



Sexual violence and unwanted pregnancies in migrant women

In the past year, migration to Europe from Africa and the Middle East has reached unprecedented levels. In 2016, 181 405 migrants reached the shores of Italy and more than 5000 died trying to reach the southern coasts of Europe.¹⁻³ Many migrants seek to escape war, poverty, persecution, or ill treatment in their countries of origin. However, migrants are often victims of torture and sexual violence during their journey or time in Libyan prisons. Several studies and international organisations have highlighted that migrants from sub-Saharan Africa are at a high risk of sexual victimisation and that many women are forced to pay for their migration through prostitution or are subject to brutal sexual exploitation and torture along the journey.³

This gender-based violence against migrants can have substantial and long-lasting negative effects on the victim's mental, physical, reproductive, and sexual health, resulting in serious public-health implications for the accepting country. Moreover, in post-migration countries, these women frequently experience social, cultural, and economic barriers, which also facilitate gender-based violence. However, few studies have highlighted the problem of violence against refugee women.

We wish to share the sudden changes in the urgent health-care needs of these women, as witnessed at the Public Centre for Sexual and Domestic Violence (SVSeD) at the University Policlinic in Milan, Italy. SVSeD represents a referral emergency centre that offers health, social, psychological, and legal support to women, men, and children who are victims of sexual abuse and domestic violence. Notably, since July, 2016, the number of health-care requests from migrants has increased substantially.

For the initial reception, migrants are allocated to communities, mostly in northern Italy (especially in Lombardia), where they wait for several months for a decision on their status as refugees or asylum seekers. Currently, migrants arrive in Milan a few days after landing on the southern shores of Italy and, in agreement with the 2015 Italian regulations,⁴ are rapidly housed in several accommodation centres in and around the city. Moreover, since March, 2016, all new, irregular migrants who have made the crossing from Turkey to Greece have been repatriated to Turkey, in compliance with European Union and international law.⁵ However, these regulations have forced many more people to go through Libya, which is a much more dangerous route and puts people at a high risk of experiencing violence.

In 2016, we assisted 11 women and one man who were sexually abused during their migration to Europe. 11 of them came to SVSeD in the second part of 2016, whereas only one came before July. Ten of them claimed to have been sexually abused and tortured during their stay in Libyan camps or prisons; two during the African route. Six people (including the man) were raped by a group of men and six by a single man. One showed HIV seroconversion. Eight women became pregnant as a result of the sexual violence, of whom seven asked for an abortion in Italy. Five of them were beyond the first trimester of pregnancy (14–19 weeks of gestation). All had been tortured by burning and beating with various types of weapons. The need to abort the pregnancy appeared to lead the women to report their abuse. These cases probably represent only the tip of the iceberg of sexual violence in human trafficking, since many rape victims might be too ashamed to seek help.

This change in trend at our centre strongly suggests that the organisation of a systematic protocol for health intervention should be a priority to address health-related problems

associated with human trafficking and, in particular, the specific issue of pregnancies and abortion requests resulting from sexual violence. This problem was highlighted by McGinn and Casey,⁶ who claimed that refugee women escaping from conflict violence created the need for better targeting of reproductive health services and psychosocial services in refugee settings. It is the responsibility of humanitarian non-governmental organisations and of the accepting countries to provide safe abortions to women who become pregnant as a result of rape and adequate ethnopsychiatric care for post-traumatic stress disorder. This care will improve women's health and human rights and save lives.⁷

Furthermore, there are criminalistic issues to be considered. Generally, the fetuses from abortions are not preserved for possible DNA analysis. However, a recent criminal case in Milan in which eight Somali victims of torture recognised their persecutor and rapist, who also had arrived in Milan, urged us to reconsider the importance of such material as legal evidence against perpetrators.

We declare no competing interests.

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