Barriers to accessing appropriate health services for the victims of violence

The problem

A refugee's experience of trauma and displacement may present challenges to clinicians who are unfamiliar with refugee trauma and its clinical consequences. (Crosby, S. 2013). Refugees are often exposed to physical, mental and emotional torture in their native countries and a large number of women and children face violence and mental or sexual abuse during the migration travel. Post-traumatic stress disorders and major depression are the most common psychiatric conditions in refugee populations. Torture and other forms of violence continue to have a psychological impact on the lives of refugees in their host countries and are critical factors hindering access to appropriate health and social care (Alayarian, 2009).

Sexual and gender-based violence (SGBV) is also a significant problem among refugee populations. Although the majority of people who experience SGBV are women, boys and men are also targets. Reports of sexual violence against women are now emerging from Syria. Sexual and gender-based violence has important consequences such as genital injuries, sexually transmitted infections and HIV infection, unwanted pregnancy, forced abortion, infertility and long-lasting mental illness (Keygnaert I et al., 2016). Not only has SGBV significant clinical consequences, it may also trigger social stigma and even ostracization of women from families and/or communities.

Evidence on the barrier

In general, torture and SGBV survivors are often reluctant to seek treatment because they fear social stigmatisation, discrimination and further social isolation by community/family members. As a consequence, victims of violence may communicate a range of nonspecific health problems in order to avoid disclosing information about their actual experience.

Cultural and language barriers may also impact upon the individual and prevent them from discussing their needs. For this reason, clinical encounters are often complicated by inadequate communication between health provider and patient. Telling torture history is very difficult and painful for victims, explaining personal details and recalling the abuse is even more difficult if the listener does not share the patient's language. Furthermore, cultural differences, such as different ways of understanding mental illness and healthcare systems, increase communication barriers (Crosby, 2013).

For the issues described above, one of the most important barriers to access to health care services for torture victims is the lack of trust between clinician and patient. Due to the refugee's perception of discrimination based on legal status, the common refugee fear of being arrested or deported on the basis of his/her past experiences or personal information, lack of trust is an obstacle to obtaining adequate knowledge of the refugee's history and sufficient data in order to detect physical and psychological symptoms related to past traumatic experiences during the primary care visit (Alayarian, 2009).

Obstacles to establishing a trustworthy rapport, language and cultural barriers, emphasise the need to provide care for this particularly vulnerable group with appropriately trained staff. In most cases, neither health practitioners nor cultural mediators and interpreters are trained to talk about violence. Health providers often operate without specific knowledge or validated tools for the evaluation of psychological symptoms and mental disorders (Asgary & Smith, 2013). Moreover, for psychologists, it is difficult to conduct therapy with a victim of violence through an interpreter who may not be sensitive to the issues of torture and sexual abuse. (Asgary & Smith, 2013)

The lack of coordination between health services, NGOs and local authorities and the lack of a formal

network impede the development of effective interventions and the possibility to ensure global treatment for torture victims. One barrier to the effectiveness of resources identified is the absence of specific measures that meet the needs of women victims of violence, such as rapid processing of work and residence permits. The additional difficulties faced by some migrant women, such as lack of social support or economic resources, imply greater obstacles to their empowerment through access to employment and housing. (Briones-Vozmediano, La Parra, & Vives-Cases, 2015).

Finally, the lack of legal frameworks preventing sexual violence and clarifying migrant women's legal status often creates barriers to seeking help and health care. The absence of legal context often puts migrant women at risk of further exploitation and abuse when seeking help in the aftermath of sexual victimization and inhibits their access to health care (Keygnaert I et al., 2016). Furthermore, lack of entitlement and clinical documentation prevent health professionals from effectively utilising information from previous psychological and physical evaluations, thus jeopardizing the success of primary care.(Briones-Vozmediano et al., 2015)

Measures to address the barrier

Since the experience of sexual violence or torture often leads to social stigma and prevents survivors from seeking help from routine mental health services, it is vital that an integrated and sensitive approach is developed, that incorporates mental health services in primary care clinics or in community based-services (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016). Developing an integrated, sensitive approach to mental health care that considers the interrelationship of individual, family and community and the interconnection of physical, psychological and social problems has proved to be an effective strategy to ensure adequate care for this vulnerable group (Crosby, 2013).

Staff with specific competences is fundamental to respond to the needs of survivors of torture and sexual violence in an appropriate and sensitive manner (Hassan et al., 2016). To this end it is necessary to train a new breed of practitioners who are competent and sensitive and have the skills needed to deal with significant, emotionally draining situations, especially when taking care of underserved and marginalized populations without social support (Asgary & Smith, 2013).

To maximize the quality of the clinical encounter and to minimize the risk of errors, bilingual clinicians or qualified interpreters should be familiar with international guidelines on providing care to victims of violence and should be aware of the cultural impact of violence on patients' communities and the risks related to disclosure. To this end the Istanbul Protocol of the United Nations is an excellent tool that can help health providers recognize and treat cases of torture or institutional violence (Akar, Arbel, Benninga, Dia, & Steiner-Birmanns, 2014).

When using interpreters or cultural mediators it is important to ensure the person in need of support trusts the interpreter and is happy to talk to them, and to make sure whether the language, dialect, gender, religion and region that the interpreter is from are all appropriate. Even when all these criteria are met, it is important to check that the client does not know the interpreter. The use of phone interpreting when sensitive topics are to be discussed should be considered.

Provision of care and services to victims of violence is also a socio-economic and political issue, calling for government attention in approving structured laws which increase provision of services and resources (Briones-Vozmediano et al., 2015), including access to housing, financial assistance, help in finding employment, free legal assistance, advice and support for social integration (Briones-Vozmediano et al., 2015).

A facilitating factor is the establishment of a comprehensive and systematic approach to collaboration with social and advocacy organizations, in order to address the multiple ethical and professional concerns in

providing sound medical, social and legal services. At the social health level it is vital to create institutional support through government agencies and local health institutions (Asgary & Smith, 2013).

Successful example

Caring for trafficked persons **(Borland & Zimmerman, 2009, 2012)**

"Caring for trafficked persons-Guidance for health providers "(Borland & Zimmerman, 2012) are recommendations developed in 2009 by the International Organization for Migration (IOM) and London School for Hygiene and Tropical Medicine (LSHTM) in order to help health providers who may now or in the future provide direct health care services for individuals who have been trafficked. They are designed to accommodate varying degrees of contact with and involvement in the care and referral of people who have been trafficked.
In particular, the document aims to target: GPs, primary care providers, private and public health providers, emergency room staff, health centre staff, such as receptionists or technical staff, clinicians, outreach care providers in fields such as sexual health or refugee/migrant health, mental health care professionals, e.g. psychologists or psychiatrists.
The guidance document presents: background information on human trafficking, current knowledge on the health risks and consequences of trafficking and guiding principles in the care of trafficked persons.
Also 17 action sheets covering the following general areas are provided:
• tools for the patient encounter, such as trauma-informed care and culturally and linguistically responsive care;
• approaches to various aspects of medical care, such as comprehensive health assessment, acute care, communicable diseases, and sexual and reproductive health;
• strategies for referral, security and case file management, and coordination with law enforcement.

Facilitator's guide (Borland & Zimmerman, 2009)

The IOM and LSHTM in 2012 in a second step also developed a facilitator's guide and accompanying materials for individuals who wish to carry out training for health providers. The training is designed for all types and levels of health providers (e.g. nurses, medical technicians, doctors, counsellors, etc.), particularly those actively providing services.
The Facilitator's Guide contains basic information for the facilitator on how to prepare before the training takes place and information to facilitate Training on Caring for Trafficked Persons Core.

These guidance documents provide:
• An overview of the session including: objectives and timetable;
• Facilitator notes giving detailed instructions on how to facilitate each part of the session, including activities;
• PowerPoint slides;
• Hand-outs related to the session.

In conclusion, health care providers can play an important role in assisting and treating individuals who may have suffered unspeakable and repeated abuse and the guide (Borland & Zimmerman, 2009, 2012) provides a practical approach - to be adapted to the local context - to address trafficked persons health-related problems.

The full training package is also available online at the IOM Bookstore (http://publications.iom.int/bookstore) and at the LSHTM website (http://genderviolence.lshtm.ac.uk/category/reports/).

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