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Forced migration, SGBV and COVID-19

UNDERSTANDING THE IMPACT OF COVID-19 ON FORCED MIGRANT SURVIVORS OF SGBV

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Executive Summary

Forced migrant survivors of SGBV constitute some of the most marginalised groups within countries of refuge. This report explores the effect of the COVID-19 pandemic on forced migrant survivors of sexual and gender-based violence (SGBV) and the organisations which support them across the five countries involved in the SEREDA project; the UK, Turkey, Tunisia, Sweden and Australia. Interviews with 52 survivors and 45 service providers identified a number of effects associated with the pandemic which impacted on the lives of forced migrants and survivors of SGBV, undermining their coping, recovery, ability to integrate and potentially increasing their vulnerability to further abuse and exploitation.

The study identified the impact of the emergency at three levels:

- those which are likely to affect the general population;
- those that are likely to be specific to forced migrants, and;
- those that arise because of the intersection of forced migration with SGBV.

While it was evident that experiences during the COVID-19 crisis varied by legal status, country, and gender, forced migrant survivors' precarious situations were exacerbated across different domains, including:

- **Health and wellbeing:** Undocumented migrants were anxious about seeking medical help and fearful of health charges or being reported to immigration authorities and deported. Some survivors of SGBV required continued treatment for injuries and chronic conditions post-violence but they reported barriers to accessing specialist services, including reproductive health services.
    - **Social isolation** exacerbated existing feelings of loneliness, sadness, and anxiety about income, health, and the future. The crisis has profoundly affected mental health of forced migrant survivors, the majority of whom have already experienced multi-layered trauma.
    - **Digital poverty** excluded many from participating in online support groups and some spent long days alone, sleeping, overthinking their past and worrying about future.

- **Economic:** Without savings, individuals were unable to stockpile food items and feared going hungry. Survivors struggled to receive support due to pandemic restrictions, which included suspension of some support services. Work previously available in the informal economy disappeared. The stress of these socio-economic burdens was exacerbated by increased care and domestic responsibilities as schools closed.
    - For survivors of SGBV, without resources and outside of social protection, losing income opportunities increased economic hardship. The vulnerabilities and precarity experienced pre-COVID-19 due to their gender, care responsibilities and insecure immigration status, increased vulnerability to abuse and exploitation.

- **Accommodation:** Forced migrants living in shelters, shared accommodation and overcrowded housing with shared kitchens and toilets were unable to self-isolate. Living in overcrowded facilities generated health risks and anxiety about contracting the virus.

- **Legal:** Legal status introduced a range of barriers which shaped survivors lives from no access to public funds and services, including healthcare, not being allowed to work or to open a bank account. Slowing down of asylum seeking and resettlement processes meant putting their lives on hold even longer.

- **Amplified vulnerability:** Some forced migrant women were trapped between remaining in abusive or exploitative situations or homelessness as they did not qualify for public housing and support.
    - Service providers were concerned that **long-term emotional and psychological impacts** of violence would emerge post-crisis, coupled with the longer term **economic implications** for resources, access and employment.

- **Access to services:** Restrictions implemented to control COVID-19, including working from home, self-isolation and physical distancing, significantly affected the nature of support service providers were able to offer survivors. Welfare organisations transitioned to remote, phone and online service delivery. Some organisations in humanitarian contexts lacked infrastructure to shift to remote working.
    - Across the five countries nearly all **face to face activities were suspended** during lockdown.
    - Across the five countries service providers noted that SGBV **case management had become slower** than usual.
    - The increased demand for services in the crisis coupled with working from home put **staff under psychological and emotional strain** at the same time as they experienced their own anxieties about health and isolation.
    - Service providers anticipated in the longer term increased **competition for, and diversion of, funds** as priorities changed post-crisis.

In the interests of protecting public health and ensuring individuals' rights, this report offers the **immediate recommendations** to governments during social distancing measures, including:

- Ensure **social protection and basic safety nets** for all forced migrant populations regardless of legal status;
- Ensure **access to universal health for all**; revoke all medical charges;
- Ensure **availability of emergency accommodation and safe shelter** for all survivors of violence.

Also, as countries begin to ease pandemic restrictions and move toward recovery, we include recommendations for **longer term measures** to governments and service providers, including**:**

- Mainstream a gender perspective in response, recovery and preparedness plans and include **specific measures for forced migrant SGBV survivors**;
- Expand **women's economic empowerment** programmes to support survivors to become self-reliant, and **decrease dependency on aid**;
- Design interventions in ways that **support survivors' coping and recovery** mechanisms through consultation with survivors and those who work with them.

1. Introduction

The emergence of the COVID-19 pandemic has had an impact on populations across the globe, but not all populations are affected equally. Pre-existing health and socio-economic inequities shape people's vulnerability to the disease, exacerbating unequal societal structures as they determine inequitable health and socio-economic outcomes across different members of society. For instance, in the UK and the US higher rates of infection and mortality are becoming evident for Black, Asian and Minority Ethnic (BAME) groups[i]. Emergent studies[iiiii] highlight an association between lockdown and increased intimate-partner violence (IPV). Concerns have been widely expressed that forced migrants across the globe, many of whom live in crowded, sometimes makeshift accommodation with poor access to food, sanitary items and healthcare and those who are dependent on Non-Governmental Organisations (NGOs) or the informal labour market, may be at particular risk and particularly unable to protect themselves from infection or to care for themselves with infection.

This report explores the effect of the COVID-19 pandemic on forced migrant survivors of sexual and gender-based violence (SGBV) and the organisations which support them. Based on interviews with 52 SGBV survivors and 45 service providers in five countries we examine multiple accounts of the impact of the public health emergency. Analysis reveals three levels of effect: those which are likely to affect the general population, those that are likely to be specific to forced migrants and those that arise because of the intersection of forced migration with SGBV. The report is divided into six sections. The next section sets out the background to the study and its aims and objectives. Section 3 outlines the methods. Section 4 looks at the experiences of service providers and sets out the findings from survivors highlighting the general, forced migrant and SGBV specific findings. Section 5 offers a conclusion and Section 6 some recommendations.

2. Background

Many forced migrants have been subject to sexual and gender-based violence (SGBV) at multiple points of their life and across the refugee journey which includes during conflict, flight, life in camps, informal urban settlements and detention as well as in countries of refuge and resettlement.

While there is no universal definition of SGBV (see Simon-Butler and McSherry[iv]), the United Nations High Commissioner for Refugees (UNHCR) has stated that the term encompasses:

> *any harmful act that is perpetrated against one person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life*[v].

The majority of forced migrant survivors of SGBV are women although SGBV also affects men and individuals from sexual and gender minority groups. Forced migrant survivors of SGBV constitute some of the most marginalised groups within countries of refuge. Legal and social conditions vary by country and can impact on access to healthcare, welfare, housing and work. Despite the international community calling for specific actions to protect forced migrants in the COVID-19 crisis (see WHO guidance[vi] and the Global Humanitarian Response Plan[vii]) and interventions by some actors, on the whole the situation of forced migrants is deteriorating across the globe. Protection of forced migrants amid the pandemic is an urgent matter of public health and human rights but there is a lack of evidence about how the emergency is affecting individuals and the agencies supporting them, particularly where forced migration intersects with SGBV.

This report presents findings of the "*Forced Migration, SGBV and COVID-19*" project led by the Institute for Research into Superdiversity (IRiS), at the University of Birmingham, UK in partnership with Refugee

Women Connect with the support of the Universities of Melbourne, Australia, Uppsala in Sweden and Bilkent, Turkey. The study was initiated in response to conversations with research partners and anecdotal information showing that the forced migrant survivors experience an array of effects on their everyday life as a result of self-isolation, social distancing and changes in service delivery during the crisis.

The project aims to identify the effects of COVID-19 on forced migrant SGBV survivors and the organisations that support them with a view to providing insight that can aid policymakers and practitioners to ameliorate those effects.

Objectives include:

1. To identify the immediate and longer term effects of the COVID-19 pandemic and the associated public health measures on forced migrant survivors, including:
    - Exploring the impact of COVID-19 restrictions and guidance experienced by service providers on the nature of support available to forced migrant survivors;
    - Examining the consequences of loss of support, livelihoods and social networks on survivors and COVID-19-related forced migrant survivors' needs;
    - Documenting physical, psychological and public health risks associated with the effects.
2. To identify mechanisms and strategies for mitigating the effects of COVID-19 infection for forced migrant survivors and the organisations that work with them.

3. Methods

This project builds upon a multi-country study of SGBV and forced migration known as the SEREDA[viii] project. To urgently collect data about the effect of the crisis we returned to individuals previously interviewed for SEREDA enabling speedy access to respondents. In a two-week period running from 14th to 28th of April 2020 we contacted 48 female and four male survivors and 45 service providers in five countries (Figure 1): the UK, Turkey, Tunisia, Sweden and Australia. We used a combination of methods including short telephone interviews, communication via emails and "What's App" messages to make contact and collect qualitative data. We also examined recent press releases and publicly available data.

Table 1 Research participants by country

	Australia	International	Sweden	Tunisia	Turkey	UK	Total
Survivors	N/A	N/A	9	12	11	20	**52**
Service Providers	7	2	4	9	10	13	**45**

Ethics approval was gained from the University of Birmingham Ethics Committee, as an extension of the SEREDA Project. We contacted those survivors we knew were living alone by telephone message or WhatsApp taking care to only reach out to those who we knew, from previous interactions, were safe to pick up messages. Interactions commenced with questions aiming to ascertain safety and a discussion of the project aim and objectives before requesting informed verbal consent prior to the start of phone interviews. When using email and WhatsApp, respondents were sent information about the project and asked to consent before responding. Interviews were undertaken by the research team in Arabic and English across countries, while interpreters with experience working with forced migrant survivors assisted with data collection in Turkey and Tunisia. In Australia, survivors already interviewed for SEREDA were largely still partnered or living with children, presenting safety risks should they be re-contacted for an interview for this study under lockdown conditions. Therefore, no survivor interviews were undertaken in Australia.

Survivor respondents ranged in age, racial background and legal status. Some 30 (58%) originated in sub-Saharan Africa, 16 (31%) Syria, two from the Balkans, two from Iraq, one each from Lebanon and Turkey (see Appendix). The term forced migrant included refugees, asylum seekers, refused asylum seekers, undocumented migrants and spouses of forced migrants. We asked one question "*How has the COVID-19 emergency affected your life?*" and probed across different areas, including their socio-economic situation, food security, work, social connections, access to welfare, healthcare and their wellbeing.

Service providers ranged from international, national to local NGOs, public institutions and private service providers working with forced migrants. Respondents included NGO directors, migration and protection programme managers, SGBV personnel, psychologists, doctors and social workers (see Appendix). We asked service providers the following questions:

1. *How has the COVID-19 crisis affected the work of your organisation and your work with other agencies?*
2. *How has COVID-19 impacted on the SGBV survivors so far?*
3. *Are any groups or people with certain statuses that are more/less affected?*
4. *What do you anticipate the longer term impacts being on SGBV survivors?*
5. *Which SGBV interventions do you think stand out as the most critical in the current crisis?*
6. *What actions can be taken to reduce the negative effects of COVID-19 on SGBV survivors?*

Data was collected in various forms: email and WhatsApp responses, some verbatim recordings of short interviews and some interview summaries which included notes of key issues emerging from conversations. All data were anonymised and stored in an encrypted data storage facility. In order to undertake the data analysis, we identified key themes and used these to create an analysis grid to condense, process and compare data. Findings are set out in the sections below. Findings are general to all countries except where specific countries are identified.

4. Findings and analysis

4.1. Service providers and the COVID-19 emergency

Restrictions implemented to control COVID-19 varied across the five countries but included working from home, self-isolation and physical distancing. These measures significantly affected the nature of support service providers were able to offer survivors. Service providers adapted their services to new circumstances and tried to continue offering support as much as possible but with varying degrees of success.

Welfare organisations and projects supporting forced migrants reprioritised their services by revising the mission of their work, partnerships and budgets, as well as rapidly transitioning to remote, phone and online service delivery. Across the five countries nearly all face to face activities were suspended. When remote and online delivery was not feasible, projects cancelled their work or postponed activities until after the COVID-19 emergency. Service providers sought to continue to support the most vulnerable forced migrants at risk of destitution. Initiatives implemented included:

- Distribution of food parcels to people in need
- Regular welfare calls to check on users' wellbeing
- Arranging helplines
- Distribution of vouchers and increased cash assistance following price rises
- Arranging emergency and temporary accommodation for survivors
- Providing welfare and immigration information, arranging referrals to specialist services
- Producing information materials about COVID-19 prevention in different languages and formats
- Providing medical and some therapeutic psycho-social services by phone

- Organising social group meetings online for women
- Increasing social media visibility to reach out to users
- Organising community-based initiatives to support destitute forced migrants
- Fundraising and developing new models for identifying funds
- Offering training to staff on COVID-19 protection and self-care
- Advocacy to the government representing forced migrants' needs (UK, Tunisia)
- Providing information and medical check-ups by mobile clinics (Tunisia).

Across the five countries service providers noted that SGBV case management had become slower than usual, and as a result their workload increased with ongoing but unresolved SGBV cases. Specialist services for survivors of violence attempted to follow-up cases with police, social services and other agencies to help pursue justice and support survivors' health, wellbeing and safety (UK).

The majority of service providers recognised that moving to remote service delivery meant they were unable to reach all those in need. Destitute forced migrants with irregular immigration status were seen as facing particular difficulties as they struggled to access the Internet. Some providers responded by arranging mobile and data top-ups to enable users to access online services.

Although some organisations transited online relatively easily, others especially in humanitarian contexts lacked infrastructure to shift to remote working. Across countries, specialist providers of mental health and psycho-social support (MHPSS) noted challenges related to trust, safety and protection associated with offering remote support. Closure of specialist services often deterred specialist referrals. The suspension of psycho-social support activities removed the only lifeline for some survivors, which significantly undermined their wellbeing. Many empowerment programmes relied upon by survivors to aid recovery also ceased operations.

In the UK and Tunisia, NGOs played an important role in mobilising governments to support forced migrants during the pandemic. In the UK, NGO coalitions advocated for cessation of medical charges for forced migrants with no recourse to public funds (NRPF). Having NRPF status exacerbated physical and mental health problems as individuals were pushed towards destitution and unable to access public emergency accommodation or food vouchers. NGOs also advocated for the provision of multilingual COVID-19 information and the suspension of evictions from asylum accommodation.[ix] In Tunisia, an international NGO advocated for the Ministry of Human Rights to consider the situation of migrants. As a result, the issue of migration received the Government's attention and a three-month temporary regular status was granted to migrants who could then access social protection.

COVID-19 responses frequently involved strengthened coordination between different stakeholders in undertaking joint work aimed at supporting survivors. Weekly online NGO meetings generated a spirit of collaboration (UK, Tunisia, Turkey). Community-based initiatives played a significant role in food distribution and mobilisation of other local resources such as food parcels, meals and hygiene kits. Yet gaps remained in communication between civil society and public administrations because of changes in the functioning of public institutions. On the one hand, organisations noted a decreased number of referrals but on the other, referrals for practical support increased but with longer waiting times.

Service providers noted an increase in reports of domestic violence associated with lockdown, suggesting that self-isolation at home was not safe for all. Survivors were said to be less likely to report violence and/or seek support given that perpetrators were more likely to be present at home. They found escape and access to refuge difficult due to restricted access to, and capacity of, services. In one Turkish municipality, SGBV reporting increased threefold. In Australia, while calls to a national helpline dropped 5%, there was a 20% increase in using an online chat service, indicating that women needed

help but were unable to call from home. Calls to a men's helpline by perpetrators also increased significantly.

Closure of schools and nurseries in the UK, Australia, Turkey and Tunisia increased parental care responsibilities for service provider staff which had to be managed alongside growing workloads. The increased demand for services in the crisis coupled with working from home put staff under psychological and emotional strain at the same time as they experienced their own anxieties about health and isolation. Some service providers noted reduced delivery capacity associated with increased workload and caring responsibilities. Frontline workers reported anxiety, frustration and fatigue exacerbated by feelings of helplessness in reaching out to people in need. Many practitioners in Turkey were concerned about losing progress made after years of work assisting forced migrant survivors in rebuilding their lives.

Longer term impacts: Service providers anticipated in the longer term increased competition for, and diversion of, funds as priorities were anticipated to change post-crisis. Specialist providers feared that funding for MHPSS support to survivors of violence would have been diverted to emergency responses. Moreover, they were concerned that prolonged isolation and loss of social networks would diminish trust, the backbone on which the relationships between services and users rest, thereby undermining the effectiveness of their services. Time will be needed to rebuild survivors' trust in people and services. Service providers anticipated an influx of SGBV reporting post-lockdown and feared they would struggle to meet the scale of need.

4.2. Impacts of COVID-19 on survivors

There are three ways that forced migrant survivors of violence experience the impacts of the COVID-19 crisis. These are ways that a) are similar across the general population; b) relate specifically to their status as forced migrants; c) are distinct to their experience as survivors of SGBV. They are discussed in turn below.

4.2.1. General effects of COVID-19

Health and wellbeing: survivors reported being fearful of seeking general medical help because they were concerned about contracting the virus. Several women with underlying medical conditions struggled to access treatment with appointments being delayed. Many respondents reported deteriorating mental health due to loneliness, stress and anxiety, although arguably the impact of wellbeing was intensified for survivors given their underlying traumas (see below).

Economic: Many interviewees used to work before the crisis, but restrictions meant they lost their jobs and income making them dependent either on others or on NGOs. Respondents reported increased food prices and the need to swap to cheaper products or choose between essential goods such as food or hygiene products. Some women in the UK, Turkey and Tunisia experienced food shortages, especially of specific non-local foodstuffs.

4.2.2. Impacts of COVID-19 on forced migrants

Forced migrant survivors of violence experience the effects of COVID-19 in ways that relate to their status as forced migrants.

Health and wellbeing: Undocumented migrants were anxious about seeking medical help and fearful of charges or being reported to immigration authorities and deported. Some participants expressed concerns that national policies on COVID-19 were inequitable. Several asylum seekers in Sweden were concerned that policy did not take account of their vulnerability:

> *We don't have the same degree of immunity as the Swedes. The difficulties we experienced and the lifestyle we had in our countries are so different than the ones of the Swedes. The government knows that, yet still decided to follow different policy than the rest of the world* (Syrian woman, 30s, refugee, Sweden).

Asylum seekers in the UK worried they would not be a priority for access to a ventilator if needed. Some respondents worried that mortality rates in the forced migrant population would not be recorded and thus they were invisible to authorities and did not matter.

Forced migrant survivors were deeply affected by social isolation which exacerbated existing feelings of loneliness, sadness, and anxiety about income, health, and life. Forced migration uproots people from their homes and social connections. Thus, many had no family or friends to rely on. Some were gradually rebuilding social networks which enabled the gradual rebuilding of hope, dignity, and confidence. Enforced self-isolation undermined their ability to maintain these nascent social networks especially when their financial situation limited access to telephones or the Internet. Extra solitary time compounded marginalisation of some forced migrant groups, for instance those from sexual and gender minorities. The closure of places of worship deprived many of a key source of support. Isolation, limited social contact and no access to services reminded some survivors of the restrictions they faced in conflict and under siege pre-flight. Reminders of the past affected their mental health and disrupted ongoing coping strategies. Anxiety and stress associated with the pandemic exacerbated existing concerns:

> *You know when you already have a problem and another comes on top it makes the problem bigger like when it's just one problem, but if you already have all those underlying things carrying this and that trauma, layers and layers of different things* (West African woman, 40s, asylum seeker, UK)

Economic: Forced migrants were in theory receiving some support from either humanitarian organisations, states or municipalities which for the most part remained unaffected by the crisis despite the rise in costs. In Turkey, the most disadvantaged were forced migrants under International Protection who received no support and less support than individuals under temporary protection. Forced migrants receiving vouchers were no longer able to convert them into cash as they used to with friends in order to access a wide range of cheaper shops and top up their phones (UK, Tunisia). Respondents without a bank account were excluded from online bill payments or using public transport which shifted to only accepting bank cards (UK). Without savings individuals were unable to stockpile food items and feared going hungry. Respondents with refugee status in general received support, held bank accounts and could receive their regular allowances electronically (UK, Tunisia, Turkey). Survivors in the UK frequently relied on food banks and charity support, yet some had to choose between buying essential food items or cleaning products.

Many respondents in the UK were still able to access aid albeit with longer waiting times, while most forced migrant women in Turkey and Tunisia, struggled to access support due to pandemic restrictions, which included suspension of some charitable projects. Some respondents feared criminalisation associated with breaking restrictions if they attempted to access support (Turkey, Tunisia). Some had previously depended on charitable services to help them rebuild their lives, but those charities were unable to offer support. Language and practical barriers amplified in the crisis and further limited access to support.

Work previously available in the informal economy, e.g. in retail, cleaning and care sectors, disappeared for respondents. Women with children reported the stress of these socio-economic burdens alongside increased care and domestic work as schools closed. In Tunisia, single women were unable to afford milk and nappies for children, some of whom were born of sexual violence, and no support was provided for children below the age of eight months.

Forced migrant workers working in agriculture (Turkey), forced migrants with zero hour contracts (UK) and forced migrants with no contracts (Tunisia) were unable to access any state benefits and they were excluded from the safety nets implemented for the general population across countries.

Accommodation: Many participants living in the UK, Tunisia and Turkey described inadequate living conditions which intensified during lockdown. Forced migrants living in shelters, shared accommodation and overcrowded housing with shared kitchens and toilets were unable to self-isolate. Living in overcrowded facilities generated health risks and anxiety about contracting the virus from co-residents who went in and out of shelters without protection. Some migrants were threatened with eviction in Turkey and Tunisia after losing their jobs. Forced migrants living in shared and council accommodation in the UK lacked access to working washing machines which were important for hygiene purposes. Also, in the UK, poor quality asylum housing was not repaired, with respondents believing they had been abandoned during the crisis.

Education and digital resources: Many forced migrants living in shelters had limited access to TV, Internet and phones. Digital poverty excluded many from participating in online support groups and some spent long days alone, sleeping, overthinking their past, and worrying about their future. Others were excluded from learning opportunities which for many provided much needed distraction. Closure of colleges prevented forced migrants from mixing undermining efforts to integrate with settled communities. In Sweden, schools continued for children below 15 although some chose not to send their children because of health concerns. In the UK and Turkey, the move to online education was problematic with families unable to access learning materials because they lacked resources (devices, Internet, or phone credit) or because of language barriers. Distance education was said to be problematic for girls who were expected to undertake chores rather than schoolwork (Turkey).

Legal: Legal status introduced a range of barriers which shaped survivors' lives, from preventing access to public services, including healthcare, not being allowed to engage in paid employment and opening a bank account. Undocumented migrants, refused asylum seekers and migrants with other irregular statuses were excluded from state support schemes introduced during the emergency. The absence of support increased vulnerability and destitution restricting opportunities to rebuild their lives and integrate. In some countries those without refugee status are considered temporary visitors and as such are not a priority for international organisations or local authorities (Tunisia, UK). In addition, closure of government facilities caused visa and residence delays across countries. In Turkey for some forced migrants the closure of facilities meant documents became invalid and work permits could not be renewed. Closure of borders prevented voluntary return to countries of origin.

Amplified vulnerability: Survivors in the UK did not trust public support for undocumented migrants and suspected that support initiatives were intended to identify and deport them. In Tunisia, forced migrants initially thought the requirement to wear face masks was intended to discriminate against them because initially rumours had spread that migrants carried the virus. In Sweden, survivors considered that as migrants they are in disadvantaged position as they could not afford to take leave and continued working in high risk jobs during the pandemic to make a living. Respondents found it difficult to access adequate information on COVID-19 from government websites relying on multilingual information offered by NGOs. Several respondents reported experiencing hostility in publics spaces during the pandemic (Turkey, Tunisia, Sweden).

Silver linings: The negative effects of COVID-19 predominate but respondents also identified positives which included eviction orders and asylum applications being put on hold, reduced reporting, and some releases from detention centres. Thus, some forced migrants found themselves in less stressful situations than before (UK), while some with expired permits were granted temporary status (Tunisia).

For some, working opportunities emerged or continued uninterrupted in the pandemic, for instance among the Afghan community in the construction sector (Australia) and among refugees in the care sector (UK). For others, working and supporting a Covid-19 national response meant an opportunity to pay back to a country that provided them with refuge (Sweden). Many communities found new ways of working and supporting each other, perhaps strengthening pathways for integration in the longer term. For instance, in the UK new community groups have emerged offering support and increasing availability of food parcels and other essential items.

4.2.3. Impacts of COVID-19 on forced migrant survivors of SGBV

Health and wellbeing: Some survivors of SGBV required continued treatment for injuries and chronic conditions post violence, but they reported barriers to accessing specialist services, including reproductive health services. Pregnant women and rape survivors delayed visiting hospitals due to anxiety about catching the virus or medical charges and limited access to antenatal and postnatal care was reported in Turkey and Tunisia. Service providers expressed concerns about the difficulty of undertaking therapeutic phone consultations with survivors.

The crisis has profoundly affected the mental health of forced migrant survivors, the majority of whom have already suffered multi-layered trauma. The pandemic restrictions compounded survivors' existing mental health disorders through triggering bad memories, restricting critical social support and creating another layer of trauma. The crisis halted survivors' plans for rebuilding their lives, and as many explained, it "imprisoned" them in unwanted locations:

> *I feel that as if I were inside a jail because of Corona…As If I were tied with a chain. I can no more recognise myself! I feel exhausted…I hate my life…We can no more think or work for our future* (East African woman, 30s, irregular status, Tunisia)

In the UK, those awaiting asylum decisions had to wait even longer. Whilst dealing with past trauma, the virus provided an additional stressor making their lives harder. Survivors in Tunisia, who were still in transit, considered the crisis as the worst thing that could happen to them after all the efforts they put into fleeing their countries. In Turkey, the disease was described as a bigger stressor than experiences of war and family abuse.

Many survivors compared the pandemic restrictions to those they experienced during exploitation such as enforced isolation, limited freedom, and no access to support. For those who experienced conflict and torture, lockdown activated painful memories of the self-isolation they deployed to protect themselves from violence. Some said they were forced to relive their traumas because of a lack of the distractions they usually employed to pass the time such as going outside, meeting friends and attending support groups.

Thus, the virus presents a series of problems adding to multiple existing stressors particularly for marginalised individuals with no support. Many survivors disclosed experiences of flashbacks, self-harm, anxiety, frustration, sleeping difficulties, and eating disorders exacerbated by social distancing measures. For some the pandemic conditions generated suicidal thoughts:

> *Because of past violence, sometimes it makes me get those suicidal thoughts, I don't know how to explain it. You know when you feel like you are stuck. Start getting flashbacks, frustrated, start thinking too much…* (Sub-Saharan woman, 40s, asylum seeker, UK)

Economic: For survivors of SGBV, without resources and outside of social protection, losing income opportunities increased economic hardship. The vulnerabilities and precarity experienced pre-COVID-19 due to their gender, care responsibilities and insecure immigration status, increased their

vulnerability to abuse and exploitation. Some relied on food supplies from their neighbours, family remittances from their country of origin or took out loans. In countries in which humanitarian aid was suspended, providers said women and girls became more vulnerable. Over time they also believed that interpersonal violence within the home would increase because of lockdown tensions and post-lockdown poverty.

Accommodation: Service providers reported a decrease in the number of safe houses for women escaping violence. In the UK survivors with NRPF status were ineligible for emergency accommodation, leaving them the options of remaining in an abusive relationship, homelessness or sofa surfing. In Turkey and Tunisia shelters did not accept newcomers.

Legal: Delays in processing survivors' claims could be a source of relief but on the whole the delays added to their sense of despair. Slowing down of bureaucratic processes of asylum seeking and resettlement meant putting their lives on hold even longer and being overwhelmed with a sense of uncertainty which hindered their recovery. For instance, refugees in Tunisia were frustrated because the resettlement programme was suspended. Survivors were stuck in exploitative situations, unable to flee amid pandemic restrictions. Delays in legal procedures and registrations with public authorities slowed down survivors' access to assistance that depended on their status (UK, Turkey).

In the UK, asylum processes shifted online or were being processed by post but service providers explained how in the pandemic it became more difficult for solicitors and risky for survivors, during intensified social-isolation, to work with the traumatising material needed to evidence their claims.

Amplified vulnerability: Service providers expressed concerns that some forced migrant women with NRFP status (UK) or temporary visa holders (Australia) were trapped between remaining in abusive or exploitative situations or homelessness as they did not qualify for public housing. There were reports of interpersonal violence increasing in these groups and expected a further rise in reporting post lockdown (Australia, UK, Turkey). Reporting and help-seeking during lockdown may be affected by survivors belittling their own suffering when compared to the COVID-19 threat to their and their children's overall survival:

> *COVID's isolation challenges across mainstream society and it impacts on victims/survivors living with violent and controlling perpetrators are amplified for those that have cultural and linguistic barriers to help seeking, trauma backgrounds, visa insecurities, history of displacement and poverty…* (Local NGO, Australia)

In Sweden, a public service provider believed that secondary school closures would increase the risk of honour-based violence, while in the UK the risk of exposure to honour-based violence was said to deter domestic violence survivors from accessing support.

In Turkey, economic hardship, lost jobs and income manifested in increased domestic violence also endangering children's safety. Amendments to criminal law concerning probationary release of SGBV perpetrators increased risks of renewed perpetration and elevated survivors' anxiety. Service providers also raised concerns that survivors locked in with perpetrators would lose the social and psychological resilience gained through the therapeutic work that they had provided prior to lockdown.

In Tunisia, the issue of sexual abuse and exploitation in 'pretend' marriages was reported as a growing concern. Adolescent girls agreed to pretend they had marital relations with partners met in Libya in the expectation of better protection and an expediated procedure for couples. During the COVID-19 emergency adolescent girls became trapped in such exploitative relationships and faced additional health risks and criminalisation when forced by their "partners" into prostitution, thus breaking pandemic restrictions.

Longer term impacts: Service providers were concerned that the long-term emotional and psychological impacts of violence would emerge post-crisis, coupled with the longer term economic implications for resources, access and employment. Practitioners expected women to be at increased risk of exploitation as they struggled to repay debt and lacked job prospects. In Turkey, some practitioners anticipated that survivors would return to abusive partners because they had no other form of economic support. International service providers pointed to socio-economic deprivation generating increased SGBV in the form of sex trafficking and child marriage among groups previously not at risk, as well as increased intensity for groups already at risk. Some respondents who had survived trafficking were concerned about receiving potential new threats from traffickers. Some providers identified a disproportionate risk of contracting the virus among survivors of sex trafficking and that survivors of trafficking may be criminalised for breaching pandemic restrictions.

5. Conclusions

Interviews with survivors and service providers identified a number of effects associated with the pandemic which impacted on the lives of forced migrants and survivors of SGBV, undermining their coping, recovery, ability to integrate in countries of resettlement and potentially increasing their vulnerability to further abuse and exploitation.

Service providers often had to reduce their capacity at a time when need increased, moving to remote working and supporting staff stressed by balancing work and care responsibilities whilst aware that needy clients were going unsupported or under-supported. Forced migrants experienced increased economic hardship, food insecurity, exclusion from services, poor and overcrowded housing conditions, and enhanced isolation exacerbated by their status and sometimes by communication problems and digital poverty. Health services were restricted, and sometimes unavailable, and psycho-social problems were exacerbated by lockdown and social distancing measures.

SGBV survivors experienced an extra layer of vulnerability when compared to forced migrants. Crisis measures could force them to remain in abusive relationships and reduced the available escape routes. Risks of abuse and trafficking increased in the absence of economic support and state protection. The loss of NGO wellbeing and material support increased uncertainty, and hours of isolation forced survivors to relive their experiences without access to social networks to offer comfort and strength. Counselling was interrupted and health services for SGBV related injuries hard to access. Those who struggled to move forward with their lives observed feeling themselves ‘slipping backwards’ with fears that progress made would be destroyed. Service providers observed the decline in survivors' conditions but lacked the resources to intervene and worried that the long-term impacts would continue beyond the end of the pandemic. Both service providers and survivors observed that state responses to forced migrant survivors were negligible and in some instances state inaction, termed elsewhere by Davies et al. (2017) as "violent inaction"[x] exacerbated survivors' vulnerability.

The term forced migrant hides the heterogeneity of status and experience of individuals who have been forced to flee their homes. It was evident that experiences during the crisis varied by legal status, country, and gender. Findings suggested that women were the worst affected and were particularly vulnerable where they were alone with caring responsibilities. Other vulnerabilities reported across countries included:

- Having existing medical conditions or disabilities (Turkey, Tunisia, UK)
- Pre-existing mental health conditions (UK)
- Having been trafficked or engaged in sex work (Tunisia, Turkey)
- Detainees with limited freedom of movement (UK)
- Migrants under International Protection (Turkey)
- Individuals living in shared accommodation including hostels and shelters (Tunisia, UK)
- Individuals with no recourse to public funds (UK, Australia, Turkey)

- Forced migrants working in the informal economy (Turkey, Tunisia, UK)
- Undocumented migrants (Turkey, UK)
- Young migrants including adolescent girls and unaccompanied minors (Tunisia)
- Older forced migrants (Sweden, Turkey, Australia)
- LGBTQi (Turkey, UK)

Our findings highlight the necessity for urgent action to meet the needs of individuals who might be described as some of the world's most vulnerable people, to ensure that they survive the crisis and can move on with their lives when it has passed without encountering further harm. The need to access free medical services without encountering the risk of being detained is obvious but it is also evident that survivors urgently require sufficient cash to cover immediate food and hygiene costs, access to digital devices to enable them to reach online services and remotely school their children, safe shelter away from perpetrators, safe housing that enables individuals and family groups to self-isolate and specialised trauma-informed remote psycho-social support. In the final part of the report we set out our general recommendations. Separate documents are available setting out country-sepcific recommendations for the UK, Turkey and Tunisia (also see Appendix).

6. Recommendations

In interests of protecting public health and ensuring individuals' rights, this report offers the following **immediate recommendations** during social distancing measures:

To governments:

- Ensure social protection and basic safety nets for all forced migrant populations regardless of legal status
- Ensure access to universal health for all, revoke all medical charges and ensure risk of immigration exposure is suspended
- Ensure availability of emergency accommodation and safe shelter for all survivors of violence
- Suspend actions to identify and deport undocumented migrants and release immigration detainees.

To service providers:

- Offer new channels for help seeking and reporting abuse for survivors living with perpetrators, such as online tools, alert systems, and designated helpdesks/safe spaces
- Ensure access to multilingual and culturally accessible information on COVID-19, SGBV prevention and support for survivors
- Ensure mental health services are trauma-informed and therapeutic support is available including offering telephone top-ups to provide access

As countries begin to ease pandemic restrictions and move toward recovery **longer term measures** are needed including:

To governments and service providers:

- Mainstream a gender perspective in response, recovery and preparedness plans and include specific measures for forced migrant SGBV survivors
- Ensure that the needs of forced migrant survivors are accounted for in recovery and preparedness plans when considering potential future crises
- Mainstream the responsibility for SGBV mitigation and reduction across actors in different sectors, including through building partnerships with community organisations and local formal, informal and faith leaders
- Account for survivors of trafficking and other less visible forms of violence in plans and actions

- Work to support men with mental health needs to prevent escalation of tensions and perpetration of violence in future crises and in recovery following the pandemic
- Design interventions in ways that support survivors' coping and recovery mechanisms through consultation with survivors and those who work with them
- Expand women's economic and social empowerment programmes to support survivors to become self-reliant, and decrease dependency on aid.

To funders:

- Ensure sufficient funds are available for essential SGBV services (including prevention)
- Ensure flexibility in SGBV service delivery enabling local organisations to deliver services in ways that meet different needs of survivors
- Support the capacity development of women's organisations to enable them to provide adequate and trauma-informed assistance.

Appendix

1. Sample

Table 2: Category of service providers participating by country

	Australia	International	Sweden	Tunisia	Turkey	UK	Sub-total
Local NGO	5			3		3	11
Regional NGO						4	4
National NGO	2		1	3	5	4	15
International organisation		2		3	4		9
Public institution			3		1		4
Faith-based						1	1
Private						1	1
Total	7	2	4	9	10	13	45

Table 3: Demographics of survivors participating by country

		Sweden	Tunisia	Turkey	UK	Sub-total
Gender	Female	6	11	11	20	48
	Male	3	1			4
Total		9	12	11	20	52
Age	20s	1	4	3	3	11
	30s	4	7	6	11	28
	40s	4	1	1	4	10
	50s			1	2	3
Total		9	12	11	20	52
Country/region of origin	Albania				2	2
	Iraq	2				2
	Lebanon	1				1
	Sub-Saharan Africa		12		18	30
	Syria	5		11		16
	Turkey	1				1
Total		9	12	11	20	52

2. Country-specific recommendations

The following recommendations respond to most pressing issues evident in each country.

To the UK Government:

- Revoke NRPF to forced migrant survivors of violence in need of protection regardless of their legal status
- Extend the withdrawal of medical charges related to COVID-19 to other existing medical conditions to ensure survivors with irregular immigration status can access healthcare without fear
- Establish an immediate 'firewall' to prevent information sharing between immigration control and public support services including health and policing
- Stop sharing information regarding irregular migrant patients between the healthcare services and the Home Office beyond the COVID-19 concessions
- Work with subcontractors of the Victim Care Contract and other appropriate services to ensure survivors of human trafficking and exploitation are able to receive support
- Prevent exacerbation of destitution by ensuring survivors have adequate resources including digital access, safe and appropriate housing;
    - Lift restrictions on taking out cash and online use of Aspen Card
    - Provide a £20 per week rise in asylum monetary support during the crisis, in line with Universal Credit
- Create a safe reporting mechanism for survivors that is responsive to the structural inequalities specific to forced migrants living in the UK
- Ensure equitable access to mental health support for survivors regardless of their legal status.

To the Turkish Government and service providers:

- Mainstream and expand social assistance for SGBV survivors and those at risk of SGBV in forced migration journeys, including:
    - Individuals excluded from temporary protection, e.g. survivors with a temporarily unclear marital status (e.g. due to separation)
    - Individuals under International Protection and undocumented forced migrants, including those who had been trafficked, smuggled, or trapped in other abusive and exploitative relationships
- Support provision of adequate accommodation and shelter, or subsidised housing, to all survivors regardless of migrant status
- Ensure access for all survivors to SGBV specialist services at municipal level
- Ensure social protection for forced migrants undertaking precarious work
- Establish safeguarding and coordination measures for local informal aid initiatives to prevent risks to exploitation

To the Tunisian Government and service providers:

- Ensure timely cash assistance, safe and accessible distribution of vouchers and food items for all forced migrants regardless of their legal status
- Ensure minors are adequately supported and protected from abuse and exploitation
- Improve shelter conditions for forced migrants in ways that support safe self-isolation and wellbeing, provide resources/activities to help pass time in isolation
- Improve coordination between UN agencies and community organisations in facilitating support to forced migrants at risk
- Improve communication channels with forced migrants, including on their entitlements to assistance and complaint mechanisms

- Raise public health awareness among forced migrants residing in urban settings and in shelters by providing multilingual guidance on response in case of medical emergency, COVID-19 infection, and treatment
- Ensure access to medical check-ups for all new coming migrants regardless of their status
- Mainstream integrating forced migrants in employment and education sector across regions; develop coherent guidance and procedures, sensitise staff in local public administration, education and employment sectors
- Increase awareness of migrants on shared rights and responsibilities
- Facilitate learning about Tunisian and migrant cultures to develop cultural competencies and dialogue

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