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Increased vulnerability to gender-based violence (GBV) in refugee women in humanitarian settings. Identifying the gaps

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Abstract

Gender based violence (GBV) remains one of the most serious threats to the health and safety of women worldwide. The problem is even more pronounced in refugee populations where women are at increased risk of violence. Continuing international conflict has resulted in several million people seeking asylum in other countries each year, over half of whom are women. A systematic literature review of articles published between 2010 and 2020 was conducted. Databases included PubMed, PsychINFO and Google Scholars. Thirteen studies met the inclusion criteria. Study findings indicate that refugee women are extremely vulnerable to gender-based violence and although international NGOs and UN agencies have published guidelines relating to the prevention and management of GBV, they usually fail to address the complex dynamics and factors contributing to GBV exposure of female refugees. From our review is obvious that these services and/or interventions are either not available or the affected populations don't have satisfying access, use, uptake and quality, due to a range of different barriers. In conclusion, it is unlikely that the flow of refugees will diminish significantly in the near future. A genuine commitment to protect refugee women from gender-based violence needs more action to tackle the various causes of vulnerability to violence, and to provide adequate services for those experiencing such violence, is needed.

Keywords: gender-based violence; female refugees; humanitarian setting; barriers; review

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Background

The global migrant/refugee crisis is now at the highest level ever recorded, with about 65.6 million people worldwide forcibly displaced as a result of persecution, conflict, generalized violence, or human rights violations in 2016 (1). Of these, 22.5 million were refugees; 2.8 million, asylum seekers; and 40.3 million, internally displaced persons within their own countries. Conflict affected refugees and internally displaced persons (IDPs) are at increased vulnerability to gender-based violence (GBV). One in five female refugees or internally displaced persons (IDPs) are estimated to experience sexual violence in their lifetime; yet, even this high figure may be underestimated due to significant under-reporting of GBV (2). For these populations, violence may occur within the context of war or conflict, during transit and displacement, and in the camp/settlement setting. The consequences can be extremely serious. For example, it can lead to mental disorders, obstetric complications, sexual dysfunctions, unwanted pregnancies, unsafe abortions and sexually transmitted infections (3). Gender-based violence (GBV) in humanitarian emergencies is progressively recognized as a global public health problem. The global public health community is progressively recognizing GBV as a significant issue affecting the health of women (4).

The humanitarian field has responded to the burden of gender-based violence (GBV) through the development and implementation of interventions and services, whereas guidelines have been established to support the development of minimum package of services to prevent and respond to GBV in humanitarian settings (5,6). In response to efforts to address GBV, health, psychosocial, and protection services have been implemented in humanitarian settings, but GBV remains under-reported and available services under-utilized (2).

The primary objectives of the systematic review are to 1) synthesize data about the gender-based violence (GBV) among female refugees, 2) mention any existing programs/ practices/ interventions used for the identification and preventions of GBV in the humanitarian settings, 3) identifying the barriers in using GBV existing services.

Methods

Definitions

The population will be restricted to refugee, internally displaced, or conflict-affected women who live in the situation of humanitarian settings. In this review, refugees and IDPs will be defined as people who have been displaced or fled within or outside their home countries because of armed conflict and other situations of violence (not related to natural disasters).

A humanitarian setting is one in which an event or series of events has resulted in a critical threat to the health, safety, security or well-being of a community or other large group of people. This can be the result of events such as armed conflicts, natural disasters, epidemics or famine, and often involves population displacement (7). In this review, the situation of humanitarian settings is defined using the criteria specified by the Sphere Standards as a range of situations including conflict and complex political emergencies in all countries (8,9).

Gender-based violence (GBV) was defined in accordance with UNHCR GBV guidelines as "an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females" (10). Thus the term GBV includes but is not limited to acts of sexual violence, including sexual exploitation and/or abuse; forced prostitution; domestic violence; trafficking; forced prostitution; domestic violence; trafficking; forced/early marriage; and harmful traditional practices such as female genital mutilation, honor killings and widow inheritance (a type of marriage in which a widow marries a kinsman of her late husband, often his brother) (10). Harmful traditional practices were not included in this review.

Literature Search

A systematic review of academic literature was conducted focused on gender-based violence in refugee women in humanitarian settings. The methodology of this systematic re-

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view was based on the six stage framework outlined by the Cohrane Handbook for Systematic Reviews of Interventions (11): (1) identifying the research question; (2) developing search protocol; (3) identifying relevant studies based on search protocol; (4) study selection; (5) charting the data; (6) collecting, summarizing and reporting the results. A narrative synthesis of the results is provided, based on PRISMA principles (12). For academic literature we searched Pubmed, PsychINFO and Google Scholar.

A list of key search terms was developed through a preliminary review of the literature on GBV. The search terms included "Refugee", "Women", "Gender Based Violence", "GBV", "sexual violence", "humanitarian settings". The bibliographic search was carried out in March 2020 and was limited to results occurring from 2010 till today. All relevant materials were considered. Studies not published in English and review studies, were excluded. Inclusion criteria required those displaced by conflict in complex humanitarian settings. We excluded studies that focused on displacement associated with natural disasters, those focused on female genital mutilation as a form of sexual violence, studies in which it was unclear as to whether the study population was migrant or refugees or if the results were not stratified on the basis of migrant or refugee/IDP status. Once potential articles and reports were identified by our search procedures, titles, abstracts, and/or summaries were examined to see whether to determine they addressed this review's key component. After this, we undertook a full resource review of remaining search results.

Results

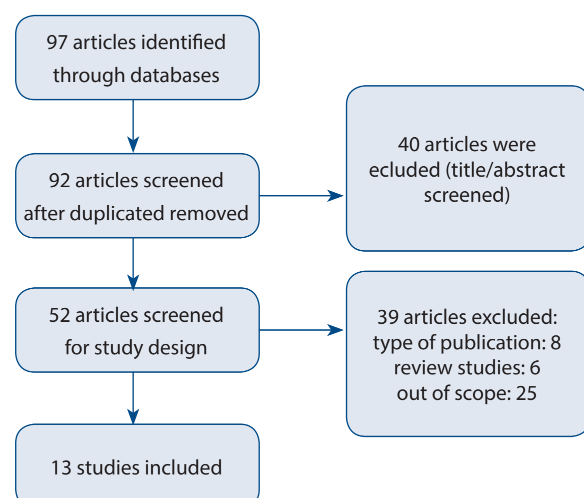
Search results

A total of 97 articles were identified. After removal of duplicates, 92 articles were included in the title/abstract review. Of them 40 articles were excluded based on their title and/or abstract screening. From the 52 articles included in full text review, 39 articles were excluded by the following criteria: type of publication (comments, letters, books, notes, editorial, abstracts of lectures and dissertations, etc, n=8), review studies (n= 6), out of scope (studies were not about female; concerned genital mutilation/cutting; concerned physical disasters, etc, n=25). The selection of the 13 studies included in our review is summarized in Figure 1. The synthesized results of these articles are discussed below.

Characteristics of the studies and their populations

The 13 articles selected were all published in English between 2010 and 2020 and conducted in 11 different countries (Canada, Democratic Republic of Congo, Belgium, Netherlands, Uganda, Kenya, Ethiopia, Cameroon, Pakistan, Myanmar, Colombia). Studies involved 2800 refugees, asylum seekers or IDPs in total. Participants came from 23 different countries (Guatemala, El Salvador, Honduras, Colombia, Argentina, Dominican Republic, Peru, Mexico, Democratic Republic of Congo, Afghanistan, Former USSR, Iraq, Iran, Slovakia, Czech Republic, Somalia, Sudan, Ethiopia, Kenya, Cameroon, Myanmar, Burundi, Eritrea). The study sample sizes ranged from 12 to 600. The age range varied 15 - 99 years of age.

Extracted information related to the study characteristics included: First Author (year of publication), Country of study, Country of origin of refugee/displaced, Age range (years), No. of females in sample (N), Type of GBV, Prevention/management measures against GBV, Barriers to reporting. Extracted data are presented in the following figure.



DOI: 10.26386/obrela.v3i2.169

Types of gender based violence (GBV)

Results from the literature review suggested that refugee women are extremely vulnerable to gender-based violence, with most cases consisted of multiple forms of violence occurring in one incident with multiple perpetrators (24). Below, we summarized types of gender-based violence found in our review:

(a) Sexual violence

Sexual violence was prevalent in most of the reviewed studies (14 - 16, 18, 19, 21 – 25). The bulk of the sexual violence cases consisted of rape (15, 16, 20, 23 – 25), sexual coercion (24), trafficking (23, 25). In a study of sexual violence among host and refugee population in Djohong District, Eastern Cameroon (21), lifetime prevalence of sexual violence among the female refugee population found to be 40.8%, while the prevalence of sexual violence over the last 6 months was 39.0%. Experiences of rape were also reported to be common among women across the included surveys. In a study among Somali women (20), rape was reported by at least 18% of the sample population. In a cross-sectional survey on gender-based violence and mental health among female refugees and asylum seekers in Kampala, Uganda (18), sexual violence was found to be 63.3%. The weighted prevalence of completed forced sex was 48.8% and that of attempted sex was 58.3% (18). Rates of lifetime reported sexual violence were 39.7% among refugee women in Eastern Democratic Republic of the Congo and the most common type of sexual violence reported was rape (50.8%) (14). Women and girls frequently were reported to become pregnant following rape and had to suffer the stigma and discrimination this brought (17). Rape, as an opportunistic violence, often occurred during transit when women depended on others to reach their destination (24), whereas in a cross-sectional study in Kitgum, Northern Uganda, over a quarter (28.6%) of women reported having suffered at least one form of war related sexual violence (16). Trafficking sometimes was associated with financial disparities, as some women reported sex work as the only feasible opportunity to improve their economic well-being (25).

(b) Emotional-psychological violence

Emotional-psychological violence was observed 5 studies (15, 19, 22, 24) and consisted mostly of humiliation, confinement and emotional-psychological abuse. In a community-based participatory research conducted with refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands, emotional-psychological violence was reported at 68% in Netherlands and 39% in Belgium (15), whereas reported incidents of emotional violence were 56% among Afghan refugees in Jalozai (Pakistan) (22).

(c) Physical violence

Physical violence largely included tactics that ranged from beating, punching or kicking, throwing/pushing and was found in 8 of the studies (14, 15, 18 - 20, 24, 25). In a study among Somali women, the physical violence was reported by at least 39% of women and girls (20). Physical violence was found alarmingly high (76.2%) among Congolese and Somali female refugees and asylum seekers in Kampala (18). 50.0% of refugee women in territories of the Eastern Democratic Republic of Congo reported physical violations, as well (14).

(d) Socio-economic violence

Socio-economic violence was observed in 2 of the included studies (15, 24). In a qualitative research in order to explore the range of experiences of GBV conducted by Wirtz et al. (24), survivors reported multiple forms of GBV including and social violence, such as community-level stigmatization, threats, or isolation of a woman. In-depth interviews with refugees, asylum seekers and undocumented migrants in Belgium and Netherlands revealed that populations in Belgium reported at 19% socioeconomic violence cases, whereas the corresponding cases for Netherlands were more than twice of it (42%) (15). Socio-economic violence consisted more frequently of the denial of legal assistance or obstructive practice related to the asylum procedure, the denial of services such as health care and discrimination/racism.

DOI: 10.26386/obrela.v3i2.169

(e) Intimate partner/ domestic/ intrafamilial violence

Intimate partners/ domestic violence was observed in 5 studies (13, 17, 19, 20, 23, 25). In a study in Dadaab refugee complex in Kenya with mainly refugees from Somalia, Ethiopia, South Sudan and Kenya (19), 66.7% of women had experienced intimate partner violence in their lifetime, with 51.0% of them experiencing intimate partner violence in the last 12 months. 31% of refugee women in the Eastern Democratic Republic of Congo also reported to have been exposed to intimate partner violence (14). Latin American women reported verbal psychological violence (insults, name calling, putting a woman down, telling her she was a bad mother, unfaithful, "worthless" or insulting her appearance) as the most common form of intimate partner violence in their adult lives, whereas frequently, more than one forms of intimate partner violence was experienced (13). Additionally, domestic violence was commonly reported in the settlements, many times reflecting the culturally accepted violence (17). Women in Colombia living in conflict areas widely reported intimate partners' violence and intrafamilial violence, often including threats, physical, and sexual violence (25).

(f) Other forms of violence

Other forms of violence reported in the reviewed studies were: abduction (14, 16, 24, 25), forced abortion (25) and reproductive control (25). Women living in conflict areas in Colombia, manifested partners' control of a woman's reproductive decisions (e.g. forced sex, forced abortion, partner control over contraceptive use, significant levels of physical violence during pregnancy), while abduction often perpetrated by strangers encountered in town (25). Refugee women in Ethiopia mentioned abduction, too, within the host country, and often across borders (24).

Prevention/management measures against GBV

Prevention measures were mentioned in 5 out of 13 studies included in the review (17, 19, 21, 22, 25). In the study concerning Afghan women living in refugee settings in Pakistan, clearly was declared that no prevention and/or management measure existed (22). In order to present the results of literature review about prevention/ management measures against GBV, we used the categorization proposed from Asgary et al. (26): (1) *Primary prevention of GBV* (e.g. identifying caused and contributing factors; transforming sociocultural norms; rebuilding family and community structures; effective service facilities; working with formal and traditional legal systems; assessment, monitoring and documentation; information, education and communication), (2) *secondary prevention of health sequelae of GBV* (e.g. HIV prophylaxis; gonorrhea and chlamydia prophylaxis; emergency contraception; group therapy counselling; education; other psychosocial support; community support groups; implementation of the minimum initial service package), and (3) *treatment of health sequelae* (e.g. Antibiotic therapy, cognitive therapies, psychotherapy, psychotropic medications).

(a) Primary preventions of GBV

The refugee population in Djohong District, Eastern Cameroon could report their assault to local authorities (police, military, district government officials, village authorities, etc) with the power to act on the information and bring the perpetrator to justice (21). In the Daddab refugee complex 53.6% women reported visiting NGOs in the camp settings, like IRC, CARE office and UNHCR, in order to seek some type of case management support (19). According to participants in the above mentioned study, attendance at one agency facilitated referrals to other organisations that could offer additional support to women (19). In a research investigated the health and justice services responses to the needs of South Sudanese refugees living in refugee settlements in Northern Uganda (17), different organisations were interviewed regarding their experiences of providing health and justice services to refugees and revealed limited service response. Service provision, on the basis of primary preventions, included: screening upon the refugees' arrival; justice services delivered by the police, UN organisations and civil society organization; psychoeducation groups with female refugees to educate them regarding access to justice

DOI: 10.26386/obrela.v3i2.169

(17). Additionally, civil society organizations and faith-based organisations engaged in raising awareness regarding GBV in the settlements, provided training for the police, and trained community leaders to act as refugee mobilisers (17).

(b) Secondary prevention of health sequelae of GBV

Refugee settlements in Northern Uganda provide secondary prevention of health sequelae of GBV among South Sudanese refugee living there (17). Among the offered services, more prevalent were health service facilities with available drugs and other treatment needed, which although present shortages in HIV and other life-saving drugs, as well as lack of specialists, including reproductive and gynaecological professionals to assess and treat female survivors of GBV (17). Some non-government, government and international organisations provide services included assessment and treatment and civil society organizations offer some limited health screening and health interventions, however there are many challenged providing adequate services for refugees (17). Additionally, local civil society organisations and NGOS provided psychological services, as individual counselling (17). In the conflict setting in Colombia there found to be often minimal or no health protection services and most participants in the survey, rarely sought or received medical care (25). On the other hand, in each displacement site in Colombia, participants reported a range of GBV survivors' services (25). Available health services included medical exams and gynecologic, forensics kits for sexual violence, HIV and STI testing, contraceptives, and post-exposure prophylaxis for HIV prevention at the local hospital and/or clinic, counseling and psychosocial, legal and protection services (25).

(c) Treatment of health sequelae

In Northern Uganda refugee settlement civil society organizations, local NGOs and faith-based organisations provided important psychotherapeutic services through refugee survivor groups, in order to assist them overcome their traumatic experiences and build resilience (17).

Barriers to reporting GBV

In a mixed-methods design study with women survivors of GBV in two camps within the Dadaab refugee complex in Kenya, barriers to accessing GBV services included stigma by family and the community, fear of further violence from perpetrators, feelings of helplessness and insecurity, being denied entry to service provision premises by guards, and fears that their case, information may not be kept confidential, and lack of knowledge of how and where to seek help, as well as language or ethnicity differences (19). Lack of knowledge of where to seek help and language or ethnicity differences were the main barriers of reporting GBV faced by refugee women in Uganda, 72.9% of the women reported seeking mental health counseling, didn't know where to go, whereas 42.2% were affected by language or ethnicity differences, 16.8% were unable to pay and 7.6% felt that they did not need counseling (18). Shame and fear were the reasons that refugee Latin American women in Toronto often didn't mention GBV problems for years (13). Poor experiences and perceptions of the survivors regarding the quality and safety of available services prevent displaced women in Colombia from seeking help, along with embarrassment and shame, concerns related to confidentiality and privacy, and barriers concerning access to service provision (inaction by the provider, delays, stigmatization in the facility) (25). Colombian women were, also, afraid of breaking up family or losing financial support (25). Refugee women's in Ethiopia main barriers to reporting included perceived and experienced stigma in health setting and in the wider community, whereas, again, lack of knowledge about the offered services and concerns about lack of confidentiality were mentioned, as well as inability to protect children while mothers sough services (24).

Discussion

Gender-based violence (GBV) in humanitarian emergencies is progressively recognized as a global public health problem, with conflict affected refugees and internally displaced persons (IDPs) being at increased vulnerability to GBV. In

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general, data on GBV within displaced populations is severely underreported, and the quality of reported data is questionable (26, 21). Violence against women is an important cause of morbidity and mortality though it receives a little attention as a public health issue but has profound effect on mental and physical well-being of the affectees (22). Although there is a huge methodological heterogeneity of studies under this review, so we cannot present accurate data on GBV prevalence among refugee women populations, GBV appears to be present at high levels among this populations, with the most reported GBV type being rape.

In the last decade, there has been a call for greater recognition of GBV in the refugee settings with many international NGOs and UN agencies (UNHCR, WHO, and IASC) have published guidelines relating to the prevention and management of GBV (26, 27). The guidelines aim to address the root causes of GBV and ensure that international human rights standards are protected and promoted, but often these guidelines fail to address the complex dynamics and factors contributing to GBV exposure of female refugees, as they tend to position refugees disconnected from context (27). From our review is obvious that these services and/or interventions are either not available or the affected populations don't have satisfying access, use, uptake and quality, due to a range of different barriers.

Social stigma and shame are among the most prevalent barriers in reporting GBV (13, 19, 25). One of the major barriers to developing effective policies and programmes to prevent GBV and to provide help and support to survivors, is the reluctance of refugee women to talk about their experiences and particularly to testify experiences of GBV (28). Additional barriers of language, cultural distance or lack of knowledge of who to report to, were mentioned as well (18, 19, 24, 25). Issues of insecurity and fear of non-confidentiality from service provision, discouraged women from seeking help (19). Based on the above mentioned, a need for interventions in order to centrally support women to access services is revealed.

Conclusions

It is unlikely that the flow of refugees will diminish significantly in the near future. Ongoing conflict and persecution in various countries will continue to augment these flows of people affected humanitarian emergencies. A genuine commitment to protect refugee women from gender-based violence needs more action to tackle the various causes of vulnerability to violence, and to provide adequate services for those with experience of such violence, is needed. Evaluations of GBV prevention efforts must be given higher priority to justify continuation or revision of recommended GBV activities/programs being implemented in diverse humanitarian settings. Findings demonstrate that survivors experience significant individual and system barriers to disclosure and service utilization. Refugee women cannot rely on short-term GBV responses but require a long-term commitment across government and humanitarian sectors to ensure protection for all women. More vigorous action is needed to prevent and to respond to sexual violence among refugees and displaced populations, identify methods to assist survivors, and hold perpetrators accountable. The review will be useful for GBV management policy and related planning. It will help researchers, policymakers and guideline developers with an interest in reduction violence against refugee women, internally displaced (IDPs), and conflict-affected populations.

Limitations

There are some limitations to this review. Our search focused on peer-reviewed publications and has excluded non-English articles. The studies came from multiple countries and considered multiple refugee nationalities and there was also heterogeneity of outcomes.

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