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Something is (still) missing? Feminist services for forced migrants surviving sexual and gender-based violence in Sweden, Australia, Turkey and the United Kingdom

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We dedicate this paper to the memory of those forced migrants we met in Turkey and who subsequently perished in the earthquake of February 2023.

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ABSTRACT

Aim: Sexual and gender-based violence (SGBV) is a clear harm for individual and family health, as well as for society at large. A feminist public health should ensure that services meet women's self-identified needs, with an inclusive definition of woman-kind and an understanding of the intersectional nature of the disadvantage that forced migrant women face.

Methods: Semi-structured interviews with 166 forced migrants who have suffered SGBV and 107 providers of services to forced migrants in Australia, Sweden, Turkey and the UK, were undertaken as part of wider project. After translation and transcription, thematic analysis sought all mentions of feminism, descriptions of services along feminist lines and evaluations of the feminist-nature of services.

Result: Services were said to be hard to approach much of the time and did not always focus on forced migrants' assessments of their own needs. Those services that did attend to migrants' own expression of their needs were said to be helpful in the recovery process. Interviews with service providers indicated that, while feminism was regularly a personal philosophy, it less often informed service design and delivery. A tension between individual empowerment and a collective assertion of women's rights is part of the contested understanding of feminism, with an intersectional criticism of secular, individualist assumptions of a wholly rights-based approach. The co-opting of women's rights to pursue a securitization agenda indicates tensions between different versions of feminism.

Conclusion: The failure to design and deliver services that facilitate forced migrants' recovery from SGBV represents an ongoing failure to understand, apply and test the insights of decades of feminism.

Introduction

The idea that women's rights are human rights has become accepted by International non-government organizations including the United Nations (United Nations, 2014) and Amnesty International. Throughout the twentieth century women's rights campaigns (e.g. Women's International League for Peace and Freedom established 1915; Egyptian Feminist Union established 1923, Arab Feminist Union established 1945) have insisted that the language of human rights **is** inherently feminist, with unions, charters and policies seeking to enforce the feminist ideal of women's and girls' (including trans and non-binary women and girls) rights to access resources and opportunities.

At the end of the twentieth century, feminism was advocated as part of the new public health - a holistic practice involving multidisciplinary activities, building towards collective action (Hammarström, 1999). The need for feminist campaigns to defend women's, girls' and LGBTQI+ rights, to claim power, demand protection and prevent violence has persisted into the twenty first century (Leung & Viana, 2021). The need

Abbreviations: SGBV, Sexual and gender based violence; SEREDA, Sexual and gender based violence in the refugee crisis: from displacement to arrival; LGBTQI, Lesbian, Gay, Bi-sexual, Trans, Queer, Intersex; NGO, Non Government Organization; UK, United Kingdom.

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for a feminist understanding of the causes and experiences of forced migration to inform and enhance the quality of social work practice supporting refugees' basic needs, employment and complex medical issues, has been well noted (Cook Heffron et al., 2016).

Forced migration involves an element of coercion – threats to life and livelihood whether from human or natural causes - which introduces a lack of safety and protection. Forced migrants unlike other migrants are rarely able to plan for departure, carry with them any material goods or vital documentation and are often forced to cross multiple borders "illegally". Their undocumented status means they have no protection against sexual and gender based violence (SGBV) and are frequently attacked with impunity (Phillimore, Block, Bradby, & Ozcurumez, 2022). Women and girls are disproportionately affected by SGBV during transit and resettlement (Rohwerder, 2016; Women's Refugee Commission, 2016). Once in camps or refuge they are further exposed to SGBV in mixed gender accommodation. Forced migrants' needs during resettlement have to be understood in the light of their various sociodemographic characteristics and meeting those needs, in both transit and resettlement, and however complex, can significantly facilitate resettlement processes, potentially addressing the gendered harms that they face (Deacon & Sullivan, 2009).

The complex and dynamic nature of forced migrant women's needs for resources and support is a compelling reason that service development should be undertaken with the participation of all the stakeholders (Çöl et al., 2020). A large proportion of resettlement services will be community-based, necessitating policies and programs that will be specific to each different community setting (Sansani, 2004).

During the 2015–2016 mass arrival of refugees into Europe associated with conflict in Syria, stories of gendered harms to women and girls in transit were widespread. But the lack of data, or even basic needs assessment, for forced refugees in transit or in settlement was striking. Far from forced migrant women's complex and dynamic needs being assessed in the context of their own sociodemographic characteristics and the community where they are based, almost no participative planning or consultation was in evidence. This absence led to the establishment of the SEREDA research project to investigate how best to support and protect forced migrants from gender and sexual based violence (SGBV) by speaking with both migrants and those who support them. SGBV is defined as harm perpetrated against a person's will, based on socially ascribed gender differences that inflicts physical and/or mental harm and may include threats to safety or integrity, coercion and deprivation of liberty, in public or in private life (UNHCR, 2011: 6).

As our project ends, and with ongoing and feminised forced migration from Ukraine and Afghanistan, we note that those women and girls seeking refuge face similar challenges (Pertek et al., 2022) and reflect on what we can say about feminist ideals informing the services available to SGBV refugee survivors. In particular, our paper explores the extent to which feminist ideologies inform service provision in Sweden, Australia, Turkey and the United Kingdom and, when they do, what difference this makes to the recovery and settlement of forced migrant women survivors of SGBV. Acknowledging the complex and dynamic nature of the needs of women on the move who are surviving SGBV, we are attentive to women's and girls' own priorities and reflect on the ways that a feminist approach can address power inequities inherent in service provision. Given that the harms involved in migratory journeys affect women and girls disproportionately, centring their voices, experiences and needs is imperative and should be the focus of any contemporary feminist approach.

Feminist approaches to services for women surviving SGBV

This paper adopts two interconnected theoretical frameworks for analysis: a public health approach and an intersectional feminist framework.

A public health approach centres the social determinants of health in our understanding of SGBV – these include gender, sexuality, class, and race. In particular, a public health approach understands SGBV to be a serious threat to health, whose harms accrue to forced migrant women disproportionately (Hourani et al., 2021). As such, a public health approach to SGBV attends to women's and girls' priorities and includes treatment for and protection from SGBV, addressing victims' own priorities in recovery from its harms. This approach also understands that forced migrant health, in transit and in the country of settlement, should attend to their own assessment of their needs and their priority-setting, as part of planning, commissioning, delivery and evaluation of how services and support are configured.

An intersectional feminist approach understands SGBV to occur within a larger context of structural systems, including economic, legal, and political factors (Montesanti & Thurston, 2015). This research thus adopts an intersectional feminist approach that contextualizes women's experiences of violence within the interaction of individual, social, institutional, and political factors (Sokoloff & Dupont, 2005).

Marrying a public health approach and an intersectional feminist framework enables us to understand SGBV from a feminist public health perspective which attends, not only to the complex connections between gender, disadvantage, and health (that is, the social determinants), but also the inequities in the distribution of power as well as the opportunities for good health (that is, an intersectional approach) (Rogers, 2006). What both a public health approach and an intersectional feminist framework have in common is that they lend themselves to a person-centred approach to understanding the effects of SGBV. The World Health Organization sees people-centred and integrated care as a means of strengthening service provision to meet key global public health challenges. But institutional conservatism in medical structures has meant that insights about the gendered nature of health and care have not transformed practice (Dyck, 2003), with some evidence that gender mainstreaming of EU policies has had a reactionary effect on gendered power distribution (Stratigaki, 2005). Feminist, person-centred approaches to health care underline taking forced migrants' own views about their experience of SGBV into account, not least in terms of how they can recover. Other professions working alongside healthcare have recognized the importance of supporting forced migrant women as they navigate and respond to their shifting circumstances during the long process of resettlement (Cook Heffron et al., 2016).

Adopting these frameworks thus enables us to centre the lived experiences of forced migrant women and, by extension, analyse whether the lived reality of accessing support of forced migrants who are SGBV survivors reflects a person-centred approach to service provision. Such an analysis is vital for informing planning, commissioning, delivery, and evaluation of how services and support are configured.

Feminist approaches to SGBV in practice

Feminism as a social movement has been based on political philosophies that are not always unified and are sometimes starkly opposed; these differences have been apparent when feminist approaches are applied to public health and humanitarian anti-violence work. From the end of the 20th century, interest in examining SGBV as an integral part of armed conflict arose, with some international organizations routinely incorporating anti-sexual violence into humanitarian capacity-building work, and others viewing gendered politics as too controversially political to be encompassed (Veit, 2019).

The incidence of gender based violence in countries of transition and of refuge has increasingly been acknowledged, as part of a spectrum of harms to which forced migrants are subject (Hourani et al., 2021; Ozcurumez et al., 2020). Even in contexts where feminist public health is an explicit policy goal, forced migrants' willingness to report SGBV is hindered by a lack of trust in medical and legal authorities (Rodella Sapia et al., 2020), shame and stigma (Papoutsi et al., 2022; Rothkegel et al., 2008). The evidence-base regarding how forced migrants access services to address SGBV is fragmented and limited with no systematic evaluation of the effectiveness of services.

Methods

In considering the extent to which feminist approaches inform ongoing service provision we draw on interviews with 166 forced migrant survivors of SGBV and 107 service providers across four countries - Australia, Sweden, Turkey, the UK, undertaken as part of the SEREDA project. Epistemologically, a poststructuralist feminist perspective informed the project as it shaped not only the positionalities of the researchers, but also the way the lived experiences of the refugees were understood and conceptualised.

> Since discourses are shared structures of meaning, women 'speaking experience' are thus simultaneously speaking to those structures in place and potentially reworking or deconstructing them.
>
> Hansen (2010: 24)

We are concerned with macro and micro levels of gender(ed) inequities and were analysing the complex relational constructions of identities in contexts that were changing.

A multi-country investigation of forced migrants' experience of SGBV from displacement to resettlement, the SEREDA project adopted a broad definition of 'forced migrant' to include those with official refugee status, those seeking asylum and those fleeing violence or persecution through other channels that were not officially recognized as refugees. The project procedure received institutional ethics approval in the four local settings and included an extensive safety protocol to address risks of participation and to ensure that information about accessing support was distributed.

The project encompassed interviews with forced migrants (most of whom identified as women) and those providing services for forced migrants, with the majority of forced migrant interviews recruited into the study through local partner organizations who were working with forced migrants. These partners included municipal, non-governmental and international organizations working with forced migrants as clients, in the four countries. Employees of the partner organizations were themselves interviewed and briefed about the SEREDA project and then distributed information sheets to clients of theirs who had disclosed experience of SGBV that they were willing and able to discuss further. Those clients that agreed to the contact, were approached by a SEREDA project team member and verbal consent to participate was agreed by phone or via social media and then confirmed after plain language information about the study had been discussed face-to-face. The information sheets were available in English, Arabic, Swedish and Turkish and members of the team were fluent in these languages. Feminism was not named as a topic in the interview questions, but was sometimes brought up spontaneously by interviewees. Where appropriate interviews were translated into English for analysis, having first been anonymized by removing identificatory information about persons and localities and allocated pseudonyms to all participants.[1] Our material was organized using a data analysis software package which supported a thematic analysis, allowing a review of all cases where feminism was mentioned explicitly, to which we added all those cases where a feminist practice was described but not necessarily named as such. We organized the different ways in which feminism was described and cited by migrants and service providers to find similarities and differences in the way the term was used to describe, praise and criticize service provision.

Findings

What forced migrants said about feminism

Across our large data set of 166 interviews, there was enormous variation in how forced migrants described their experience of SGBV and their approach to addressing the associated harms. Some migrants described their own story in very close personal terms, while others contextualized their experience in terms of wider society; there was great variation in whether and to what extent organizations who might have offered support featured in migrants' accounts. This analysis focusses on those who mentioned feminism or described the extent to which their own rights and priorities were addressed when trying to escape or recover from SGBV.

In Australia and Turkey women appreciated the statutory protection of women's rights, even while also experiencing structural gendered violence. The formal safe-guarding of rights in contrast with a denial of basic human rights was noted by Aisha, in her 20s and originally from Afghanistan, who had an idealised image of Sweden before she experienced it as a harsh place lacking in generosity. During flight she had heard about the wonders of Sweden:

> '… how good Sweden is with human rights, rights for women and children. I used to think in Europe there were angels living, not people.'

Zeynep, in her 50s, also challenged the idea that women's rights were safe-guarded in Sweden. Having arrived as a refugee, unresponsive service provision meant that she could not access the psychological help she felt that she needed due to a lack of spoken Swedish. She contrasted her negative experience in Sweden where violence against refugee women was dismissed as 'cultural' with Turkey, where she felt that 'women have better rights.'

Without explicitly mentioning feminism, forced migrants mentioned being empowered by specific training sessions and peer support groups, where they learned about women's rights and discussed ideas about women's roles in different cultures. Layal, in her 30s, originally from Iraq, spoke fondly of attending a women's group in Australia:

> 'I went to that women's group and there were other women around the same age as me, we chatted and we had fun and we had a laugh, and then we did an excursion and we would go and come, and I really enjoyed it… It went for 6 weeks. So yeh, I really liked it and I said to them, whenever there's a group like this, tell me because I want to go… each of us told our story and what happened. Dalal was there and she really supported us, she's really lovely and genuine… she really helped. It was important to talk, you know to get everything out and relax a little bit.'

But such empowerment seminars and trainings were sometimes experienced as unhelpful, as Farzaneh, in her 20s, in Turkey and originally from Afghanistan explained:

> 'There are seminars and other things about women's rights, but they didnt do me any good. Because when they talked about violence, rape, I feel bad. But I know that they are trying to warn us, they give information and share information here, but this is not good for me. I need to stay away from this. I think so. I push myself, I come (to the seminars on violence) even if I am reluctant; I attend and maybe it will be normal to hear these words, but it still does not help.'

The ideal of statutory protection of women's rights was appreciated by forced migrants, including a trans man who described himself as 'born as a girl' and for whom feminism meant support for LGBTQI rights. Some enjoyed the experience of collective meetings to discuss women's rights, but the solidarity of women's group encounters was not appreciated by all.

Feminist service provision

Service providers' descriptions of their work around SGBV varied greatly, with some offering a very organizational account, some discussing the politics of migration and gendered violence, while others

[1] For further details of the interviews, translation and ethics considerations see Hourani et al. (2021).

focused on stories of individual migrants they had worked with. As with the migrants' interviews, this analysis focusses on those who mentioned feminism or described an approach to providing services that was informed by migrants' rights and priorities in trying to escape or recover from SGBV.

A feminist approach informed some service provision for forced migrants. The approach of a multicultural centre for women's health in Australia was described as 'intersectional' by a centre employee, who explained the term as follows:

> 'That means that we not only address gender inequality but also all the other forms of discrimination that are facing migrant refugee women, depending on their circumstances.'

Also in Australia, a government funded health centre, was said to use 'a trauma-informed feminist perspective.' In Turkey, three individual service providers described themselves as feminist, an understanding that informed their approach to their work. Less frequent were explanations of the service itself being feminist in design, such as a trainer who described her NGO as:

> '… approaching our training from a fundamental feminist perspective. We establish an egalitarian relationship and include them more and make them think and discuss more in our training.'

Another explicitly feminist approach to service provision was described by Maya who said: 'we pride ourselves being radical feminist!' She described her NGO as offering a tailored service for newly arrived migrants in a British city, emphasizing the provision of a single setting where women and children could access services, thereby:

> '… enabling women and children to have ownership and consistency and to build a community kind of resilience and support mechanism by providing a single space'.

Built into the model of service provision was the idea that the women who had suffered violence had to evaluate how they themselves had been affected. So rather than ask professionals to make an assessment, this NGO created a community where professionals could be invited in to work with women, according to their self-identified needs. Maya said:

> 'We see people who have experienced what might be considered minor, but that might have a profound effect and … other people who might have experienced genocide and they are resilient. So even judging something or make a limitation someone's experience - we don't do that.'

This is a radical proposition: that women from across the world, can make their own assessment as to how their experience affects them and how much help they might need. The ideal of forced migrants' own voices shaping service-provision was mentioned by others, even if it was not the organizing principle of their service. For instance, in Turkey, 'cooperation and solidarity **with** refugees' was named as important, rather than 'working **for** refugees.' Personal politics notwithstanding, services tended to rely on a professional's assessment of the type and level of support to be made available, rather than taking the client's own account. Even in professional-centred services, providers talked about empowering women and building confidence for self-expression and claiming rights. But some noted that SGBV trauma led to under confidence and difficulty in women articulating their needs, let alone to claiming their rights.

Other views

Forced migrants commented on the extent to which their reception and treatment was responsive to their own assessment of their needs, even if feminism was not explicitly named. A refugee from West Africa in the UK said that a local grassroots charity had offered key and continuous support in navigating health and housing services, and dealing with government agencies. Several women in the UK mentioned both primary healthcare and day-care centres as offering good support, responsive to women's self-identified needs, because these are, according to a Swedish-Kurdish-British woman:

> 'Places people are familiar with - they feel comfortable with. They know you and they see you on a daily basis and there's more chance that you would tell them something.'

Specific support workers who gave particular care, offering navigational support were named by migrants as especially helpful and responsive. This picture of good quality, constructive and continuous support was reflected in how some services in the UK and Sweden were tailored for newly arrived forced migrants to create space for women to be with their children, and, with time, disclose SGBV, such that appropriate services could be provided. In Australia and Turkey, we heard that the more autonomy and choice women got, and the more their individual circumstances were considered, the more supported they felt and the better their prospects of integration (Phillimore et al., 2022) and recovery.

Alongside the examples of service provision that made space for refugees to describe to define their needs, were examples of women feeling unable to describe their experience at all, let alone identify what they needed to recover. Aisha from Afghanistan, felt that for two years after her arrival in Sweden, since she couldn't speak English or Swedish, she remained unable to communicate and so was locked into fearing the dangers she was trying to escape.

Some services in the UK were described as unresponsive, as untrustworthy in terms of client confidentiality, insensitive to the trauma of SGBV and sometimes punitive, in moving women from hospital to hospital or blocking access to services on grounds of migration status. Of significant concern is that women were reporting symptoms and problems to health and social services and were not necessarily being picked up as having suffered SGBV. One particularly harrowing illustration was Zahra's immense difficulty in getting essential medical treatment in the UK, due to her undocumented status. Zahra did not speak English, so her daughter was translating and advocating for her mother, making clear that the failure to respond to her mother's symptoms was systematic rather than individual. The sense of the whole system being unforgiving and punitive was echoed by Ayesha, a divorced woman in her 40s living in Sweden. She described how her unhappiness and illness made it extra difficult to concentrate and so she sometimes made mistakes.

> 'Here when you go to a doctor, they do not control everything from their computers. They write on a paper. The doctor gave me the paper, but I forgot to give it to the social worker, and they made it a big deal.'

Ayesha's intense difficulties with navigating the system were confirmed by a local friend who offered help and commented:

> '"Wow! That is very hard!' Even though she understands the language and the rules she was very surprised how hard everything is. If you do a single mistake, you cannot take your money … when I do something wrong, they cut my money."

This interview was cut short because of Ayesha's sobbing.

Women who had been through very difficult times wanted to support others. Women helped one another to navigate the complexities of the Swedish welfare system and mutual support was a recurrent theme in all the countries. A woman in Turkey said 'I feel more comfortable with women' and this was a reason for building solidarity, as women in Australia said, to make things easier for others.

Unresponsive service providers

Service provision regularly fails to understand, let alone meet the needs of refugees (Bradby, Humphris, Newall, & Phillimore, 2015) and marginalized patients (Bradby et al., 2020). The failures of services not only represent an unmet need for social and health care, education and housing, but also lost opportunities for disclosing SGBV that could increase the chances of carrying unaddressed and unresolved trauma in isolation. SGBV survivors can meet service providers on multiple occasions before injury and trauma, whether ongoing or past, are reported in a way that professionals act upon. Effective treatment and prevention of SGBV is based on a wide range of service providers being aware and responsive to the possibilities of disclosure. In the evidence that we report here, the extent of joined up, victim-centred services, based on solidarity that would enhance the possibility of disclosing SGBV, for prevention and healing, is limited.

Feminist service provision should ideally centre on the needs of women (including trans and non-binary women), joining up services to counteract gendered harms and misogynist aspects of medical practice, as part of holistic service provision. Even where the feminist ideal has been operationalized, criticism has been levelled at inequitable outcomes (Blackford & Street, 2002), a promotion of gender conservativism (Shai et al., 2021) and a failure to inclusively define the category of 'woman' to cover queer undocumented (Luibhéid, 2002) 'aliens' (Grosfoguel et al., 2015). Some of the failure to achieve a feminist transformation of the gender politics of service provision is associated with being co-opted by the forces of financialized capitalism (Shai et al., 2021; Shildrick, 1997).

Conclusion

This analysis of interview material explored the extent to which feminist ideologies inform service provision for forced migrant survivors of SGBV in Sweden, Australia, Turkey and the United Kingdom, where attention to women's and girls' own priorities and to how power inequities are managed are seen as key. For the most part, services are not configured in ways that attend to survivors' self-identified needs, nor to facilitating the expression of those priorities. Forced migrants who have suffered SGBV do not routinely encounter services based on solidarity to support women's self-identified needs and access to services that would support recovery. Service providers and migrant women identify the need for empowerment, whether or not this is addressed in the design of services with which they are engaged. Our material includes examples of service providers who facilitate and respond to women's expression of their own needs and support access to appropriate services and resources. Women's own experience of these services is largely, but not only, positive. The complex and dynamic nature of forced migrant women's needs for resources and support are reflected in their accounts. The need for inclusive consultation to ensure that services meet those needs was less in evidence, but not wholly absent.

While we identified examples of successful services that involved forced migrant women, the goal of building good quality service provision that responds to the ongoing shifts in forced migrant women's needs is not straightforward. Complex and shifting needs, which are related to individual and community characteristics have to be constantly reviewed, evaluated and reconfigured. Crucially, service providers need familiarity with the causes and experiences of forced migration and how the global refugee regime responds to forced migrants (Cook Heffron et al., 2016). As the governance of forced migrants shifts, so too must the provision of services.

To capture this constantly shifting process is not straightforward, given the number of stakeholders and other variables, including the various temporalities through which the trauma of SGBV and the process of resettlement are experienced (Papoutsi et al., 2022). Capturing the multiple dynamics relevant for designing services that are in contention is a challenge. One possible strategy to address this highly complex and changing field (Ozkaleli, 2021), is to examine 'relational pragmatics' as a means of framing the relational agency within the context of the multiple temporalities that apply (Emirbayer & Mische, 1998). Our material shows that women's needs are multiple and changing, while service provision tends to be fixed and unresponsive. Supporting refugee women's agency in the context of relational dynamics requires a model that can encompass a complex dynamism. As discussed by Ozkaleli (2021), the relational pragmatics approach "allows room for moving within different temporalities" (2) and hence reminds researchers, policymakers and practitioners of the complex power structures that refugees have been dependent on. Reckoning different temporal and relational contexts would widen the flexibility and increase the adaptability of service provision and facilitate better utilization of resources and networks. Mobilizing services in accordance with the narrative of the person of concern, that is the forced migrant who has experience SGBV, would also enable the integration of a feminist understanding of care. Feminism is (still) missing in service provision for the survivors of SGBV, as Egan (2019) notes in her research on feminist knowledges and practices in the field of sexual assault service provision in Australia. In line with her argument, our research also accentuates the significance of feminism as "an understanding that has been written into the fabric of service provision" (Egan, 2019: 176). Egan underlines that we need to attend to 'how knowledges about sexual assault are implemented in practice' since feminist responses to sexual violence cannot be unproblematically equated with a single form of intervention or service.

The wide range of views in our material must be seen alongside the contested nature of feminism itself: an intersectional feminist practice is about building collective action to claim resources and opportunities, while supporting women's empowerment. In an extremely inequitable world, individuals' ability to assert claims is highly differentiated and, what is more, the individualism of feminism is open to criticism as a secular (Fahlevy, 2018) and a Western construct (Mernissi, 1991) that is not universally applicable.

The securitization agenda of national politics, enhancing the vulnerability of forced migrant women and girls to SGBV (Freedman, 2016), has accompanied feminist foreign policy deploying the language of feminism to justify women-focused overseas development. Such development work has been criticized for of deploying an individualized rights-based Western-centric model of feminism (also known as White feminism), the dangers of which can be seen in the co-opting of the defense of women's rights to justify military intervention.

The fundamental feminist insights around the need to address inequalities in power, influence and resources, to build solidarity to support access to equitable health and social care and other services, have not been systematically built into service provision. The ideals of women's rights being human rights and feminism being an integral part of an effective public health are far from upheld in the practice covered by our study. The tension between individual and collective empowerment has not yet been explored as part of a holistic responsive service delivery, driven by the needs, values and priorities of forced migrant women and therefore the insights of feminism have not been taken up and have not been tested.

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