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Title

Structural violence and marginalisation. The sexual and reproductive health experiences of separated young people on the move. A rapid review with relevance to the European humanitarian crisis.

Key words
Unaccompanied minors, asylum seekers, refugees, sexual and reproductive health, adolescent, child sexual exploitation, child abuse, violence.

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Abstract

Objective
To explore the main sexual and reproductive health issues for separated young migrants.

Study Design
We conducted a rapid review.

Methods
The search for papers published between 2000 and June 2017 included peer reviewed and 'grey' published literature from range of databases including Medline, AMed, Embase, ASSIA, Scopus, Web of Science and websites of international organisations (Missing Children Alliance, UNFPA, WHO, UNHCR, Human Rights Watch, UNICEF and FBX Centre for Health and Human Rights) took place over 4 months. Themes emerging from the included studies and papers were synthesised.

Results
We found 44 papers from a range of countries of which 64% were peer-reviewed and 36% were from 'grey' literature. Structural violence and marginalisation were the key analytical themes that emerged and included young people's vulnerability to violence, unmet knowledge and service needs, barriers and stigma, and poor SRH outcomes.

Conclusions
This is the first known review to summarise the key SRH issues for separated young migrants. As Europe hosts the greatest number of separated young people in recent history, their unique SRH concerns risk being overlooked. Public health practitioners and policy makers are encouraged to challenge the gaps that exist in their services.

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Introduction

A striking feature of the recent humanitarian crisis facing Europe is the large number of displaced migrant children and young people either in transit, missing or settled in European countries. While some travel with their families, there are many who travel alone or with an unrelated adult, [1] and can be defined as 'separated children'. [2] Unaccompanied children are defined by the UNHCR as a non-EU national or stateless person below 18 years of age, who are 'separated from both parents and are not being cared for by an adult who, by law or custom, is responsible to do so', while those who have made an application for asylum in a host country are defined as 'Unaccompanied Asylum Seeking Minors (UASM)'[3] However, the Separated Children Alliance in Europe argue that the more inclusive term 'separated children' rather than 'unaccompanied children' better reflects the circumstances of young people who find themselves without guardianship, and incorporates the social and psychological impact of separation.[4] In this review a range of terms will be used depending on the term used in the original report but all will refer to the crisis for separated young people.

Unprecedented numbers of separated young people have recently arrived recently on European shores. The last few years have seen the number of separated children crossing the EU-Balkans border increase dramatically, with almost 90,000 'unaccompanied asylum-seeking minors' registered in the EU in 2015. [5] Whilst there was a slight reduction in 2016,[6] a consistent proportion of applications continue to be made by children under 14 years of age.[6, 7] Whether travelling through forced displacement or through their own agency, separated children are both a global phenomenon and high risk population, whose needs, especially their sexual and reproductive health needs, are not being met.[2] While the needs of separated children are a global public health concern, the majority of data and commentaries on separated children relate to the current humanitarian crises faced by those in the European region.

Although it is known that adverse outcomes can be prevented with timely interventions of services during and following a humanitarian emergency,[8] and that individuals have the right to information on sexual and reproductive health (SRH) and to access services that contribute to well-being, free from discrimination,[9] this does not appear to be happening. In emergency situations, in the face of immediate survival concerns, provision of food and shelter largely take precedence, with SRH needs commonly overlooked.[10] Sub-optimal services are provided around family planning (including access to short and long term contraceptive methods, as well as emergency contraception), prevention of STIs and HIV, safe abortion services, antenatal care and the prevention and treatment of sexual and gender-based violence,[8] leading to adverse health outcomes and poor quality of life.[2]

Adolescence is a continuum of substantial cognitive, behavioural, psychosocial and physical change. Throughout these stages, the presence of adults and social structures are crucial in guiding young people into early adulthood.[11] Adolescents are particularly vulnerable during an emergency situation. Developmental immaturity, estrangement from social structures, disruption of education and an imbalance in power relations place young people at a heightened risk for sexual exploitation, violence and abuse, STIs and HIV, unwanted pregnancy, unsafe abortions and engagement in exploitative labour.[12]

A review of the SRH needs of migrant young people, with particular reference to separated children, and the ways in which these may potentially be addressed, was undertaken.

Methods

A rapid narrative review [13] was conducted to explore the SRH needs of separated young people over 4 months. Due to the heterogeneous nature of the studies, the small number of empirical studies as well as importance of including reports from international organisations this method was deemed to be the most appropriate. [7] The process included defining the problem, searching for appropriate literature, screening and selecting papers using predetermined inclusion criteria, reviewing papers and extracting data, summarising findings and drawing conclusions. [14]

Medline, AMed, Embase, ASSIA, Scopus, Web of Science and Google Scholar and websites of international organisations (Missing Children Alliance, UNFPA, WHO, UNHCR, Human Rights Watch, UNICEF and FBX Centre for Health and Human Rights) were searched for papers published between 2000 and June 2017 to identify relevant English language published peer reviewed and grey literature. References lists of retrieved articles were also searched to maximise the scope of the search.

Search terms including 'adolescent', 'refugee' and 'asylum seeker' were combined with terms to describe the phenomenon of interest, 'sexual health', 'reproductive health', 'sexually transmitted infections', 'contraception', 'sexual exploitation', 'sexual abuse', and 'gender-based violence'. MeSH (Medical Subject Headings) keywords and free text terms were used when necessary. Titles and abstracts were screened and data, from the relevant full text articles that

fitted the inclusion criteria (SRH, separated young people), were extracted using pre-designed data extraction forms. All study designs, other than case studies, were included. Studies were sourced worldwide due to the small number of studies related specifically to the recent European crisis. Included reports and papers were read and coded and then translated and synthesised, first into descriptive themes and subsequently into analytical themes.[15]

Results

Forty four papers/reports were included, of which, 64% (28) were peer-reviewed and 36% (16) were grey literature. Included studies/reports were largely qualitative studies, cross sectional surveys and service assessments. Two main analytical themes emerged in relation to SRH and migration of young people; structural violence and marginalisation, which included four key descriptive themes. These can be seen in Table 1.

STRUCTURAL VIOLENCE
Violence and vulnerability

Vulnerability to violence was one of the most defining features faced by separated children.[2, 16] Separated children are at a heightened risk for sexual violence, exploitation and abuse due to the perilous nature of travel and subsequent risk of exposure to traffickers. A multitude of risk factors contribute to this, including the loss of social and familial structures, an imbalance in power relations, physical immaturity and a reliance on traffickers to ensure border crossings. [17, 18 19] Overwhelmingly, young people fleeing situations of conflict and persecution also experience an increased risk of violence while in transit to their destination country of refuge. Reports from international organisations on the situation of unaccompanied minors in Europe have found young people to have either experienced sexual violence during transit, or fear sexual violence during their movement to the destination country. [2 20, 21]

Evidence from interviews with 100 unaccompanied asylum seeking minors in the UK found violence to be the primary reason for flight from their country of origin, with over a third of interviewees reporting rape before flight, [16] leaving them vulnerable to significant adverse physical and psychological health.[18] Experiences of violence can affect a young person's overall well-being, their ability to settle in their host country and can contribute a significant public health burden through the impact of poor SRH outcomes, including STIs, HIV, physical trauma, unwanted pregnancies and the obvious psycho-social ramifications. [16 12]

Many European countries struggle to uphold basic minimum reception standards for refugees. In particular, the conditions for refugees in Greece have been described as 'inhuman', with living spaces described as unsanitary, extremely unsafe and barely able to meet even basic survival needs. [2, 22] Such dire living conditions place all migrants living there at an increased risk for sexual and gender based violence.[23] For young people, poor reception and protection by the host country can leave them ill-informed and ill equipped to manage their own well-being and safety. A study of former unaccompanied asylum seeking minors in the UK found considerably high rates of reported sexual maltreatment much of it perpetrated at the destination where the minors were living. [24 20] The participants cited their own ignorance regarding the possibility of sexual maltreatment, as well as a lack of understanding of their rights in the host country as the principle factors affecting their vulnerability. Further compounding this, the failure of authority figures to protect young people, as well as living situations placing them directly in vulnerable situations, such as sharing with the opposite sex or living with mixed sex adults, exposed minors to unnecessary dangers.[24]

Unmet knowledge and service needs
Migration challenges, including navigating the asylum systems of a foreign country, can result in young people feeling powerless, which can affect their ability to take care of their sexual health needs themselves. A study of refugees from a wide range of backgrounds found that their definition of sexual health and wellbeing was closely related to an ability to exert agency in sexual and reproductive health matters.[25] Therefore both a sense of control and sexual and reproductive health literacy is essential in achieving good sexual and reproductive health outcomes for young people who are separated and 'on the move'. However, studies examining the contraceptive knowledge of young refugees have found very low levels of sexual health literacy. [26-29] Socio-economic, educational and cultural background, societal taboos and the disruption to schooling as a result of displacement, have been found to adversely impact this knowledge base. [30, 31] Low levels of contraceptive and condom use knowledge can increase the likelihood of misunderstandings regarding sexual health and can place young people at risk for HIV, STIs and unintended pregnancy through poor knowledge of how infections are transmitted and misconceptions regarding contraceptive use. [26, 29] This may also result in beliefs that create difficulties for young people in negotiating safe sex with their partners. [30] Targeting SRH literacy through targeted interventions has the potential to significantly improve the lives of young people.[11]

Currently access to SRH services for refugees in camps or in transit can be severely impeded, [32] either through a lack of awareness of services in refugee camps or the inability to access them during transit.[33] Meanwhile once settled into the temporary or permanent host country, migrants can face considerable barriers to service access, including language barriers, socio-cultural barriers, insensitive or discriminatory care and inappropriate patient-provider sex discordance. [34,

[35] Currently the Netherlands offers full access to reproductive health services for all asylum seekers which is perhaps why, with increasing length of stay, abortion rates that are high on initial reception for asylum seeking women are lower compared to those in the rest of Western Europe.[36] Other countries in Europe may follow suit through the strategic WHO European Action Plan for universal access to adolescent sexual and reproductive health services.[37]

MARGINALISATION
Barriers and Stigma

Barriers, social stigma and the sensitive nature of sexual and reproductive health can prevent individuals from seeking help regardless of age or social background. For example, a study assessing the impact of violence on the reproductive health of Syrian refugees found that over half of them had not sought medical other help, even through informal social networks, despite having experienced sexual violence (Masterson et al 2014). Further barriers included lack of knowledge of the benefits of seeking treatment, inadequate medical and psycho-social resources, in addition to taboos around speaking of sexual violence in the community. [27, 33] For those whose cultures strongly regulate female sexual behaviour, taboos are likely to exist regarding the disclosure of sexual violence for girls.[24, 28, 38] Meanwhile, taboos surrounding sexuality and masculinity limit the potential for boys to talk about sexual violence. Studies addressing the gendered experiences of sexual and gender-based violence indicate that boys experience a similar risk to girls in regards to sexual exploitation and abuse, and yet this risk is often both overlooked and under-represented in the literature. The perception that boys are at a reduced risk of sexual violence, and reduced reporting of sexual violence by boys mean that male victims may be overlooked and that protection measures can easily fail to consider their unique needs.[18] Barriers exist both on the individual and structural level through gendered experiences and misperceptions of vulnerability and the risk of violence.

Studies examining contraceptive use and attitudes among young migrant populations have also found shame and embarrassment in obtaining contraception hinder both access and use. [29, 35] Furthermore, for girls, especially unmarried girls, culturally prescribed gender roles which expect only married women to access such services, can result in poor SRH outcomes. [36] This may be in stark contrast to the host community, where local young people may have greater access – both social and institutional – to SRH services. [35] Taboos regarding adolescent sexuality, the appropriateness of SRH service access and shame in seeking SRH are considerable barriers that must be considered in addressing adolescent SRH of separated young people.

Adverse SRH Outcomes

A multitude of factors, from low SRH literacy, vulnerabilities to sexual exploitation and abuse, early sexual début, socio-cultural taboos and an inability to access services, can result in young people having an increased risk of sexually transmitted infections and HIV. [31, 39] Young people are at risk for contracting all types of STIs, with asymptomatic HIV and chlamydia infections the most likely to occur in adolescents. [40] Over half of new HIV infections occur in young people aged 15 – 24, [39] whilst very young adolescents are at a heightened risk for contracting HIV and all types of STI due to their immature physical development.[18]

Global studies suggest that migrants are more likely to have an earlier sexual début and engage in risky sexual behaviours than the stable population or than they would have in their host country.[41] A study examining reproductive health services for refugees across a number of refugees camps found early sexual début reported in all sites. Unwanted pregnancy was a common problem stemming from early unprotected sexual activity, with girls as young as 12 reported to be pregnant.[42] The disruption of social structures and the forming of relationships as a coping strategy for parental loss in conflict, were found to be a significant contributing factor in early unions through a desire to seek comfort in others following trauma and displacement.[10] While social isolation has been shown to contribute to risky sexual behaviour and likelihood of sex work,[25] poverty is considered the root cause. [42, 43] Poverty resulting from displacement, abuse from humanitarian workers, smugglers and personnel in authority can result in the engagement of young people, both male and female, in 'survival' sex. [39] [19]

For many Syrians fleeing conflict, the syndromic treatment of STIs has not been available, through both a lack of resources and lack of seeking healthcare for symptoms. [32] Further, significant barriers in seeking treatment for STIs can exists especially when citizenship status is not secured; There may be a general sentiment of distrust regarding the healthcare systems of the host country, with anxiety regarding provider confidentiality and risk to residency status if found to test positive for a serious sexually transmitted infection.[29]

Unintended pregnancies can result from sexual violence, sexual exploitation and/or a lack of contraceptive access and knowledge. [44] Preventing these pregnancies can reduce the need for unsafe and clandestine abortions, and, consequently, increase opportunities for the education and advancement of young people, as well as their ability to rebuild their lives after transition to a new country as an unwanted pregnancy can significantly affect and alter an adolescent's future and ability to pursue employment and education. [45]

Demonstrating this burden of disease both on the public health system of the host country and the individual, a study in the Netherlands found that the overall abortion rate and ratio to be one and a half times higher for asylum seekers than the general population, with births for young asylum seekers eight times higher than the national average and with the highest rates closest to arrival time and gradually decreasing with greater length of stay.[36]

Discussion

The key overarching analytical themes that emerged were structural violence and marginalisation which incorporated violence and vulnerability, unmet knowledge and service needs, barriers and stigma and adverse SRH outcomes. Structural and political factors influence vulnerability to violence both at an individual level and through inequity in information and service provision. Being marginalised and rendered invisible as a result of stigma, discrimination and barriers to access leads to adverse sexual and reproductive outcomes which can result in further marginalisation.

We acknowledge the limitations of this review. We acknowledge that some studies may have been missed in this rapid review approach. [46] We included using only papers published in English, studies not specific to Europe, and we did not appraise the quality of included papers. However because of the lack of available data and the limited empirical research evidence on this topic this was deemed to be the most pragmatic approach.

Whilst the findings may not differ from those of the adult refugee and migrant populations, most of the available studies focus particularly on women, [47 48, 49] Our specific focus on the challenges for younger people is supported by evidence from other contexts where, entire generations of young people, male and female, are exposed to conflict, violence, trauma and marginalisation.[50] The health of separated young migrants is an important factor for integration and subsequent economic and social well-being. Refugees in the EU have previously suffered from poor SRH outcomes, due to the failure of European SRH policies to effectively reach them.[9] Refugees have the same right to health as the stable population, and the rights of adolescents have been clearly acknowledged – including the right to sexual and reproductive health services. Adolescent sexual reproductive health is at risk of being overlooked within the current global crisis. It is therefore imperative that their SRH needs are met while in transit and during the resettlement process with barriers to achieving good SRH outcomes overcome. The WHO ‘New European Action Plan’ promises to address these inequities.[37] Within context of the current European humanitarian crisis, extended application processes for asylum, the use of smugglers, very high risk routes, the capacity and willingness of countries to host separated young people, short and longer term problems with regard to addressing the SRH needs of youth are key issues that need to be considered.

Conclusion

Despite their increased risk for adverse SRH outcomes in crisis situations, separated young people can become invisible [51] as migration is conceptualised as an activity of adults and intact families rather than an act undertaken by lone young people. We argue that this renders them subject to structural violence and marginalisation. [52 53] Their unique needs risk being overlooked.[54] As Europe currently hosts the greatest number of separated young people in recent history, their SRH needs represent a significant public health burden, and it is imperative that their SRH needs are therefore fully acknowledged and met.[55]

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