

Sexual violence against migrants and asylum seekers. The experience of the MSF clinic on Lesvos Island, Greece.

Short Title: Sexual violence among people in transit.

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Abstract

Objectives

Sexual violence can have destructive impact on the lives of people. It is more common in unstable conditions such as during displacement. On the Greek island of Lesbos, Médecins Sans Frontières provided medical care to survivors of sexual violence among the population of asylum seekers arriving there. This study aimed to describe the patterns of sexual violence reported by migrants and asylum seekers and the clinical care provided to them.

Methods

This is a descriptive study using routine program data. The study population consisted of migrants and asylum seekers treated for conditions related to sexual violence at the Médecins Sans Frontières clinic on Lesbos Island (September 2017-January 2018).

Results

We enrolled 215 survivors of sexual violence who reported and were treated, of whom 60 (28%) were male. The majority of incidents reported (90%) were cases of rape; 174 (81%) of survivors were from Africa and 185 (86%) occurred over a month before presentation. Half the incidents (118) occurred in transit, mainly in Turkey, and 76 (35%) in the country of origin; 10 cases (5%) on Lesbos were also observed. The perpetrator was known in 23% of the cases. Only XXX received mental health care, and the need exceeded the capacity of available mental care services.

Conclusion

Even though the majority of cases delayed seeking medical care after the incident, it is crucial that access to mental health services is guaranteed for those in need. Such access and protection

measures for people in transit need to be put in place along migration routes, including in countries nominally considered safe, and secure routes need to be developed.

Introduction

Sexual violence is widespread, and is reported to be particularly common in unstable environments such as in displaced populations and conflict zones [1]. It is defined as *‘any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work’* ([2], p. 6).

Rape is an act of sexual violence and involves oral, anal or vaginal forced penetration by any part of the body or by any kind of object [2], and is undertaken against both sexes. Sexual violence can cause life-changing health and social problems for its survivors [3].

There are many potential consequences of sexual violence, including sexually transmitted infections (STI), vaginal/rectal bleeding, other genital or body injuries, pain during sexual intercourse, unwanted pregnancy, psychosomatic issues, mental health problems, and even suicidal ideation, self-harm, and death [1, 4]. Longer term impacts may include behavioral problems, isolation, guilt, rejection by the family or an inability to take care of the family, preventing a woman from marrying due to cultural taboos [5, 6]. People who experienced sexual violence in the past are also at higher risk of further attacks in the future [7]. Furthermore, it may also have a societal impact, and can considerably destabilize communities, in particular when used as a weapon of war [8].

Due to its stigmatizing nature, survivors of sexual violence do not always seek care, or may do so with a delay, compromising the medical care that can be provided (as elements such as post-exposure prophylaxis for Human Immunodeficiency Virus (HIV) and other sexually transmitted diseases are contingent on early presentation). Men may be disproportionately affected by limited

or delayed health-seeking behavior for sexual violence: while sexual violence can affect both women and men [2], men may find it much harder than women to talk about sexual violence, as they are expected to be “strong” and not to show weakness and lack of masculinity [9], or possibly because sexual violence services are linked to female health centers [10].

A number of studies have focused on sexual violence in unstable contexts; of those, most were conducted in conflict or post-conflict zones [4, 11-13]. A much more limited number of studies have focused on sexual violence among people in transit (this includes refugees, migrants, and asylum seekers); often in specific contexts, such as among migrants in transit in South and Central America (xxx) and among refugee populations during/following conflict (xxx). Out of all migration contexts, only a few studies have been published on sexual violence among displaced populations attempting to enter Europe. Keygnaert et al. [14] highlighted the risk of sexual violence that sub-Saharan migrants and asylum seekers faced when attempting to cross to Europe from Morocco. Freedman highlighted how insecurity and vulnerability towards sexual violence among women is increased by current European Union policies, and that insufficient medical and psychological support are being provided for female victims of violence in their countries of origin or in transit [15].

Sexual violence can and does occur anywhere along the route of displaced populations to safety. Medical care needs to be provided as soon as possible afterwards in order to be effective. Therefore a better understanding of the patterns of sexual violence and the needs of its survivors in different contexts is required, in order to improve and upscale the provision of care to this extraordinarily vulnerable population [16]. Health projects in migration settings offer an opportunity to understand and to document the risks and needs of migrants and asylum seekers who have experienced sexual violence, and to show the needs of these people as they flee their

country and seek asylum. Ideally such projects improve the screening process for sexual violence among people in transit or among people who are involuntarily contained for indeterminate periods of time, and result in better packages of care for sexual violence survivors.

The Greek island of Lesbos is very close to the Turkish border, and was the first arrival point and a geographically restricted site for a large number of people seeking safety on European soil. The medical humanitarian organization Médecins Sans Frontières (MSF) operated a clinic for survivors of sexual violence in this area.

The aim of this study was to describe the patterns of sexual violence experienced by migrants and asylum seekers residing on Lesbos Island as reported to the MSF Clinic, and the clinical and mental health care provided to them, between September 2017 and January 2018.

Materials and methods

Design

This was a descriptive study using routine program data.

General Setting

Since early 2015, Greece has been at the forefront of the European refugee crisis. Greece is a country with many island communities. Lesbos is the third largest island of Greece, with an area of, approximately, 1,600 km² and it is located in the northeast of the Aegean. It is only 10 km away from the eastern coast of Turkey and so the most accessible island within the European Union. Its population, according to the 2011 census, is almost 86,500.

In March 2016 the Balkan route was closed and the EU-Turkey deal was implemented a few days later. According to the new regulations [17], asylum seekers had to complete their asylum procedure at the first landing point, the Greek islands, with no option to move to the mainland (hence a geographical restriction) unless they were deemed vulnerable. As a result, the islands became congested, accommodating many more migrants and asylum seekers than what was originally planned [18].

According to the United Nations High Commissioner for Refugees (UNHCR) official website, the population of Moria's camp (the largest and most congested camp on in Lesvos) reached 5,000 at the beginning of September 2017, overwhelming its original planned capacity of 2,300 [19]. Moreover, with only occasional transfers of people to the mainland and a total of 8,474 people arriving on in Lesvos between September 2017 and January 2018, a vast increase in the population accommodated in Moria's camp was seen over this period. By February 2018, the camp still had approximately 5,000 residents [19]. All camps on Lesvos are administered by the Greek authorities, with the support of UNHCR.

Specific setting

MSF has provided health services on the island of Lesvos since July 2015. The Greek public health system was already overwhelmed by the economic crisis that started in 2009, with increased demand and decreased resources [20, 21]. In addition, many of the people in transit on the islands had significant psychiatric needs, commonly due to trauma they faced in their country of origin or during the migration. Their needs exceeded the capacity of the trained staff in the local health care system, particularly the capacity to provide psychiatry and trauma therapy. The lack of appropriately trained cultural mediators was also a problem.

In view of these needs, MSF aimed to cover this gap by adapting its activities in the summer of 2017. A clinic was set up in Mytilene, the capital of Lesbos, for the provision of mental health care for migrants and asylum seekers who had developed severe mental health disorders, including people who experienced torture and sexual violence at any point in their travels or prior to departure. Medical care and social support was also offered to such individuals. The sexual violence database was established the same period when the new clinic was set up. Additionally, by the end of 2017 an outpatient clinic was set up just outside Moria's camp, providing paediatric and sexual and reproductive healthcare services, including sexual violence care for survivors presenting less than 120 hours after the assault (in contrast with Mytilene's clinic, where there was no such limitation on the timing of the incident). This time limit was established for the outpatient clinic because of the small capacity of this clinic and taking into consideration the effectiveness of the medication offered in case of sexual violence. Data from all these sexual violence cases were entered in the same database.

Survivors of sexual violence with medical needs could either present themselves directly to one of the clinics requesting medical assistance, or could be referred to the sexual violence service by MSF staff from the other services (psychologist, doctor) or by another health Non-Governmental Organization (NGO). Mental health care was initially offered to migrants and asylum seekers who were either referred by MSF staff or who were self-referred. After September 2017, the mental health services also accepted referrals from other health NGOs, but no longer accepted self-referrals.

The medical and mental health care services were tailored to the needs of this group. Specifically, sexual violence survivors were offered a package of medical care based on the MSF protocol that consists of prevention of HIV (facilitating access to the hospital for Post Exposure

Prophylaxis [PEP]), treatment of STI, emergency contraception, vaccination against Hepatitis B and Tetanus, and care of wounds or health complications after the sexual violence (**Table 1**).

Provision of a medical certificate was also offered, covering the medical examination of the patient and the incident as reported by the patient. Follow up appointments were scheduled based on the first assessment of needs, with an average of three total visits.

Table 1: MSF protocol on health services offered at Lesvos MSF clinic to survivors of sexual violence, 2017-18.

Medical Management of Sexual Violence	
Interval §	Services recommended*
≤72hours	Post exposure prophylaxis (PEP) for HIV**
	Emergency contraception
	STI prophylaxis †
	Tetanus vaccine
	Hepatitis B vaccine
	Mental health care
>72 -120 hours	Emergency contraception
	STI prophylaxis or treatment
	Tetanus vaccine
	Hepatitis B vaccine
	Mental health care
>120 hours - 6 months	STI prophylaxis
	Tetanus vaccine
	Hepatitis B vaccine
	Mental health care
<p>*All the services were provided after patient's consent and according to their health status and the type of sexual violence. Care of physical injuries and referral for termination of pregnancy (in case of a positive pregnancy test) was also offered. Additionally, medical certificate was offered to all patients. ** In contrast with other contexts, in Greece MSF facilitates the access to PEP rather than administering it directly, due to the Greek legislation.</p>	
§ Time intervals as used in MSF SV database	
† Sexual Transmitted Infections	

Study population and period

We included in the study all male and female migrants and asylum seekers who sought care for sexual violence with MSF on Lesvos Island, Greece between 1st September 2017 and 31st January 2018. This included individuals seeking care in the outpatient clinic in Moria, and individuals seeking care in the Mytiline mental health clinic.

Sources of data and variables

All the data were extracted from the standardized, pseudonymized MSF database for sexual violence (as described in Loko Roka et al. (2014) and the waiting list of the mental health department of Lesvos Project. The outcome measurement was the number of survivors of sexual violence. Other variables were age, sex, nationality, location of incident (categorized as country of origin, in transit, on Lesvos), time between incident and presenting for care (categorized as <72h, 3d-1m, 1m-1y, >1y), type of perpetrator, type of sexual violence (categorized as reported, as rape, forced prostitution, and sexual touching), and associated violence. No information was collected systematically on the time spent in transit; anecdotal reports suggest this ranged from several weeks to multiple years, with 6 months being the median duration of travel.

Analysis and statistics

The data analysis was performed using Epidata Analysis software version 2.2.2.186 (EpiData Association, Odense, Denmark). A descriptive analysis was done: means (standard deviations) were calculated for continuous data. Categorical data were summarised using frequencies and proportions. Groups were compared using the Chi-square test. P-values <0.05 were considered significant.

Ethics approval

As *a posteriori* analysis of routinely collected programme data, the national ethics bodies in Greece did not consider this study as falling under their jurisdiction for ethics review. As the study was considered low risk and of public health importance, it was conducted under the exceptional approval of the medical director of Médecins Sans Frontières-Operational Centre Brussels.

Results

Between September 2017 and January 2018, the MSF clinic on Lesbos recorded 215 patients who reported experiencing sexual violence. The socio-demographic characteristics of these survivors of sexual violence and the location of the incident are shown in **Table 2**. Among these cases, 155 (72%) were female and 60 (28%) were male. The vast majority of the patients [208 (96%)] were accommodated in Moria camp. The majority of the incidents of sexual violence [118 (55%)] occurred during migration, most of which in Turkey, and 76 (35%) occurred in the country of origin. Ten incidents (5%) in Lesbos were also documented. Only 6 (3%) of the cases presented in the appropriate timeframe to receive optimal care (<72 hours).

Table 2: Characteristics of 215 survivors of sexual violence, visiting the MSF clinic, Lesbos, Greece (September 2017-January 2018).

Characteristics	N	(%)
Total	215	(100)
Age group (years)		
≤10	<5	(<5)
11-20	42	(20)
21-30	88	(41)
31-40	71	(33)
>40	11	(5)
Mean (SD)	28.2	(8.2)
Sex		
Female	155	(72)
Male	60	(28)
Current migrant camp		
Moria's camp	208	(96)
Karatepe's camp	6	(3)
Other	<5	(5)
Nationality groups		
Central and East Africa ¹	95	(44)

West Africa ²	78	(36)
North Africa ³	<5	(<2)
Middle East ⁴	25	(12)
Other	12	(6)
Not Recorded	4	(2)
Location of incident		
Country of origin	76	(35)
In transit		
<i>Turkey</i>	106	(49)
<i>Other transit country</i>	12	(6)
Lesvos	10	(5)
Other/unknown	11	(5)
Interval between incident and presenting for care		
<72 h	6	(3)
3 days-1 month	22	(10)
1 month-1 year	174	(81)
>1 year	11	(5)
Not recorded	2	(1)

1Central and East: Congo, Democratic Republic of the Congo (DRC), Central African Republic (CAR), Ethiopia, Eritrea

2West: Cameroon, Nigeria, Mali, Burkina Faso, Gambia, Guinea (Conakry), Guinea Bissau

3North Africa: Morocco

4Middle East: Afghanistan, Iran, Iraq, Syria, Palestinian living in Syria

Characteristics of the cases seen by MSF, stratified by location of the event, are shown in **Table**

3. Timeliness of presentation was directly related to the attack occurring prior to arrival in Greece. A higher proportion of reported attacks on male survivors took place during migration period (34%), rather than in the country of origin (16%). The incident characteristics, stratified by location of the event, are presented in **table 4**. Incidents tended to be more violent in the country of origin than in transit, with higher proportions of armed perpetrators (country of origin 45% vs transit 14%, $p<0.01$) and with more associated violence (country of origin 71% vs. transit 43%, $p<0.01$). Perpetrators of incidents during migration were more likely to be civilians who were unknown to the survivors.

Table 3: Characteristics of 215 survivors of sexual violence presenting at the MSF clinic, stratified by location of the sexual violence incident, Lesvos, Greece (September 2017-January 2018).

Characteristics	Location of incident					
	In Country of origin		During Transit ⁵		On Lesvos	
	n	(%)	n	(%)	n	(%)
Total	76		118		10	
Age group (years)						
≤10	1	(1)	1	(1)	0	(0)
11-20	14	(18)	21	(18)	4	(40)
21-30	33	(43)	51	(43)	2	(20)
31-40	22	(29)	41	(35)	3	(30)
>40	6	(8)	4	(3)	1	(10)
Sex						
Female	64	(84)	78	(56)	7	(70)
Male	12	(16)	40	(34)	3	(30)
Nationality groups						
Central and East Africa ¹	38	(50)	47	(40)	6	(60)
West Africa ²	22	(29)	49	(42)	1	(10)
North Africa ³	0	(0)	1	(1)	0	(0)
Middle East ⁴	11	(14)	12	(10)	2	(20)
Other	5	(7)	5	(4)	1	(10)
Not Recorded	0	(0)	4	(3)	0	(0)
Interval between incident and requesting care						
<72 h	0	(0)	1	(1)	5	(50)
3 days-1 month	1	(1)	20	(17)	1	(10)
1 month-1 year	69	(91)	94	(80)	2	(20)
>1 year	6	(8)	3	(3)	1	(10)
Not recorded	0	(0)	0	(0)	1	(10)

1) Central and East Africa: Congo (Kinshasa) Congo (Brazzaville) Central African Republic, Ethiopia, Eritrea. 2) West Africa: Nigeria, Mali, Burkina Faso, Gambia, Guinea (Conakry) Guinea (Bissau) Cameroon. 3) North Africa: Morocco. 4) Middle East: Iran, Iraq, Syria, and Afghanistan. 5) Transit means between country of origin and Lesvos

Table 4: Characteristics of 215 sexual violence incidents, stratified by location of the sexual violence incident, among survivors of sexual violence visiting the MSF clinic, Lesvos, Greece (September 2017-January 2018).

Characteristics	Location of incident					
	In country of origin		During Transit ¹		On Lesvos	
	N	(%)	N	(%)	N	(%)
Total	76	(100)	118	(100)	10	(100)
Type of perpetrator						
Unknown civilian	11	(14)	49	(42)	7	(70)
Known civilian	7	(9)	26	(22)	2	(20)
Military	17	(22)	1	(1)	0	(0)
Smuggling groups	3	(4)	13	(11)	0	(0)
Family member	11	(14)	3	(3)	0	(0)
Institutional agent	9	(12)	4	(3)	0	(0)
Policeman	6	(8)	1	(1)	0	(0)
Organized gangs	1	(1)	0	(0)	0	(0)
Other	2	(3)	4	(3)	0	(0)
Not Recorded	9	(12)	17	(14)	1	(10)
Armed Perpetrator						
No	17	(22)	67	(57)	7	(70)
Yes	34	(45)	16	(14)	0	(0)
Not recorded	25	(33)	35	(30)	3	(30)
Type of event						
Rape	74	(97)	107	(91)	10	(100)
Sexual Slavery and forced prostitution	1	(1)	8	(7)	0	(0)
Sexual touching	1	(1)	0	(0)	0	(0)
Not Recorded	0	(0)	3	(3)	0	(0)
Location of incident						
During migration	4	(5)	68	(58)	7	(70)
Daily activity	10	(13)	20	(17)	1	(10)
Home	27	(36)	3	(3)	0	(0)
Institution	14	(18)	7	(6)	1	(10)
Abduction situation	5	(7)	0	(0)	0	(0)
Other	1	(1)	1	(1)	0	(0)
Not Recorded	15	(20)	19	(16)	0	(0)
Associated violence:						
None	22	xx	xx	xx	7	70
Beaten	25	(33)	28	(24)	3	(30)
Tortured	9	(12)	4	(3)	0	(0)
Witness of violence	13	(17)	1	(1)	0	(0)
Sexual exploitation	1	(1)	8	(7)	0	(0)
Detained/ incarcerated	4	(5)	4	(3)	0	(0)
Robbed of property	1	(1)	1	(1)	0	(0)
Forced labor	1	(1)	5	(4)	0	(0)

1) Transit means between country of origin and Lesvos

Health services provided by the MSF clinic to the patients are shown in **Table 5**. Termination of pregnancy was requested by 3 out of the 10 pregnant women who attended the clinic. It could not be ascertained whether pregnancies were the result of the rape.

Table 5: Health services provided to 215 survivors of sexual violence at the MSF clinic in Lesvos, Greece (September 2017 - January 2018).

Health services	Females		Males	
	Provided		Provided	
	n	(%)	n	(%)
Total	155		60	
Eligible for PEP ^a	5	(3)	1	(2)
Access to PEP (among eligible)	5	(100)	1	(100)
Eligible for Emergency Contraception	5	(3)	NA ^b	
Provision of Emergency Contraception (among eligible)	3	(60)	NA	
Sexually transmitted infections: prophylaxis/treatment	92	(59)	29	(48)
Tetanus vaccination	66	(43)	26	(43)
Hepatitis B vaccination	64	(41)	26	(43)
Physical examination ^c	134	(86)	39	(65)
Genital examination	101	(65)	22	(37)
Anal examination	33	(21)	22	(37)
Mental health care				

^a PEP: post-exposure prophylaxis for HIV;

^b NA: not applicable

^c Investigation for wounds

The number of new referrals to mental health services at the MSF clinic (n= 825 in the whole period) and the number of clients on the waiting list by month are shown in Figure 1, where new referrals increased from less than 100 to more than 300 during November 2017, and then decreased to less than 100 again for the following month. The number of persons on the waiting list for mental care increased from less than 100 to 553. The numbers increased substantially in November 2017 coinciding with referrals being accepted from other health NGOs, rather than only through MSF services and self-referrals. Numbers on waiting list for

Fig 1: New referrals to MSF mental health care and total number of patients waiting list, Lesvos 2017.

'Insert Fig 1 here'

Discussion

This study of survivors of sexual violence among migrant and asylum seeker receiving care in MSF clinic on Lesvos Island, showed that almost all survivors had experienced the violence before reaching Lesvos. About a third of the incidents occurred in the country of origin and almost half during transit in Turkey. However, a number of incidents also occurred on Lesvos itself, reflecting a gap of the protection services on the island. Out of all types of sexual violence, rape accounted for more than 90% of the incidents reported.

A surprisingly high proportion of survivors (28%) were male, in contrast with another survey by MSF which showed that 17% of male refugees underwent sexual attack in their efforts to leave from Central America (MSF, 2017). Other studies also present lower proportions of male survivors, including in an urban slum in Kenya (8%) and in post-conflict settings such as Liberia (2%) and eastern DRC (3%) [11-13]. There have also been reports of sexual violence affecting men and boys in the Middle East, as well as in Greece [10].

However, our findings echo other studies in conflict areas of DRC, showing that 24% of adult males had experienced sexual violence at some point of their life [22], and in Lebanon with 20% of survivors being men and boys [23]. We do not know the reasons for the high rate of male survivors in our study. The fact that the clinic mainly offered mental health care services may

have lowered the barrier for men to seek care, as sexual violence does not need to be disclosed at entry with such a setup. Also, the trust developed from patients towards the psychologist during mental health treatment might have led to disclosing and referral for medical care. Sexual violence towards men may also be more prevalent in populations of migrants and asylum seekers, as it is a common component of torture, which is often directed towards men, and of humiliating and intimidating practices by officials and gang leaders who act as facilitators for the migration process (termed “migration professionals” in [14]). The observation that male survivors were more common in incidents during the migration phase supports this speculation.

While the majority of the asylum seeker population in Lesbos came from the Middle East, the most common countries of origin among sexual violence survivors were DRC and Cameroon, both for incidents perpetrated in the country of origin and for incidents occurring during transit. From our data, it is not possible to discern whether this reflects differences in prevalence of sexual violence according to the survivor’s nationality, or rather differences in health-seeking behavior (possibly also linked to differing lengths of stay on Lesbos, depending on country of origin).

Strikingly, the study showed that countries such as Turkey usually considered safe for migrants and asylum seekers, present a high risk of sexual violence; half of the reported sexual violence occurred there.

The perpetrator was known to the survivor (including family members) in 23%. This is a lower proportion than sexual violence in more stable communities; for example in the UK the perpetrator was known in 71% of the cases reported [28]. One possible reason for this difference could be that the population in this study consisted of migrants and asylum seekers. This

vulnerability was seen by others as a reduced likelihood of reporting if abused. This notion was supported by the observation that it was mainly the incidents during the migration period which were perpetrated by unknown aggressors.

Many migrants and asylum seekers, including survivors of sexual violence, requested mental health support. The need for psychological care could not be met, reflected in the long waiting list after Nov.2017 (Fig.1). Anecdotally, a volunteer doctor working in the camp reported finding the mental health services so overwhelmed there was no point in referring people who would normally benefit from mental health services.

We found that 94% of the survivors of sexual violence had been raped. This is much higher than what has been reported in other settings. In South America 60% of sexual violence was about rape [29], whereas in United States of America 21% of sexual violence survivors may be raped [30]. A suspicion of sexual slavery or trafficking was sometimes present during consultations in the clinic but there was no hard evidence, as the information revealed by the patients was not always complete or they had not understood what exactly had happened. In our setting we think that sexual violence types other than rape may be underreported. As expected, sexual slavery/exploitation occurred more commonly during the highly vulnerable migration period.

Medical care of the sexual violence survivors was usually relatively limited once patients were identified, as most sought care months after the event, limiting the treatment options available. In contrast, the psychological impact of sexual violence and working in a cross-cultural manner was often complex and the lack of access to mental health care contributed to delays in the psychological assessment and adequate support of the patient. As psychological support is the mainstay of care for survivors presenting late when medical treatment is limited, this placed a

constraint on the quality of care provided. It was challenging for MSF to meet this huge need for mental health support. Sexual violence services, including mental health support, should be an intrinsic component of care in all migration contexts, ideally offered along the route as well as in reception hotspots. Additionally, protection services need to be strongly reinforced to ensure that no new incidents of sexual violence can occur during the reception period, and to provide a sense of safety that will prevent deterioration of mental conditions as a consequence of the history of sexual violence.

There is strong evidence that countries considered safe such as Turkey (and Morocco, as in Keynaert et al. [14]) did not manage to protect people who are on the move. Considering also the fact that Turkey, for example, offers temporary protection only to Syrian refugees, including permission to stay, basic rights and services (<https://cutt.ly/PewijE0>). Action needs to be taken to make health services available for cases of sexual violence and to ensure people without documentation can still access protection services by these transit countries, as well as by EU Member States, whose pursuit of externalization migration policies is likely contributing to lack of safety and accountability of displaced populations experiencing sexual violence.

We have shown that care can be provided, and even in a way that was accessible for male survivors, which is rarely achieved to this extent. The MSF model can thus be considered appropriate for identification and provision of care for both male and female survivors of violence in an asylum seeker/migrant population, though issues of scalability need to be examined, considering the long waiting times. Since MSF is an NGO, other actors, including governmental authorities, should take up similar programs in all settings, particularly hotspots for new arrivals, to ensure prompt and comprehensive care for sexual violence survivors. The

capacity of mental health care services must be properly planned to adequately meet the needs of this group.

This study had some limitations. There was a relatively small number of sexual violence survivors who attended the clinic, which limits the amount of data available for analysis of risk factors. Correct categorization of the cases was often difficult due to limitations imposed by the fields in the new database and, in some cases, because of lack of full information disclosed by the patient. This was compounded by having to work cross-culturally and in different languages, which may have caused misunderstandings. All these may have resulted in missing or incorrect information. There may be some selection bias, as the matter may be too sensitive for survivors to present to strangers..

Conclusions

Between September 2017 and January 2018 sexual violence was a significant problem for migrants and asylum seekers arriving in Lesbos, which can blight their lives. The medical services MSF provided were able to cope with the numbers, but the inadequate capacity of the mental health services made it difficult to refer and support all those survivors of sexual violence who would have benefitted from such services. Therefore, when designing projects to provide care for survivors of sexual violence it is crucial that more attention is given to the mental health needs of this vulnerable group. Furthermore, care possibilities and protection measures for people in transit need to be put in place in other countries, including those currently considered as safe, and routes that migrants use need to be made safer.

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