THE EUROPEAN INSTITUTE OF
WOMEN'S HEALTH

WOMEN SEEKING INTERNATIONAL PROTECTION IN THE EUROPEAN UNION

2023 REPORT

CONTENTS

1 EXECUTIVE SUMMARY

Context: Removing barriers and empowering migrants to integrate and contribute to European society is increasingly important due to the continued influx of people seeking international protection as a result of conflict and climate change and continental economic stagnation. Supporting this vulnerable population requires an integrative approach that considers their mental health.

Objective: This report examines the need to address gender differences in refugee, asylum seeker, and displaced person mental health, specifically depression, anxiety, and Post-traumatic Stress Disorder (PTSD); synthesizes examples of mental health interventions that respond properly to women seeking international protection's psychological distress; and provides respective evidence-based policy implications.

Key Findings: Women seeking international protection are at greater risk of developing depression, anxiety, and PTSD compared to male migrants and settled Europeans. They must contend with the harmful effects of gender-based violence and overcome barriers of social isolation, cultural stigma, and the shortage of providers who understand their language, culture, and experience. Successful interventions ensure that these women have access to strong social networks, social services and legal support, and culturally-competent providers.

Policy Implications: Policies and programs should prioritize disaggregated data collection and representation in studies and trials. Improving these women's access to services requires supply- and demand-side levers, such as on the supply side, potentially employing those seeking international protection as part of the mental health workforce and simultaneously introducing training for medical professionals at undergraduate and postgraduate levels on gender-sensitivity, cultural-competency, and discrimination; on the demand side, de-stigmatizing mental health so that women are receptive to support. It is critical that any program integrate with Social Determinants of Health (SDoH), such as by increasing the affordability and availability of contraception and childcare. Stakeholders can continue to refine the policies to be more cost-effective while continuing to listen to the lived experience of these women.

ALL SOURCES REFERRED TO IN THE BODY OF THIS REPORT AND IN THE REFERENCES

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2 CALL TO ACTION

SOURCE:ESTONIA INTERNATIONAL CENTER FOR DEFENSE & SECURITY

MASS MIGRATION

In 2015, Europe declared a migration crisis and the numbers continue to rise due to humanitarian crisis, war and conflict, and natural disasters.[1,2,3]

962,200 applications were lodged in the EU in 2022, an increase of 52% in comparison to 2021.[1]

ECONOMIC STAGNATION

GDP growth is slower in the EU than other regions of the world.[4] The rising cost of living is the most pressing worry for 93% of Europeans.[5]

The migrant community can contribute to economic growth when given the resources.[6,7]

CURRENT EU FOCUS ON MENTAL HEALTH

Examples include:

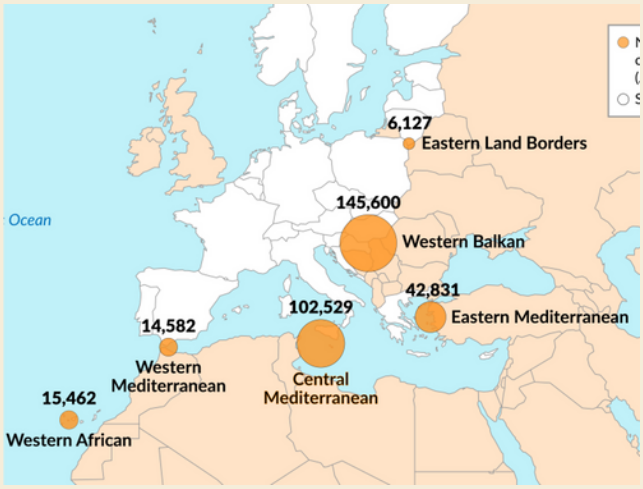
- The European Commission has launched a Comprehensive Approach to Mental Health.[8]
- The IOM launched a 2030 Agenda to "Leave No Migrant Behind".[9]

ADDITIONAL BARRIERS

Migrant women face additional barriers to access care, including:

- Language[10-16]
- Cultural stigma[10,12,14,16-19]
- Economic dependence[10,20]
- Labour discrimination[21]
- Health status[22-24]
- Etc.

2 KEY FACTS



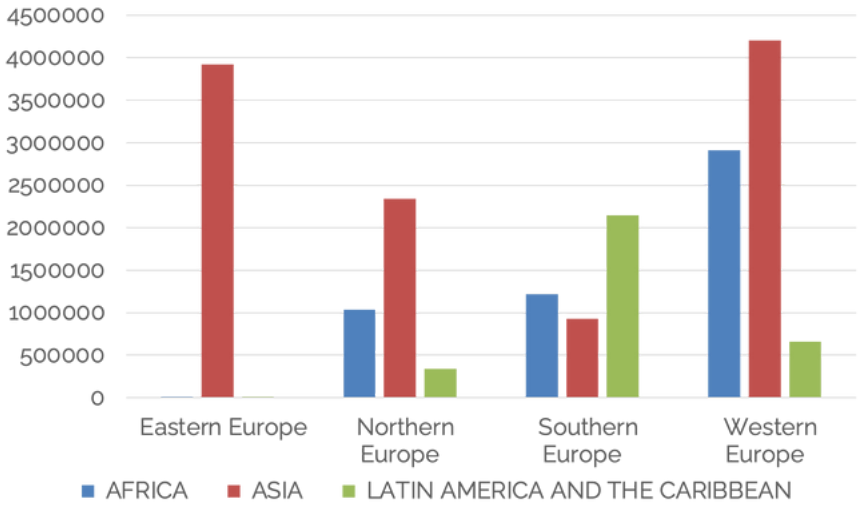
TOTAL NUMBER OF BORDER CROSSINGS BY PEOPLE SEEKING ASYLUM IN 2022

- Main nationalities for women registered at arrival to Italy and Malta along the Central Mediterranean route are **Côte d'Ivoire, Guinea, Afghanistan, Tunisia and Syrian Arab Republic**.
- Main nationalities for women registered while transiting through the Western Balkan region are **Syrian Arab Republic, Afghanistan, Türkiye and Islamic Republic of Iran**.
- While most women from South-East Asia travel more frequently with their families (men and children), **women from sub-Saharan countries travel more frequently alone**.

Source: Frontex (we have reworded "Illegal border crossings" as "border crossings by people seeking asylum"; IOM DTM Europe FMS[25]

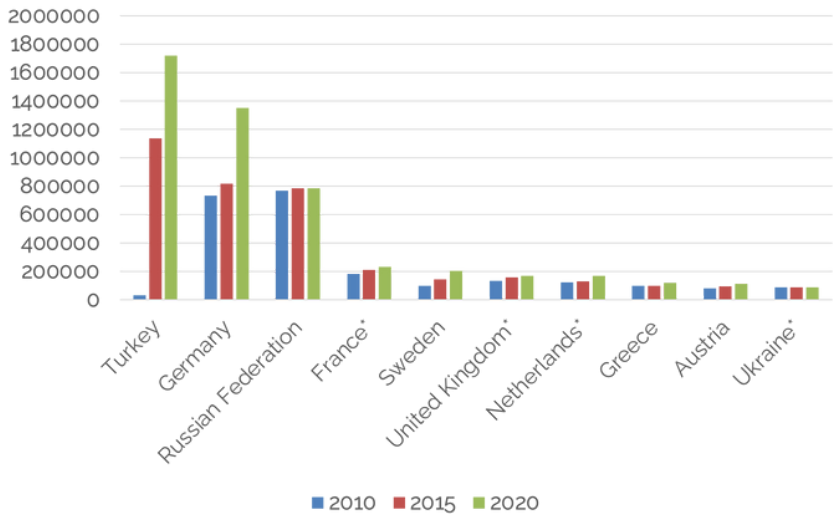
- **Asia / Middle East make up the highest migration flows** in all parts of Europe except Southern Europe
- **African populations tend to migrate to Western Europe** (>30%France), while **Latin American to Southern Europe** (>50% Spain)

FEMALE MIGRANT DESTINATION BY ORIGIN, 2020



Data includes all types of immigrants .
Source: United Nations Department of Economic and Social Affairs, Population Division (2020). International Migrant Stock 2020.[26]

TOP 10 DESTINATIONS FOR FEMALE MIGRANTS FROM WESTERN ASIA

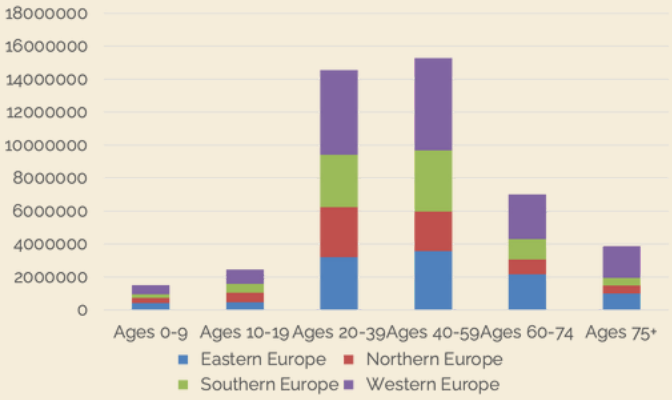


Source: United Nations Department of Economic and Social Affairs, Population Division (2020). International Migrant Stock 2020.[26]

- Migrants from the Middle East appear to **remain in Turkey and Russia** (even if their destination is further west in Europe)
- The highest number of female migrants from the Middle East **migrate to Germany**

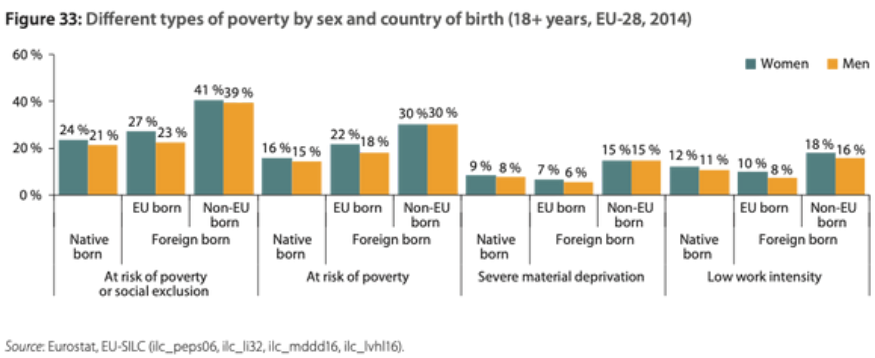
MIGRANTS BY AGE GROUP AND DESTINATION, 2020

- Most female migrants immigrate between **ages 20-59**
- **Western Europe absorbs the highest share** of female migrants at all ages



Source: United Nations Department of Economic and Social Affairs, Population Division (2020). International Migrant Stock 2020.[26]

DIFFERENT TYPES OF POVERTY BY SEX AND COUNTRY OF BIRTH, 2014



Source: Poverty, gender and intersecting inequalities in the EU Review of the implementation of Area A: Women and Poverty of the Beijing Platform for Action[27]

- The migrant population of the EU faces a **higher risk of different types of poverty** than native-born
- **Poverty and mental health are inextricably linked** [28]

3 LITERATURE REVIEW METHODOLOGY

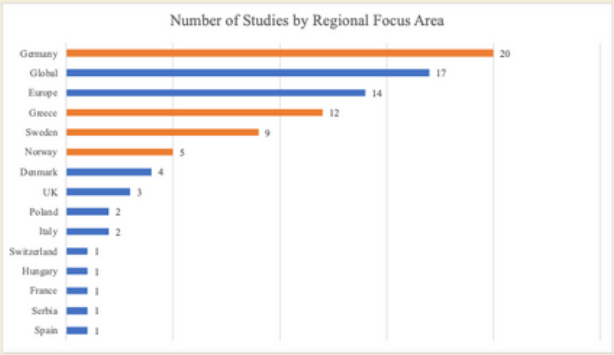
This review employs a targeted literature review (TLR) and pearl-growing strategy (PGS) to investigate the prevalence, risk factors, and interventions for women seeking international protection. The TLR provided a more comprehensive database search, while the PGS provided a more flexible search following relevant citations and non-academic publications.

TARGETED LITERATURE REVIEW (TLR)

Three bibliographic databases were searched (PubMed, Scopus, and Cochrane CENTRAL). PubMed yielded 60 results, Scopus 50 results, and Cochrane 7 results. 26 of the articles were excluded due to geography (e.g., not in Europe) and population (e.g., men only) and 15 were duplicates. The TLR identified a total of 69 papers.

PEARL GROWING STRATEGY (PGS)

PGS included grey literature, such as EU guidance, to incorporate relevant and influential works in the field primarily sourced via Google Scholar. PGS identified a total of 24 papers.



Across both strategies, half of the studies emerged from Germany, Greece, Sweden, and Norway.

4 LITERATURE REVIEW FINDINGS

PREVALENCE

30%+[29-38]

Prevalence of depression, anxiety, and PTSD across genders. Some studies exceed **70%**,[39,40] specifically in refugee camps and refugee housing facilities.[41-43]

Women at all ages generally report higher levels of distress.[16,19,30,33,34,36,37,40,44-48]
However, this must be interpreted with caution as men may be less likely to report stress symptoms to “save face”.

This vulnerability is even more acute for unaccompanied minors[45,49-51] **and during maternity.**[52-54]

DIAGNOSIS

·Near-term measures may **underestimate prevalence** of mental illness due to:

- Migrant focus on **safety, security, and legal status;**[14,17,55-58]
- Expressions of mental illness **differ by gender and culture;**[13,30,59] and
- **Fear of losing a child** to social services.[10,18]

"you have some people that were there [in the refugee camp] before, who were saying if you're not careful with your kids, they're going to take your kids away." [10]

RISK FACTORS

Risk factors pre-migration & during migration:

- **Torture**[60-61]
- **Gender-based violence** and sexual trauma[2,14,19,23,29,62-64]

Women may hesitate to report traumatic experiences due to shame or fear of retaliation. An Afghan refugee explained,

"I told my father 'Why, why did you marry me? I didn't want to.' And he started hitting me, so much. Every time I felt like complaining again, I was in a very difficult situation, I would remember what happened the last time I spoke with my father, and I would just… stay… silent." [14]

Risk factors post-migration:

- **Lack of social support** and separation from family[15,31,33,34,45,52,61,65,66]
- **Lower educational levels**[2,14,43,47,67]
- **Chronic conditions**[22-24]
- **Pregnancy**[18,52-54]

BARRIERS TO ACCESSING CARE

- Delays in accessing **sexual and reproductive healthcare.**[2,29,63] For example, when sexual assault leads to pregnancy, by the time these women arrive, it is too late to terminate or beyond the recommended 10-week antenatal care appointment.

- The most cited barrier is **language.**[10-16]

- **Cultural stigma** may prevent women seeking international protection from pursuing mental health support for themselves or their loved ones.[10,12,14,16-19] For example, on the ferry to Greece, a humanitarian aid worker recounted,

"A family alerted the medical team that Rozana a woman of Kurdish ethnicity needed assistance for an emergency, but nobody seemed willing to define the nature of the problem. On reaching her…[she was] writhing on the floor and calling out…that she 'wanted it to end'. She then rushed to the ferry edge and climbed with one leg over the railing before being pulled back by the team and fellow passengers… This case highlighted the stigma associated with mental health, the initial denial that this was a mental health crisis, followed by the family initially refusing to accept that she had acted in a way that suggests suicidality." [17]

- **Difficulty navigating healthcare** systems in host country.[2,14,47,67]

- **Labor discrimination**[21] may keep women economically dependent[10,20] and restrict their access to employer-sponsored supplementary health insurance where relevant.

INADEQUACIES OF EXISTING MENTAL HEALTH SUPPORT

Once women seeking international protection overcome the initial barriers to access healthcare, that healthcare may be inadequate. There is a fundamental supply limitation - a **shortage of language-concordant and culturally-competent mental health providers.**[13,68,69]

"Here in Europe, many psychologists can't understand us. And they don't have any solution to give us. […] But in Afghanistan they know our problem and it's easy to find a solution for us."
- Syrian Asylum Seeker in Greece[13]

Beyond this, women may suspend treatment for a variety of reasons, such as:

- **Mistrust of providers** [13,14]
- **Continuous relocation**, especially in the first months of resettlement [13,31,67,70]
- **SDoH and legal concerns** overshadowing mental health [13,68,69]

Lastly, there is limited **research on effective treatment** for this vulnerable population. At present, society still lacks precision medicine that properly account for sex and gender differences.[71]

SUCCESS FACTORS OF INTERVENTIONS

SOCIAL SUPPORT [10,15,21,31,33,45,61,65,66,72-74]

"You feel 'ok there are more women that have the same problem'. This makes you feel better and stronger to continue."
- Syrian asylum seeker in Greece [13]

PEER PROGRAMMES

Peer counseling may be effective ways to curate social support and seamlessly integrate SDoH,[13,69,74] while also treating more individuals and alleviating the burden on the mental health workforce. These programs positively impact the peer counselor, giving purpose to their struggles, and the participants.[72]

PROVIDER LANGUAGE & CULTURAL COMPETENCY [11,13-15,18,45,75-77]

"There are things that I can express more when I speak my language"
- Asylum seeker in Ireland [10]

IN-PERSON & DIGITAL OPTIONS [13,69,78]

It is important to provide options for in-person and digital settings so that individuals are empowered to make choices that align with their preferences. This approach engenders a sense of autonomy where women feel that their voices are valued and their preferences respected.

STEPPED CARE MODELS [13,69]

Stepped-care models involve shorter and simpler first-step interventions that may be delivered by trained lay-counsellors before more specialized treatments. This model can be an effective way to supplement over-burdened clinicians and ensure the individual is directed to the right level of care.

INTEGRATION WITH SDOH [13,18,41,56,69,74]

This holistic approach tackles not only the immediate mental health concerns but also addresses the underlying structural determinants that impact women's overall quality of life.

"Integration policy is health policy and visa versa" [72]

CASE STUDIES OF SUCCESSFUL INTERVENTIONS

Case Study – Peer Support Intervention in Spain[74]

Phase 1

Training peer counselors

1st Session - Project was explained in detail, emphasizing the importance of viewing the sessions as a flexible collective-building process

2nd - Explore the individual and sociopolitical reasons behind migration.

3rd-9th - Forum structured around 'migratory mourning', the key challenges faced upon arrival: social network, language, culture, land, status, ethnic group and health (Atxotegui, 2000). Share personal experiences and build them into a 'rebuilding a life' narrative alongside others.

10th-12th - Assessing strengths and positive changes experienced following migration as well as on future expectations.

All sessions followed a similar structure: (a) guided relaxation; (b) individual reflection; (c) the sharing of migratory stories; and (d) the presentation of community resources found in the city by the participants related to the session content.

Phase 2

Peer support groups

Participants now trained as mentors worked as cultural peer-support group facilitators, recreating the previously received peer-support sessions in their native language

Results

Improvements in four dimensions of Posttraumatic Growth (indicator that refers to the positive transformations a person undergoes): 1) appreciation of life, 2) personal strength, 3) relating to others, and 4) new possibilities.

The program proved especially useful to **early and late middle-aged women with university studies**.

This study suggests the importance that being able to participate in **mutual support settings alongside peers**, with whom they share the same language and/or culture..

This type of intervention **minimizes the asymmetric power relations between providers and refugees**.

TABLE 1 Participant characteristics of the community-based intervention (n = 47)

	n	Age	Gender	Level of education	Place of origin
Mentor group	11	20–64	4 women 7 men	4 secondary level 7 university level	El Salvador, Colombia, Venezuela, Cameroon, Somalia, Western Sahara, Morocco, Palestine and Ukraine
Cultural peer-support group (Spanish)	5	26–51	2 women 3 men	5 secondary level	Honduras, Venezuela and El Salvador
Cultural peer-support group (Spanish)	10	21–63	8 women 2 men	1 no education 4 secondary level 5 university level	Cuba, Colombia, Venezuela and El Salvador
Cultural peer-support group (Ukrainian)	8	30–50	5 women 3 men	8 university level	Ukraine
Cultural peer-support group (French)	13	18–40	1 woman 12 men	10 no education 2 primary level 1 secondary level	Cameroon, Burkina Faso, Guinea-Bissau, Gambia and Ivory Coast

Case Study – Central Clearing Clinic (CCC) in Germany[13]

Programme

Appointments were made via telephone and through email by social workers, volunteers, physicians, or by refugees themselves. A nurse with experience in mental health care made an initial estimate on case severity in order to adjust waiting time and give preference to the more severe cases to optimize resource allocation.

All psychiatric assessments were conducted by physicians experienced in transcultural psychiatry. Daily presence of at least one psychiatrist who spoke the most frequent language (Arabic) as a native language.

Language barriers was addressed in three ways: (i) a native Arabic speaking physicians provided care for the bigger part of Arabic speaking patients; (ii) interpreters for the main languages (Arabic and Farsi/Dari) were present in the CCC all the time, and (iii) for other languages on-demand interpreters and/or a video-based interpreter service was in use.

At the CCC a range of the most commonly used **psychiatric drugs was available on site.** Additionally, **psychotherapeutic short-term interventions were offered as a group program to Farsi and Arabic speaking women**.

Results

Main results of the present investigation were:

1. **Central clearing clinic is a feasible** and probably superior institutional strategy to provide mental health care
2. Stressful and traumatic life and flight experiences are associated with complex psychopathological reaction pattern with **unipolar depression, posttraumatic stress disorders and adjustment disorders being the most prominent** disorders

Unipolar depression was more frequent in female refugees (47% vs 37% of those referred) whereas addiction and psychotic syndromes (6% vs 1-2%) were diagnosed more often in male refugees. **PTSD was the same for both male and female (24%).**

Success Factors

1. For refugees, **diagnosis is associated with particular difficulties**: different concepts of illness and mental health, varying expressions of psychological distress as well as a lack of acceptance and trust in an unknown health care system. **Important that evaluators understand these cultural differences.**
2. The **availability of professional interpreters, respective bilingual physicians** was a major advantage of the CCC. The financial as well as the organizational burden could not have been carried out by the regular mental health care system.
3. By conceptualizing the CCC as a central access point **located next to the central registration authority for refugees**, we alleviated the access to mental health care. This may be superior to community-based programs because refugees move around. The CCC became a stable contact they could return to whilst having to make an odyssey through different accommodations and institutions during the first months in Germany.
4. **Triage** to identify the appropriate level of care. Group therapies and stress relief groups for milder mental health conditions must be made more widely available.

LIMITATIONS

- **Risk of bias**, such as publication bias and positionality bias
- **Geographic gaps**, specifically in Turkey and France
- Limited discussion on **national policies** and how those influence migration journeys[20]
- Limited discussion on the **association between culture of origin, systematic gender inequality, and mental health**[79,80]
- **Absence of studies measuring outcomes** for women seeking international protection specifically, regarding:
  - Affordability
  - Comparative analyses (e.g., how experiences may vary based on culture)
  - Trauma-informed practices
  - Digital programs Interventions to combat discrimination

AREAS FOR FURTHER RESEARCH

- **Representation in R&D**, including disaggregating by region of origin
- **Evaluation of efficacy of trauma-informed care**, psychotropic treatment, and non-medical SDoH interventions on mental health
- **Cost-effectiveness analyses**
- **Lessons learned** from other re-located crisis survivors, where applicable

5 POLICY IMPLICATIONS

This section translates the learnings from the literature review to policy implications for continental and national European entities.

RESEARCH & DEVELOPMENT

Collecting and analyzing **disaggregated data** by sex, gender, age, ethnicity, and refugee status is crucial to develop more targeted interventions and inform evidence-based programs.[11,81] The **data collection starts at the point of arrival** and mental health screeners can be embedded into arrival surveys.[37,56,82]

European leaders must advocate for the **increased representation of women seeking international protection in epidemiological studies and clinical trials** for mental health interventions with informed consent and compensation.

All policies and programmes must be co-created with women seeking international protection.

AWARENESS

To increase awareness of mental health, governments and organizations can launch **de-stigmatization campaigns** for both women and men (aligned to European Commission's Comprehensive Approach to Mental Health to "tackle stigma and discrimination")[8].

Since women seeking international protection may turn towards their faith leaders for guidance, these campaigns can **partner with faith leaders** to de-stigmatize mental health and act as points of referral.[10,15,73]

Across all initiatives, leaders must consider **terminology that describes migrants from crisis zones respectfully**[83] (e.g., "seeking international protection" to recognize as formal process).

ACCESS

To **increase supply of trauma-informed, culturally-competent, and language-specific care**, European leaders should utilize migrant resources and consider the following strategies:

1 **Establish accelerated career paths for migrant health professionals** to allow them to practice in the host country

Consider the qualifications of migrant clinical workers and identify ways to reduce barriers for them to practice or up-skill, providing supplementary education modules where necessary.

2 **Expand peer mentor programs** (aligned to the EU STRENGTHS program) [69]

Allocate resources to develop and implement peer mentor programs. These mentors can offer a relatable and empathetic connection that encourages these women to seek help, navigate the healthcare system, and engage in therapy more effectively.

3 **Engage IOM cultural mediators** (aligned to IOM 2030 Agenda)[9]

IOM cultural mediators, often former asylum seekers, can facilitate comm-unication between mental health professionals and this population

4 **Increase gender-, cultural-, and racism-sensitive trainings** for health care professionals (aligned to European Psychiatric Association (EPA) guidance[77] and European Commission's "initiative for more and better trained professionals")[8]

To **encourage demand**, leaders should:

1 **Ensure information is easily accessible** in multiple languages

Organizations can leverage behavioural science to improve signposting and direct these women to the appropriate support systems.

2 **Offer a range of digital, multi-media and in-person programs**, including targeted programs for adolescents due to their heightened risk[45,49-51] (aligned to European Commission's goal to "boost the mental health of young people")[8].

3 **Design referral pathways from mobile clinics and primary care** into social and mental health services in the community setting.[75,84,85]

Since this population often presents in physical health settings,[13,30,59] frontline workers can continue to improve these processes and into social and health care settings.

CROSS-SECTOR COORDINATION

Supporting this vulnerable population requires a **multi-disciplinary** approach, including:

- Disaggregate women seeking international protection-**specific endpoints in existing programmes**. For example, governments can disaggregate these women when measuring the effectiveness of housing initiatives. Housing data will influence SDoH and mental health.

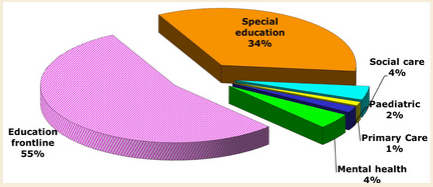
- **Simplify and accelerate the visa application process** as immigration stressors may overshadow other initiatives.[13,68,69]

- Accelerate the **right-to-work for asylum seekers**, as this simultaneously improves mental health of the individual and increases net contribution to society.[6,7,21]

- **Integrate social and health care services** as interventions can improve outcomes for both sectors, and therefore need not be resourced by one, such as for:
  - **Language** programs[10-16]
  - **Sexual & reproductive health**[2,19,23,29,62-64]
  - Affordable, accessible **childcare**[10,18]
  - **Gender-based violence** protection[14,86]

EXAMPLE OF CROSS-SECTOR COSTS OF PSYCHIATRIC DISORDERS IN CHILDREN

United Kingdom, 2001



Snell et al JCPP 2013

Majority of costs lie in the education sector with an equal amount drawn from social care as from mental health care.

There is **hope for "the future about us and of our children**. Think about the progress. The children being a doctor, an engineer having a bright life and a bright future. This makes us feel confident."

- Afghan asylum seeker in Greece[14]

"I want to do something, **I want to give back** to the people that have accepted me to their community in the first place."

- Asylum seeker in Ireland[10]

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