schedule was used to guide the interview; however, overall a story-telling approach (Atkinson, 1998) was adopted. Story-telling and biographical-narrative interviews are different from semi-structured interviews. The focus of story-telling should be linked to broad narratives, interested in exploring in-depth lived experiences, including contexts, identities, different stages of life and ways of sharing personal and collective experiences.

This encouraged women to tell the story of leaving their country of origin and coming to the UK and how they had experienced life in this country including any services they had had contact with for migration, health and social issues including violence exposure. The first three interviews focused more on lifeline accounts of violence exposure (community-based women) whereas the interviews with the 6 service users placed particular emphasis experiences of getting help, which for them was a current part of their experiences. Interviews were transcribed and thematically analysed. In coding data we commenced with first-order categories of (i) reasons for leaving (ii) migration journeys (iii) experience of violence in the UK and (iv) help-seeking journeys. We tracked major exposures to violence over participants' lives (depicting these in graphical form) to enable analysis of how these exposures interacted with migration decisions and experiences and consequences in terms of mobility and health.

Results and key findings

Participants' ages ranged from 23-54 years and they came from several countries: Tanzania (2), Democratic Republic of Congo (1), Pakistan (2), India (2), Sri Lanka (1), and Uganda (1). At the time of interviews, women could be described as seeking asylum (4), refused asylum (1), on a spousal visa (1) and indefinite leave to remain (3). We acknowledge the differences in experiences of people with different rights in the UK but for brevity, we will refer to all our participants using the all-encompassing term 'migrant' as "any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country" (Refugee Convention, 1951). Time in the UK ranged from 1-10 years. The figures below depict our timeline analyses covering the life narratives. Across the experiences of all women we identified three majors themes.

Violence and oppression as triggers for mobility

All women told of how different forms of violence and oppression in childhood, youth and young adulthood led to leaving their countries of origin. Women described being victims of child maltreatment, witnessing violence and experiencing IPV as young married women. Describing a childhood where violence was normalised, Maria tells:

We'd run in the cold to the neighbours and lock the door and sleep there and grow up with that life like that (P01)

They differed in the urgency and level of choice surrounding their departure – one woman explained the acute risk she faced in relation to conflict-related violence and persecution in the Democratic Republic of Congo whereas Flora, from Tanzania, explained how she sought freedom from gender discrimination and oppression, *inside me I thought 'this place is not safe for me'.* She had an 'arranged' marriage at 14 years but was allowed to pursue an opportunity to study temporarily in the UK. Later in the UK her consciousness about her situation was raised and she resisted returning to Tanzania and was forced to break off all ties with her family. A young woman was smuggled into the UK, facilitated by her family in Sri Lanka to keep her safe following her traumatic and unlawful detention, and rape and torture at only 18 years of age. Sadly, all of the women interviewed (bearing in mind, the

majority had left their countries to escape GBV) were victimised in the UK and this explains the high level of mobility within the UK also. Maria left her children behind in Tanzania in order to escape IPV; she was forced her into a situation of impoverishment following an experience of abuse in the UK:

I decided to get married to another man here. But it was worse because he didn't want me even to go out, I have to stay at home, to stay inside. He beat me once but I said "no, you can't beat me" and then because [I was in] a place and I didn't know anyone, because I'm not getting time to go outside, so even if he will do something, no one knows you. He give me a hard time but when he beat me up, I just walk out with nothing. I remember it was night, with nothing, and then I walk, I don't know where I'm going…..I thank God now, now I'm ok. Yeah I just left. Without anything, everything, I left it, because he was telling me if I'll go what he will do. And if I'd run he will get me and kill me. Because I didn't know that time that if you get problem like this you can go to police and all these things. (P01)

Interconnecting domestic servitude [fulfilling definitions of modern slavery] and intimate partner and family violence

Regardless of women's circumstances for leaving their country of origin, domestic servitude was a reality for the majority of the women interviewed. A Pakistani woman who married a British national was forced to prepare food each day for 30 members of her husband's family; she was threatened by her husband with being sent back to Pakistan where she feared further (and potentially more severe) 'honour'-based violence. Maria from Tanzania was smuggled into the UK but then sent to work in a household where she was exploited. The connection with IPV comes about as women attempt to escape one form of violence (modern slavery/IPV) only to experience another (IPV/modern slavery). This pattern is reflected in the timeline of 'Matilda' (see Figure 2) who told of her experience of persecution, domestic slavery, IPV and the maltreatment of her child, a harrowing journey through the asylum process and a subsequent four-year relationship where she again was subjected to abuse. She says of the now grown-up child she brought to the UK:

My daughter, she is very quiet, she doesn't laugh, she doesn't know happiness (P03)

Kasuni, the Sri Lankan woman (whose family had her sent to the UK) expected her to be cared for by her brother in the UK; however, she too described behaviours consistent with exploitation, and once her work was no longer required, she was told to leave her brother's home despite having no resources or leave to remain/legal status in the UK.

Figure 2 Matilda's story depicts interconnections of different forms of violence

Barriers to help-seeking and mental health crisis as a turning point

All women we spoke to had reached a point of despair during their time in the UK. Part of this was the difficulty they experienced in accessing help, invariably leading to them reaching a point of crisis. Following on from above, seeing no way out of her situation, Kasuni took a medication overdose:

I felt I was happier in hospital than in my brother's house. I got involved with the other patients, and nurses were coming often to take my blood pressure. Good response from nurses. (P07)

Prisha's situation epitomises both the vulnerability and resilience of non-UK women. She was raped by a house mate in the first few days of arriving in the UK to study and attended a GP for help:

I went to the GP when my difficulties started. He said "Why are you wasting your time and my time? You are fine, nothing wrong with you." I collapsed so many times at home. I wanted to know what was going on, I knew it was stress, but there is the GP which we can't go to and I can't go straight to hospital. He was Indian, Asian, they do this with their people mostly; if it was English person, he would have treated me better. Now my doctor is an English lady - she referred me to hospital (P04)

She tells of how *I tried to commit suicide many times, but better now because I know there is someone [from specialist service] with me. (P04)*

Clara of Indian heritage who had lived in the UK for several years from early youth was exposed to severe sexual violence when she married in late adolescence. She described having little understanding about what was happening to her and how her own family members, who were aware of the violence, blamed her:

They [family] told me I was demon possessed. They used to say when you have children, things will get better. (P05)

These examples of collusion with the abuser and denial of the abuse behaviours and impacts on the part of family members demonstrate powerful relational, community and socio-cultural barriers. AS a consequence, women were denied access to services and to wider community involvement which perpetrated the lack of knowledge about their rights.

When I was in London too, I hadn't heard of these organisations. The environment in which we grew up, I didn't know I had to go to someone to ask for help, but I was suffering within myself. (P05)

In the absence of any family or community support, Clara went on to attempt suicide:

I was admitted to hospital; then, a few organisations came to see me, used to come to my home. They used to give me tablets - every day, then alternate days, and then weekly. Then I found [specialist (migrant) women's service]. (P05)

Since I knew M, my life changed

Surviving a suicide attempt led most of the women to the attention of health and social services, and individuals within those services. For the first time in their lives, they felt listened to and understood:

I was in domestic violence situation, one of my friends told me about the Refugee Centre; they made an appointment for me with M. Since I knew M, my life changed, because was feeling like I was going to die, my husband did so many things to me. I used to think, "why didn't I die?" (P06)

Clara who suffered intimate terrorism and extreme sexual violence was silenced by her own family and community shows the process of developing a trusting relationship with a service provider. Similarly, Kasuni (P07) below describes the process of releasing the trauma.

If someone isn't pushing me, I couldn't come out to the world [but] because of M, I came to know there is a world outside as well. She pushed me and supported me. I started having confidence in her, [felt] secure sharing with her. I hadn't told doctors everything as well. Similar culture helps, emotional words [that] can't [be spoken] in another language. We are not same language - but there is Hindi - international language so she can understand that too (P05)

Before I used to be very nervous when talking about my life. When I went to art therapy, I felt I had freedom to talk about my life. And I cried after that, and felt better as I didn't have it all inside anymore. She [art therapist] explained things in a positive way and calmed me down; her words were helpful (P07)

The introduction of professional support in women's lives brought change, growth and independence but it also brought a sense of loss:

I have been in contact with own family in Pakistan - except my father. He used to say "wherever you're married, spend your whole life there, until you die there". I don't care about that now. (P09)

Prisha experienced loss of her partner in response to her decision to report her rape.

He [her husband] knew about the rape, but told me to keep quiet. If he supported me at that point, I could have gone ahead. He didn't want to talk about it…Later, he told me not to go to the police about rape, I said "I need to do something as it's killing me inside", I reported and he left me. (P04)

Most women had now escaped the violence but continue to take active steps to ensure their safety from ex-partners and family members. Their recovery journeys are life-long. Flora, one of the two participants originally from Tanzania, has had her asylum claim declined on two occasions and has two young children; shortly after the interview, she was compelled to move to another part of the country to reduce risk of abuse from a former partner. Since 14 years of age, she has been trying to reach a place of safety and stability. Of her childhood she said she wanted her family *to be proud of me, to see that I can do different from others and it doesn't matter that I'm a girl.* Her reality has been that being a girl does very much matter.

Discussion

This research set out to examine experience of sexual violence and gender based violence (SV/GBV) among migrant women in the UK with a particular emphasis on exploring help-seeking journeys since arriving in the UK. British reports highlight startling statistics in relation to burden of SV/GBV in migrant women's lives, in particular, the high frequency of post-arrival experiences of abuse. There is also evidence of deteriorating mental health in this population, reflecting the cumulative effects of stress associated with the migration and integration process and lack of protective factors in the structural and socio-cultural environment; migrant people face multiple issues including uncertain immigration status, unemployment, discrimination, economic disadvantage, poor living arrangements or conditions, isolation, previous trauma and recent or ongoing abuse. The reviews, supported by the primary study, highlight the enormous impact of SV/GBV on the lives of non-UK women in terms of mental and physical health, and poor education, economic, social and work outcomes. There was also indication of intergenerational transmission of this disadvantage. The nine women interviewed recounted experiences of SV/GBV that did not occur in isolation; rather there was marked poly-victimisation and exposure to multiple forms of abuse. These were pre-migration conflict-related sexual violence; intimate partner violence across the lifespan, from childhood witnessing to pre- and post-migration abuse by partners; child maltreatment (in relation to self and own children); forced/child marriage and threat of honour-based violence; sexual assault and rape by strangers, acquaintances and partners; and human trafficking and domestic servitude consistent with provisions in the Modern Slavery Act (UK Government, 2015).

This research demonstrates individuals standing in the path of multiple forms of exclusion. Therefore, intersectionality is an appropriate framework for discussing it (Crenshaw, 1989).

In the context of GBV, intersectionality allows exploration of the various ways in which gender interacts with other identities such as race, immigration status, victimhood, culture, poverty, social class and religion to shape structural and political aspects of violence against migrant women (Crenshaw, 1994). Intersectionality theory is essential to recognise issues unique to migrant women survivors of GBV because it encourages examination of overlapping forms of subordination derived from multiple identities held by migrant/women. In the UK, a migrant woman faces multilayered vulnerabilities, in particular those associated with the interaction of gender, ethnicity and immigration status. However, they are not only at risk of being 'othered' (Grillo, 2013) in the British/receiving country context; their choices around rejecting/escaping subordination and abuse mean they are also at risk of being 'othered' for dishonour within their own cultural contexts - *My father used to say "wherever you're married, spend your whole life there, until you die there, my izzat*". There were many examples of women in our study dominated within their own families and communities in a context of families and communities already marginalised by wider society. The overlapping systems of subordination associated with the many different identities create the conditions that increase women's ongoing vulnerability to violence as shown in themes *Violence and oppression as triggers for mobility* and *Interconnecting domestic servitude and intimate partner and family violence* where women are shifitng between different contexts and facing different combinations of identities, subordination and risk. These multiple dimensions of subordination damage women's help-seeking efforts and create extreme stress leading to poor health outcomes. This was echoed in the pattern of women in the current research reaching a point of mental health crisis prior to any kind of effective support reaching them. Women also spoke of what they relinquished in order to escape violence and subordination or to seek justice.

The only way forward is for all sectors and services to confront the multilayered and routinised forms of domination that often converge in these women's lives, and hinder their ability to create alternatives to abusive relationships and the other forms of violence they experience e.g. forced labour, sexual exploitation. Relative to their non-migrant counterparts (in the UK), many migrant women are burdened by poverty, child-care responsibilities, and the lack of job skills (Burchill, 2012). These burdens, largely the consequence of gender, race and immigration status, are then compounded by the discriminatory employment and housing practices migrant people face. These converging systems structure the experiences of migrant women survivors of SV/GBV in ways that require intervention strategies to be responsive to these intersections (Crenshaw, 1994).

A good example of the structural issues facing immigrant women in the UK concerns the requirement to be married for two years prior to applying for own right to remain. Many migrant women, as demonstrated in our reviews and research interviews, are reluctant to leave even the most abusive of partners for fear of being deported. When faced with the choice between protection from abusers and protection against deportation, many migrant women choose the latter (Crenshaw, 1994) *At the time, I was so scared, used to cry all the time, and used to think they'll send me back, it's easy to do anything to anyone in Pakistan*. Although a waiver now exists for cases of domestic violence (Home Office, 2015), women remain vulnerable as they have limited access to resources to enable them to gather the

evidence to meet the conditions established for the provision. Indeed many of the women we spoke to were isolated within their own or husband's family and were wholly dependent on husbands as their link to the outside world including for information regarding their legal status. It also means that victims are less likely to challenge their own negative perceptions (e.g. as seen in our research, to challenge 'residual' mistrust of police and other public services). They also suffered abuse under threats of deportation by their husbands. A further barrier concerns women who are married to men who themselves are without legal immigration status in the UK. These women suffer in silence for fear that the stability of their entire families will be undermined should they seek help. Language barriers present yet another structural problem that limit opportunities for non-English-speaking women to take advantage of existing support services. Similar barriers were identified in relation to migrant victims of rape. We documented a compelling story of a young, well-educated Indian woman who came to study in the UK with her husband and was raped by a housemate shortly following her arrival. Her husband threatened to leave her if she reported the rape. She sought help from a GP of her own cultural group for her mental health issues who also sexually assaulted her. It was seven years before she came to the attention of services and this only happened because she was suicidal. She is now receiving counselling to deal with trauma of her experiences and fears she will have her application to remain in the UK refused. The prospect of returning to India is unbearable for her and was the primary concern she had at the time of interview.

Strategies based solely on the experiences of women who do not share similarly diverse backgrounds will be of limited utility for those whose lives are shaped by a different set of obstacles. Drawing on Crenshaw (1994), because the disempowerment of many migrant women who have been abused is in large part a reflection of the barriers that exist in their lives, these interventions are likely to reproduce rather than effectively challenge their subordination. This is reflected in the reality that for many, the costs of escaping violence exceed the costs of living with it. Although funding shortages and cutbacks are a persistent threat to the support than can be offered to victims of SV/GBV, public and third sector services in the UK increasingly recognise the need for training as well as specialist organisations which can be differentiated from mainstream services (e.g. Women's Aid) and specialist services within mainstream women's services (e.g. community outreach). Specialist organisations, for example the Southall Black Sisters[1] and Daughters of Eve[2] provide women-only spaces for women and girls from various ethnic minority communities affected by GBV including honour-based violence, rape or sexual assault, domestic violence and abuse, trafficking, forced marriage, child sexual abuse and female genital mutilation. Specialist organisations aim to work in line with a 'led by and for' ethos and exist to overcome the language and cultural barriers that prevent victims seeking help, providing culturally sensitive and empowering services provided by skilled professionals who understand survivors' needs. The interviews conducted as part of the current study revealed a hugely positive impact of such specialist services, and though these services came

[1] http://www.southallblacksisters.org.uk/

[2] http://www.dofeve.org/about-us.html

extremely late in women's journeys, for many, they represented a turning point *I used to feel to feel like a leaf who would fall down when the wind would blow….now I feel stronger*.

Implications

One of the key messages then arising from this research must be the need to increase understanding and awareness of frontline professionals and service providers about the dynamics of structural intersectionality, and exercise this understanding in working with migrants and migrant women across sectors. This review and primary research has suggested how factors like conflict, poverty and gender dimensions underpin early exposure to violence (in home countries) but how the nature of vulnerability shifts substantially as women enter new geographical, social and cultural spaces and 'become migrant'. This is reflected in both the harrowing experiences reported in relation to the migration journey and the challenges that await in destination countries. The location of migrant women at the intersection of race, immigration and gender makes the actual experience of SV/GBV qualitatively different from that of white women or native born women. The fact that migrant (and minority) women suffer from the effects of multiple subordination, coupled with institutional expectations from police, UK Visas and Immigration, health, housing and other public services including services aimed at supporting women survivors of SV/GBV, based on inappropriate non-intersectional contexts, shapes and ultimately limits the opportunities for meaningful intervention on their behalf. Williams Crenshaw (1994) also argues that intersectional dynamics of crisis intervention may go far towards explaining the high levels of burnout experienced by providers/professionals who attempt to meet the needs of migrant women victims.

Thus, not only do those working with migrant persons across sectors need increased understanding of the intersectionality phenomenon, but services need to have specialist reach including staff that share language and cultural backgrounds; capability around responding to disclosure and handling referral safely and sensitively; cultural competence and confidence to challenge harmful community norms; access to trained interpreters; options for migrant/women to exercise choice (e.g. can request female interviewer for police or immigration interviews); trauma-informed practice across contexts in which migrant people/women present (Sweeney et al, 2016) (ref); and utilising multiple pathways to inform newly arrived and current migrants (e.g. access to information on risks, rights and services via multiple avenues to community groups; early intervention and long-term engagement with survivors and those at risk). Only in bringing these threads to our policies, practice and research work with non-UK survivors can we begin address the toxic and perpetuating mix of marginalisation and violence in the lives of so many.

References

Atkinson, R. (1998). *Qualitative Research Methods: The life story interview* Thousand Oaks, CA: SAGE Publications Ltd.

Anitha, S. (2008). Neither safety nor justice: the UK government response to domestic violence against immigrant women. *Journal of Social Welfare & Family Law, 30(3)*, 189–202

Anitha, S. (2010). No Recourse, No Support: State Policy and Practice towards South Asian Women Facing Domestic Violence in the UK. *British Journal of Social Work, 40*, 462–479.

Christie, G. & Goodwin, K. (2009). Refugee Women's Resource Project*. Asylum News*, 1-3.

Baillot, H., Cowen, S. & Munro, V. (2009). Seen and Not Heard: Parallel Dissonances in the treatment of rape narratives across asylum and criminal justice contexts. *Journal of Law and Society, 36*(2), 195-219.

Baillot, H., Cowen, S. & Munro, V. (2012). Hearing the Right Gaps; Enabling and Responding to Disclosures of Sexual Violence in the UK Asylum Process. *Social and Legal Studies, 21*(3), 269-296.

Bogner et al., D., Herlihy, J., Brewin, C. (2007). Impact of sexual violence on disclosure during Home Office interviews. *British Journal Of Psychiatry, 191*, 75-81.

Burchill, J. (2011). Safeguarding vulnerable families: work with refugee and asylum seekers. *Community Practitioner, 84*(2), 23-26.

Caning, V. (2013). International conflict, sexual violence and asylum policy: Merseyside as a case study. *Critical Social Policy, 34*(1), 24-45.

Crenshaw, K. (1994) Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. In M. F. Albertson & R. Mykitiuk (Eds), *The Public Nature of Private Violence* (pp 93-118). New York: Routledge.

Girma, M., Kershaw, I., Lousley, G., Radice, S. & Walter, N. (2015). *I am human: Refugee women's experiences of detention in the UK.* London: Women for Refugee Women.

Girma, M., Radice, S., Tsangarides, N., Walter, N., Sands, P., Stevenson, J. & Besong, L. (2014). *Detained: Women asylum seekers locked up in the UK.* London: Women for Refugee Women.

Graca, (2015). Use of domestic violence services by Portuguese women in England*. Journal of Family Welfare and Social Law, 37*(1), 38-52.

Grillo, R. (2013) An excess of alterity? Debating difference in a multicultural society. In *S.* Vertovec, *Anthropology of Migration and Multiculturalism*. Routledge: Abingdon.

Hubbard, A., Payton, J. & Robinson, A. (2013). *Uncharted Territory: Violence against migrant, refugee and asylum-seeking women in Wales*. Cardiff: Wales Migration Partnership.

Imkaan (2016, April). *Women's Mental Health and Well-being: Access to and Quality of mental health services.* London: Imkaan.

Kalt, A., Hossain, M., Kiss, L. & Zimmerman C. (2013) Asylum Seekers, ,Violence and Health: A Systematic Review of Research in High-Income Host Countries. *American Journal of Public Health, 1*03(3), e31-e42

Larasi, M., Roy, S. & Tweedale, R. (2014). *"This is not my destiny" Reflecting on Forced Marriages In England and Wales*. London: Imkaan.

Lavender et al., T., Baker, L. & Richens, Y. (2006). Current service provision for women in the UK who have undergone FGM. *British Journal Of Midwifery*, *14*(8), 465-466

Marsh, V. & Sharma, S. (2016). Migrant Women's Rights to Safety Project. Manchester: Safety for Sisters.

Psarros, A. (2014) . Women's voices on health: addressing barriers to accessing primary care. London: WHEC.

Refugee Council. (2009, February). *The Vulnerable Women's Project Refugee and Asylum Seeking Women Affected by Rape or Sexual Violence.* London: Refugee Council.

Refugee Council. (2012, March). *The experiences of refugee women in the UK*. London: Refugee Council.

Rogstad, K & Dale, H. (2004). What are the needs of asylum seekers attending an STI clinic and are they significantly different from those of British patients. *International Journal of STD and AIDS, 15*(8), 515-518.

Scottish Refugee Council. (2009, November). *Asylum seeking women: Violence and health*. Glasgow: Scottish Refugee Council.

Selkirk, M., Quayle, E., & Rothwell, N. (2014) A Systematic Review of Factors Affecting Migrant Attitudes Towards Seeking Psychological Help. *Journal of Health Care for the Poor and Underserved, 25,* 94–127.

Social Perspectives Network. (2006). *Meeting the Mental Health Needs of Refugees, Asylum Seekers and Immigration Detainees (SPN Paper Ten)*. Chichester: London Development Centre.

Sudbury, H. & Robinson, A. (2016). Barriers to sexual and reproductive health care for refugee and asylum-seeking women. *British Journal of Midwifery*, *24*(3), 275-281.

Sweeney, A., Clement, S., Filson, B. & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development. *Mental Health Review Journal*, 21(3), 174-192.

Thiara, R. & Roy, S. (2012). *Vital Statistics 2: Key findings report on Black, Minority Ethnic and Refugee Women's and Children's experiences of gender-based violence*. London: Imkaan.

UN General Assembly. (1951). *Convention Relating to the Status of Refugees*. United Nations, Treaty Series, vol. 189, p. 137