"Journey of hope": a study on sexual gender-based violence reported by asylum-seeking women during their journey to Europe

"Viaggio della speranza": uno studio sulle violenze sessuali subite dalle donne richiedenti asilo nel corso del loro viaggio verso l'Europa

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ABSTRACT

OBJECTIVES: to describe sexual gender-based violence (SGBV) reported by asylum-seeking women during their journey from their country of origin to Italy, using data obtained from medical record of asylum seekers hosted between June 2016 and December 2017 at the "T. Fenoglio" Red Cross Reception Centre, one of the largest Italian regional hubs; to evaluate if, based on these data, it is possible to hypothesize an underreporting of SGBV from these women.
DESIGN: cross-sectional study.
SETTING AND PARTICIPANTS: 2,484 asylum-seeking females hosted in the centre for initial-reception of Piedmont and Valle d'Aosta regions (Northern Italy) between June 2016 and December 2017.
MAIN OUTCOME MEASURES: prevalence of SGBV.
RESULTS: among the women arrived at the centre, 46 reported being victim of SGBV during their journey to Italy (prevalence: 1.85%; 95%CI 1.39-2.46), 37 of which with reliable and verified data supported by health certification documentation (prevalence: 1.49%; 95%CI 1.08-2.05). Women who suffered SGBV have a higher prevalence of diseases than their counterpart (more blood, digestive, neurological, psychological, genital diseases, and AIDS), are more frequently pregnant, and asked more frequently for a voluntary interruption of pregnancy.
CONCLUSIONS: the low prevalence of SGBV identified suggests that underreporting and under-recognition of the phenomenon are possible. This highlights the need to offer a psychological support to all migrant women at their arrival in the Italian hubs, also when they do not report violence.

Keywords: asylum seeker, sexual gender-based violence, migrant women, regional hub

WHAT IS ALREADY KNOWN

- **During the journey from their countries of origin to Europe, the asylum-seeking females are at high risk of suffering from sexual gender-based violence.**
- **This risk is particularly high if the journey implies to cross Libya.**
- **Women who are victims of sexual gender-based violence have a higher probability of physical and mental health consequences.**

WHAT THIS PAPER ADDS

- **For the first time, the prevalence of sexual gender-based violence in asylum-seeking women hosted in an Italian regional hub was estimated, corresponding to 1,49 every 100 women.**
- **Women victims of sexual gender-based violence arrived in Italy slightly sicker than their counterparts and about half of them were pregnant.**
- **More than one-third of these women asked for a voluntary interruption of a pregnancy, suggesting that this is the main factor that led them to denounce the violence.**

RIASSUNTO

OBIETTIVI: descrivere le violenze sessuali riportate dalle donne richiedenti asilo nel corso del viaggio dalla loro nazione di origine fino in Italia, usando i dati contenuti cartelle cliniche dei richiedenti asilo ospitati tra giugno 2016 e dicembre 2017 al centro di accoglienza "T. Fenoglio" della Croce Rossa, uno degli *hub* regionali italiani più grossi; valutare, inoltre, se sulla base dei dati si possa ipotizzare una sottostima delle segnalazioni di violenza da parte di queste donne.
DISEGNO: studio di prevalenza.
SETTING E PARTECIPANTI: 2,484 donne richiedenti asilo arrivate alla struttura di prima accoglienza di Piemonte e Valle d'Aosta tra giugno 2016 e dicembre 2017.
PRINCIPALI MISURE DI OUTCOME: prevalenza di violenze sessuali riscontrate all'arrivo al centro.
RISULTATI: tra le donne arrivate al centro, 46 hanno riportato una violenza sessuale nel loro viaggio verso l'Italia (prevalenza: 1,85%; IC95% 1,39-2,46), di cui 37 con dati verificati e supportati da documentazione sanitaria (prevalenza: 1,49%; IC95% 1,08-2,05). Le donne che avevano subito una violenza sessuale avevano una prevalenza maggiore di patologie rispetto alle altre (in particolare patologie del sangue, digestive, neurologiche, psicologiche, genitali e AIDS); inoltre, tra loro era più alta la percentuale delle donne incinte e particolarmente alta quella di coloro che richiedevano un'interruzione volontaria di gravidanza.
CONCLUSIONE: la bassa prevalenza di violenze sessuali identificata suggerisce una possibile sottostima dovuta a una sottosegnalazione e a un sottoriconoscimento del problema. Questo suggerisce la necessità di fornire un supporto psicologico a tutte le donne al loro arrivo negli hub italiani, anche se non riportano violenze.

Parole chiave: richiedenti asilo, violenza di genere, donne migranti, *hub* regionali

INTRODUCTION

As a main consequence of the Arab Spring and the Syrian Civil War, between 2015 and 2017 almost three million people reached the European Union in search for international protection from war and violence.[1] Due to its geographical proximity to Libya, by the end of 2017 Italy had welcomed 167,335 refugees, 186,648 asylum seekers, and 715 stateless people.[2] A number of regional hubs provided temporary hospitality, health care, and education for these migrants.

At the moment of their arrival, asylum seekers are affected by several communicable diseases, including respiratory infections, and non-communicable diseases such as gynaecological and obstetric complications, physical injuries, depression, and anxiety. As several studies show,[3-5] actual health outcomes vary significantly and they are the result of the degraded health systems in their home country and of the hazards of the journey.

According to Bouhenia et al.,[6] migrants coming from Africa spend on average 399 more days travelling than people coming from the Middle East or Asia. Furthermore, they spend much of this time (180 days) in Libya.[7] Libya is a necessary midway for most migrants landing in Italy, with major hazard for migrants' health due to high rates of violence (88.2% for women and 93.6% for men) and sexual violence (53.3% for women and 18.9% for men) experienced there, and practically no access to health care.

Indeed, only 12.7% of migrants who arrived in Europe are women,[8] but they are the most exposed to sexual abuses, tortures, and human trade during the journey.[4] Migratory violence adds up with widespread sexual gender-based violence (SGBV) in the home country. According to most recent data, 30.0% of women have experienced intimate partner violence and 7.2% from non-partners in their lifetime globally.[9] These figures rise up to 65% and 21% in the sub-Saharan region.[10] As a result, at the moment of their arrival in the host country, victims of SGBV often suffer from physical injuries, abortions, depressions, and higher rates of HIV and sexually transmitted diseases (STDs).[11]

The World Health Organisation (WHO) has long stressed the health detrimental consequences of violence and highlighted the risks of underreporting due to fragmented data collection and conflicting social norms. This is particularly significant for migrant people.[9]

The quantitative survey of Bouhenia et al.,[6] conducted in the "Jungle" camp in Calais, describes several types of violence endured by migrants during the journey; however, it underlines as a limitation the small numbers of women in the sample and the possible under-reported number of sexual violence, thus pointing to the need of targeted SGBV research.

A recent study by Castagna et al.[10] evaluated the health of 143 migrant women, mainly from Nigeria, the Democratic Republic of Congo and the Ivory Coast, who were admitted at the Rape Centre "Soccorso Violenza Sessuale" at Sant'Anna Hospital in Turin between 2007 and 2016. The mean age of the women was 26. The study reported that 136 had experienced sexual violence (92.6% of them in Libya) and that, in most cases (72.8%), the perpetrator was previously unknown to them. For 30.2% of the women, the violence resulted in pregnancy and in 15 cases they received a therapeutic abortion at the Sant'Anna Hospital. The number of women received by the Centre increased significantly over the years under study, as a consequence of rising numbers of asylum seekers settling in Turin at that time.

Overall, existing studies on the topic offer discording estimates of SGBS in migratory situations, and data about the relationship with their perpetrators and the location vary significantly,[12] but there is widespread agreement that it constitutes a human tragedy with detrimental health consequences.[9]

This study aims to describe SGBV reported by asylum seeking women during their journey from their country of origin to Italy, using data obtained from medical record of asylum seekers hosted between June 2016 and December 2017 at the "T. Fenoglio" Red Cross Reception Centre, one of the largest Italian regional hubs. Moreover, it aims to evaluate if, based on these data, it is possible to hypothesize an underreporting of SGBV from these women.

MATERIALS AND METHODS

The study was carried out at the "Teobaldo Fenoglio" multifunctional reception centre (hub) in Settimo Torinese managed by the Italian Red Cross, where asylum seekers destined to Piedmont and Valle d'Aosta regions (Northern Italy) are hosted after arriving in Italy.

The centre only hosts adults or parents with minor children; unaccompanied minors follow a different path. Upon their arrival, all asylum seekers undergo a medical examination to assess general health conditions and, if necessary, treatments are administered.

For each asylum seeker, a physician of the centre fills in a medical record, reporting personal data, the results of the physical examination, vital signs (heart rate, blood pressure, and oxygen saturation), nutritional status (assessed through body mass index – BMI), any drugs and/or medications administered, and the need for hospitalisation.

A chest X-ray to check for tuberculosis, if necessary, can be performed inside the camp. To investigate further pathologies or manifested disorders, besides the first visit at the camp, other specialist visits can be performed in various local hospitals.

In the study, all the women that arrived at the centre from June 2016 to December 2017, for whom medical records were retrieved and digitalized, are included.

Variables considered are: date of birth, nationality, origin, disembarkation date, date of arrival in Settimo Torinese, countries crossed (if they were mentioned), pregnancy, any pathologies at the arrival (coded using the International

Classification of Primary Care, 2nd revision – ICPC-2R)[13] with related therapies, subsequent pathologies related to prolonged permanence in the centre and associated therapies, and BMI. Asylum seekers were grouped by their area of origin, considering 7 macro geographical areas: the Horn of Africa, Central and South Africa, the Middle East, North Africa, the East and South Asia, the Sub-Saharan Africa and a residual category that includes other areas of origin, mainly the Balkan and ex-Soviet Union areas.

A specific focus was devoted to any findings or hypotheses of violence or torture suffered with related notes.

Data were described using absolute frequencies and percentages. Acts of violence are described using prevalence over 100 women and the corresponding 95% confidence interval (95%CI).

Analyses were performed using SAS V9.4.

RESULTS

In the period considered, 2,484 women were admitted at the "T. Fenoglio" centre, being about 19% of the total population admitted. Characteristics of these women could be found in table 1: more than 55% of them were between 18 and 24 years old and most of them came from the Sub-Saharan Africa area (68%). During their permanence in the centre, 206 women were hospitalised: 35.92% of them was treated in a hospital specialized in obstetrics and gynaecology, while the remaining 64.08% was treated in other local hospitals.

From medical records, 53 cases of torture (prevalence: 2.13%; 95%CI 1.63-2.78) and 46 of sexual violence have been identified (prevalence: 1.85%; 95%CI 1.39-2.46), 37 of which with reliable and verified data supported by health certification documentation (prevalence: 1.49%;

VARIABLES	WOMEN NO SGBV		WOMEN SGBV	
	No. (%)		No. (%)	
Sample	2,447		37	
Age Classes				
< 18 years	254	(10.4)	1	(2.7)
18-24 years	1,351	(55.2)	29	(78.4)
25-34 years	680	(27.8)	7	(18.9)
>35 years	157	(6.4)	0	
Missing	5	(0.2)	0	
Provenience				
Sub Saharan Africa	1,654	(67.6)	34	(91.9)
Central and South Africa	40	(1.6)	2	(5.4)
Horn of Africa	558	(22.8)	1	(2.7)
Middle East	89	(3.6)	0	
North Africa	94	(3.8)	0	
Others	12	(0.5)	0	
Pathologies at the arrival	529	(21.6)	11	(29.7)
Type of pathologies				
General and unspecified (A)	110	(4.5)	1	(2.7)
Blood, Blood Organs and Immune Mechanism (B)	3	(0.1)	3	(8.1)
Digestive (D)	76	(3.1)	3	(8.1)
Eye (F)	8	(0.3)	0	
Ear (H)	1	(0.1)	0	
Cardiovascular (K)	9	(0.4)	0	
Musculoskeletal (L)	27	(1.1)	0	
Neurological (N)	16	(0.7)	2	(5.4)
Psychological (P)	6	(0.2)	2	(5.4)
Respiratory (R)	68	(2.8)	1	(2.7)
Skin (S)	130	(5.3)	1	(2.7)
Endocrine/Metabolic and Nutritional (T)	6	(0.2)	0	
Urinary (U)	3	(0.1)	0	
Female Genital (X)	38	(1.6)	2	(5.4)
Sexually transmitted diseases	0		3	(8.1)
Pregnancy	252	(10.3)	20	(54.1)
Request for voluntary interruption (% on pregnant women)	14	(5.6)	14	(70.0)

Table 1. Characteristics of women admitted to the "T. Fenoglio" in the period 01.06.2016-31.12.2017, stratified by presence or absence of sexual gender based violence (SGBV).
Tabella 1. Caratteristiche delle donne ricoverati nella clinica "T. Fenoglio" nel periodo period 01.06.2016-31.12.2017, stratificate per presenza o assenza di violenza sessuale (SGBV).

95%CI 1.08-2.05). The remaining 9 cases were presumed by the physician who visited the women, but they were not ascertained due to a lack of collaboration. The majority of women (No. 25; 67.6%) reported that the violence was committed during their stay in Libya.

About 80% of the women who suffered a SGBV are in the age class 18-24 years, as opposed to 55% in the other women in the considered sample, and they come mainly from Sub-Saharan Africa (91.9% *vs* 67.6%; p-value=0.002), including 25 out 37 (67.6%) that are Nigerian.

At their arrival, women who suffered SGBV had a higher prevalence of diseases than their counterpart (29.7% *vs* 21.6%, p-value=0.23), with more blood, digestive, neurological, psychological, and genital diseases; conversely, they had a lower percentage of skin diseases. Moreover, three of these women were affected by AIDS, a pathology that was not diagnosed in all others.

Out of 37 victims of SGBV, 54% (20 women) appeared to be pregnant (2nd-3rd month of gestation on average) and 14 of them (70.0%) applied for a voluntary interruption of pregnancy in Italy. These percentages are higher than those found for other migrant women in the considered sample (10.3% pregnant women, of which 5.6% asked for a voluntary interruption of pregnancy; p-values for both comparisons <0.0001).

From medical records, it was possible to identify 6 women who were certainly victims of trafficking[14] (16.3%), although further cases were suspected. Moreover, 8 women (21.6% of the total) reported that they were sold and forced to prostitute themselves, often with the complicity of the relatives themselves, especially uncles or aunts who took over after the death of the women's parents.

Finally, 25 women reported about violence on the first visit (the 67.6% of the total) and they were immediately received by a psychologist. The rest asked for help later, probably encouraged by someone in the camp, as it was referred by the camp psychologist. Only 3 (8%) women officially reported the SGBV to the police and two of them were transferred to a protected facility.

DISCUSSION

In the last decade, several pieces of evidence were provided to demonstrate that SGBV is a constant risk for migrant women[15-17] and qualitative studies highlighted that sexual assault is a very likely event throughout the entire journey to Europe.[18]

Three main routes have been identified to reach Southern Europe: the Eastern Mediterranean to Greece, the Western Mediterranean to Spain, and the Central Mediterranean route to Italy.[19,20] Among these routes, the latter is known to be the one at higher risk of physical and sexual violence, mainly because it requires to cross Libya, where women are systematically under threat of being raped by smugglers, and sometimes by the Libyan police itself.[21] Consistently, in the samples considered in this study, most of the women who suffered SGBV came from Sub-Saharan Africa, mainly from Nigeria, and they probably arrived in Italy by crossing Niger and then Libya, where the majority experienced the sexual abuse.

A recent systematic review on the prevalence of SGBV among refugees[12] pointed out the difficulties in measuring the magnitude of this phenomenon, observing that its percentage varies between about 0% to about 100%, with no clear explanation of this heterogeneity. In fact, the large variation described in the review did not depend on the countries of origin, on where data were collected (health units, refugee camps, and community), or on which instrument was used to collect SGBV.

In the present study, a prevalence of SGBV of 1.85 every 100 women was observed, lower than what was expected. The present results suggest that probably the interpretation of this low percentage is more in the line of under-reporting rather than a real smallness of the phenomenon. Underestimation of SGBV is indeed common, because of women's fear of retaliation by other community members as well as their fear of a possible negative impact on their asylum care or stay in the country.[22,23] In the present sample, two factors are evident: first, women who suffered SGBV are sicker than their counterpart, experiencing more neurological, psychological, genital, and sexually transmitted diseases; second, their request for voluntary pregnancy interruption is 12 times higher than that of other women in the considered sample. These two factors suggest that these women are willing to overcome the barriers of reticence and to talk about the suffered violence almost exclusively when they have some specific and related healthcare need, particularly if they want to interrupt their pregnancy. The latter has been the more evident driver, also considering that rape is one of the few cases for which legal abortion is permitted in most of the African countries.[24]

Because of the aforementioned reasons, in this survey it has probably identified only the portion of women who experienced SGBV with related physical health problems or unintended pregnancies. It may be likely that women who suffer post-traumatic stress disorder, depression, anxiety, sleep disturbances, self-harm, and suicidal behaviour as a consequence of SGVB do not report about violence to the physician during visits. This could be due to different reasons, in particular, because the symptoms may appear several weeks after the episode, and then, they might not be recognized by the women as a health problem related to the violence; finally, since in most cultures there is a tendency to blame the survivor in the cases of violence, these symptoms might be perceived by women as an expression of guilt or shame.[25] Anyway, WHO recommends not to force a woman to talk about a SGBV she may have experienced if she does not want to, even if physicians presume it happened.[11]

CONCLUSIONS

The possible underreported prevalence of SGBV in migrant women and the evidence of a high probability of physical and mental health consequences due to this violence[25-27] suggest the need to offer a psychological support to all migrant women at the time of their arrival in the Italian hubs, even if they do not report violence. This support could also help women to promote their right to have a fear-free life and to be in charge of taking decisions regarding their own sexual and reproductive conduct. Furthermore, it could help the identification of possible mental health disturbances and the referral to public mental health services, with the goal to assure a successful and constructive integration of asylum-seeking women in the Italian society. Moreover, further epidemiological surveys are needed to estimate more precisely the dimensions of the SGBV phenomenon. In particular, the new studies might accurately describe the population (i.e., ethnicities, country of origin, individual characteristics) and the settings (migration routes, condition of the journey) investigated. Only with a depth analysis of population characteristics it will be possible to compare the prevalence data obtained and explain differences.

Conflict of interest: none declared.

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