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MIGRANT WOMEN'S MENTAL HEALTH & WELLBEING



AUTHOR

FROHAR POYA

EDITED BY: ANNA ZOBNINA

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FORWARD

MENTAL HEALTH & WELLBEING OF MIGRANT AND REFUGEE WOMEN



Mental Health and Wellbeing can play a crucial part in migrant and refugee women's and girls' paths to integration, developing their full capacities and accessing and exercising their human rights in their new home countries.

Unaddressed and unresolved traumas, whether resulting from direct violence and discrimination, or from witnessing such violence inflicted on others, can lead to impaired functionality of life and reduced capacity to engage in social and economic activities.

The availability of quality, women-centred and culturally appropriate support services for migrant women, and the low threshold in accessing such services, remain some of the key factors in helping migrant women who may suffer from mental distress, disorders and psychological ill-health.

"While biological differences between women and men may lead to differences in health status, there are societal factors that are determinative of the health status of women and men and can vary among women themselves. For that reason, special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities."

Convention on the Elimination of Discrimination against Women (CEDAW), General Recommendation N 24 (Women and Health)

INTRODUCTION

Over 20 million migrants live in Europe and over half of them are women and girls. Migrants and refugees, in particular women, face **multiple challenges including difficulties in accessing health services, education and employment.**

While preparing this report, we came across a lack of data on migrant women accessing health services and, specifically, mental health services in different European countries. Therefore we are aiming to publish this report as a door opener for a more comprehensive research and data collection (both quantitative and qualitative) on the mental health of migrant women in Europe.

Migration is always a stressful event and it can have a profound impact on one's mental wellbeing. For many refugees and asylum-seekers who have left their country of origin forcefully, this effect is greater and can lead to severe depression and other profound negative consequences for mental health.

For migrant women and girls, poverty and destitution, unemployment, detention, discrimination, legal dependency on spouses, and social, religious, cultural and

peer pressures within the communities, can all influence mental health and mental illness.

Furthermore, migrant and refugee women and girls are at risk of specific forms of violence such as sexual and reproductive violence, sexual exploitation, prostitution and trafficking.

This report is an overview of mental-health, wellbeing and mental ill-health among migrant and refugee women and girls. The report consists of mainly primary data - interviews with different **expert practitioners working with migrant women in Europe, as well as the testimonies of migrant and refugee women themselves**, and secondary desk research - looking at existing policy reports, and academic research conducted with migrant communities.

Our interviewees range from highly experienced professionals working in the area of preventing and combating violence, prostitution, female genital mutilation, victim support and assistance, specialists in maternal health and mental health, along with the migrant women who generously shared their stories and insights.

OBJECTIVES OF THIS REPORT IS TO PROVIDE A SYNOPSIS OF

- Different experiences of migrant and refugee women and professionals working with migrant women
- A summary of different mental health factors that can trigger mental illness.
- A snapshot of challenges and root-causes which have a particularly grave impact on the wellbeing of migrant women,
- Barriers to accessing health and mental health services,
- Useful approaches for addressing migrant women's needs in relation to mental health and wellbeing.



AN OVERVIEW

COMMON MENTAL HEALTH CONDITIONS

MAJOR DEPRESSION DISORDER

Major Depression Disorder has many faces, including emotional symptoms (emptiness, self-blame), physiological-vegetative symptoms (loss of energy, fatigue, sleeping disorder), cognitive symptoms (pessimism, negative self-concept, suicidal thoughts) and behavioural symptoms (slower speech). Research has shown that migrant women have higher levels of depressive symptoms.

SOMATIC SYMPTOM DISORDER

Somatic Symptom Disorder describes an individual's distress caused by (typically) multiple, current, somatic symptoms that disrupt daily life. The most common somatic symptom is 'pain' whose severity or existence cannot be explained medically. Individuals with somatic symptoms tend to carry increased worries related to the symptoms. Despite similarities across cultures, differences in somatic symptoms occur due to their linguistic or cultural factors.

ANXIETY DISORDER

Anxiety Disorder is an umbrella term for a great variety of disorders relating to excessive fears, anxiety and behavioural disruptions. While fear is an emotion we naturally feel when facing direct and concrete danger, anxiety relates to future threat, autonomic arousal, perceived immediate danger, avoidant behaviour and extreme physical arousal. Common anxiety disorders include social anxiety disorder, panic disorder, agoraphobia and generalized anxiety. Many of these anxiety disorders occur twice as frequently in women as compared to men.

POST-TRAUMATIC STRESS DISORDER (PTSD)

Post-Traumatic Stress Disorder (PTSD) relates to an event that is a direct or indirect "exposure to actual or threatened death, serious injury, or sexual violence" (DSM-V). Children are at increased risk of developing PTSD when witnessing or learning that a traumatic event occurred to their primary caregivers. Common symptoms of PTSD are flashbacks and nightmares, intense or prolonged psychological distress, avoidant behaviour, negative self-worth, hypervigilance and feelings of detachment from others (DSM-V). Several studies have proved that, despite higher exposure to traumatic events in men, women are twice as likely to develop PTSD.

FACTORS RELATED TO MENTAL HEALTH AND ILL-HEALTH OF MIGRANT WOMEN

Both risk factors and protective factors can affect migrant women's mental health and ill-health. Both risk and protective factors may relate to biological, hereditary and familial characteristics. However, they very often relate to wider social-environmental circumstances that protect individuals from - or expose them to - stressful and harmful situations.

Women are more likely than men to face external risk factors to mental health. Those include male violence, patriarchal family/community control, traditional harmful practices, sexual or labour exploitation, lack of social support, unemployment and poverty. These risks are often interlinked and amount to compounded and prolonged conditions of discrimination and violence, in turn, causing long term negative impacts on women's psychological wellbeing and health.

RISK FACTORS

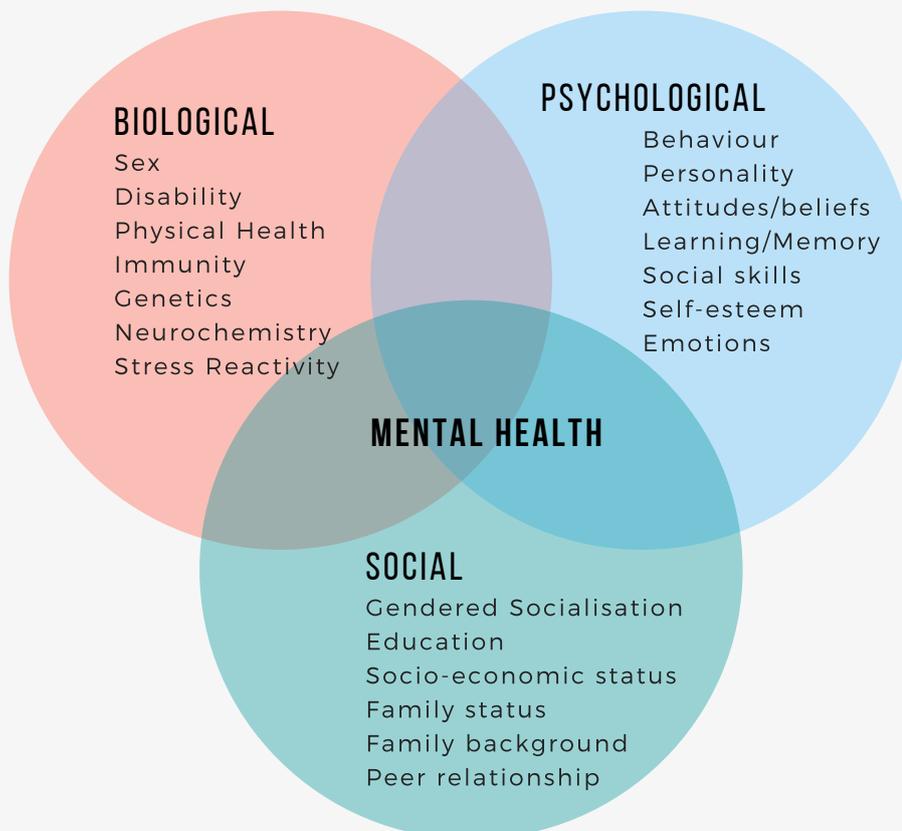
1. Male violence - refers to the acts of violence, perpetrated against women by men and/or family/community, based on patriarchal norms and practices aimed at limiting women's autonomy, including sexual autonomy, and rights.
2. Institutional discrimination - refers to the acts of exclusion and discrimination within institutions, governmental and judicial bodies, perpetuating unequal access to rights, resources and opportunities.
3. Social discrimination - relates to prejudice and stereotypes which may result in a lack of respect, suspicion, devaluation and dehumanisation.
4. Internalised discrimination - occurs when women accept and internalise stigmatising messages and stereotyping about their abilities and lack of worth.

PROTECTIVE FACTORS

1. Supportive social relationships including female friendship and networks, community and/or religious involvement, social networks with migrants of the similar cultural origin or ethnic belonging, and networks with individuals from the majority group.
2. Access to low threshold specialist services and support programmes, including women-focused, culturally sensitive and trauma-informed organisations and programmes.
3. Positive self-perception, self-esteem and the feeling of mastery.
4. Socio-economic factors, such as the levels of education, labour market status, level of income and control of its disposal, access to resources, and feelings of material control and agency.

BIOPSYCHOSOCIAL MODEL OF MENTAL HEALTH

The biopsychosocial model understands health and ill-health as one - an outcome of psychological, physiological and sociocultural characteristics and factors which influence each other. The biopsychosocial model emphasises the importance of the mind, body and environment as well as their interactions, for a person's well-being. For instance, a refugee woman who has fled her country of origin for reasons of war may have experienced a number of different life-threatening stressors compared to a man fleeing the same country, or a woman from a different age group or socio-economic background, which can develop into ill- mental health over time. Each of us carry different degrees of vulnerabilities to mental health problems which is why people can have similar experiences yet with different mental health consequences.





FEMINIST PSYCHOTHERAPY AND DIAGNOSTICS

DIPL.-PSYCH. STEFANIE BODE,
PSYCHOLOGICAL PSYCHOTHERAPIST,
GERMANY

"I understand feminist psychotherapy as a contradiction in terms. This contradiction derives from an oppressive psychotherapeutic practice that hinders women from believing in their own strength, from forming or joining women-focused solidarity groups and from standing up against the systems of oppression.

I agree with Mary Daly's feminist analysis which describes psychotherapy as a practice that inherits an unequal power relationship between therapist and client wherein the therapist is portrayed as the knowing helper and the client as the disordered dependent.

Following Daly's analysis, psychotherapy fixates on individual problems that, on the contrary, should be seen through a lens of structural feminist analysis. The privatization of problems in psychotherapy reinforces feelings of responsibility and guilt within the client. Mary Daly concludes that feminist psychotherapy can essentially not exist.

Based on my experiences, there are commonalities in women who seek therapy. Accordingly, women come to therapy with little expectations, need for harmony and psychologise to an extent that they blame themselves for everything.

Most of the women I work with in particular lack social support and therefore have a strong need for having their experiences and emotions validated.

In our culture, we are continuously unlearning to help each other before sending someone to an expert. Our societal problems are reflected on the individual level and society dictates us to solve them there. This however negates the structural aspects of our problems and only manifests inequalities.

Women are taught to adjust to unfair circumstances while being discouraged to change the world around them. Focusing on unhealthy attitudes rather than unhealthy situations goes hand in hand with self-blaming, victim-blaming and, in the theoretical framework of psychoanalysis, mother-blaming.

I highly criticize the German context wherein psychotherapists are taught to be politically neutral which constitutes a barrier to critical societal stances in psychotherapy.

There are individuals who suffer from a mental disorder that requires psychotherapeutic or psychiatric treatment. But generally, we need strengthening feminist movements, consciousness raising groups and rape crisis centres with feminist analysing as an alternative approach to women's mental well-being. To this end, women should be informed more critically about the negative consequences of psychotherapy and referred to such, only if really necessary. With that in mind, I hope for more feminist approaches that increase affection, sympathy, patience and respect for each other."



THREE PHASES OF MIGRATION

IMPACT ON MENTAL HEALTH OF MIGRANT AND REFUGEE WOMEN

PRE-MIGRATION

Pre-migratory experiences of migrant and especially refugee and asylum seeking women, may include male violence against women, persecution for political, ethnic and religious reasons, exposure to torture & witnessing the death of beloved ones, lack of food and water, homelessness and lack of other basic needs for oneself and others (e.g. children, and family members, and witnessing others' suffering).

DURING MIGRATION

Migrant women face an increased risk of male violence against women, infectious diseases, human trafficking and other physical harms such as sexual violence, abuse and exploitation. A particularly high risk arises from unsafe means of transports such as boats, enclosed trains, trucks or crossing dangerous landscapes by foot on their way to Europe and after entering the European Union. Mass accommodation facilities present a risk of sexual violence and assaults, diseases, unhygienic and crowded facilities/conditions.

POST MIGRATION

Long and unpredictable asylum processes increase the feeling of uncertainty, helplessness and the risk of developing PTSD, anxiety, depression, suicidal ideation and suicide attempts. Lack of women-focused and culturally fair services is a barrier to accessing help and care after being subjected to violence. Fear of compromising application status by disclosing information on the violence suffered risking on-going violence and re-traumatization. Stressors relating to acculturation concern gender roles, adaptation to cultural norms, language barriers, economic hardship, access to health care and discrimination. These stressors relate to poor mental health including psychosomatic symptoms, identity-confusion and feelings of marginalization.

FEMALE GENITAL MUTILATION

DR. CAROLINE MUNYI,
HEALTH COORDINATOR OF AKIDWA, NATIONAL
NETWORK OF MIGRANT WOMEN, IRELAND

"One of the effects of FGM is not what happens to the body being cut, which is physical, but a woman suffering from trauma. The flashbacks of what happened to her a long time ago can be traumatic and can contribute to poor mental health. Let's say a woman is pregnant, she dreads the whole process because of the pain she goes through- again this contributes to poor mental health. Woman with FGM may fear having regular intimacy and sex.

When we talk about FGM, how do we make sure women can access services in a culturally appropriate way? What I mean is, we want a woman to feel understood when she accesses services. For example, when a woman goes to hospital, to a maternity ward, she should feel understood, accepted, and not judged. FGM is a cultural practice and the woman did not have a say or consent to - what was done to her, it happened because she was a girl born in a certain culture, therefore we need to have people in health services who are culturally aware of these kinds of practices. In year 2000 I was talking to a group of women who had gone through FGM. One woman told me that when she was giving birth in a hospital in Ireland with her first baby, instead of doctors and midwives taking care of her, they were calling other members of staff to come and look at this woman's body which was different to what they normally see. They were looking at her body in surprise and laughing amongst themselves.

She described it as a freak show and felt ashamed and extremely traumatised. If there were someone from the same cultural background working in the ward, things might have been different. She could have explained to others about FGM and ensured help and support for this woman to deliver safely and calmly.

This is also very important in the mental health services. The patient should not be judged but be accepted. **When a woman accesses mental health services, she not only wants to be listened to but also be understood. It is not just about cultural appropriateness but cultural understanding too.** What I mean is that you can't force your way of thinking on those who have lived a completely different way of life and were brought up with a different way of thinking. You can not just change things in a person in one go.

We may see a woman with FGM, but there might be other causes contributing to her mental well being. She might be a victim of domestic violence which comes before FGM issue. She may want to go to college and she doesn't have financial means, or she may not have accommodation; she may have bad news from her family back home: issues that needs to be looked at first. Migrant women suffer a lot from different issues. Things were hard for migrant women before the COVID, now with the current pandemic, women suffer even more, not even being able to access services like Akidwa can cause them a lot of suffering."

PROSTITUTION

**PIERRETTE PAPE,
CO-FOUNDER OF ISALA,
BELGIUM**

"As a frontline organisation working to support women in situation of prostitution, we can confidently say that the vast majority of them are migrant women. To be more specific, they face double jeopardy of being migrant and coming from a minority group. The prostitution system and exploiters always look for the most vulnerable, and migrant and minority women and girls are the best targets for the sex industry.

While in prostitution, they live in a very isolative and manipulative environment where they lost a lot of self-esteem. They don't know anymore how to say 'I' or to understand their needs. The whole exploitative strategy directly targets the self-esteem of these women and girls : manipulation, false promises, violence, threats on the family, isolation... in order to break their identity and transform them into objects.

Moreover, many of them live in apartments of terrible condition, in hotels or on the streets. If they try to rent a place, the owner asks for a job contract, which they don't have as it is highly difficult to find a job when you are a migrant woman with no residence status or don't speak the language of the country you ended up in. So the owners also contribute to exploitation by asking for high rents and threatening to denounce the women to the immigration services.

When the women come to isala, they say they want to find « a normal job », which means that they, deep inside themselves, know that prostitution is not a normal activity and that it has impacts on their mental health. But they won't talk about health at first. When you are in this migration survival situation you want to feel in control. In fact, you don't have the time to reflect too much. Some survivors I work with still struggle, after 20 years, with their trauma. Yet, people don't want to recognize the long-lasting and tremendous impact of sexual violence.

For us at isala, health is as important as housing. Due to the repeated sexual violence and the situation in prostitution, many women feel detached from their body. We've seen women who clearly have health problems. Some problems are visible, you see that the

teeth are in a very bad condition or the posture is revealing back pain but they would not talk about it. Some other problems are invisible to people who are not trained to work with victims of prostitution and sexual violence, but these impacts are detrimental, they affect women in their capacity to regain confidence. That's why we propose a diversity of activities to the women, starting of course with Inon-judgmental listening, but also dance or painting, discussing women's rights, walking in the forest, so that they can take a step back and trust themselves again.

Some women we helped to exit prostitution started to have health issues afterwards. They at last went to a doctor to care for something that they were putting away for a long time. The body keeps the harm and when the women exit prostitution, the body asks for care. It might be very difficult for them to deal with health issues, but it's also a step in regaining control over their life and their body.

The problem is that psychology and other forms of mental health treatments are not considered as basic medical acts, not for the general public, and even less for migrant and refugee women. It is expensive to consult a psychologist, and it is still considered as a 'weird thing to do' for many people. It is also very difficult to find health professionals that speaks the language, who are feminists and who have no prejudices.

Why, would you ask, do these women not speak about their situation? Because women are not believed. And because they are not believed, they don't trust that people can help them. If we'd have a new system where women are believed, it would be an enormous step for them to trust themselves and trust that the system in place can truly support them. As long as societies don't recognise sexual violence and prostitution as human rights violations, women and girls trapped in the sex industry will be denied their basic rights. We need to acknowledge, as a society, that prostitution is against equality between women and men; by doing so, all services, included mental health support, will become part of comprehensive and strong exit programmes to support victims and survivors, and to disrupt the system of prostitution."

PROSTITUTION

TESTIMONIES

GABRIELA* **ACCOMPANIED BY ISALA ASBL,** **BELGIUM**

"I'm relieved to be out of prostitution, I feel very good now. My life has been difficult, and I'm determined to find a job. My dream would be to have a house in the country with my daughter. She is in a foster home since she was little, because I couldn't look after her, but I am in contact with her all the time. I can finally take care of myself, refocus, priorities my needs. I used to help people a lot, I used to help other women in prostitution, but now I'm going to take care of myself.

I'm afraid to see a psychologist, because I'm afraid of what it will bring to surface. I have a lot of things in my head, and I like those experience to stay in my head. I don't want it to become true, it would be too hard to cope otherwise. I was forced to see a psychologist when my mother died, I was 4-5 years old, but I was not understood. There was violence in my family, and if I see a psychologist, I'm afraid of remembering all that, and the experiences of what I went through. The associations and organisations I met during the prostitution period did not try to help me.

I no longer have any contact with my family, they didn't help me. When my mother died, my sister and I were placed with my grandmother and my uncle was violent, but nobody reacted. I went to a boarding school when I was 14, and that is when the prostitution started, but I don't want to talk about it. The last contact I had with my sister was when I wanted to redo my papers, because they were taken away from me when I arrived in Belgium when I was 18. My sister offered to help me to register and redo my identity card in Romania, but in return she asked me for 3000 euros, which I refused.

I'm not worried about the COVID-19 virus. I want to work as soon as possible, also because I have to pay my rent, which I'm behind. I'm afraid of ending up on the street again. I really want to find a job, but it's so difficult here. Sex buyers have contacted me during the lockdown, it makes me angry! I'm also angry because it's hard to come out of what I've been through and I don't think it's normal: when you 'are a whore', when you have money, the doors are open. When you do something wrong, you have lots of friends. Now that I'm trying to do something good with my life, there's no one, everything is closed. It's revolting!

I'm determined to get out of all this. I'm very resourceful; I speak several languages. I hope it works out. I don't want to hear about the time I was in prostitution, or that word anymore! I promised myself I would stop when I got my passport, and that's what I did. It's recent, but I have to hold on. I have the right to be happy, don't I? And I like coming to isala asbl, because I can express myself and I am listened to."

*not the real name

DOMESTIC VIOLENCE

**BASSMA CHAOKI,
MONIKA MULTICULTURAL ASSOCIATION, FINLAND**

"It is very important to understand what is happening to a woman who is a victim of domestic violence. I always show to these women the **circle of violence** and explain that violence might be mental, physical, or social and all of that might have an effect on them.

At the Monika Association, we do a lot of trauma work. Sometimes a woman comes to me and says:

'Bassma, I'm feeling that I'm getting crazy' or 'I'm not myself anymore' or 'I cannot manage anymore. I can't concentrate.'

Usually they have a lot of amnesia. They come with depression. They come with dissociation.

The migrant women who use our services are so different. Sometimes they come from countries where there is war. So if you have war trauma and if you have travelled to Finland it can be traumatic. I have also noticed that some of the women who came to Finland after 2015 have more than family or partner violence and trauma, it is also about their childhood. I have noticed this, because sometimes I've done everything that I know, but the woman is still not okay, so I had to ask about her childhood.

A lot of them have had domestic violence since childhood, a lot of them have attachment problems and so the trauma is not only that: 'I'm divorced now or my husband is hitting me now', it is what we call: **A complex trauma or long trauma.**

Long trauma is a mix of different things: sometimes the women who migrate have been abused in their childhood, they carry sexual trauma from very early age; they can be the victims of honour related violence or sexual violence, all-in-one.

As a result of that, most of the time women who are victims of such long violence and trauma identify themselves as objects, and this means there is also an identity crisis.

In Monika, we deal with domestic violence and we see the honour-related violence, and now in the past several years we have been working with the victims of human trafficking too.

There is a lot of difference between domestic violence and women who have been trafficked. I usually see a woman with family violence about eight to nine times, but I have been seeing the women who are victims of human trafficking for one and a half years.

The difference is the dissociation: how they look at their body. They feel like they are nothing, especially when they have children out of this sexual abuse. They sometimes say: 'I hate my child,' and then we need to work on mother and child relationship and attachment."

Help and support: When a woman comes to me and talks about her problems, I send her to the integration Center where she can have individual guidance and support, where she can learn Finnish languages, use computers, study English and meet with others. Women can also have a mentor. The mentor's job is one-on-one: they will be together for one hour each week. The mentor teaches her Finnish language or teaches her computer. She may also teach her how to search for jobs and fill in job applications. Then there is the shelter. Women who are in danger and are mentally, physically or socially abused can go to the shelter. The shelter has almost the same work that we do in the crisis centre, but it is for a short time. After the shelter, they come back to us to continue the work. You see, it's like a rolling ball, it's to help them to stand on their feet."

DOMESTIC VIOLENCE

ANONYMOUS, A BRAZILIAN WOMAN IN BELGIUM

"I met my ex-husband after coming to Belgium in 2017. I noticed he was drinking a lot, at beginning I thought that this is cultural and maybe in Belgium people drink like this, but as time passed, he became more controlling and manipulative. Back then I didn't know his manipulation, I used to think it was normal. Eventually he started becoming very jealous, drank even more and was very aggressive with his words. He didn't want me to wear certain clothes, speak loud (as we Brazilians do), he started controlling my food, which direction I look at when we were out. He basically controlled every single thing I did. He even started to take my income away. I worked and he took all my money away. I got pregnant, I became depressed. He harassed me. He harassed me into having sex with him.

My child was born premature. I was 9 months pregnant. He and his mum started yelling at me one day and I was made to clean the toilet by bending on my knees, and because of stress my waters broke.

One fact about domestic violence is that it doesn't have to be physical. As victim of domestic violence, people ask me if he hit me, if I ended up in hospital, if I went to the police? domestic violence is not about punching someone until she bleeds, it is about controlling the woman. Not only he took away my income but after the birth, my baby's income benefit went into his account too. We got married when I was 6 months pregnant, so I got visa, but this became a threat towards me. He was saying if I leave him, they will take my papers and my child away and I will be deported. All of this was abuse, all of this was violence - as strong and hurtful as someone punching you. One day he became so aggressive that he started to shake me and the next morning I left him.

First I went to a friend's place, then I went to the police who didn't help me. they interrogated me, by asking why I didn't report this before, why did I made my baby go through all this, why haven't I left him before, why haven't I been to shelter, does my doctor know about this? I didn't leave him because I didn't have anywhere to go, I didn't have an income, I was scared.

Second what did I had to tell my doctor, that he is forcing me into having sex with him - my own husband is forcing me into sex. I didn't have physical evidence, like bleeding. I went to CPIS, they told me they cant help me, because I am still married and I should ask him for financial help. I called the shelters in Brussels and most of them didn't even picked up the phone. All of this is violence, and **the violence did not just come from him, but the violence comes from the system; the system that is supposedly to help and support you.**

I am going through divorce and he has asked for the full custody of my baby, because I have no income. Yes: I don't have job, I don't know the language, and the system doesn't help me. I paid the lawyer by launching online pot where Brazilians all over the world denoted some money. **It is so hard to survive as woman victim of domestic violence, that is why a lot of women stay in violent relationship, especially migrant women, because they have no help or support from the system. They have nowhere to go to. If you are married to a Belgian and if you complain you have a chance of losing your visa. The system refuses them and make things hard for them, so they rather live in the violence relationship, get beaten up, get abused, even die but have a roof over their head and some food for their children, and not to be deported.**

The cultural differences makes accessing psychological help very very difficult. In here I was told by the therapist to stop co-habiting with my 6 months old baby, because I am making the baby dependent. A friend of mine who is also a victim of domestic violence was forced to sign a paper in the court to stop breastfeeding her 10 months old baby. So how can we help women in this situation psychologically when the system makes everything hard and worst for you. I have been seeing a therapist, but its through a Brazilian association in Belgium who helps mothers, and women with experience of domestic violence. I feel comfortable and free talking to a Brazilian therapist, because they understand me better. With Belgian therapist I feel I am not being listened to or understood. I feel being judged then being listened to and being supported."



SURVIVING HUMAN TRAFFICKING

MALAIKA ORINGO,
FOOTPRINT TO FREEDOM, NETHERLANDS

TESTIMONIES

"As a survivor of trafficking for sexual exploitation, when you are interrogated by the police, the questions are not asked from a correct perspective; being about sexual exploitation is very uncomfortable. Explaining about my vulnerability and about my exploitation was re-traumatising, so I was traumatised the whole time. When you are not able to tell them the exact dates, times, countries you crossed, and the real identity of the trafficker, they refuse your case. This means being withdrawn from any support (income, housing, medical insurance, and access to education). **There is a real lack of consistency and discrimination in the support system.**

One crucial thing that is particularly important when it comes to victims of human trafficking; if they do not get the support they need from the authorities and when their permits are withdrawn, they become desperate and very vulnerable and they are at risk of being re-trafficked. The women end up in the streets without shelter or income. You are approached by traffickers called 'madams'. They tell you that they are trying to help and will get you a job. They usually recruit a lot of girls who are undocumented and ship them to Germany, Belgium, and Italy. **Some of my friends fell into this trap and later I found out that they were sold into prostitution.**

The reason I avoided this re-trafficking was because I had good support from my social worker. She helped me to get a scholarship to study, so I had something to hold on to. For a lot of people if you do not have work, are not able to go to school, do not have a home, you are desperate to take any kind of opportunity that comes your way. And you are most likely to end up in prostitution, sexual exploitation and violence. Once you do not belong to a system, the abuser knows that the police are looking for you, therefore the abuser threatens to report you. The only thing that can rescue you from this situation is the law, which you cannot go to.

Sometimes girls are trafficked more than three times within the European countries.

As an undocumented woman, you go to therapy, you get out and then you need to think of running from the police, you do not know where to stay, you do not have food, all the outside environment is so negative and so traumatising, that the therapy is not welcome. So for anybody to get comprehensive mental healing, there should be a coordination between frontline services. I also suggest that alongside holistic and authentic therapy, they should also consider **external factors such as housing, income and asylum, which can all impact the mental well-being of a person.**

When I was given the possibility to see mental health practitioners, they did not give me a chance to be part of the mental health planning. During the sessions they had the idea that anybody who comes from Africa, this is what they need. They had already made up their mind on the kind of questions they will ask and the kind of answers they will get. My psychologist, and a lot of people involved with my case, were not culturally informed, and they were not flexible. The people I met were not really specialised in migrant women issues, and perspective of trafficked survivors.

I wanted to use restorative therapy, I wanted to heal, to fight and move on. There was not anything in place to make this happen, and therefore I did not feel helped. Every session they were dragging me back into my past and I wanted to move forward. From my understanding they could not incorporate the strength-based approach with their mental health approach. What I mean by strength based is that **I wanted to tell them about my dream and my goal and where I wanted to go, and I felt that as an undocumented woman, I don't have the right to dream, to walk and to move forward. "**



MATERNITY & MOTHERHOOD

**JOHANNA SCHIMA (HEAD OF EU DELEGATION)
& LAURENCE VANDEN ABEELE (HEAD OF MMM BELGIUM),
MAKE MOTHERS MATTER**

"The right to health and to maternal health are both human rights. Nevertheless many disparities regarding safe access to health care persist between the various EU Member States (MS). Make Mothers Matter advocates for the right to access maternal health care (MHC) for all mothers.

It is estimated that 1 in 5 women will develop a mental illness in the perinatal period*. The most prevalent peripartum mental health problems are depression and anxiety. This adversely affects the mother and her overall health and the infant's health and development, disrupting mother-infant and family relationships. Depression or anxiety are not just the result of a hormonal imbalance, they are linked to the tremendous physiological, psychological and social changes in women's lives during this period. It is well established that transition to motherhood increases women's vulnerability to the development of mental disorders.

Evidence shows that perinatal mental disorders have increased since the COVID-19 outbreak. The causes are varied: changes in birth protocols (separation of the baby from the mother, obligation to wear masks during labour, prohibitions to being accompanied during labour), reduced access to health (long travel distances for examinations), de-prioritisation of non-urgent care, etc.

If native mothers already experience a very vulnerable period during pregnancy and postpartum, migrant mothers are even more affected, severely impacting their mental health.

Migrant mothers experience the existence of barriers in accessing maternal health care in Europe such as high out-of-pocket payments, language barriers and the absence of clear policies and information, a fear of being deported, the distances to medical facilities, and biases among health care professionals.

Mothers, in general, report disrespectful and discriminatory practices, physical abuse and

abandonment at health care facilities on a daily basis. These practices are also present among vulnerable groups, such as migrant women.

Mothers complain of poor relationships and communication with health care professionals, including inadequate clarification or explanations regarding the ordinary procedures. Language barriers and the absence of clear policies and information available in various languages create further problems. Disrespectful practices could be manifested in many different ways, such as negligent, reckless, discriminatory acts performed by health professionals. To cite some: episiotomies without consent, the use of unnecessary force such as abdominal compression and the lack of information on the procedures.

Many pregnant migrant women do not enter the health care system for fear of deportation. In some countries (such as Germany, Croatia) health professionals are required to report the immigration status of their patients; in others, (such as Denmark, the Netherlands) this is prohibited."

RECOMMENDATIONS

In order to overcome the biggest obstacles preventing all women from safe access to MHC care, all EU MS, which have acceded to the core UN human rights treaties and the Charter of Fundamental Rights of the EU and committed themselves to the UN 2030 Agenda for Sustainable Development and to the European Pillar of Social Rights, need to make sure these commitments are effectively translated into practice.

It is important to raise awareness among policymakers, the general public but also among health care professionals and migrant women and other vulnerable groups of mothers. Mothers need to know their rights, and to receive the necessary information on how to access proper maternal care.

MOTHERHOOD IN MIGRATION

ZEINAB NOURZEHI,
REFUGEE ARTIST,
GREECE

TESTIMONIES

"When we arrived from Turkey to Greece, they took us to Camp Moria. I was seven months pregnant. In the camp, they gave us a tent for two persons and asked us to go and find a spot to put our tent up. The place was very dirty, and it was cold at the time we were there. We couldn't sleep at night because it was freezing in the tent and the ground was wet. Because of the cold you could hear children crying until morning. Also, in the nights, young men were getting drunk and were making a lot of noise. There were fights between different groups of migrants, including killing and beheading. Families with women and children were often caught between these fights. I remember a pregnant woman being caught between one of the fights and losing her baby. Luckily, we were moved from the camp three weeks before giving birth to my daughter. They provided us with accommodation that we shared with another family. In the camp we had access to 'doctors without borders'. Once we were out, they gave us special insurance where we can only access emergency wards in hospitals.

Now I am pregnant with my second baby and have sleeping problems. **I have nightmares of what I had seen in Camp Moria and back in my country.** I wake up with sweat and panic-attacks and cannot put myself back to sleep. In my dreams, I see us in Camp Moria, I see my daughter being slowly drowned in the rainwater inside the tent and I can't save her, or I see someone stabbing my husband. **I know I am not there anymore, and I am safe but the trauma is here with me.** Here, we have a social worker assigned to us, she has given me a number where I can call and ask them to book me an appointment with a mental health doctor. I do not know how long it will take to book an appointment and how long after that to see a doctor. As we don't have an ID card, it is hard for us to access anything. It has been two years and we have not even had an asylum interview yet. Only recently we paid 250 euro to a lawyer, so he can get us an appointment with the Piraeus Asylum Office. Finally, now we have been given an interview. I am also worried about this, because a lot of people have been refused by them. Apparently the investigation takes up to seven or eight hours. The decision can take from one month up to a year.

Once we have the interview and we get the answer, we have one month to leave this place, and find our own accommodation. That is why you see a lot of refugees and their families sleeping rough on the streets, and in the parks. They don't have enough income to rent a place. The aid organisations bring them food and register their names to eventually move them to other camps. Greece is a poor country, even its own people live in extreme poverty, and right now it is overwhelmed by a lot of migrants who need help and support. "



Detail from a painting by
Zeinab Nourzahi, Refugee
Artist

MULTIPLE DISCRIMINATION

FABIENNE EL-KHOURY,
PUBLIC HEALTH RESEARCHER,
SORBONNE UNIVERSITY, INSERM-FRANCE

"It is not one type of people, one type of problem, one type of solution. I would say because there are structural reasons and sexual racism that can affect women's mental health despite their generational difference and where they come from; Sub-Saharan Africa, North Africa or Asia. So, there is structural racism that is common, but I think I did not see one reason, there are different needs, for example there are migrant women who came after traumatic events in their country of origin or during their migration passage.

So, these women have different mental health problems because they are just traumatised and they need special care but also other problems.

There are, for example, first generation women who have lived here for ten years or fifteen years, who came here educated and have postgraduate diplomas and stuff. We know that low education levels are usually correlated with worse mental health. Unemployment is also linked to mental health problems.

Migrant women have more mental health problems compared to French women who have the same education level and job status. This is probably due to the discrimination and structural racism, all the micro-aggressions that they live through all the time.

Even for second generation women. In France, there are studies that show that they are discriminated against during job applications, for salaries, for a lot of stuff. So in the end all this discrimination contributes to a worse mental health.

I worked a lot on maternal and postpartum depressive symptoms and mental health. I saw that first and second generation migrant women had more postpartum depression than other women. There is a European paper that says that women of migrant origin have more depressive symptoms than other women in Europe. What is interesting is when we look at postpartum depression that it's even worse among women from Sub-Saharan Africa. When you ask adults below the age of 50, about their perceived health, it's correlated with mental health because you usually don't have chronic disease.

When a woman comes to La Maison des Femmes (its a medico-social structure which accompanies women victims of violence) her first care is physical health, stuff like abortion or if she has genital mutilation, or maybe she simply just wants contraception. Some women are usually victims of violence. In order to support these women, they have medical doctors, gynaecologists and midwives to take care of physical illness or physical symptoms, but also there are psychologists to take care of mental health problem. There are also representatives from the police and sometimes there are specialists who help women with going to the police in order to be protected from her aggressor. Some women come just because they know that they can have access to the police, and are able to say: "I am being abused or I am the victim of violence." The problem for most of these women is the finances and resources. A woman victim of violence doesn't need one thing, she needs a lot of things. She needs physical health check-ups and sometimes protection and care. She needs mental health care and sometimes judicial help [such as] police to help and to protect her. It's important to show the women that they are protected from the aggressor."

YOUNG MIGRANT WOMEN AND GIRLS

**NATASHA NOREEN,
RADICAL GIRLSSS, ITALY**

"Mental health for me has always been one big confusion. I came to Italy as an adolescent when I was 14 years old. At an age when you are questioning everything around you. When you don't know the language you feel that everybody is going to hurt you. I came from a completely opposite culture, I came from an Islamic country to a country with more open and liberal religion. **It was very confusing and that confusion led to my anxiety.**

In school, I didn't know the language and so I didn't fit in. I didn't understand anything and it was very disturbing. The fact that I wasn't put in the same class as people of my age, it hurt me a lot. The demotivation and the depression was so strong that I wouldn't go to school even though the school was five minutes from where I lived. I couldn't tell this to my parents, I couldn't tell it to my friends because I didn't have any friends. I felt abandoned and lonely. My father doesn't talk to me, I have two brothers whom I have no relationship with. I came to build my relationship with my mother last year. I have no Pakistani friends, because I was told that my thoughts and ideologies are harmful to them and to their cultural values. As a teenager, I wanted to do what other young people of my age did in Italy - to go out, to get drunk. **My family never understood how painful it was to become who I am.** This caused me to have very strong depression, I was suicidal most of my teenage years.

When you are in a foreign land you want to connect with your community, but for me the community was the oppression that I left behind and I didn't want to be part of.

By refusing their identity I refused my own identity. I also didn't fit in with the natives, I was bullied in school because of my background. I still find it difficult to understand racism. I believe in Europe the governments have not put strong integration policies in place. We never understood the integration processes, as it wasn't explained to us. Nowadays I am in touch with girls from South Asian backgrounds and many of them have the same story: **being bullied, exclusion, lack of empathy and sympathy including from their teachers.**

The first psychologist I went to was through a family centre which was not very helpful at all. Then I was introduced to a governmental psychologist, which was the worst. I had twenty sessions with her, and she always made me feel that I was doing something wrong. Whenever I spoke to her she would show a reaction that I was making things up, I am imagining things, it's my illusions that I feel unsafe. She never gave me the sense of sympathy or empathy, which I needed. At the same time I was going to my school psychologist too. She never took me seriously, she took me as another teenager who didn't want to study and get out of school. She asked me to take vitamins for mental health, so I can feel better. She never tried to figure out what was happening. I felt I had to do all this to save myself, so, on the one hand I was trying to save myself and on the other hand I was killing myself and the help I always got was to kill myself rather than save myself. "



BARRIERS

ACCESS TO SERVICES AND SUPPORT PROGRAMMES

LEGAL & ECONOMIC STATUS

The accessibility of services is strongly determined by migration status. Undocumented migrant women in particular face more obstacles in accessing help. In many EU states, mental health services are not covered, or only partially covered, by public health or insurance. If mental health services for migrants are not available, the cost for self-funded therapy is a considerable barrier to many migrant women, especially those with children they support.

LANGUAGE & CULTURE

Language is not only crucial to accessing mental health services but also undermining the quality of services. Research in 16 European countries indicates that more than 40% of the health services do not provide any form of translation services and 54% reported that they have no immigrant staff (Kluge et al, 2012). Our interviews in the field indicated the lack of culturally competent and sensitive services that examine and appropriately respond to migrant women's needs, which included women-focused services.

SOCIAL & CULTURAL STIGMA

Cultural stigmas relating to mental health restrain women from seeking help. Many believe that struggling with mental health is synonymous with being 'crazy'. In other cases, the fear that others (family, community) find out, constitutes a considerable barrier to accessing help.

LONG WAITING TIME

One of the important barriers described to us by migrant women and professionals working with migrant women were the long waiting lists. In almost all EU member state countries, there is a minimum of a 3 - 6 month waiting period.

LACK OF SPECIALIST SERVICES

One of the the most significant barriers to migrant women being able to address their mental ill-health is the lack of specialist female-focused and trauma informed services. Considering the significant gendered and sex differences in migrant women's needs in relation to mental health, the lack of service providers able to meet such needs, as well as the lack of low-threshold services, constitutes a particular barrier to migrant women's attaining well-being.



ACCESSING SERVICES

**THALEIA PORTOKALOGLOU,
MENTAL HEALTH COORDINATOR**

MELISSA NETWORK, GREECE

"The approach of our organisation (Melissa Network) is based on the notion of community. We are a network that runs an innovative integration program where migrant and refugee women are actively engaged, rather than a centre providing services. **Our programme is holistic, as it weaves a combination of educational classes, art workshops, mental health support, capacity building workshops, legal and social support.** Our aim is to promote empowerment through a safe and creative space where women can share their knowledge, strength and initiatives.

In Greece, it is quite difficult for someone to access mental health services. At the moment, organisations that provide mental health support to refugees are full and it's very difficult to find available appointments, especially with a psychologist. Psychiatric appointments are easier to find as psychiatric services are available within the public services, like hospitals. However, regarding regular psychotherapy that most migrant and refugee women are in need of, the resources as well as the access are becoming more and more limited. If someone manages to get access, unfortunately, the psychotherapeutic process does not last for long since there is a long waiting list. So, it is often the case that even if someone enters therapy there is no consistency and the therapeutic relationship, which is extremely important, cannot develop effectively."

**YASAMAN HEIDARPOUR,
CULTURAL MEDIATOR**

"For all migrants, especially migrant women accessing any kind of services including mental health are difficult.

In Greece, everything moves very slow, there is a waiting list to access any sort of services. From my experience, when I wanted to make an appointment with an external mental health specialist, we were told to wait for a month or more.

Some of the women who come to Melissa want to see a mental health specialist, because of their traumatic experiences in their own country and/or on their migratory journey. Many women have experienced bad things during their journey to Greece.

For newly arrived migrants, there is a real lack of basic or primary information about the available services. Migrants arriving in Greece are often confused and lost as to what to do and where to go. It will help if they have the primary information of what they can do and where to go for help and support in the camps or upon their arrivals. On the other hand, **having the information does not mean they automatically can access everything.** If they don't know the language, they will not be able to make a connection with the organisations.

Not knowing the language is one of the main obstacles in accessing services. Services are struggling with the interpretation, there is a lack of interpreters. Furthermore, there are some migrant women who do not want to see a mental health practitioner, because of cultural taboos and stigmatisation attached to mental health. In some cultures you see the mental health doctor if you've gone mad, so they avoid any kind of link to mental health topics. But then even if they want to see a mental health practitioner, it is not that easy; they have to know where and how to access one, and if they don't know the language, even making an appointment is difficult."

**PATRICIA VIVIANA PONCE,
HAURRALDE FOUNDATION,
SPAIN, BASQUE COUNTRY**

"In Spain, the state of mental health services is extremely poor. They are slow with a long waiting list. In Basque especially, the public health services need urgent attention and should be improved.

On the other hand, psychiatric services directly put women on medication of anti-depressants. Most of the women who come to these services are already diagnosed with pathological problems. Thus, **we see that the prevention system is failing, and mental health is not given importance to migrant women's wellbeing.**

It is necessary to consider migrant women's mental health as important and provide the necessary and satisfactory services. The waiting times should be reduced. The mental health professionals should offer counselling and psychotherapy sessions by listening to women then putting them directly on medication. Monitoring and prevention are essential and it is necessary to invest into public funds. The NGOs must work with trained and specialized personnel, especially with women who are victims of violence and sexual abuse.

Best approaches may include counselling and therapy, but also preventive approaches such as safe spaces, and other services that women can be referred to.

The program that we currently have is to pay attention to the cases of women who already had mental health issues. Unfortunately, with the Covid-19 their situation has aggravated.

These women face many socio-economic difficulties such as losing jobs or the job loss of their family members, leaving them with an uncertain future. In our organization we are tackling these issues by providing services such as recycling workshops, learning the Spanish language, and supporting them with their integration processes."

**ZARGHONA RASSA,
BRITISH AFGHAN
WOMEN'S SOCIETY, UK**

"It is not easy at all for the Black and Minority Ethnic (BAME) women to access services; not mentioning it's hard for them to actually be able to reach out to these service providers due to the restrictions within their own family and community, and the negative stereotype about mental health in their community. Secondly, it takes months and sometimes years for women to be registered and get recognised as in need of proper and regular mental health treatment. Also, once the women are referred to the mental health specialist by their GPs, they must wait for a long time to be seen. **For a woman who is mentally ill, unfortunately, sometimes, it is too late, especially in the cases of women who must stay in relationships with violent partners.**

**SHAZA ALRIHAWI, GIRWL,
GERMANY**

"In Syria, I was a professional working as a psycho-sociologist. **When I arrived in Germany, my education and qualifications were not recognised. I felt like nobody** understood me. Being professional and knowing that I have a mental health problem gave me more pressure and stress. Here, it is very hard to understand the health system. Here, you have to go to your family doctor first and he/she refers you to a specialist or you have to find a specialist yourself. In order to see a mental health specialist, there is a waiting time of six to eight months. When you are mentally ill, these months are a long time to wait. You don't know what is going to happen; you may even kill yourself.

I got a referral from my family doctor to a specialist. When I went to see him, he was a male doctor. He started checking my physics (knees, shoulders, back) and told me there was nothing wrong with me. I told him "I thought you were a psychologist, I am physically well, but I am mentally ill." He told me "It's better you shut your mouth, maybe you also lose weight." I felt worse and just ran from there. After a while I was diagnosed with severe depression, because I was alone, I was missing my family (who are still in Syria). This time I got a referral with a different doctor who was a woman; a white German woman. I was happy to see a woman, I thought she would understand me better. I asked if we could speak English, my German was limited and I would feel comfortable expressing myself in English. She said "no", I must speak German, that I had been living in Germany for 4 years and if I couldn't speak the language, how did I want to manage myself. And that it must be difficult for women from my culture to live in Germany. She told me "you should choose a country which suits your cultural background."

"I felt she was punishing me for not being able to speak German and wearing a scarf. **When accessing services, language is a real problem in addition to cultural barriers. There is culture behind language, you may say one thing and mean it something else culturally.**"

**ANILA NOOR, NEW WOMEN
CONNECTORS, NETHERLANDS**

"I came to the Netherlands about seven years ago as an asylum seeker. When we first arrived here, we had to stay in a refugee camp until our asylum case was being processed. In the camp, I met a lot of women from different countries who were in real need of psychologists, but unfortunately, due to cultural and language barriers, they couldn't access any mental health professionals, besides, there weren't any mental health professionals available in these camps. Having this kind of service in the asylum camps are very important. As a migrant woman, you go through a lot of trauma, not just through the migratory journey but also by not being understood by the natives. I am from Pakistan, I am Muslim and I am Sunni and a lot of people didn't understand why I was here and were questioning me, this caused me so much trauma. I started developing psychological problems and dog phobia.

I needed to heal, you do need a healing process to overcome what you have gone through as a migrant woman. So I went to my doctor and he referred me to a psychologist. There was a minimum of three to six months waiting time. I went to the counseling sessions only three times because I didn't feel comfortable with the psychologist who was a Dutch woman.

There were cultural and religious barriers, I felt as if I were giving her cultural training. She didn't understand why I feared dogs and developed dog phobia. I had to explain myself culturally and religiously and gave her reasons behind whatever I was telling her. It took a lot of my energy and I felt more depressed than before. So, I felt it was wasting my time. So, I left after three sessions."

**EVA VALENTOVÁ,
ASSOCIATION FOR INTEGRATION AND MIGRATION,
CZECH REPUBLIC**

"In the Czech Republic there are two types of migrants, one is included in the public health insurance system and another one is not, so those who are included are people with the permanent residence, members of EU nationals, and people employed by the Czech employers. **But self-employed and people with long-term residence are not included in the public health insurance, they always have to pay.** In regards to mental health, even if you are part of public health, you need to pay. You have to pay 40 euro per hour, but in Czech that is a lot of money.

The main problem in Czech Republic is that mental health is not even recognised by the majority as a standard way of treatment. There is still stigmatization and stereotyping towards mental health care, left from the communist times. Even the healthcare system is not very welcoming or user-friendly for the majorities. And this can also be a huge obstacle to migrants.

In regards to women experiencing domestic violence, we try to refer and cooperate with other specialist services to help them. Our job is to settle their residency situation in the country, because often under the legislation if a woman wants to divorce, especially for women whose status is based on family reunification, they will lose this status, which means losing the full residency. There are options to get another kind of residency, however it is not an easy procedure, legal assistance is necessary in these cases. In cooperation with other organisations, we help them to get accommodation and support them with other social services if necessary.

In these cases, the main problem is the language barrier. We have a network of intercultural workers, who will help with interpretation and also at the same time explain the intercultural context to our clients. **The huge problem is when they need to be accommodated in a shelter, and if they have a very big language barrier they will be rejected by the shelter.**

For asylum-seeking women who are experiencing domestic violence, inside the refugee camps, they have separate rooms and sometimes separate buildings for these women who are being abused, single women and single mothers. In Refugee camps, psychologists and therapists are assigned to them, but then there is a language barrier. They try to provide interpretation but for some languages its difficult to get an interpreter, i.e. Thai language has one certified interpreter in the whole country and it was similar for Somali. With Somali ladies we also had to deal with their illiteracy, these things are very difficult to deal with for everybody, not just refugee services but all assistance services. **In Czech Republic, the migrants face important language barriers, which makes access to mental health much difficult, they can not express themselves as they would like to.** There are also huge cultural barriers for women from third-country nationals to access services."

**MARY MOZAFARY,
HUNGARY**

"In Hungary, the situation of migrants is changing every year. It is getting worse. In 2015, when I arrived in Hungary, the borders were open and there were not a lot of restrictions. You were kept one or two nights in the police station. We were put in a cell. For me, it was the first time that I experienced being in prison and all my concerns and abnormalities started from there. For me, being locked up in that room was unbelievable, although there was another family with their children in the same cell, but I felt extremely uncomfortable. **In my country, I was a lawyer and judge, but for the first time I experienced being a prisoner, and it was extremely hard for me.** After that, we were transferred to a camp, which was 40 minutes away from Budapest.

At the time, Hungary was a transit zone for many migrants. The migrants were only passing through Hungary on their way to other European countries like Germany, France, Sweden, UK and so on. The camps were completely full and did not have a place to accommodate people. People slept in the metro stations, parks, and streets. In the camps, many people shared rooms, but I was on my own and **as a single woman, I was scared and started not to feel safe.**

As the immigrant numbers started to rise, they were told that they should find a place in the camp for themselves. People were constantly coming to my room to see if it was free. Sometimes they would knock on the door, sometimes they tried to push themselves in. Inside the camp, some migrants were using drugs and there were often fights between groups of migrants. During the night, I began to stop sleeping, I was scared that someone would enter my room. My sleep problems went on for three months. This is on top of my mental pressure of what I was going through as a single migrant woman (the things I went through on the migratory journey, leaving family and friends behind, and worrying about their well being, leaving my professional job).

In the camp, there were free lawyers from Helsinki, and doctors from Cordelia (it is a mental health organisation that helps migrants) to give services to people in the camp. I finally decided to get help and went to see a doctor. I told them about being unsafe, stressed and constantly scared. The doctor gave me sleeping pills, but even taking those pills did not help me, did not make me feel safe. Eventually, my lawyer worked hard on my case and my asylum was accepted. Since I am out of the camp, I do not experience much difficulty accessing any services."

**VERONIKA SUSEDKOVA,
UNITED KINGDOM**

"By being involved with different groups of migrant women, and being a migrant woman myself, people face different barriers according to their migration status. I came to the UK through EU free movement, and so I didn't face some of the barriers compared to women who come through restricted immigration system. If you are an asylum-seeking woman, that is a really horrible route to go through. I feel I've had an easier experience because I've had similar rights to British citizens.

'Power of peer' [support] is important in relation to the mental well-being of women in general. I have been able to get support because of the work I do. On the way, I have picked up skills and ways of coping for myself and ways of working with others. This has helped me to protect my mental health and well-being and has allowed me to pass my skills onto others, both in a professional and personal capacity. What we hear from women and what we see in the way women interact when support is available is important. Women inform each other when the service is good, and we tell each other when the service is not working. I have been involved in one of the mental health support services, which offers support to all women in the community regardless of the immigration status, and there are no formal barriers to access it. **We have seen the effectiveness of both when women come for support through word of mouth and informally and when women are referred through formal routes.** When a woman moves, she loses the support and her networks and for a woman who has moved from her country of origin, it takes time to figure out who the allies are, even if the allies are not from the same country or don't speak the same language. **Some of the key things women talk about are isolation, loneliness and the fear of not knowing how to navigate the new system.** For example, when a woman arrives to a new country on her own or with her partner and whether she has children or not, she is on her own. Because often, the man will go out and do things and the woman is left alone (I am not talking about women who are allowed to work), so she does not know how to access the local services. However, once she gets to know about local support and gets to know other women in the community, she becomes part of the network.

Although language can be a barrier in getting mental health support, for many, mental health is simply a taboo. In some cases, the family and the community stop women from getting mental health support, because they want to keep women under control. **In this regard I do not just talk about migrant women: this happens everywhere, it's the patriarchal, sexist, and misogynist society we are in, because of cultural norms, and how the society is set up, seeking support beyond something that is necessary is often not acceptable.**

So, for a migrant woman who needs visa and citizenship, going to ESOL (English for Speakers of Other Languages) classes is encouraged, but anything beyond that is not necessary. Therefore it is **important to build a 'service within the service' in order to support some migrant women.** For example, by providing network building, cultural awareness raising, learning vocabulary about expressing oneself in relation to mental well-being via the language classes, where many women come, should be considered."



CONCLUSIONS

The narratives in this report are from professionals working with migrant women, and migrant and refugee women themselves. The experiences, which are varied and based in different EU countries (**Belgium, Hungary, Italy, Greece, UK, Czech Republic, Spain, France, Germany, Netherlands, Finland and Ireland**) give us a substantial overview of what is being achieved and what needs to be tackled in relation to mental health care systems in Europe.

During migration, in addition to living with pre-migration traumatic experiences, many women encountered different stressors, such as restrictions and barriers in access to housing, education, health, career; low or no income, the burdensome and unwelcoming processing of their asylum cases, lack of governmental support and discrimination in the services, which left them with feelings of anxiety, depression, and post-traumatic stress disorder. Some of these women often linked their negative emotions such as stress and anxiety to loss of professional status and having no power over their lives - they felt like they had 'become a nobody'.

The report highlights the importance of overcoming language barriers, the gaps in the intercultural understanding of the professionals, long waiting times to see a mental health specialist, lack of access to basic information, lack of awareness about services and the cultural taboos about mental health within the migrant communities. **The emphases on training and recruitment of professionals from the migrant background in the health care system, availability of specialist services with expertise in service provision for women, women friendly programmes and support groups in assisting women in distress and with poor mental health, were highly recommended.**

By exploring the impact on mental health of women-specific issues such as motherhood and maternity, as well as the forms of violence primarily affecting women among migrants such as domestic violence, prostitution, trafficking and female genital mutilation, this report gives different viewpoints on how the authorities can review their policies and approaches and embed the suggested recommendations in their existing systems.

RECOMMENDATIONS

- **Holistic approach to service provision that includes proactive community outreach, with a focused outreach to migrant, refugee, minority ethnic women.**
- Training for professionals to raise awareness about human rights based, culturally sensitive and women-focused practices in relation to migrant women's mental health.
- **Inclusion in the support programs of safe means of transportation, child care, language courses, adequate social and financial support for migrant women.**
- Early awareness raising programs for migrant and refugee women with information and support about women's human rights and access to services including health and mental health services. Such information must be provided before women are seeking help in a crisis, especially in cases of domestic violence.
- **Female interviewers and interpreters, as well as legal support, to enable women to disclose their migratory history, including any history of violence, abuse or exploitation.**
- Human rights based educational and recreational programmes for **young migrant women and girls**, such as theatre, dance, sports and creative activities, to boost confidence and open a discussion about identity, culture and tradition.
- **Training and awareness raising for educators, teachers and social workers, on human rights based cultural diversity, cultural sensitivity and integration.**
- Establishing an informed mental health referral system in cooperation with governmental services, social assistance, shelters and the police.
- **Establishing culturally sensitive services with culturally and human rights trained mental health practitioners and non-discriminatory and non-prejudiced counselling environments where women with different backgrounds are welcome.**
- Reducing waiting time to access professional mental health practitioners and/or specialist services and/or a fast referral for women-led community support programmes.
- **Development and support of local domestic violence support groups and drop-in service with focus on women from different backgrounds.**
- Support and development of holistic, women-led feminist **Exit Services** for women exploited in prostitution and victims of trafficking for sexual exploitation.
- **Support and funding for the existing women-led organisations, which already work with women victims and survivors of violence and discrimination.**
- Support and funding for migrant women-led organisations that offer variety of services including: women focused services; women only shelters; women mentors; language courses; legal support; awareness raising workshops and resources; psychologists and counsellors. It is more likely that they reach out to and provide information and support to migrant and refugee women and girls in accessing the mental health services they need.

USEFUL RESOURCES

GOOD PRACTICES ON MIGRANT WOMEN'S MENTAL WELLBEING

- **Women-Centred Principles:** <https://womencentre.org.uk/wp-content/uploads/2020/04/Applying-Women-Centred-Principles.pdf>
- **Briefing on migrant women and mental health:** <https://womencentre.org.uk/wp-content/uploads/2021/06/WomenCentres-contribution-to-ENoMWS-report-women-migrants-and-mental-health-May-2021.pdf>
- **Comment améliorer le recours aux services du social et de la santé pour les femmes ayant vécu l'exil:** <https://www.cultures-sante.be/nos-outils/outils-promotion-sante/item/516-comment-ameliorer-le-recours-aux-services-du-social-et-de-la-sante-pour-les-femmes-ayant-vecu-l-exil-tables-sante-migrants-2018-rapport.html>
- **COVID-19: SU IMPACTO EN LAS MUJERES INMIGRANTES DE LA CIUDAD DE VALÈNCIA:** <https://asociacionportimujer.org/wp-content/uploads/2020/11/Informe-Covid-PortiMujer.pdf>
- **Radical Feminist Therapy; working in the context of violence by Bonnie Burstow:** <https://drive.google.com/file/d/1xhSvKqGXnWuwEY6SwP9rD1QX8lCwpiRS/view?fbclid=IwAR32Y5wUr01wP4XG7KB5tY2la32fe92fVUcyIVq0-cGtoXszA2fcLWS9PA>

MATERNAL MENTAL HEALTH

- **Migrant and Refugee pregnant women mental health:** <http://www.europeanjournalofmidwifery.eu/Addressing-mental-health-issues-among-migrant-and-nrefugee-pregnant-women-A-call.108626.0.2.html>
- **Maternal and mental health of immigrant women:** <https://www.gmmh.nhs.uk/download.cfm?doc=docm93jjjm4n895.pdf&ver=1674>

WOMEN AND MENTAL HEALTH

- **Let's Talk: Mental Health Experiences of Migrant Women, Report, Ireland, AkiDWA January 2020:** <https://akidwa.ie/wp-content/uploads/2020/01/LetsTalk2.pdf>
- **Women at the Centre:** <https://www.centreforwelfarereform.org/uploads/attachment/429/women-at-the-centre.pdf>
- **WHO women's mental health:** http://apps.who.int/iris/bitstream/handle/10665/66539/WHO_MSD_MDP_00.1.pdf;jsessionid=29E7E007741F794C7AF353A6E530930B?sequence=1
- **How to maintain the mental wellbeing after a year of pandemic lockdown,** Association for Integration and Migration, Czech republic: https://www.migrace.com/adm/_upload/docs/preklad_tipy_psychoterapeutky_eng_1623409471.pdf
- **Psychosocial and Mental Health Aspects of Women's Health:** http://apps.who.int/iris/bitstream/handle/10665/61376/WHO_FHE_MNH_93.1.pdf?sequence=1
- **Women's wellbeing:** <https://www.hsconsultancy.org.uk/system/resources/2/working-towards-womens-wellbeing-unfinished-business.pdf?1302161290>
- **Young women and mental health:** <https://weareagenda.org/wp-content/uploads/2020/11/Struggling-Alone-3.pdf>
- **Social determinants of immigrant women mental health:** <https://www.hindawi.com/journals/aph/2016/9730162/>
- **Women in Migration Emotions and Mental Health in the Czech Republic:** https://www.migrace.com/adm/_upload/docs/sheet_mental-health_1619708373.pdf

TRAUMA

- **Trauma informed approach:** <https://weareagenda.org/wp-content/uploads/2020/11/Struggling-Alone-3.pdf>
- **Trauma and prostitution:** <https://www.trauma-and-prostitution.eu/en/>
- **Trauma in exiled women, group psychotherapy:** <https://www.cairn.info/revue-l-autre-2011-3-page-327.htm?contenu=resume>

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ENoMW

European Network of Migrant Women is a migrant-women-led feminist, secular, non-partisan platform that advocates for the rights, freedoms and dignity of migrant, refugee and ethnic minority women and girls in Europe. Our diverse membership includes the women from almost all regions of the globe and extends to over 50 grassroots and advocacy groups in over 20 European countries.



www.migrantwomennetwork.org | info@migrantwomennetwork.org

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