# TSINAAT NAY IYOB YIHABENA:
# DIRECT AND INDIRECT VIOLENCE FACED BY ERITREAN WOMEN ASYLUM SEEKERS

by
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# Abstract

*Background*

Female irregular migrants, including those with claims for asylum, have a high unmet need for sexual and reproductive health services both while migrating and after arrival in their host country. Researchers originally designed the study to explore the reproductive health needs of Eritrean women asylum seekers who had arrived in Israel since 2007. Participants' responses prompted researchers to expand the study, to also investigate the sexual violence and exploitation that the women had experienced both en-route to and after arrival in Israel.

*Methods*

This is a qualitative methods study. Phase I investigated barriers to the access of contraception from the health systems perspective. Data collection included semi-structured in-depth individual interviews with 25 adult key informants (e.g. health providers, case-workers, government officials, members of International NGOs, activists in the asylum-seeking community, NGO workers, and researchers). Phase II of the study investigated the sexual violence and exploitation experienced by female Eritrean asylum seekers in Israel. Phase II consisted of 12 semi-structured in-depth individual interviews (6 men and 6 women) and 8 focus group discussions (4 groups of men and 4 groups of women, N=44) with Eritrean community members living in Israel.

*Results*

Participants reported that sexual violence and exploitation had become normalized en-route to Israel.  Irregular status and movement hindered access to the

institutional support needed to prevent the perpetuation of these practices. Participants indicated that the need for protection from this abuse continued in Israel as a result of political and economic marginalization. In spite of a need for protection including reproductive health services, including family planning methods, women reported being unable to access these services due to a number of structural barriers to careseeking in for asylum seekers in Israel.

## *Conclusion*

Interviews and focus group discussions revealed both a considerable risk of sexual violence and exploitation throughout Eritrean women's migration experiences and a limited access to sexual and reproductive health services. Our findings of an increased vulnerability to abuse and limited recourse to support of women migrants corroborates previous research indicating that these risks are experienced across contexts.

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# Chapter One

## Preface

## *Acknowledgements*

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My Habesha godparents Hailemichael and Tsehaye Gebremichael and Baba Hailu stood by my mother and me when we had nothing and our troubles tried to swallow us up. All of their love and support, irrespective of the nature of the challenges that we faced, gave us rest and hope in difficult times. They were the tree that provided us shade and shelter in the worst of times. They provided light when life seemed dark.

Hatiney Leteberhan's arrival from Eritrea when I was twelve expanded our small family. My aunt's presence offered me a window into my mother's past and proved to my young self that my mother and I were never alone in this world; our support system extended beyond our immediate community in the United States. My ability to speak Tigrinya is in no small part a result of my desire to communicate with her in those early years. She has always been willing to discuss anything with an open mind and is a trusted source of advice in my family. My family in Ethiopia, and in particular Azeb, her husband Teklu, my cousins Leah, Eyerus, Hirit, Tekle, Tesfaye, Tewelde who, in

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develop my character in ways I do not yet fully comprehend. I do know that these subtle changes will be a source of reflection for the rest of my life.

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*Reflection*

I collected data both in August of 2012, and from November 2012 until September 2013 in Tel Aviv, Israel. In August, I traveled to Tel Aviv, Israel where I spent three weeks conducting ethnographic mapping in order to identify various NGOs and clinics through a contact with an NGO worker. I first went to a health clinic set up for refugees providing services in the central bus station. The line for the clinic was comprised of approximately 100 people from Eritrea, Ethiopia and Sudan who were in need of medical attention. When one of their physicians heard me conversing with patients in both Tigrinya and English, he asked me to translate for other waiting patients. The small ad-hoc clinic did not have translators and the volunteer physicians were doing their best to provide services with a limited staff and medical supplies. The level of frustration of patients and staff was palpable. I described the objectives of the study I was conducting to one of the physicians and she connected me with Dr. Nadav Davidovitch, an epidemiologist and public health physician who, not long after, agreed to be the local collaborator on the project. It is interesting to consider that while my initial intent was to create a map of all of the facilities providing services to the asylum-seeking population, I was immediately immersed in the problems that I intended to research because of my Tigrinya, Amharic and Arabic language skills and the clinic's desperate need for translation services. My language skills forced me to switch from an objective observer to a participant helping to temporarily alleviate the problems that I had come to research. With each group I felt a deep connection. I spent years studying Arabic. While living in Cairo for a year, I worked with and made friends with Darfuri refugees. Hearing the Amharic speakers reminded me of Addis Ababa where my mother lived for many

years and where I visit frequently. I am an Ethiopian-American who was raised in a community of Ethiopian and Eritrean refugees in the United States. I identified with the Ethiopian and Eritrean Tigrinya-speaking people because they reminded me of my childhood's loved ones. I acknowledge that our shared Tigrinya-speaking origins deepened my sense of empathy and urgency in conducting my research. I could see that the overwhelming majority of Tigrinya speakers waiting in line were Eritreans and I already knew that the majority of asylum seekers in Israel are Eritrean.

In addition, while my initial proposal included the asylum-seeking Sudanese population in my research it soon became clear that, while this population's needs was similar to the asylum-seeking Eritreans, the nuances of their situations were different enough to require two separate studies. It would have required developing additional contacts in each community and arranging focus group discussions and individual interviews with both communities. This bifurcated study was not feasible within the initial time that I allotted myself. I was also eager to learn more about Eritrea. I was curious to learn more about the trajectory of the country since it was sold to the Italians by Ethiopian Emperor Menelik in the late 1800s. I also wanted to understand the historical factors that contributed to the Ethiopian-Eritrean war of 1998 that divided Tigrinya-speaking communities in our homelands and in the diaspora. As an ethnic Tigrinya from the Ethiopian side of the border, with family and friends from the Eritrean side of the border, I have always been curious to know the backstory behind the anecdotes of love and betrayal in our homelands' which reverberated in the tensions in the diaspora. I craved information that would contextualize the politicized and often ethnically and religiously tied discourse that I heard from Eritreans and Ethiopians in the

diaspora. I wanted to read and reflect more on the social, political and economic context of Eritrea to enable me to better understand the historical context of my own ethnic group in Ethiopia. I was interested in piecing together the events that comprised the horn of Africa's historical trajectory. On a social level, I also was making friends in the Eritrean asylum-seeking community in Israel who enjoyed discussing the historical context of the area as well. All of these factors contributed to my ultimate decision to focus on the Eritrean population for my research study.

I returned to Israel after completing my Johns Hopkins University oral examination, arriving at the beginning of a war between Gaza and Israel in November of 2012. The cited reason for the war was to stop the inflow of rocket-fire in the south of Israel (IDF) and to end occupation of the West Bank and the blockade in Gaza (Hamas). The war, named "Operation Pillar of Defense" by the IDF and "Operation Stone-Baked Clay" by Hamas began on November 14th and lasted for eight days (1). It began after an Israeli Defense Forces killed Ahmed Jabari, a chief in Hamas' military wing (2, 3). The IDF attacked 1500 sites in the Gaza strip (4) resulting in approximately 167 deaths (5) and 840 wounded Palestinians (6). Hamas fired 1,456 missiles (7) that reached Israel and for the first time since the Gulf War in 1991, Tel Aviv was hit. Rockets were also targeted at Jerusalem (8). By the end, six Israelis were killed and 222 were injured (9). After nearly a week in Tel Aviv with the sounds of sirens and explosions, I went to Haifa for two weeks to wait out both the fighting and a subsequent attack in Tel Aviv (the bombing of a bus that injured 28 people) (10). The bus bombing was the first attack of its kind since 2006 (11). When a ceasefire was announced, I returned to Tel Aviv. This experience added another dimension to my understanding of the clash between a nation's

obligations under international law and regional interests; the missiles brought me out of the land of theory and into the raw historical and political reality of the Levant region, helping me to further contextualize Israel's policies towards non-Jewish asylum seekers.

As soon as I returned to Tel Aviv, I began volunteering as an interpreter for Eritrean, Ethiopian and Sudanese asylum seekers at various governmental and nongovernmental facilities and clinics as well as for individuals who, through word of mouth, sought linguistic help. I interpreted for asylum seekers who, among many things, needed: 1) legal advice to get their family members out of detention; 2) clarification of national misidentification that could result in their deportation; 3) financial redress for work-related injuries; and 4) case-report interviews for the United Nations High Commissioner for Refugees for those who had been released from the Israeli detention facilities, and for women seeking refuge from domestic violence. Interpreting for asylum seekers who sought to access Israeli institutional support made me keenly aware of visible and invisible structural roadblocks which ostensibly were intended to comply with the Geneva Convention's *non-refoulement* policy, but which in fact marginalized the asylum seekers. These personal interactions enabled me to empathize with the frustration experienced by asylum seekers' with the limited capacity of international agencies to address the root causes of the disenfranchisement of asylum seekers.  My awareness of these structural roadblocks provided new lines of inquiry during interviews and informed my understanding of all of the factors involved in accessing social services including health care.

In the clinics, when listening to and talking to patients in the waiting room, I gained insights into their individual experiences that would serve as the foundation for

my research study.  My Tigrinya, Arabic and Amharic language skills improved considerably as I conversed with them and as I later attempted to provide the best socio-linguistic interpretation possible for the patients.  During my time there, I learned medical vocabulary and the symptoms of physical and psychological ailments commonly experienced by traumatized populations. While interpreting for a psychologist, I learned in detail about the Sinai torture houses from their survivors and observed the long-term mental health impacts of their traumas. While interpreting for the gynecologist, I learned how the rapes experienced by women en-route to Israel affected the functioning of a woman's reproductive system. While interpreting for primary care physicians, I learned that in addition to common health concerns, patients also exhibited a range of psychosomatic ailments.  There was also joy - I will never forget the day I translated for a 21 year-old woman as she gave birth to a baby girl. She was alone in Israel and did not have a partner or husband.  Despite longing for her mother, her emotional strength impressed me and the nurses and physicians attending to her needs. The child, named Hiyab (gift from God) was a gift for me as well.

Working in the clinics, I also became keenly aware of their limited ability to provide comprehensive and consistent health care services.  As noted above, I personally identified with the Eritrean population as they reminded me of loved ones.  Speaking their language allowed me to learn subtleties of their experiences during the stages of their migration; people felt comfortable sharing their narratives with me. While this deepened my insight, it also made me emotionally sick at heart.  Over the eleven months that I spent interpreting for and collecting data from asylum seekers who had been raped and tortured, I experienced vicarious traumatization. As I reflect, I do not believe that my

intense internal emotional state influenced my behavior during interviews. Frequent analytical discussions with Dr. Davidovitch and Nora Gottlieb throughout data collection were critical to creating and maintaining a balance in my analysis. I also learned the importance of psychological preparation for researchers conducting fieldwork with people who have been raped and/or tortured.

While I was interpreting, I also began arranging interviews to begin Phase I of my study. I was provided a list of potential key informants from the staff at various NGOs as well as faculty and students at Ben Gurion University. Recruiting key informants was the easiest part - most of them were eager to be a part of the study. I hired a research assistant who was a doctoral candidate researching health system barriers faced by all non-Jewish migrants in Israel. She was an Israeli citizen and had lived in Tel Aviv for six years. The assistance of an Israeli researcher who was familiar with social norms, fluent in Hebrew, and who had already conducted research among similar populations in Israel was a source of great insight and support. She helped me navigate the complexities of the Israeli healthcare system and provided information about Israeli health, immigration and economic policies that created asylum seekers' political, social and economic realities. During interviews, key informants were open and willing to discuss the challenges of providing services for the Eritrean community in light of increasingly restrictive Israeli immigration policies. Not surprisingly, however, I observed that those who worked closely with the Eritrean community (such as case workers, and community activists) had a deeper knowledge and understanding of the challenges facing them both in Eritrea and in Israel than those who had only an institutional knowledge of their situation. The inclusion of both well-informed and uninformed key informants helped me

to understand the reasons behind Israeli policies. Furthermore, Eritrean activists, who worked closely with both the humanitarian community and the Eritrean population, provided a multi-faceted analysis as to why policies were enacted and how they shaped the lives of asylum seekers.

Recruitment for the individual interviews for Phase II of the study was more complicated: I felt intimidated by potential participants because I had just spent several months listening to people's frustration with researchers who asked for people to share personal, and often painful, information but whose efforts did nothing to improve their lives; I dreaded being resented as a privileged researcher from the USA who, while I looked and spoke like them, was perceived as having no other genuine interest than to use their suffering to boost my own career objectives; coming from a religiously conservative home, I was painfully aware of how some potential participants might react to the subject of my research; I was worried about being perceived as their enemy because of my Ethiopian heritage; I was concerned that any referrals for care that I might provide after an interview might not prove fruitful in a fragmented social system; finally, since I was interpreting and recruiting from the Physicians for Human Rights-Israel Open Clinic, I did not want patients who were seeking medical care to feel pressured to participate in my study. These layers of complexity forced me to evaluate my recruitment strategies and adapt them to this highly sensitive situation. For example, before patients arrived for the day, I posted signs in Tigrinya around the Clinic with information about the study and what room they should report to if they wanted to be interviewed. I also provided the clinicians with recruitment scripts and told them not to identify me as the interviewer, particularly if I was interpreting for their patient. I did not want potential participants to

feel *any* pressure to be interviewed - I considered each of them as if they were my own mother and wanted them to be comfortable in their decision to participate.  When participants did walk through my door, they were eager to share their experiences. I felt confident that they had come of their own volition and that I doing my best not to take advantage of a marginalized population.

Despite my efforts to avoid offense, there were times when I was harangued by community members who came into my room to vent their frustration with the system and previous researchers' inability change the institutional barriers that marginalized them. It was obvious that their frustration was justified but that there was little that could be done to change their reality without major immigration policy reform.  I was humbled and tormented by the awareness that I could do no better.  I felt both upset and inspired after these emotionally-charged encounters and I am grateful for them - they reinforced my goal of conducting research that would illustrate the connection between their individual health concerns and the state and international policies and practices that facilitate and exacerbate them.

Recruitment of participants for Phase II focus groups were difficult to assemble for the same reasons as the individual interviews, but were markedly more difficult for two important reasons. First, I was not recruiting potential participants at the Clinic but rather met with them during their free time. Asylum seekers' long and inflexible working hours in the informal sector made it difficult organize a convenient time for everyone to meet.  Secondly, in assembling group discussions, I was aware that the political polarization towards the Eritrean government (tension between those that support the Eritrean administration and those that oppose it) within the community might affect

participants' willingness to speak freely. Despite these difficulties, with the help of

community activists and researchers, eight focus group discussions were

conducted. Before the beginning of each discussion, I shared all relevant information

about my background and my study. I also shared what the limited realistic outcome of

the study would be and allowed participants to ask me any questions before beginning. I

made it clear that it was their choice to participate. Although I was once accused of being

a spy sent by either the Ethiopian or the Israeli government in order to undermine the

unity of the Eritrean community, I believe that my candor facilitated honest, dynamic and

richly detailed discussions. These conversations often began focusing exclusively on the

external political factors that negatively influenced the community and, only later when

participants felt more at ease, delved into personal and community-based problems. I

learned from this that when a community feels that their humanity is under siege because

of a failure by outsiders to contextualize their behavior within the wider framework in

which they live, they are more likely to initially highlight external causes for their

suffering than to disclose personal and community-level dynamics that may be

exacerbating their difficult circumstances.

During Phase II interviews and focus group discussions, I realized that I was

personalizing the participants' experiences because of my own community's history of

flight from war-ravaged Ethiopia in the 1980s. As I connected the narratives of my

community to the Eritreans who most recently fled the Horn of Africa, I noticed the

repetition of certain traumatizing experiences and the rawness of forced migration

became even more real to me. I was unprepared for the toll that comparing the narratives

would take on my psyche. For example, when discussing domestic violence and the

recent surge in wife-murders in the asylum-seeking community in Israel, I questioned the participants with a keen interest because I am aware of the domestic violence in my own community. I desperately wanted to understand this behavior without judgment. I concluded from my discussion with the men in my focus groups that the harshness of being forcibly uprooted from one's home and all of its corresponding consequences without a guarantee of seeing your home and loved ones left behind again, was a tremendous underlying source of their frustration and emotional intensity. While the stateless situation of Eritreans in Israel and the traumas of crossing the Sahara and the Sinai were more extreme, the fundamental dynamics were the same as those who fled Ethiopia and Eritrea thirty years ago. I learned that the challenges of forced irregular migration had both strengthened and hardened the emotions of those who endured it. After observing and processing the harsh and beautiful facets of human nature that arise in any human population under pressure, I feel more in-tune with the difficult decisions that people make in order to survive. As a result of my research and the internal processing that it triggered, certain fundamentals of human existence have become clearer to me.

After eleven months of data collection, I returned to the United States. I used the following nine months to analyze my data and write an article for the Johns Hopkins School of Public Health Magazine about my experiences interpreting for survivors of human trafficking, torture and extortion in the Sinai Peninsula. In the spring of 2014, I traveled to Ethiopia where I observed the Adi Harush and Mai Aini Eritrean refugee camps located in a remote area of western Tigray. The camps were full of Eritrean refugees fleeing deteriorating political, social and economic conditions in their

homeland. I visited the camps in order to better understand the conditions that prompt so many people to embark on the dangerous journey to Israel. The surrounding villages and towns were not much more developed than the tents and mud homes in the camps. My most surprising observation was that the camps were dynamic - full of makeshift barbershops, cinemas and stores which illustrated the power of human dignity and resilience. Talking with Eritreans living in the camps and the officials working there, I learned more about the physical endurance that traveling on foot across the Eritrean-Ethiopian border required and about the many people who died along the way, often as a result of the Eritrean government's shoot-to-kill policy on the Ethiopian border. When I returned to Addis Ababa, I met with refugee officials who told me about the physical and psychological dangers of living in the refugee camps. The harsh realities of the camps and my conversations with those that lived and worked there helped me to understand why people left and migrated to Israel, despite the known dangers involved in crossing the Sahara and the Sinai Peninsula. In addition, I attended the University of Oxford's International Summer Course in Forced Migration during the summer of 2014. Studying with scholars and migration experts from around the world helped to put the experiences of Eritrean asylum seekers in Israel within the global context of increasingly restrictive refugee policies in industrialized host countries. Learning about other countries' struggles to uphold their humanitarian obligations while maintaining their national interests, connected the situation of asylum seekers in Israel to a global phenomenon.

I returned to Tel Aviv in September of 2014 to write my dissertation in the environment in which I collected the data. Being immersed again in the African asylum-seeking community provided me with the energy that I needed to write my thesis. After

my dissertation research, my visit to the camps, and my training at the International Summer School in Forced Migration, I was able to engage on an even deeper level with the community of Eritrean asylum seekers in Tel Aviv. I noticed that the size of the community had diminished considerably because of increasingly punitive Israeli policies towards asylum seekers. Although some of my contacts and friends were now in detention facilities, I was able to locate and reconnect with people I knew from before. I learned from our shared daily activities about the political tension between the majority opposition members and those that chose to align themselves with the Eritrean administration. I also conducted formal and informal member checks with key informants and members of the Eritrean asylum-seeking community. The process of checking the results with participants, particularly women from the Eritrean community, was critical to the quality of the data. Their confirmation of the results, coupled with recommendations for policy changes, gave me the confidence to continue writing and present the findings at the International Drylands, Deserts and Desertification Conference in 2014. I was reminded of the importance of the integrity and veracity of the work that I intended to publish. I also visited the Holot and Saharonim Detention Centers in the Negev desert and learned about the conditions there. The number of Eritrean and Sudanese men confined there astounded me. I had the privilege of meeting with a group of Eritrean and Sudanese men detained there to learn more about their experiences. They explained that the detention authorities hired Tigrinya-speaking Israeli guards to gather information about them, misinform and pressure them into self-deporting. A number of the detained population had developed severe mental illness in the 8 months since their detainment. They described the solitary confinement of community leaders as a tool used

to weaken their unity and resilience. They shared that they had difficulty accepting the reality of indefinite detention. After our conversation, they invited the group I was with for lunch. As we ate the grilled meat prepared for us, I fought to more fully comprehend the fear that they experienced. Being there helped me to understand why so many asylum seekers refused to report to the facility, undertaking the risk of being arrested while hiding in Tel Aviv. I also understood why they continued to protest, even marching out of the facility and walking back towards the Sinai Peninsula.

I made two very early morning visits to municipal visa-renewal locations. Each time I saw nearly one-thousand asylum seekers in line to renew their visas as required by new legislation that mandated two months visa renewals - allegedly in retaliation for the refugee protests in January and February of 2014. The initial location was more visible which disturbed the residents of the area. As a result they moved it to a remote location near abandoned warehouses. On both occasions, they entered a fenced-in area and the guards were aggressive. The looks on people's faces were unfamiliar. They were the look of humans pushed past trauma, past exasperation and into a state of being that I did not recognize.

Despite all of the new political, legal, economic and emotional difficulties, life continued - babies were born, people laughed and worked, weddings took place. In retrospect, while I believe that my thesis research is informative, I am acutely aware of how much more there is to understand about the underlying dynamics of the Eritrean community in Israel and of the experiences of forced migrants globally.

*Tsega Gebreyesus*

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### *Figures and Tables*

# Key migration terms

The following definitions are from the glossary of the International Organization for Migration (12).

**Forced migration** - a migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes (e.g. movements of refugees and internally displaced persons as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects).

**Irregular migration** - Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries it is entry, stay or work in a country without the necessary authorization or documents required under immigration regulations. From the perspective of the sending country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfill the administrative requirements for leaving the country. There is, however, a tendency to restrict the use of the term "illegal migration" to cases of smuggling of migrants and trafficking in persons.

**Asylum seeker** - a person who seeks safety from persecution in a host country and has made a claim for refugee status.

**Refugee** – a person who has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.

**Economic migrant** – A person leaving his or her habitual place of residence to settle outside his or her country of origin in order to improve his or her quality of life. This term is often loosely used to distinguish from refugees fleeing persecution, and is also similarly used to refer to persons attempting to enter a country without legal permission and/or by using asylum procedures without bona fide cause. It may equally be applied to persons leaving their country of origin for the purpose of employment.

**Stateless person** - A person who is not considered as a national by any State under the operation of its law" (Art. 1, UN Convention relating to the Status of Stateless Persons, 1954). As such, a stateless person lacks those rights attributable to diplomatic protection of a State, no inherent right of sojourn in the State of residence and no right of return in case he or she travels.

*Non-refoulement* - policy prohibiting the return of persons seeking protection to the countries in which they fear persecution.

**Push-pull factors** - Migration is often analyzed in terms of the "push-pull model", which looks at the push factors, which drive people to leave their country (such as economic, social, or political problems) and the pull factors attracting them to the country of destination.

**Smuggling** - "The procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a State Party of which the person is not a national or a permanent resident" (Art. 3(a), UN Protocol Against the Smuggling of Migrants by Land, Sea and Air, supplementing the United Nations Convention against Transnational Organized Crime, 2000). Smuggling, contrary to trafficking, does not require an element of exploitation, coercion, or violation of human rights.

**Trafficking in persons** - "The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" (Art. 3(a), UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the UN Convention against Transnational Organized Crime, 2000). Trafficking in persons can take place within the borders of one State or may have a transnational character

**Chapter Two**

**Introduction**

## *Sociopolitical Context of Eritrean Migration*

Eritrea's independence from Ethiopia in 1991 was led by the Eritrean People's Liberation Front ("EPLF") and its leader, Isaias Afewerki, became President of the post-war interim government (13, 14). In 1995, a body consisting of members of the EPLF central committee, representatives elected by regional assemblies, major economic and social groups, women and the Eritrean diaspora worked closely with international legal experts for 27 months to draft a National Constitution which was ratified by a National Assembly in 1997 (15, 16).

The terms of the National Constitution, however, were never implemented by Afewerki and his ruling party (17). In 2001, the government asserted a de facto "State of Emergency" which it justified by the country's recent border dispute with Ethiopia (18)[i]. This State of Emergency was not approved by the members of the National Assembly pursuant to the requirements of the Constitution and, therefore, was an unconstitutional assertion of power (18). In 2003, the National Assembly was dissolved (18). Under the State of Emergency, the government abolished the Constitution's guarantees of civil protections for free speech, press, association, assembly and religion (21).

Under the State of Emergency, independent media lost their licenses, journalists were imprisoned, military conscription was extended from 18 months to indefinite periods of time, non-state sanctioned religions were made illegal, and political dissent was considered treason (13). Violators of the government's vision of the State of Emergency "are often held indefinitely without access to family members, prison monitors, or lawyers. To this day, there are no public trials and no appeals. Persons inquiring about a relative's whereabouts risk being jailed themselves" (22)[ii]. The United

States Department of State and the United Nations Special Rapporteur state that various human rights abuses have been committed by the administration including: extrajudicial killings, torture, arbitrary arrest, politically motivated disappearances, executive interference in the judiciary, detention of political prisoners and detainees, lack of due process and excessive pretrial detention, infringement of privacy rights, restrictions on press and internet freedom, restrictions on academic freedom and cultural events, corruption and lack of transparency, systematic sexual abuse of women serving in the military by commanders, discrimination of the Kunama ethnic group and limits on freedom of movement and travel (23-25). Moreover, Eritrean citizens are arrested for treason if they are suspected of actively challenging government policies (23). The nonexistence of a free press[iii] combined with the banning international agencies, including the UN Special Rapporteur, from entering the country makes it extremely difficult to determine the numbers and conditions of prisons and prisoners, military conscripts and the conditions of service, torture and direct deaths at the hands of the regime (23).

President Isaias Afeworki and his administration, however, assert that the purpose of these policies is to counter a Western-backed Ethiopian threat to the economic and political sovereignty of the nation (27). Despite the official cessation of the war in 2000, Ethiopia and Eritrea have been in a stalemate and have continued their hostilities through proxies by supporting various rebel movements throughout the Horn of Africa (19).  In 2013, however, the new Ethiopian Prime Minister Hailemariam Desalegn indicated the Ethiopian administration's interest in peace talks without preconditions (19)[iv]. From the perspective of the Ethiopian government, the resolution of the border dispute would

allow the Eritrean regime to end its de facto State of Emergency and halt the exodus of Eritreans to Ethiopia (19). Ethiopia currently hosts approximately 100,000 Eritrean refugees including, in the past seven months, an influx of over 15,000 people (19, 28). President Afeworki has turned down[v] Ethiopia's overtures for peace talks (19).

President Afeworki does not acknowledge publicly that there is a mass exodus of Eritreans seeking asylum and has referred to reports from the UN and the international media as Western fabrications intended to undermine the credibility of Eritrea's self-reliance in order to maintain western dominance in the area (27). In addition, Araya Desta, Eritrean Ambassador to the United Nations, asserted that the Eritrean administration does not extra-judicially imprison, torture or kill its citizens (29) and that the Human Rights Watch and the UN Special Rapportuer's reports to the contrary are intentionally misinterpreting information regarding Eritreans in the diaspora as a political tool to undermine the credibility of the administration (29). Desta argues that human rights abuses within Eritrea are not so extraordinary to warrant the attention of the UN Human Rights Council or the Social, Humanitarian and Cultural Committee (Third Committee) (29).

The majority of the hundreds of thousands of Eritreans have fled to neighboring countries including Ethiopia, Sudan, Israel, Egypt, and Kenya (13, 30).  A small number have reached or been resettled to the United States, Canada, countries in Western Europe, and Australia (13). According to a spokesperson from UNHCR-Ethiopia ("United Nations High Commissioner for Refugees"), since last March of 2014 an average of 2,000 Eritreans have been crossing the border into Ethiopia and have settled in refugee camps in the areas that border Eritrea (28)[vi]. The terms of the 2001 State of Emergency

forbid travel outside the country by anyone subject to military conscription (13, 14, 23).

Since military conscription extends to all men (under the age of 54) and women (under

the age of 47), (31)[vii] those who seek to leave the country are forced to use irregular

routes (31). Although Ambassador Desta, denied that Eritrea has a shoot-to-kill policy for

people crossing the border irregularly, (29)[viii] according to the UN Special Rapporteur,

Eritrean border officials have "standing orders" to shoot-to-kill those attempting to cross

the borders and an "unknown number of people" have been shot near the Eritrean borders

with Djibouti, Ethiopia and Sudan, allegedly for attempting to cross (31). There has been

a recent decline in the number of these shootings; scholars reporting to the UN, however,

state that this is due to military officials earning money by selling Eritreans captured at

the border to human traffickers (31)[ix]. There are no data regarding the overall numbers of

Eritrean women leaving the country, nor any information regarding other demographic

characteristics.

### *Eritrean migration to Israel*

Prior to 2009, many Eritrean asylum seekers migrated from Eritrea through Sudan

and then to Libya in the hopes of crossing the Mediterranean Sea to seek asylum in

Europe (33). In 2009, Muammar Qadaffi entered into an agreement with the European

Union that barred asylum seekers access to the Mediterranean Sea (33). As a result, many

people migrating from Eritrea shifted their destination from Europe towards Israel (34).

The overwhelming majority of Eritreans who arrived in Israel between 2007-2010

voluntarily entered the country through the Sinai Peninsula (35).

Until recently, there were a number of reasons why Israel was a preferred

destination for Eritreans seeking asylum.  Firstly, Israel is a close geographic neighbor.

Secondly, there is the well-founded fear of forced repatriation to Eritrea by other host countries in the region (including Libya, Sudan, and Egypt) (13, 36-38). Until recently Israel, as a participant of the 1951 Geneva Convention and its corresponding 1967 Protocol, did not practice *refoulement* (the return or expulsion of refugees or asylum-seekers to places where their lives or freedoms could be threatened) of Eritrean asylum seekers (13, 39). Thirdly, Eritreans seek to avoid encampment in countries like Ethiopia and Sudan where there are policies restricting their movement (30). Finally, Israel is considered a more hospitable economic environment (13, 40). While the overwhelming majority of Eritreans who have entered the country since 2007 do not have permission to work formally, the money earned working informally is enough to support their subsistence (40).

### *Human trafficking*

From mid-2010, however, many of Eritrean asylum seekers that arrived at the Israeli border had been kidnapped by traffickers[x] and taken to the Sinai Peninsula against their will (42)[xi]. Money earned from ransoms was the main incentive for the Sinai trafficking chain of kidnap and torture (44). The ransom demanded per captive ranged from $25,000 to $50,000, and was largely financed by family members who sold property, begged in churches, and took loans from banks and friends (44). Upon ransom payment, some captives were released (43). Others were sold to another trafficker, and still others were murdered despite payment (43). Many women who are currently in Israel were ransomed from the Sinai by Eritrean men in Israel in exchange for domestic partnerships with them (46). People were held hostage by traffickers in the region for under a week to more than a year (44). The Sinai Peninsula was the site of what the UN

has referred to as one of the most underreported humanitarian crises in the world (35). Criminal gangs operate through complex networks with impunity, and the region is fraught with serious human rights violations, torture and human trafficking (35). The experiences of asylum seekers in the Sinai have been well documented.  According to Human Rights Watch, torture techniques included but were not limited to:

> *"rapes of both women and men; electric shocks; burning victims' genitalia and other body parts with hot irons, boiling water, molten plastic, rubber, and cigarettes; beating them with metal rods or sticks; hanging victims from ceilings; threatening them with death; and depriving them of sleep for long periods. Victims are also threatened with organ harvesting"* (44).

All asylum seekers, including survivors, are driven to the Egyptian-Israeli border and told to run across to Israel (44)[xii].

## *Israel's policy towards asylum seekers*

Israel actively participated in the drafting as well as ratified the *1951 Geneva Convention,* which provided asylum to the refugees of World War II, and the subsequent *1967 Protocol,* which extended the *Convention's* temporal and geographic limitations.  Both the *Convention* and *1967 Protocol* require a host-country to provide asylum to:

> *A person who owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions; is outside the country of his nationality and is unable; or, owing to such fear, is unwilling to avail himself of the protection of that country (47).*

Under the *1951 Geneva Convention* and the *1967 Protocol*, official recognition of refugee status obliges host-states to either incorporate these refugees into the national fabric (47), provide a mechanism for them to receive refugee status in another willing host country, or provide adequate protection until it is safe for them to return home (48).

Despite the rules of the *1951 Convention* and *1967 Protocol,* the Israeli government has not set up an infrastructure to conduct a transparent, coherent refugee determination procedure for determining the individual refugee status of any non-Jewish asylum seeker (40, 49). Since 1951, less than one-percent of asylum seekers in Israel have been granted official political asylum (refugee recognition) (50). Israel's desire to uphold its international image by adhering to international law is in direct conflict with: 1) its pressure to maintain a Jewish demographic majority in the country; 2) its fear of becoming a destination country for more migrants seeking asylum; 3) its beneficial relationship with the Eritrean administration (51); 4) its relative inexperience with non-Jewish migration; 5) the internal challenges of integrating Jewish migrants from all over the world; and 6) the ongoing Palestinian conflict where "the right of return" is an issue of contention (40, 49, 52, 53)[xiii].

Informal estimates indicate that there are 35,000 Eritreans in Israel, the vast majority of whom seek political asylum (54). Until early 2013, it was impossible to assess whether Eritrean asylum seekers qualified for official individual refugee status because they were forbidden from submitting an application for the formal Refugee Determination Status procedure ("RSD") (40, 55-57). Instead they were granted a prima facie "temporary group protection status" with a conditional release from detention that allowed them to remain in the country until the Israeli government deemed it safe for them to return to Eritrea (58). All infants and children of Eritreans, including those born in Israel, have the same temporary status (59). Temporary protection status does not allow them to work legally, does not come with provisions for access to any social

services afforded to refugees under international law, and does not allow them to participate in Israel's National Health Insurance program (58)[xiv,xv].

This conflict between Israel's international treaty-based commitment to acknowledge and accept refugees and its perceived need to maintain the Jewish identity of the State is evident not only in the current administration's reluctance to determine the status of Eritrean asylum seekers, (52) but also in its negative treatment of them in public discourse, (60) and its attempt to criminalize their entry and detain them without assessing their claims for asylum (55). In addition, and in asserted violation of the principle of *non-refoulement* (defined above)[xvi], in 2012 the Israeli Knesset passed an Amendment to the *Anti-infiltration Law of 1954 (*the "*3rd Amendment")* (55). The original *Anti-infiltration Law* in 1954 was designed to prevent the re-entry of Palestinians and the entry of other Arab nationals from "enemy states" into Israel (52). The *3rd Amendment* was designed in order to detain non-Jewish asylum seekers, mainly from Eritrea and Sudan, who entered Israel irregularly via the southern border for 18 months to two years without trial (40, 49, 55). Since the *3rd Amendment*'s implementation in 2012, most Eritreans seeking entry into Israel are returned to Egypt at the newly-constructed border fence; those that are allowed in are detained in the *Saharonim* detention facility in the Negev Desert (58, 62, 63). At *Saharonim*, human rights NGOs report that detainees are offered the option of either returning to Eritrea or continued detention (58, 62, 63). As a result of the policies under the *3rd Amendment*, the numbers of new arrivals from Eritrea have considerably diminished (57, 64). In addition, the *3rd Amendment* also stipulated that irregular migrants already living in Israel were "infiltrators" that would be subject to similar detainment in *Saharonim* should they be suspected of criminal activity (39, 55,

58, 62)[xvii]. The implied, but not stated, subjects of this regulation were Eritrean and Sudanese asylum seekers (55, 65). As a result of the *3rd Amendment*, the term "infiltrator" is often used by the administration and in the media to refer to Eritreans and have incited anti-African asylum-seeking protests, some of which have become violent (52, 60).

On March 12, 2013, human rights organizations in Israel joined with the UNHCR in petitioning the Israeli High Court to rule the *3rd Amendment* unconstitutional on the grounds that persons seeking asylum were refused entry at the Israeli border and that the protracted detainment of persons seeking asylum without assessment of their claims breached international law (62). On September 16, 2013 the Israeli High Court abolished the *3rd Amendment* and required that all those detained under its terms, the majority of whom were Eritrean and Sudanese, have their asylum cases examined (55). In response to the High Court's ruling and pressure from human rights organizations, some of the detained asylum seekers were released from Saharonim and the Israeli government began allowing Eritrean asylum seekers to apply for official refugee status (55). If their applications met the criteria for official refugee status, Eritrean asylum seekers would be guaranteed almost all of the rights of Israeli citizens and permanent residents, including access to National Health Insurance coverage (49).

In an attempt to circumvent the High Court's ruling, (55) the Israeli government issued a fourth Amendment to the *1954 Anti-infiltration Law* in December of 2013 ("*4th Amendment*") (55). The *4th Amendment,* like the *3rd Amendment*, allowed for the detainment, without trial of newly arrived irregular migrants in *Saharonim* for up to one year (55). The *4th Amendment* also called for the detainment of single Eritrean men who

had come to Israel more than five years ago (prior to December 31, 2008) (55, 66)[xviii].

Under the guidelines of the *4th Amendment*, single Eritrean men who arrived in Israel

more than five years ago began receiving one-month summons to report to the newly

constructed *Holot* "open detention" facility and were subject to arrest and forcible

relocation if they did not voluntarily respond (55). Those who did respond were sent

directly to the *Holot* facility (55)[xix].

Since its opening in 2014, approximately 672 Eritrean men have been detained at

*Holot* (55)[xx]. While *Holot* allowed asylum seekers "freedom of movement," they were

required to report for check-in three times a day (55). The UNHCR stated that this check-

in requirement, combined with *Holot*'s location in the uninhabited areas of the Negev

Desert, undermined the Israeli government's assertion that *Holot* is an "open

facility"(67)[xxi]. Israeli and international human rights organization's reports indicated

that, as with the detainees in *Saharonim*, asylum seekers at *Holot* are offered money to

sign "voluntary" forms indicating their desire to return to Eritrea or go to another country

(55). The UNHCR has condemned this practice as a breach of the obligations under the

*1951 Geneva Convention* and *1967 Protocol* because the choice of detainment without

trial or leaving Israel is not a real choice (39, 55, 57, 64)[xxii].

In early 2014, in response to the *4th Amendment*, thirty-thousand African asylum

seekers staged the largest protests of migrants in Israeli history (69-72)[xxiii]. On June 27,

2014, in another demonstration protesting the *4th Amendment,* one thousand detainees,

marched out on foot from *Holot* (73). In a press release from Tel Aviv, the detainees in

*Holot* demanded: 1) a fair asylum-seeking procedure in Israel according to the guidelines

codified in the *Geneva Convention and Protocol*; 2) intervention of the UNHCR if Israel

does not process their refugee applications in a systematic, coherent and unbiased manner (73). The detainees threatened to leave Israel though the Sinai Peninsula if their demands were not met (73). Those involved in the march were forcibly taken to *Saharonim* detention facility for three months for breaking the rules of detainment (74)[xxiv]. The leaders of the hunger strike were placed in solitary confinement (74). The *4th Amendment* was overruled by the High Court in September of 2014 on the grounds that detention of asylum seekers in *Holot* breached the basic law of the right to human dignity and freedom (75). The Court demanded that all asylum seekers be released from *Holot* within 90 days (66). Right-wing parties in the Israeli Knesset are now attempting to pass legislation that would nullify the High Court's ruling (76).

The UNHCR's definition of an asylum-seeker is a person who claims to have fled persecution in their home country but whose status has yet to be definitively evaluated and determined (32). While over ninety-percent of Eritrean asylum seekers have been granted refugee status in host countries around the world, (77) only two have been recognized as refugees in Israel (56, 57). Given the high total refugee recognition rate of Eritreans, (77, 78) and Israel's refusal to provide access to a formal determination of refugee status procedure that meets the criteria of the UNHCR, (58) I will hereafter refer to Eritreans in Israel as "asylum seekers"[xxv].

The specific aims of this dissertation study are to qualitatively describe in three chapters: (1) the sexual violence experienced by Eritrean women asylum seekers *en-route* to Israel; (2) the sexual violence and exploitation faced by Eritrean women asylum seekers *living in Israel*; and finally (3) the multiple level barriers to accessing contraception for Eritrean women asylum seekers *living in Israel*.

## *Guiding frameworks*

Several models and theoretical perspectives guided me as I was collecting and analyzing data, as well as writing this dissertation. Models that proved especially valuable for my purposes were Zimmerman's model of migration and health and the McLeroy's Social Ecological Model (79, 80). Zimmerman's model, designed to frame the connection between population movements and the accumulation of adverse health outcomes within a migration cycle (79, 81-85) provided a mechanism for organizing the experiences of Eritrean women seeking asylum within the separate phases of their movement. The Social Ecological perspective, developed by sociologists and expanded by psychologists, is widely used in the field of public health (86-88). McLeroy's Social Ecological Model for behavior and health provided a mechanism for categorizing the various levels or systems of influence on Eritrean women's experiences in accessing reproductive health care (80). While there are many versions of the social ecological model operationalized in public health, McLeroy's model is often used as a basis from which to extend (89).

In addition to these models, I drew on the concepts of intersectionality and structural violence. Both intersectionality and structural violence are theoretical perspectives created by sociologists and operationalized in many fields including medical anthropology that provide a basis for interrogating power structures (90-93). Intersectionality was drawn from critical black feminist theory (90, 91) and structural violence has been operationalized in critical medical anthropology (92, 94). In line with the original objective of critical theorists, both of these theoretical perspectives reflect a multi-disciplinary attempt at "identifying with the suffering of the exploited and

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disenfranchised" (95) by understanding the systems of domination and power in which

they live (96, 97). This understanding should have the goal of "liberating" minds from

oppressive systems of thinking in order to create an impetus for change (96, 97).

Intersectionality provides a mechanism for assessing how the demographic characteristics

of an individual or group (e.g. gender, social and economic positioning) intersects with

the power structures in which they live and how this in turn creates circumstances of

vulnerability and oppression. The structural violence perspective enables an

understanding that for marginalized populations there is a "structural vulnerability" (93)

and that individual agency is constrained by a wider risk environment (98). These lenses

revealed the layers of oppression experienced by Eritrean women within the Israeli state

and society and helped me analyze how power differentials impact the political and

economic stability of Eritrean asylum seekers in their daily lives.

### *Models Guiding This Research*

- #### *The Zimmerman Model for Migration and Health*

Migration theory has focused on explaining the political, social and economic reasons

for population movement, but has not routinely examined the nexus of migration and

health. Cathy Zimmerman, Mazeda Hossain and Ligia Kiss at the London School of

Hygiene and Tropical Medicine have sought to draw attention to this oversight by

presenting a more pointed emphasis on understanding how patterns in migration

influence migrants' health (79). Published in 2011, their seminal article "Migration and

Health: A framework for 21st Century Policy-making" presented a five-stage model

describing the various health risks experienced by migrants throughout the trajectory of

their movement (79). Zimmerman's Model "lays out a migratory process framework that

highlights the multi-staged and cumulative nature of the health risks and intervention opportunities that can occur throughout the migration process, and points to the potential benefits of policy-making that spans the full range of migratory movement" (79, 99). The five stages or phases of the Zimmerman Model are: pre-departure, travel, interception, destination and return (79). This "life course" approach acknowledges the critical influence of temporality in migration health research (100).

The "pre-departure stage" is characterized by risks for negative health outcomes that a migrant experiences prior to leaving their home country (79, 83). The factors affecting risk of poor health outcomes at this stage and compounding those at later stages may include "biological characteristics, local chronic disease patterns and pathogens, environmental factors, and political and personal circumstances (e.g., human rights violations, interpersonal violence)" (79, 83).  At this stage, Zimmerman et.al argue that the health characteristics of pre-departure migrant populations vary, which in turn has implications for disparities in the health of these populations throughout the trajectory of their movement (79, 83). This stage is particularly relevant in the case of asylum seekers and refugees as their reasons for migrating might include political repression, conflict and difficult social and economic circumstances (101).

The "travel" or "transit" stage of migration in this model encompasses the time spent in between the country of origin and the country of destination (79, 82, 99).  This stage in movement is often comprised of multiple stops lasting variable periods of time. It is during this stage that many adverse experiences occur impacting health including trafficking, sexual violence, and depending on the mode of movement, certain environment-related dangers (dehydration, etc.) (82, 99). These adverse events are

particularly likely among those migrating irregularly irrespective of their reasons for movement (102). This is one of the most under-researched of all of the five stages (79) and is the subject for Manuscript One.

The "interception" stage occurs when migrants experience temporary detainment or spend time in refugee camps (79, 84). This phase is particularly relevant to the context of forced migration, as many migrants spend time in detention facilities and in UNHCR-sponsored refugee camps (30). Adverse health outcomes may occur during this time but vary depending on the context (i.e. the quality of detention facilities vary country to country) (79, 84). Detainment during this phase is one of the main predictors of negative physical and mental health outcomes in forced migrants (103, 104).

The "destination" stage of the model refers to the period wherein migrants settle temporarily or for longer periods in their intended location (79, 81). During this stage, the level of integration of migrants into the national fabric has implications for their health and wellbeing (79, 81). The destination stage is important because any adverse health outcomes are not only compounded by previous phases in the model, but it is during this time that many migrants seek care for the health problems that they accumulated throughout the trajectory of their movement (79, 81). Difficult living conditions, language barriers and prejudices (e.g. xenophobia, racism) create a complex environment that shapes the vulnerability of migrants at this stage (105). Manuscripts Two and Three concern this phase of migration.

The final stage of the model is entitled "return" (79, 85). The return stage is characterized by returning to countries of origin either temporarily or permanently (79, 85). It is a stage in which returnees introduce new pathogens into the home environment

(79, 85). During this time, migrants may experience the "cumulative toll" of the adverse health consequences of their movement, particularly in the case of survivors of human trafficking or other irregular migrants who had difficulties during their movement (79, 85). The nature of repatriation is also important to consider as those who returned voluntarily and safely have different experiences than those who were forced (85). In the case of labor migrants, this phase may also mean an improvement in health as they may return to their homeland with more resources (85). This phase may also mean a return to difficult living conditions and limited access to care (102).

In 2011, PLoS Medicine published a series of subsequent articles that explored each of these stages through the lens of a particular health concern (79, 81-85). Previous research on migrants has used the Zimmerman's model has been used to assess the health of women migrants, particularly those that have been trafficked (99). While previous research has used the Model as a frame for reflecting on violence that occurs at each stage, the model has not been used to explore the intersection of the many environments that they traverse and the demographic characteristics of women asylum seekers (106) and the combined impact on their vulnerability to sexual violence as they transit within countries and across international borders. This study seeks to follow one group of women asylum seekers as they migrate irregularly across two stages of the Zimmerman's model to assess the changes in risk to sexual violence with context.

- ***The Social-Ecological Model***
Originally developed in the field of sociology, social ecological models have been adapted and applied across numerous disciplines including the study of human behavior. The basic premise of social ecological models is to illustrate the interconnectedness of

people and their environments in a dynamic, bi-directional process (86, 87). The purpose of understanding these complex multi-dimensional interactions is to understand how they create sub-optimal conditions for wellbeing, and if so, how to change them to improve lives (80, 107, 108). The Social Ecological model is particularly important in the field of public health as it depicts the factors that influence health ranging from macro- to the micro-levels and has the potential to identify points for strategic interventions to mitigate these poor health outcomes (80, 88, 107, 108).

In the 1970s, Urie Bronfenbrenner, a developmental psychologist and professor, deviated from the original ecological framework, by creating a model incorporating the various environmental and social influences on the dynamics of relationships and child development (86, 87). He argued that in order to understand development "one must understand the ecological systems in which growth occurs" (86, 87). Bronfenbrenner's model is comprised of four environmental systems: (1) the Microsystem is comprised of the most immediate institutions and groups that directly and most immediately impact a child's development; (2) the Mesosystem refers to interactions between various microsystems in which a child lives (a group of microsystems); (3) the Exosystem or "formal and informal social structures" that do not encompass a child's immediate settings but play a role in shaping them; and (4) the Macrosystem or "general prototypes existing in a culture or subculture that set patterns for structures at the concrete level" (86, 87). The various "systems" of Bronfenbrenner's social ecological model are commonly adapted and operationalized in public health research and practice (80, 88, 107, 108). The categories of the various systems of influence vary across models but two dynamics are consistent across all iterations: (1) behavior is affected by multiple levels of

influence; and (2) individual behavior both shapes and is shaped by the wider political, economic and social environment (80, 88, 107, 108).

This dissertation draws upon McLeroy's version of the Social Ecological Model to categorize the layers of influence on contraceptive care-seeking behavior for Eritrean women in Israel(80). I applied this version of the framework because its levels aligned well with my line of thinking when developing this study, particularly related to characteristics including systemic barriers to health services, role of gender, economics, and policy (88, 107). For the purposes of this dissertation (Manuscript 3), we create a "health systems" category within McLeroy's organizational level (80), arguing that it is worthy of investigation to understand the various influences hindering access to contraception. Previous research on access to reproductive health care services for migrant women have operationalized the social ecological model in order to understand the various layers of influence on their behavior (109).

### *Critical theoretical perspectives*

In addition to the models framing the findings of the different manuscripts within my dissertation, I drew on critical theoretical perspectives to guide study design, data collection and data analysis throughout my dissertation. The term "critical theory" originally referred to the early 20th century group of German philosophers and social theorists within the Frankfurt School, who examined how the ruling class exerted its domination through the power of ideas (95). Later critical theorists, particularly in the post-modern era, were characterized by being circumspect of scientific objectivity and suspicious of language and other representations (Michel Foucault being one notable representative of this tradition) (96, 97). The term "critical theory" also has a broader

meaning in the social sciences – one that is more applicable to this dissertation – which involves contemporary dissections of the sources of power in human society, and includes more contemporary currents such as critical race theory, feminist critique, queer theory, and approaches associated with structuralism and post-structuralism (97).

Critical theory challenges the credibility of established knowledge by interrogating underlying power structures and examining how these shape observable social phenomena, including health outcomes (96). Through analyses of the status quo, critical theorists challenge normative systems and explore seemingly hidden phenomena (95). Throughout the 20th century, this theory has given rise to a number of theoretical perspectives that critique common practice with particular focus on the nexus of power, oppression, and inequality in oppressing marginalized populations (90, 95-97). The goal is to identify the societally determined circumstances that oppress individuals and groups so as to find a mechanism to liberate them from these systems of domination (90, 95-97).

Two concepts arising from critical theoretical perspectives in particular seemed most appropriate for my study: (1) structural violence; and (2) intersectionality. Throughout data collection, analysis and the dissertation writing process, these perspectives channeled my intellectual exploration of how power structures mold the lives of the some of the world's most marginalized populations. Recent research assessing the determinants of the health of immigrants in the United States has found the use of critical theories necessary for understanding the interaction between demographic factors and context (109, 110).  My hope is that this reflection on the various systems that silently and powerfully steer the life experiences of Eritrean women asylum seekers in Israel, will

provide a more comprehensive understanding of the adverse health outcomes that they incur.

- *Intersectionality*

Research has increasingly indicated a need to understand inequities in health within the framework of intersecting processes of social power relations, such as gender and class (111). Intersectionality, originally coined by legal scholar Kimberle Crenshaw in 1991, was significantly expanded on by sociologist and black feminist scholar Patricia Hill Collins (90, 91, 112). Collins argues that neither race nor gender theory is sufficient alone to understand black women in the United States and their experiences with violence and historical oppression (90). This lens was used as a means to understand the many layers of oppression experienced by black women in the United States (90, 91). In the ensuing decades, intersectionality (as a theory) helped research consider the ways in which social, cultural and biological characteristics as well as categories such as race, gender and class interact on many levels creating and/or perpetuating circumstances of injustice, oppression and social inequality (the intersection of multiple forms of oppression) (91, 112). Scholars argue that neglecting the influence of these powers has significant human costs as "those who are poorest and most oppressed by gender and other forms of social inequality" are those who experience the worst health outcomes (111).

For my purposes, this theoretical perspective provided a foundation from which to explore the ways in which society uses various descriptive categories to classify Eritrean migrant women seeking asylum which results in a multi-layered susceptibility to violence and marginalization. Previous research among immigrants in the United States called for

the application of intersectionality as a lens for understanding social determinants of their health (106, 110). The intersection of these categories creates a complex vulnerability that has many threads and is difficult to unravel. The various characteristics of Eritrean women in Israel that have implications for increasing their vulnerability while in transit and in their country of destination include, but are not limited to, their migrant status in each host country, their class, ethnicity, race, gender and religious background. These characteristics create a vulnerability to violence perpetrated within the asylum-seeking community, as well as in the external communities of the contexts through which they traverse. The intersection of various oppressions including race, gender, migrant status, class, religion and education provided the opportunity to contextualize a seemingly homogenous migration experience within the diversity of demographic characteristics and the political, economic and social contexts through which they traverse.

In this dissertation I expand on the Zimmerman Model by arguing that in seeking an understanding of the layers of vulnerability to negative health outcomes that migrants experience, one must explore the various intersections of demographic backgrounds of the movers and the variations in the local political, social and economic contexts that they traverse. This focus expands upon the model's previous application in exploring trafficking, biological pathogens, and irregular migrants, to focusing on how externally enforced systems of oppression (status and level of affluence) shift as women change locations and how these changes influence their vulnerability to sexual violence. This intersection may be useful in understanding the heterogeneity of risks to adverse health outcomes across the stages in the model. Further, I focus on the gendered nature of Zimmerman's migration model by focusing on experiences among women seeking

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asylum and the risks to sexual violence that they are at a heightened risk for experiencing while in-transit and once they have arrived in their country of destination. In my dissertation, I am also using the social-ecological model and critical theory, which expands upon the model's previous applications.

- ***Critical Medical Anthropology and Structural Violence***
  Critical medical anthropology is considered a blend of critical theory and practical ethnographic approaches in understanding the effect of social, political and economic inequality on the health of populations (113). The political economy of health is a core concept within critical medical anthropology that explores the role of policy and wealth in determining access to health care services (114). Largely influenced by Merill Singer, critical medical anthropology focuses on identifying (through research) ways in which the situation of research participants can be improved (114). Critical medical anthropology is defined as:

> … a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction between the macrolevel of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular folk beliefs and actions, the microlevel of illness experience, behavior, and meaning, human physiology, and environmental factors (114).

This theoretical lens acknowledges the impact of the wider social environment on individuals experiences with health and illness while simultaneously understanding the role of individual agency (113, 114). Structural violence, commonly used in public health, arises from a critical medical anthropological approach.

Originally coined by John Galtung in 1969, the term "structural violence" refers to the direct and indirect legal, historical, political and economic structures and forces that limit the agency of the poor (groups or individuals) (92, 93, 115). The extreme consequences of structural violence with seemingly intangible causes increases the

likelihood that the most vulnerable who are powerless to effect macro-level change will continue to suffer silently and those with the political and economic power to effect change, ignore these intangible root problems (92). In the case of migrants, these unseen forces rooted in increasingly restrictive immigration policies may include social stigmatization, dangerous living conditions, and the climate of fear and suspicion (116). This theoretical perspective has become well-known in recent years due to the work of medical anthropologists including Merill Singer, Nancy Shepherd-Hughes, Philippe Bourgois and Paul Farmer (93, 94, 115, 117).

This lens provided a foundation for understanding the often-limited individual and community level agency of Eritrean asylum seekers. This framework highlighted the importance of acknowledging the direct violence perpetrated against Eritrean women en-route to and in Israel, as well as the indirect "built-in" or structural violence that they were subject to throughout their movement. For example, in Manuscript One, understanding the experience of sexual violence of an Eritrean woman en-route to Israel there are two levels of violence to consider. There is both the direct violence perpetrated by smugglers, rapists, traffickers, bandits, and fellow migrants, and the structural violence of deteriorating conditions in their home country (chronic wars, history of colonialism, political repression) and their marginalization within transit countries (immigration policy, level of governance of areas, marginalization of particular ethnic groups involved in smuggling and trafficking). Manuscript Two uses the experiences of direct violence to explore the structural violence due to political and economic exclusion in Israel (legal limbo status, no access to formal work sector, detainment policy, no access to social welfare system). Manuscript Three explores marginalization within the

health care system to understand structural barriers to careseeking that are rooted in

policy (no access to the national health insurance program, legal limbo status,

unaffordability of other options including private insurance).

# Chapter Three

## Manuscript One: Sexual violence experienced by Eritrean women asylum seekers en-route from Eritrea to Israel

*Abstract*

**Background**

Eritrean women asylum seekers face a considerable risk of sexual violence as they migrate irregularly from Eritrea to Israel.

**Methods**

Thirteen in-depth interviews and 8 focus group discussions were conducted with men and women of reproductive age from the Eritrean community in Israel.

**Objective**

This qualitative study investigated the circumstances of risk to sexual violence.

**Results**

All men and women participants had migrated irregularly between 2007 and 2012 and had either personally experienced, witnessed, or heard of sexual violence during the journey.  Perpetrators included traffickers and bandits as well as fellow migrants.  Lack of legal status and its corresponding institutional support created the circumstances of risk in which women found themselves.  Irregular movement created a dependency on human smugglers and made women asylum seekers vulnerable to trafficking.  The need to move clandestinely both created and perpetuated the normalization of sexual violence throughout the journey.

**Conclusion**

Risk for sexual violence among Eritrean women asylum seekers migrating irregularly may vary not only according to context but also by the intersections of women's legal status and the financial and social resources available to them throughout their movement. The theory of intersectionality, which posits that the intersection of

gender and power is critical to understanding the experience of marginalized populations, elucidated the heterogeneity of experiences within the "travel stage" of Zimmerman's model for migration and health. An examination of the cyclical and cumulative phases of movement enabled an understanding of the intersections of characteristics that lead to inequality. This combination allowed for a more inclusive interpretation of the experiences of women themselves and the risks they incur.

## *Introduction*

According to the United Nations High Commissioner for Human Rights, a large proportion of migrants endure human rights violations, discrimination, and exploitation throughout their migration experiences (118). Asylum-seeking migrants are particularly vulnerable to abuse due to the often irregular nature of their movement, the breakdown of traditional forms of protection and support, and an inability to avail themselves of the protection of their home country (119). While the percentage of asylum-seeking migrants is unknown, research indicates that female asylum seekers, in particular, suffer a heightened risk of sexual violence (30, 120-125).

Estimates from 2012 indicate that 5,000 of 35,000 female asylum seekers in Israel are from Eritrea (54). While the overall number of Eritrean women seeking asylum is unknown, according to UNHCR estimates, approximately 4,000 people flee Eritrea for Ethiopia and Sudan each month (13, 30, 126). Since the implementation of a de facto State of Emergency in 2001, the ruling party in Eritrea has become increasingly authoritarian with a zero-tolerance for any form of opposition (13, 14, 23, 127). The terms of the 2001 State of Emergency forbid travel outside the country by anyone subject to military conscription (13, 14, 23). Since military conscription extends to all men (under the age of 54) and women (under the age of 47), those who seek to leave the country are forced to use irregular routes (31). According to the UN Special Rapporteur on Eritrea, human rights violations occurring in Eritrea include extrajudicial killings, torture, arbitrary arrest, obligatory conscription into the military for indefinite duration, incommunicado detainment, and detainment without due process (23). The regime has expelled international nongovernmental organizations, closed its main institution of

higher learning (the University of Asmara), and persecuted anyone who challenged

government policies or did not belong to the four state-sanctioned faiths (Eritrean

Orthodox, Roman Catholic and Lutheran churches, and Sunni Islam) (13). In response,

more than 200,000 Eritreans have fled the country since 2004 (30, 45).

We draw on a framework for health and migration to contextualize the sexual

violence perpetrated against Eritrean asylum-seeking women on their journeys. The

guiding framework for this paper is Zimmerman's model (See Figure 1) (128) which

depicts a migratory process with multiple stages resulting in cumulative threats to mental

and physical health (79).
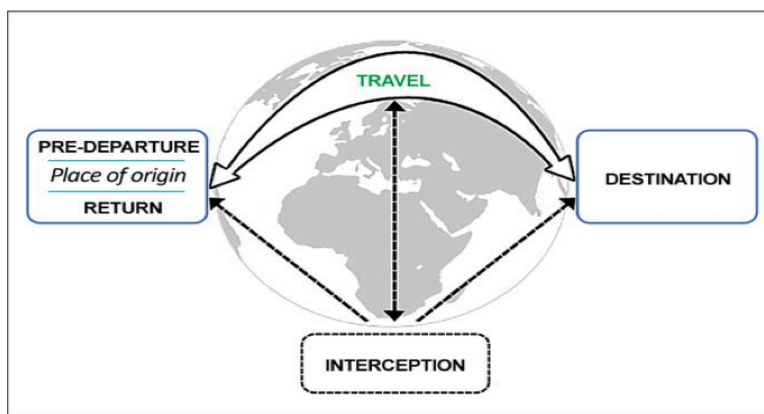


**Figure 1.  Zimmerman's Model**
*Source:* Zimmerman, 2011

It highlights the importance of conceptualizing contemporary migration as a complex

"multistage cycle that can be entered into multiple times, in various ways, and may occur

within or across national borders"(79). The model outlines five stages: 1) pre-departure;

2) travel; 3) destination; 4) interception; and 5) return (79). Zimmerman argues that

clarity about the events at each stage is critical to understanding the cumulative effect of

all experiences on health and strategizing appropriate interventions (79).

Within the field of migration and health, the travel stage is one in which many female migrants experience sexual violence and has been one of the less researched periods within the migration experience (79). Previous research has been mainly limited to situations of human trafficking, experiences during war, or situations occurring in refugee camps rather than focusing on experiences during flight (79, 99, 123, 124, 129-133). This paper uses qualitative methods to explore the sexual violence perpetrated against Eritrean asylum-seeking women as they traveled between Eritrea, their country of origin, and Israel where they sought asylum (79).

## *Methods*

The data for this study was comprised of two phases of data collection. Phase I included individual interviews with 25 key informants conducted from January 2013-April 2013. Phase II consisted of 12 individual interviews (with 6 men and 6 women) and 8 focus group discussions with Eritrean community members conducted from April-September 2013. This paper is based on both one interview with an Eritrean activist from Phase I and the 12 interviews and 8 focus group discussions (N=44) with Eritrean community members.  Interviews and focus groups discussed participants' perspectives on Eritrean women's vulnerability to sexual violence and exploitation en-route to and in Israel in addition to other topics not relevant to this paper. Ethical approval was obtained from Johns Hopkins University, Ben Gurion University and the Physicians for Human Rights – Israel Open Clinic.

### *Participants, sampling and procedures*

Phase I and Phase II individual in-depth interviews lasted approximately 1.5 hours and 2 hours, respectively. The first author conducted 21 of the 25 interviews with Israeli

participants in English with the help of a research assistant. The first author conducted

the remaining four alone. Some key informants used Hebrew when necessary, which was

then translated by the research assistant. In order to be eligible, Phase I participants had

to be over 18 years of age. Participants from Phase I were recruited from a list of

potential participants provided by various domestic and international NGOs, the Ministry

of Health, private clinics and Ben Gurion University. Participants from Phase II were

recruited from the Physicians' for Human Rights – Israel "Open Clinic" (134). The

"Open Clinic" was identified in preliminary ethnographic mapping of locations where

Eritrean asylum seekers frequently use reproductive health care services. Staff was

provided with verbal information about the study and recruitment scripts were translated

to English (from Tigrinya) for the staff to understand. Signs describing the study were

posted in the clinic. The first author conducted all interviews with asylum seekers in

Tigrinya in a private room in the facility. Oral consent was obtained before data

collection began. All participating asylum seekers were aged 18 to 49 years. Phase I key

informants provided written consent and asylum-seeking participants in Phase II provided

oral consent.

FGDs were held separately for Eritrean women and for men and lasted between

one and three hours. Initial participants were recruited via snowball sampling (135) as

well as through contacts with community activists, researchers and staff at the

Physicians' for Human Rights-Israel Open Clinic (purposive sampling) (135). The FGDs

were conducted in locations that were considered appropriate and safe by the participants

and organizers; they included back rooms in participants' stores, homes and (135) NGOs'

meeting rooms. Due to suspicion rooted in the threats of detainment and deportation, as

well as internal political tensions within their community, natural grouping methods (allowing a recruited participant to select 4-8 others to participate in a focus group discussion) were employed (136, 137). Recruitment for individual interviews and focus group discussions ended after reaching data saturation (138).

*Instruments*

The data collection instruments for the 25 key informant in-depth interviews were: (1) structured questions regarding basic demographic information as well as familiarity with the Eritrean community and; (2) open-ended questions exploring perceived barriers to contraceptive careseeking. The data collection instruments for the 12 individual in-depth interviews were: (1) structured questions regarding basic demographic information, migration histories and barriers to contraceptive careseeking after arrival in Israel and; (2) open-ended questions exploring vulnerability to sexual violence and exploitation en-route to and in Israel, barriers to careseeking, and the challenges of life in Israel. The data collection instruments for the 8 focus group discussions included: (1) a basic demographic questionnaire and; (2) open-ended questions exploring sexual violence and exploitation en-route to and in Israel as well as norms regarding fertility and family planning. This paper will focus on all data regarding the sexual violence and exploitation of Eritrean women en-route to Israel.

*Analysis*

Qualitative interviews were digitally recorded using hand-held recorders. They were subsequently transcribed directly from Tigrinya into English by a team of transcribers fluent in both Tigrinya and English. While the coder was fluent in Tigrinya, to assure full

understanding of context specific references and regional dialects, transcripts were translated into English.

Open coding and memo writing was employed for the first reading of Phase II transcripts. Subsequently, focused coding of transcripts was conducted. Axial coding of focused codes led to themes described in the paper. During the process of coding, written memos were used to inform the conceptual development of codes and themes (139). Textual data were coded and analyzed using Atlas.ti as well as manually. Member checking with a small sub-sample of the participants provided an opportunity to share findings with those affected by the research in order to ensure that the study's results were correctly interpreted (140). Information regarding the six women from the in-depth interviews is reported in Table and information on the six men is reported in Table 2 below.

**Table 1. Demographic characteristics from Tigrinya Female IDIs**

| | Participant 1 | Participant 2 | Participant 3 | Participant 4 | Participant 5 | Participant 6 |
|---|---|---|---|---|---|---|
| **Age category** | 21-25 | 26-30 | 26-30 | 26-30 | 21-25 | Under 20 |
| **Place of birth** | Adi Keyih | Asmara | Dekemhare | Asmara | Sanafe | Elabereet |
| **Marital Status** | Married | Married | Divorced | Single | Married | Married |
| **Parity** | Yes | Yes | No | Yes | Yes | Yes |
| **Travel alone** | Yes | Yes | Yes | Yes | No | Yes |
| **Countries traversed** | Sudan (3days) Egypt (3 wks) | Ethiopia (3 mos), Sudan (9 mos), Egypt (9 mos) | Sudan (1.5 mo), Egypt (1 wk) | Sudan (2 mos), Egypt (2 mos) | Ethiopia (4 mos), Sudan (1 mo), Libya (2yrs), Egypt (2 | Sudan (4.5 yrs), Egypt (3 wks) |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | mos) | |
| **Education** | Secondary | Middle School | Secondary | Secondary | Middle School | Secondary |
| **Occupation in Eritrea** | Student | Student | Teacher | Student/soldier | Farmer | Student |

**Table 2.  Demographic characteristics from Tigrinya male IDIs**

| | Participant 1 | Participant 2 | Participant 3 | Participant 4 | Participant 5 | Participant 6 |
|---|---|---|---|---|---|---|
| **Age category** | 31-40 | 21-25 | 21-25 | 26-30 | 18-20 | 26-30 |
| **Place of birth** | Adi Cha3 | Khartoum | Sanafe | Asmara | Sanafe | Adi Geble |
| **Marital Status** | Married | Single | Single | Single | Single | Divorced |
| **Parity** | Yes | No | No | No | No | No |
| **Travel alone** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Countries traversed** | Ethiopia (15 days), Sudan (1 yr), Egypt (1 day) | Sudan, Egypt (1 wk) | Ethiopia (1 month), Sudan (15 days), Egypt (3 wks) | Sudan (6 mos), Egypt (6 mos) | Ethiopia (1 mo), Sudan (1 mo), Egypt (1-2 days) | Sudan (5 yrs), Egypt (2 days) |
| **Education** | Middle School | Secondary | Secondary | College | Secondary | No formal education |
| **Occupation in Eritrea** | Soldier | Student/taxi driver | Student | Business owner | Student | Farmer, harvester |

## *Results*

All individuals, whether individually interviewed or members of a focus group,

who discussed sexual violence against Eritrean women refugees reported hearing about,

witnessing, or personally experiencing sexual violence en-route to Israel. Overall,

participants reported that sexual violence in transit was prevalent and had become an expected risk of Eritrean migration to Israel. Because there were four individuals (one selected from Phase I, and three selected from the 12 individual interviews in Phase II) whose detailed descriptions of experiencing or witnessing sexual violence in transit exemplified the information presented in the FGDs and individual interviews, we focus on their experiences as representative accounts. We quote these four participants extensively as well as report how their accounts were corroborated by the other Eritrean community members (9 remaining individual in-depth interviewees and during the 8 focus groups).

Brief narrative histories of the four highlighted individuals are provided below as case examples (See Table 1 in the appendix for additional information.) Their narrative histories collectively include common factors that appear in the migration histories of other study participants: illegal departures from Eritrea, use of smugglers, vulnerability to traffickers, time in refugee camps in Ethiopia and Sudan, exposure to bandits, and crossing of the Sinai Peninsula where human traffickers have established torture houses. The two men quoted in this paper did not personally experience the sexual violence described. Thus the information that they provide must be read and interpreted with the knowledge that they are third-party voices. The two women that are quoted alternate between first and second person narration. The second-person narration may be used as a tool for distancing themselves from the trauma of the violence that they were threatened with, or they personally incurred.

Thereafter, results are organized according to the chronology of the participants' migration to Israel. This migration process itself can be sub-divided into three stages:

departure from Eritrea; transition through Sudan; and transition through Egypt to the Israeli border (See Figure 2). Distinct factors increasing women's vulnerability to sexual violence came into play at each stage.



**Figure 2. Map of one of the typical routes illustrating Eritrean migration to Israel**
*Source:* Human Rights Watch, 2014

*Narrative Histories:*
Kibrom *was a young man in his late twenties who fled Eritrea in 2008. He crossed the Eritrean-Sudanese border alone. One of his six months in Sudan was spent in the Shegerab refugee camp. He decided to leave and paid a smuggler to take him to Israel along with a group of other Eritreans and some Ethiopians. During his journey, he was robbed by bandits, imprisoned by Sudanese authorities, and finally kidnapped and trafficked. He remained in the torture houses in the Sinai Peninsula for six months. During this time he witnessed considerable violence, including sexual violence, perpetrated against asylum seekers. He arrived in Israel in early 2012.*

Fana *was a single mother in her late twenties. She had crossed the Ethiopian-Eritrean border with her sister who died of illness along the way. She spent a brief period in Shemelba refugee camp in northern Ethiopia before she paid a smuggler to take her to Sudan. She remained there for nine months until she again paid a smuggler to take her to Israel. She was sold by the smugglers to traffickers en-route to Egypt. She spent three months in Egypt but would not describe her time there. It is unknown as to whether or not she experienced torture in the Sinai Peninsula. She arrived in Israel in 2010.*

*Tsion was a mother in her early twenties who fled forced military conscription in Eritrea. The first time she fled, she was caught and imprisoned, but the second time she was successful. She spent one year and five months in Shegerab refugee camp before moving to Khartoum where she spent another year. She eventually paid a smuggler to guide her to Kassala and then to Israel via the Egyptian Sinai where she remained for three months. She herself did not indicate any personal experience with sexual violence, however she was aware of fellow asylum seekers who were victimized. She came to Israel because she heard it was a safe place for Eritreans. She arrived in Israel in 2012.*

*Fitsum was a 32 year-old man who fled from Eritrea because he was sought by the government for questioning their policies. He crossed the border from Eritrea to Ethiopia. After a brief stay there, he paid a smuggler to take him north towards Israel where he sought political asylum. He is a community activist in Israel and spends his free time advocating on behalf of his community there. While he did not report having experienced or witnessed any sexual violence during his migration experience, he has heard many reports of violence from victims through his work as a translator for women in his community (in detention centers and hospitals). He arrived in Israel in 2008.*

### Stage 1: Leaving Eritrea

- **Repressive government and illegality of emigration**

Many participants explained that, because emigration from Eritrea is illegal for the overwhelming majority of youth, Eritrean asylum seekers, particularly those not living in the border regions, depend on smuggling networks to leave Eritrea and reach Ethiopia and other countries in the region where forced repatriation is not a concern. All of the 56 individual and focus group participants used smugglers to reach Israel. Smugglers move Eritreans asylum seekers clandestinely across Sudan, Libya and Egypt as they are all countries known for sending or attempting to send Eritreans back home if they are caught (36-38, 141).

Many individual interviewees and focus group participants reported an explicit fear of forced repatriation to Eritrea from Sudan and Egypt. Kibrom describes this fear during his imprisonment in Sudan:

> *"It [prison] was a small place and they put us all together. There they [Sudanese authorities] just beat us with metal ... a woman fainted because she couldn't handle the suffocation and so did everyone else ... They [Sudanese authorities] told us Eritreans are*

*going to go back to Eritrea and Ethiopians back to Ethiopia she said this to us. We [Eritreans] said we would rather die in prison." (Kibrom)*

Tsion stated a similar fear of capture and forced repatriation from Sudan:

*"It is partly luck… Those that took another route than we did, those that were in the car before and after me, were sold and trafficked to the Sinai. Those that were released were taken to Egyptian prison and were sent back to Eritrea." (Tsion)*

Many participants reported that the dependence on smugglers to negotiate these routes and avoid repatriation increases vulnerability to sexual violence for women asylum seekers who are a distinct minority in the asylum-seeking groups (30). Fana describes:

*"If you are passing the countries irregularly it is a matter of life and death. That is it. That is the only thing you think of when you are traveling this way. Who would help you? For instance, if a smuggler and I don't make a deal to finish what we started, no one else is going to help us asylum seekers since we are crossing irregularly…we depend on them." (Fana)*

The smuggling network often also puts women at risk for sexual violence, in many points of transit. Tsion explained:

*"Yes we paid people to take us. They were men. Women face problems with the men that guide them … In general, the men smuggling us will be forcing girls to have sex at some point along the journey." (Tsion)*

### Stage 2: Sudan

- *Absence of legal recourse and institutional protection*

While all participants reported the risk of sexual violence by smugglers in Sudan, four individual interviewees and one focus group explicitly explained that whether asylum seekers were in the desert, in refugee camps, or even in cities like Kassala in Sudan, there was a general sense of an absence of legal recourse and institutional protection. This put women at the mercy of the Rashaida, a nomadic group with citizenship in Eritrean and Sudan who play a large role in the chain of human trafficking and extortion of Eritrean asylum seekers (30). The instability due to a history of political, social and economic marginalization of the inhabitants in the border area between Eritrea

and Sudan has bred an atmosphere in which illegal smuggling activities and sexual

violence can occur without repercussions (30).  Kibrom described this situation as

follows:

> *"Even though it is technically illegal to commit the crimes that many smugglers and traffickers commit in Sudan, it feels as if there is no law there.  Even if you kill a person there you can be released by paying money. Initially crossing from Eritrea to Sudan, I didn't know the language… I didn't have anybody else… I didn't know the roads. I was alone three days and three nights.  It amazes me now that I survived [laughs].  I was thirsty, I was starving and it was very hot…I learned later that there was a simpler path I didn't know the road…by the power of God the Rashaida traffickers didn't kidnap me.  I was sure to dress like them so that I blended in…I felt like I was living in a movie.  I wanted them to think that like them I had a knife to protect me - they have a knife.  Every time the traffickers called to me I ignored them, I prayed and I kept walking." (Kibrom)*

Fitsum reported an actual instance of sexual violence that he learned of from a woman he

knew at this stage of movement:

> *"There was a woman that I met… she was a famous athlete back home in Eritrea.   When she was crossing the border from Eritrea to Sudan alone, she was kidnapped by the traffickers, by the Rashaida, and taken a few miles from Kassala.  She was kept there for one month.  They raped her many times and sometimes in a group also. Then they burned her hand; her hand is still burnt. She is a very courageous woman, the way she speaks, the ways she - she's an amazing woman." (Fitsum)*

All of the participants who discussed the conditions in Sudanese refugee camps

reported that there was an absence of legal recourse and institutional protection even in

the refugee camps as the authorities themselves were not trustworthy.  These participants

explained that generally, smugglers take new Eritrean arrivals from the border directly to

the Shegerab or Wadi Sherife refugee camps in eastern Sudan where they can be

registered with United Nations High Commissioner for Refugees (UNHCR). While

described as relatively stable in comparison to life in the desert areas, life in the refugee

camps was also considered unsafe.  Kibrom explained:

> *"I stayed for a month in the camp, I saw the situation.  The refugees they are struggling. There is a problem with getting enough food to eat, language barriers and financial insecurity. Even worse there are the Rashaida traffickers in the area looking for people*

*to kidnap. You can't go to the police if you feel threatened because the police themselves are thieves. Life was so difficult, I decided to leave for Khartoum." (Kibrom)*

Tsion confirmed through her experience the insecurity of life in the refugee camps:

*"We have to be hidden. If the Rashaidas traffickers spot you, you will be kidnapped they would eventually traffic [rape and extortion for women]. They are always searching and spying, studying whether you are alone or not. They don't care if it is a woman or a man. They spy on you. All they care about is how much money they can make out of you. After a year and a half in the refugee camp, I left for Khartoum." (Tsion)*

A few participants explicitly reported that one of the reasons Rashaida traffickers target certain Eritreans is the assumption that they have access to strong networks abroad that provide them financial support. Because Sudan forbids Eritrean asylum seekers from leaving the refugee camps (30), those who have left have found themselves in yet another situation without legal and institutional protection. Those who leave were reported to be prey to traffickers and smugglers constantly on the lookout for refugees trying to escape. Because of the risk of kidnap by traffickers, many women reported a fear of being captured tortured and raped if they leave the camps. Kibrom said:

*"I didn't tell anyone in the camps that I was leaving for Khartoum because I knew they would fear for me. There are many dangers on the road. When I finally decided to pay a smuggler to guide me, I was so scared to trust the broker who organizes the smuggling. If he wanted to do something terrible to me, he could. I didn't blend in with them so they can do anything they want. There were nine women with us. We were afraid for ourselves so you can imagine how the women felt. We always kept them in the middle of us men to protect them from being taken and raped. They, my friends in the camp, were right --I would see many horrors on the road." (Kibrom)*

Tsion reinforced Kibrom's description:

*"In order to get there [Khartoum] you take a boat. Otherwise it is by bus. Honestly it is even more difficult than crossing from Eritrea to Sudan. You get hanged [by authorities] if you get caught. Whatever papers they give you if you are a refugee... you are restricted. It makes it difficult to live so you continue on your journey and it feels like every country becomes a transit country...Most people get caught when they get off the boat because there is a 30 minute walk to get to where the bus is... that is where most people get caught...so you have to be lucky at that point because if you get caught, especially by traffickers, they will torture and rape you and send you to Egypt." (Tsion)*

Many Eritreans traveling directly from Eritrea to Israel transit through the Sudanese city of Kassala (30). Individual and focus group participants who described their time there depicted Kassala as the place where the trafficking chain of torture and extortion that ends in the Sinai Peninsula began. While asylum seekers attempt to pay larger sums to ensure their safety, Tsion concluded from her experience that, contrary to her assumption that money was decisive, chance more than financial backing determined a woman's risk of kidnapping and sexual violence:

> *"When you are leaving from Khartoum, all of the people get together and you get into a car that is going to take you to Kassala and there is another car that will take you to Egypt. So on our journey there were more men than women but we were all Eritrean and it was fine and we got to Egypt safe and I got to Israel safe. I made sure that the smugglers I paid would ensure that there wasn't kidnapping and rape. There was another car that left before us. I was there when they left and on the road they changed cars and the Egyptians sold them for a lot of money. When it comes to kidnapping and rape it depends on your luck." (Tsion)*

Contrarily, Fitsum conveyed the narrative he learned from an Eritrean woman in which finances determined a woman's vulnerability to sexual violence:

> *"Her friend recommended the same smuggler who helped her escape to Sudan. He told her "If you want to go by car, you have to pay 40,000 nakfa [Eritrean currency]. But if you are on foot, I can take you for 20,000 nakfa." ... When they reached Kassala he [the smuggler] took her phone and began chatting with someone ... she didn't understand everything. Suddenly, Rashaida came with a Toyota pick-up truck and put her in the truck. Just a few miles from Kassala. They have a torture camp. They tortured her, and they raped her and everything. Finally, she paid $30,000 and also her friend, she paid $30,000. They threw her near the refugee camp when she finally paid." (Fitsum)*

The majority of participants at this phase of the journey feared being abandoned by smugglers and attacked not only by traffickers including members of the Rashaida ethnic group, but also by bandits and sometimes even fellow asylum seekers. Tsion reported being abandoned by smugglers in the desert due to mishaps on the road:

> *"I was seven months pregnant at the time ... What was most difficult for me however was when our car burned down in Port Sudan. The smugglers took the car to have it fixed and left us there. There were 47 of us. They forced us to hide in the sand and we stayed*

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*there buried so that the Rashaidas [Rashaidan traffickers] didn't kidnap us because they would sell us." (Tsion)*

Tsion continued to describe instances where women were raped by bandits that roamed the area. Kibrom described his journey north with thirty people packed into a pickup truck. When one of the smugglers died during the journey, the remaining smugglers forced the migrants out of the truck and told them to wait in the desert while they buried their friend in his ancestral home. At their stopping place, skeletons littered the ground. The smugglers warned that the asylum seekers would meet the same end as their countrymen if they fled. Kibrom described the subsequent attack by bandits and his observation of sexual violence:

> *"Days later [after being abandoned by smugglers], a truck of Sudanese men drove by. Everyone ran. One of us died in the escape. All of the others were captured and returned at gunpoint. After recollecting the migrants, the bandits brought forward eight migrant women and raped them in front of everyone. They tore a baby off of his mother's back, threw the baby in the sand and raped the screaming mother in front of her child and husband. They raped a teenage girl in front of her cousin and brother. She was only seventeen and such a beautiful little girl. As they raped her, her family prayed the bandits would not impregnate her. The women were screaming but the bandits had weapons. I felt so powerless with the guns pointed at us. They raped them all in front of us…in front of us…Of all of the traumas I would later face, this experience stands out in my memory. There wasn't a saint's name we didn't call out to… we sat there, all of us holding back tears. After it was over, the mother of the child tried to lighten the atmosphere by making a joke. She said she should have taken contraception before leaving home ... We were afraid to be sent back to Eritrea. We sat in silence, unable to look at one another." (Kibrom)*

Fana described her own experience with rape on this phase of the journey:

> *"I did not experience force until we were on our way to Egypt where the traffickers hit my head with a metal pole. They stopped our truck in the middle of the desert to rest. It was then that they called for me. They wanted the darker woman to sleep with they said. The other women gave me up to him because they feared for themselves. There were six of them. He took me and told me to remove my pants. I told him to shoot me with a bullet. I told him that bullet would cost him his job [she is indicating that she was valuable to the other traffickers as a purchased commodity]. It was then that he grabbed a metal pole and hit me over the head and left me for dead." (Fana)*

Fana continued to describe her perspective on the experience of a woman she knew who was raped by a fellow asylum seeker.

*"A woman named Selam was among us. One of the Eritreans with us was a bad man.
He was unable to get into the Sinai with us because he angered the traffickers. He was
one of us but he decided to partner with them [the traffickers]. He was using the work to
pay the cost of travel. The money he brought was lost because he gambled it away. He
knew Selam back in Eritrea and ended up raping her on the road. She was alone when
he raped her. She got pregnant and she had an abortion when she got to Israel." (Fana)*

### Stage 3: Egypt and the Israeli border

- ### *Systematic sexual violence in torture houses*

All participants (first, second and third-party voices) explained that sexual

violence occurred in the Sinai Peninsula. After 2010, if asylum seekers were captured by

traffickers, they were kept in torture houses in the Sinai until ransoms were paid (44, 45).

These torture houses were locations in the Sinai Peninsula, primarily operated by certain

members of particular Bedouin tribes living there, in which African asylum seekers have

been tortured and extorted for ransoms since 2010 (44, 45). The type of torture includes

but is not limited to burning with boiling plastic, electrocution, forcing captives to torture

one another, starvation, beatings, sexual abuse, stringing captives by rope from ceilings,

and the extraction of organs (44, 45). Many participants explained that women,

particularly those who were unable to pay their ransoms in full, were subjected to sexual

violence during this time. Kibrom, who provided the most detail about rape in the Sinai

torture houses, described his own observation of sexual violence in the torture houses:

*"I remember a girl named Lucia who aborted a baby when she arrived here. There were
two of them together with us in the torture camps an aunt and her niece. One was 18
years old and the other was 14. We called the little one mimi or kid because she was so
young. These women were related to one of the Eritrean smugglers who had arranged to
have them cared for…he called and told them that the women were family and not to
touch them… they [the traffickers argued with the Eritrean trafficker based in Israel who
was the women's relative] got into a disagreement later on because he [the Eritrean
trafficker and relative] didn't pay them [the other traffickers in the Sinai] their
money…you know what they [traffickers based in the Sinai] did? The guards took them
into a separate room and raped them. We screamed because the boss does not want the
guards raping, he just wants money. So we told the women to scream if something
happens but they didn't. So we screamed and screamed. After he raped them, he yelled
at us, took them to another room and continued to rape them repeatedly." (Kibrom)*

Individual and focus group participants that described the Sinai torture houses stated that

sexual violence took many forms.  Kibrom explained that at times women in the torture

houses were forcibly taken as wives of the traffickers:

> *"There were eighty of us that arrived together.  Sara was already a captive there.  She was trapped there for a long time because she did not pay her ransom.  She was raped and tortured for many months.  Finally one of the traffickers decided he loved her and would pay her ransom of $35,000.  She was afraid so she agreed to be his wife.  She became his wife for three months and traveled all over the Sinai in new clothes with him.  One day they quarreled with his brother over her and they decided to put her back in the torture house with us.  Once again she was strung from the ceilings, beaten, raped and tortured.  She got pregnant.  There are many others like her who also get pregnant."(Kibrom)*

Fitsum also described scenarios in which women paid their ransoms in full but were

taken as wives of the traffickers anyway:

> *"It is true that those who do not have help, they can end up stuck- but I want you to know it is not only those women who get trapped.  Women with money do too. There was a woman who paid a $64,000 ransom but the traffickers didn't want to release her. I don't know the criterion for putting women there but sometimes they just keep them there to be their wives, to clean their surroundings and forced labor and all the stuff. She said, "I paid this money and they didn't want to release me." Paying your ransom doesn't mean you get out of the torture camp…It's not a … they don't choose. Having money doesn't always mean you will get out if you're a woman. If you're a man, for sure, you're going to get out... but if you're a woman, sometimes you can be kept there to be their [traffickers] wives." (Fitsum)*

Kibrom explained that the systematization of sexual violence in the torture houses

extended to forced sex with other captives:

> *"We were chained together men and women.  At times the guards would come in and order the men to have sex with the woman that they were chained to… we were threatened with torture…they [the guards] would tell us 'you are all going to sleep with her [a fellow captive].' They would tell us that all of us were going to sleep with her. It's by force. You don't do it willingly. If they threaten you with a wire…you're going to do it. I remember this happening to one woman who was tied between two guys. We even had to use the bathroom [men and women] while chained together.  This forced sex happened to her." (Kibrom)*

Some participants reported that sexual violence continued as long as women were in the

control of traffickers, even en-route to the border with Israel.  Kibrom stated:

*"Once you are freed, the traffickers give you a ride to a certain point on the border and drop you off. It was three women and three men. They wanted to take the women alone with them but we said no. We said they were our wives and that we wouldn't allow it."* (Kibrom)

## *Discussion*

Our principal unexpected finding is that risk for sexual violence among Eritrean women asylum seekers migrating irregularly changes with context, even within a single stage identified by Zimmerman's model. It is therefore necessary to "unpack" Zimmerman's travel stage using the critical theoretical lens of intersectionality in order to depict the heterogeneity of experiences within this stage of migration. We have established that risks during the travel stage may vary not only according to context (e.g. whether migrants are crossing borders or in ungoverned territory) but also according to the intersections of women's legal status and the financial and social resources available to them throughout their movement. Zimmerman's model provides a framework for understanding the cyclical and cumulative phases of movement, and intersectionality theory guides an understanding of the intersections of characteristics that lead to inequality, allowing for a more comprehensive understanding of the women themselves and their unique risk.

In our study, Eritrean asylum seekers moving without documentation across international borders described experiencing sexual violence and vulnerability to sexual violence. According to their descriptions, clandestine irregular movement resulted in sexual coercion by smugglers, traffickers and fellow asylum seekers. As illustrated through the representative voices of the two men and two women who we have highlighted here as well as through reports from other participants, risk of sexual violence persists throughout the journey whether participants were crossing borders, in refugee

camps, or in torture houses. Our results suggest that women's vulnerability to sexual violence is rooted in their irregular movement and the lack of any legal or institutional protection. Irregular movement and the absence of protection may lead to the normalization of as well as the systematization of this violence in the Sinai torture houses. The intersection of female Eritrean asylum seekers' legal status, gender, and their social and economic positioning fosters their vulnerability to sexual violence as they migrate within and across international borders.

Our findings support prior research on sexual violence showing that refugees, asylum seekers and undocumented migrant women are at high risk of sexual victimization (120-125).Asylum seekers and refugees rely on smuggling networks in order to reach safety, particularly in heavily militarized areas or places with difficult terrain and environments of impunity (121-124). This was relevant to the experiences of the Eritrean asylum seekers in our study as all of them had traveled via extensive smuggling networks. These smuggling networks (e.g. transporting Eritreans across the border in exchange for money) often operate alongside human trafficking chains in which force or coercion is used to transport these asylum seekers against their will to the Sinai Peninsula for the purpose of extortion (132). Participants indicated that the coexistence of these networks was a continuous source of stress as they feared being kidnapped by traffickers. Gushulak and MacPherson have stated that reliance on these types of dangerous networks is often a result of immigration screening processes that have selective pressures for immigration (132). Our results corroborate this statement as the inability to exit Eritrea legally and the strict encampment policies of the Sudan created such circumstances. It is often within these smuggling networks (e.g. migration from

Central America to the United States via Mexico, from East and West Africa to Europe via the Mediterranean, from South Asia to the Arabian Gulf), that women fall victim to sexual violence (132). Similar to the experiences of participants in our study, lack of legal status is a reason that women moving irregularly do not have recourse to healthcare, legal and other forms of institutional support (123, 133). Thus previous research findings support our understanding that the intersections of lack of legal status, gender, and socio-economic vulnerability influence risk of sexual abuse among migrant women.

Research conducted among migrants and refugees in various countries in Asia (142, 143) and Africa (144, 145) identified perpetrators of this violence as soldiers, policemen, border control, smugglers and fellow migrants – in other words a wide range of perpetrators Our study found that in addition to bandits and traffickers, perpetrators included smugglers and fellow migrants as well, corroborating previous research.

A study conducted in North Africa among male and female migrants from various West African countries found that nearly one-third (29.22%) of participants reported having experienced sexual violence themselves or being forced to watch others, including relatives, friends and fellow migrants, sexually victimized (35.06%) (121). Eritrean men's testimonies in both the overall study and in the four representative examples depicted here, support the finding that men bear witness to sexual violence (121, 146). Their experiences as both witnesses (and as people indirectly affected by sexual violence against Eritrean women) make them useful sources of data in triangulating information (147).

The strength of this study is that it is the first of its kind to explore Eritrean asylum-seeking women's vulnerability to sexual violence throughout their migration

experience.  Qualitatively exploring Eritrean asylum-seeking womens' trajectory allows

for an in-depth analysis of the intersection of the contexts and characteristics creating the

conditions of vulnerability in which these women find themselves.  The simultaneous use

of information gleaned from the interviews and focus group discussions with Eritreans as

a foundation for a more in-depth look at the migration experiences of four Eritrean

asylum seekers allowed for a more comprehensive understanding of the circumstances of

risk facing these women.

An additional strength is the inclusion of men's perspectives. We include third-

party male testimonies because male participants provided detailed information about the

reasons for women's added vulnerability to experiences of sexual violence faced by

Eritrean women. The willingness of male participant's to discuss these traumatic events

may be related to them not having been personally sexually abused. In other words, men

may have less fear of being retraumatization by sharing their narratives. While the

information is not direct, it complements that provided by the women themselves. It also

raises awareness of the potential traumatization of men as witnesses to this abuse.

Women participants at times shifted between first- and second-person narration when

describing sexual violence possibly in order to distance themselves from traumatic and

often-stigmatizing information.

The study also has limitations. The focus on the testimonies of 56 participants

may not account for the variety of experiences that women have in migrating to Israel.

Furthermore, it is possible that some women who arrived after 2007 but before 2010 did

not experience or witness any sexual violence or assault. This may possibly be due to

their luck, the less circuitous nature of their movement, and/or their migration prior to the beginning of the systematization of kidnapping, rape and torture in the Sinai Peninsula.

Study results suggest that given the circumstances in which Eritrean women find themselves (the nexus of context and demographics) as they migrate irregularly, there is a considerable risk of sexual violence. Sexual violence may result in various short- and long-term mental, reproductive and other physical health problems for survivors and for those who witness it, and can lead to high social and economic costs ranging from increased risk for unwanted pregnancies, sexually transmitted diseases, suicidal ideation and social marginalization (121, 145, 148). The repercussions of these events may have a heavy psychological impact on victims as well as those who witness these events. Future research is needed to explore these health consequences of sexual violence and other traumatic events experienced during migration among men and women asylum seekers.

Scholars argue that since the 1980s, informal routes have been increasingly used by migrants to reach destination countries (149). The channels for this informal or irregular migration ranges from land and sea to air (149) and the mixed populations found using these routes are diverse in their reasons for crossing international borders (150). They include asylum seekers and refugees, distress migrants and economic migrants (151). These informal channels require crossing borders without documentation putting many lives at risk of trafficking, human rights violations and death (152).

The term mixed movements has been used to describe these populations using these informal routes (149). Despite the diversity of experiences, migrants using these informal routes are often treated as a homogenous entity by international agencies, governments and service providers (150). The treatment of these groups as homogenous,

often influenced by the political agenda of the organization or host state, often results in an undifferentiated and politically-charged response to the diverse needs of this population (149, 150). As a result, access to asylum in host states has become increasingly difficult in recent years (153).

In order to ease the tension between domestic and regional political agendas and international obligations, The UNHCR developed a 10-Point Plan which it claims helps host states to develop migration policies that provide protection to those who need it (154). The stated purpose of this initiative is to ensure that states' fulfill their obligations to protect asylum seekers and refugees while recognizing their need to simultaneously control migration generally and limit international criminal activity (154).

The asylum-migration nexus is a term coined in the migration literature as a mechanism for describing the phenomenon of mixed movements (149, 150). This term is used given the fact that asylum seekers and refugees are often using the same informal routes as other irregular migrants (149). Both host countries and international agencies mandated to provide protection to the asylum-seeking and refugee populations within their territories must first identify forced migrants from the general irregular migrant population (150).

In the case of Eritrean asylum seekers and the informal routes that they used in order to reach receiving countries throughout Europe, eastern Africa and the Middle East, it is important to note that there are other populations migrating with them (30). While these populations may have different reasons for movement, the risks that they incur along en-route and the limited access to institutional protection may be the same or worse (149). While the purpose of this paper is to explore the risks of sexual violence

experienced by Eritrean women seeking asylum, other irregular migrant women who used the same channels to reach Israel also likely experienced this abuse. Thus despite the differences in their reasons for movement, their risks and access to care in Israel is effectively the same (50).

While our study uses the perspective of reproductive health to observe the experiences of irregular movement for Eritrean asylum seekers, there are many lenses through which to view this issue (including the predictors of survival and the male experiences of sexual violence) and other populations who have similar experiences worldwide (79). This work will hopefully spark interest in exploring these domains. Given the risks that these women incur during their migration, further research should explore women's reasons for leaving home, and continuing to traverse through difficult and dangerous terrain.

This exploratory study may prompt further research that will hopefully lay the groundwork for policy change. Research quantifying the proportion of Eritrean asylum seekers that are women is important for understanding the number of women at risk. Mixed-methods research could be conducted in Ethiopian and Sudanese refugee camps in order to understand the conditions that are encouraging people protected there to continue on to other locations. This accumulation of this information would be useful for the governments of Ethiopia and Sudan and international NGOs so as to devise sustainable solutions to camp conditions and the unique vulnerability women experience (30).

In regard to trafficking specifically, research could explore and quantify the number of groups involved in the trade and their backgrounds. Based on this work, future research could qualitatively and quantitatively investigate the structural conditions that

encourage trafficking (30). Exploring the root reasons that trafficking occurs may provide the Egyptian and Sudanese governments to develop evidence-based policy to ameliorate these conditions (30). Thus in addition to their current efforts to investigate and prosecute traffickers responsible for the abuses and hold local security officials who facilitate these abuses accountable for these crimes, there could be a mechanism for dealing with marginalization (42). Lastly, research exploring the types of services available in transit, interception, and destination countries for survivors of sexual violence, irrespective of legal status or whether or not they meet the criteria for trafficking. We also recommend increased research about the risks of sexual violence for women asylum seekers as they cross international borders globally in order to assess the various circumstances of risk. The contribution of the recommended research to evidence-based policy may give rise to the design of interventions. We recommend that throughout the process of research, policy change, and intervention, intervening agencies should consistently seek the advice of the affected community and those working closely with them as they bear witness to these experiences.

# Chapter Four

# Manuscript Two:  Experiences of sexual violence and exploitation of Eritrean asylum-seeking women in Israel

*Abstract*

**Background**

Eritrean men and women migrants, including those with claims for asylum, have limited access to institutional support in Israel. While the "temporary group protection" granted to Eritreans by Israel ensures that they are not deported, it does not confer permanent legal status, nor does it allow access to the formal work sector.

**Objective**

This study qualitatively explores how political and economic marginalization increases risk of sexual and other forms of violence and exploitation for Eritrean women asylum seekers living in Israel.

**Methods**

One key informant interview, 12 individual interviews (6 with men and 6 with women) and 8 focus group discussions (4 with men and 4 with women) were conducted with Eritrean community members of reproductive age.

**Results**

Participants reported that Israel's immigration policies influenced the political and economic marginalization of asylum seekers, limited access to institutional support for new arrivals, and hindered access to formal employment and its' associated protections. Participants also reported that political and economic exclusion shaped their risk of sexual violence and exploitation as asylum seekers in Israel.

**Conclusion**

The main finding is that there may be a connection between Israeli state-level migration policy and women asylum seekers' vulnerability to sexual violence upon arrival in their host country - the "destination" stage of Zimmerman's model. The decision of the Israeli government to grant provisional status with a stipulation banning Eritreans from the formal work sector may create conditions that foster sexual violence and exploitation. The direct and indirect consequences of this policy were reported to be both an increased vulnerability to sexual violence and exploitation as well as an increased risk of domestic violence for Eritrean women. The theory of structural violence enabled us to explore the ways in which politically-driven social inequalities contributed towards increasing women's risk of violence and exploitation.

**Keywords:** Eritrean migration, marginalization, political and economic exclusion, sexual violence, sexual exploitation, rape

*Introduction*

Globalization, political instability and increasing economic and social disparities between industrialized and non-industrialized countries have led to increased waves of transnational migration (155). Throughout the migration experience, women asylum seekers endure multiple hardships including sexual violence, the absence of social support, and the inability to avail themselves of the protection of their countries of origin or any other institutional or legal recourse (119-121). Increased transnational migration also has challenged nation-states and societies to reassess their definitions of citizenship and their willingness to integrate refugees politically, economically and socially (49, 155). This tension is reflected in the degree of access to state-provided services, like health care, to migrants - including those with claims for asylum (49, 155).

These issues have become particularly salient for Eritreans in Israel where there has been substantial anti-African asylum-seeker sentiment in the media and reflected in the law (52, 60). Since 1951, less than one-percent of asylum seekers in Israel have been granted official political asylum (refugee recognition) (50). While over ninety-percent of Eritrean asylum seekers have been granted refugee status in host countries around the world, (77) only two asylum seekers have been recognized as refugees in Israel (56, 57). This is because the Israeli government offered Eritrean asylum seekers a group protection from deportation but refused to process any individual claims for refugee status. This left Eritreans in a legal limbo in which they are neither granted official refugee status and the accompanying rights to social welfare system and the formal work sector, nor are they being deported (52, 54).

According to the United Nations (58), approximately 4,000 Eritreans flee their country each month (13, 30, 156). Some seek the refugee camps in northeastern Ethiopia and eastern Sudan, while others try to reach North Africa, the Middle East, Europe, Canada and the United States (30). The majority of the hundreds of thousands of Eritreans have fled to neighboring countries including Ethiopia, Sudan, Israel, Egypt, and Kenya (13, 30). While the initial exodus of Eritreans was predominantly male, in recent years large numbers of Eritrean women began leaving the country, often following their husbands and other family members (54). Informal estimates indicate that 7,000 of the approximately 35,000 Eritreans asylum seekers are women, the overwhelming majority of whom arrived in Israel after 2009 (157).

Until recently, Israel has been a preferred destination and, until 2012, Eritrean refugees often sought to move there from Libya, Sudan, Ethiopia and Egypt (12). This was because, until recently, the forced repatriations at the border and "voluntary" repatriations of Eritreans from Israel were far lower than those reported from Libya, Sudan, and Egypt (13). In addition, Israel was perceived to offer a more hospitable social and economic environment than neighboring countries (13, 40). While the vast majority of Eritreans who have entered the country since 2007 do not have permission to work officially, the money earned working informally is enough to sustain their livelihoods, help pay their debts, pay the diaspora tax (2%) (158)[xxvi] if they fear for their families' safety or assets, and send remittances to their families in Eritrea (40, 54).

The challenges faced by asylum seekers in Israel as a result of their temporary status have been well documented by humanitarian organizations, activists, scholars and the affected community itself (52, 55, 57, 60, 64). Temporary protected status, and its

stipulations banning asylum seekers from working in the formal sector (54), may result in a political and economic marginalization that affects women's lives and shapes the risks they incur in meeting their needs. Most research studies on sexual violence and exploitation of migrant women, including those conducted in Israel, focus on sex trafficking in the host country, experiences during war in the home country, and experiences of violence in refugee camps (143, 159-173). Little research has been conducted on the sexual violence and exploitation experienced by asylum-seeking women in Israel, despite the evidence that this is a particularly vulnerable group (168, 174). This study seeks to extend previous research by addressing how 'temporary protected status' and its impact on work opportunities and living conditions influences vulnerability to sexual violence and exploitation.

The organizing framework for this paper is Zimmerman's model for migration and health (See Figure 1) (128).
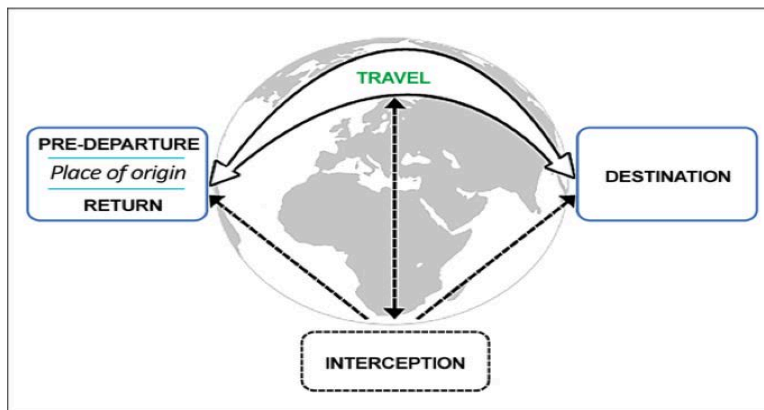


**Figure 1.  Zimmerman's Model**
*Source:* Zimmerman, 2011

The model stresses the value of conceptualizing contemporary migration as a multi-faceted "multistage cycle that can be entered into multiple times, in various ways, and may occur within or across national borders" (79). According to this theory, migration

includes the following stages: 1) pre-departure; 2) travel; 3) destination; 4) interception; and 5) return (79). Zimmerman's theory states that understanding of the events at each stage is critical to comprehending the cumulative impact of migration on health and to strategizing appropriate interventions (79).

We focus on the destination stage of the framework for three reasons. First, there is a dearth of research on asylum seekers and their vulnerability to violence and exploitation in their host countries in the industrialized world. Second, significant amounts of sexual violence and corresponding negative health outcomes that occurred during the travel stage may be compounded by additional negative experiences at the destination stage. Finally, exploring the vulnerability to abuse for these women, and its potential connection to national immigration and asylum policy, may lay the groundwork for future research and evidence-based policy changes at local and state levels (168).

*Methods*

The current study is based on data gathered from three sources: (1) one of the 25 individual in-depth interviews with key informants (in this instance, an Eritrean activist) (Phase I, January 2012-April 2013); (2) 12 individual in-depth interviews with Eritrean community members (6 men and 6 women) (Phase II, April-September 2013); and (3) 8 focus groups (N=44) with Eritrean community members (Phase II April-September 2013). Interviews and focused groups discussed key informants' and Eritrean community members' perspectives on vulnerability of Eritrean women to sexual violence and exploitation en-route to and in Israel as well as other topics (e.g. access to contraception) not directly relevant to this study. Ethical approval was obtained from Johns Hopkins

University, Ben Gurion University and the Physicians for Human Rights – Israel Open

Clinic.

***Participants, sampling and procedures***

Phase I and Phase II individual in-depth interviews lasted approximately 1.5 hours

and 2 hours, respectively. The first author conducted 21 of the 25 interviews with Israeli

participants in English with the help of a research assistant.  The first author conducted

the remaining four alone.  Some key informants used Hebrew when necessary which was

then translated by the research assistant. Participants from Phase I were recruited from a

list of potential participants provided by various domestic and international NGOs, the

Ministry of Health, private clinics and Ben Gurion University. Participants from Phase II

were recruited from the Physicians' for Human Rights – Israel "Open Clinic" (134). The

"Open Clinic" was identified in preliminary ethnographic mapping of locations where

different Eritrean asylum seekers frequently use health care services.  Staff was provided

with verbal information about the study and recruitment scripts were translated to English

(from Tigrinya) for the staff to understand. Signs describing the study were posted around

the clinic. The first author conducted all interviews with asylum seekers in Tigrinya in a

private room in the facility and oral consent was obtained before data collection began.

All participating asylum seekers were aged 18 to 49 years.  Phase I key informants

provided written consent and asylum-seeking participants in Phase II provided oral

consent.

FGDs were held separately for Eritrean women and for men and lasted between

one and three hours.  Initial participants were recruited via snowball sampling (135) as

well as through contacts with community activists, researchers and staff at the

Physicians' for Human Rights-Israel Open Clinic (135). The FGDs were conducted in locations that were considered appropriate and safe by the participants and organizers; they included back rooms in participants' stores, homes and (135) NGOs' meeting rooms. Due to suspicion rooted in the threats of detainment and deportation, as well as internal political tensions within their community, natural grouping methods, allowing a recruited participant to select 4-8 others to participate in a focus group discussion, were employed (136, 137). Recruitment for individual interviews and focus group discussions ended after reaching data saturation (138).

*Instruments*

Data were collected for the 12 individual in-depth interviews using: (1) structured questions regarding basic demographic information, migration histories and barriers to contraceptive careseeking after arrival in Israel and; (2) open-ended questions exploring vulnerability to sexual violence and exploitation en-route to and in Israel, barriers to careseeking, and the challenges of life in Israel. The data collection instruments for the 8 focus group discussions included: a basic demographic questionnaire and open-ended questions exploring sexual violence and exploitation en-route to and in Israel as well as norms regarding fertility and family planning. This paper will focus on sexual violence and exploitation of Eritrean women en-route to Israel.

*Analysis*

Qualitative interviews were digitally recorded using hand-held recorders. They were subsequently transcribed directly from Tigrinya into English by a team of transcribers fluent in both Tigrinya and English. While the coder was fluent in Tigrinya, to assure full

understanding of context specific references and regional dialects, transcripts were translated into English.

Open coding and memo writing was employed for the first reading of Phase II transcripts.  Subsequently, focused coding of transcripts was conducted.  Axial coding of focused codes led to themes described in the paper.  During the process of coding, written memos were used to inform the conceptual development of codes and themes (139). Textual data were coded and analyzed using Atlas.ti as well as manually. Member checking with a small sub-sample of the participants provided an opportunity to share findings with five study participants and a group of four other Eritrean women who had not participated in order to ensure that the study's results were correctly interpreted (140). Relevant demographic information about the six female individual interview participants is found below in Table 3.

**Table 3. Demographic information from female IDI participants**

|  | Participant 1 | Participant 2 | Participant 3 | Participant 4 | Participant 5 | Participant 6 |
|---|---|---|---|---|---|---|
| **Age category** | 21-25 | 26-30 | 26-30 | 26-30 | 21-25 | Under 20 |
| **Marital Status** | Married | Married | Divorced | Single | Married | Married |
| **Educational background** | Secondary | Middle School | Secondary | Secondary | Middle School | Secondary |
| **Time in Israel** | 3 to 6 years | 3 to 6 years | 3 to 6 years | 1 to 3 years | 1 to 3 years | 1 to 3 years |
| **Partner in Israel** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Children** | Yes | Yes | No | Yes | Yes | Yes |
| **Children in Israel** | 3 | 1 | 0 | 0 | 1 | 1 |
| **Occupation in Israel** | Hotel janitor | Unemployed | Janitor | Restaurant worker | Janitor | Janitor |
| **Living arrangement** | Shared home with partner, friends & family | Shared home with friends & family | Shared home with friends & family | Shared home with friends & family | Shared home with partner, friends & family | Shared home with partner, friends & family |

## Results

Participants identified the political exclusion resulting from provisional status and the consequent economic exclusion from the formal workforce as two principal factors that shaped their risk of sexual violence and exploitation as asylum seekers in Israel. The men quoted in this paper did not personally experience the sexual violence and exploitation described. Thus the information that they provide must be read and interpreted with the knowledge that they are third-party voices. The women that are quoted alternated between first- and second person narration. The second-person narration may be used as a tool for distancing themselves from the trauma of the violence that they were threatened with, or they personally incurred.

### Consequences of political marginalization

- ### Provisional Status

The majority of individual and focus group participants discussed stressors resulting from their status as provisional prima facie refugees in Israel. Some associated their provisional legal status with increased risks of sexual violence. Before 2012, Israeli policy towards Eritrean asylum seekers was to accord them temporary protection which meant that they were not kept in detention, but neither were they provided any social support (52, 54, 55). All participants reported that, under Israel's policy of direct settlement, they were given pre-purchased tickets and sent directly from the detention facility to Tel Aviv where they were left to fend for themselves. Some participants said that direct settlement exposed women who had no existing community of support and protection to possibilities of sexual violence and exploitation. One participant recounted her experience:

*"We took the bus and then they drop you off here [Tel Aviv]. Where do you go? To Levinsky park, where else." (Female IDI7)*

Another female participant explained the situation generally:

*"If a woman came here and she was alone, she would have begged to stay with anyone. If she did this, it shows those she is asking that she has no family. There was always a chance that they [fellow asylum-seeking men that take her in] would rape her." (Female IDI5)*

Another individual participant described her personal experience arriving in Tel Aviv as a

woman without support below:

*"I arrived here by bus with five other women. One of them had a husband in Tel Aviv who came to pick her up. The remaining four of us decided to stick together. Some men from our community saw us at the bus stop and offered to buy us dinner. We decided to go as a group. They offered us shelter at their home for the night. We had nowhere else to go so we went with them. When we reached the house there were many men in a very tiny room with four beds... A group of men decided to take one woman for themselves and I said to them 'I am going to shout, I am a virgin, I don't know [have never had sex with] any man. After all the things I have gone through coming here, you want to rape me? I am going to scream.' I screamed and screamed. One of the men raped one of my friends in front of us... I screamed 'what are you doing?' and he hit me over the head with a phone until I bled. As she was being raped, she screamed to me to shutup so that they wouldn't kill us but I couldn't. I shouted and threatened to go to the UN to report them. We didn't sleep that night...a neighbor called the police and the men fled. When the police came, I was bleeding. " (Female IDI2)*

After 2012, new arrivals were sent to detention rather than being directly settled

and that change of policy had implications for women and their children who had arrived

beforehand. One female participant explained how her husband's detention impacted her

vulnerability:

*"I can say I am better off [than my husband in detention] because I can work and come home and also raise my child but I am alone in this country with no one to support me and sometimes I would prefer for us to switch places...I am so alone. Here even if you are married there are men that check you out... there are men that would check you out while you are carrying your baby on your back ... I am fearful that worse things could happen. There are people that get close to you [a woman], and they pretend to be good to you... but in the end they end up hurting you. You may know how to avoid your enemy, but what do you do if the man who hurts you is a friend? With the struggles here [in Tel Aviv] I prefer for him [my husband] to be here instead of me because he is a man and no one would touch him. As a girl there is violence, murder, rape and so much more." (Female IDI10)*

*Consequences of economic marginalization*

- *Informal work sector*

Israeli labor policy bans asylum seekers from working in the formal sector, but employment in the informal economy is tolerated (52, 54, 55). All participants confirmed that Eritrean asylum-seeking women work in the informal work sector, often as domestic workers, to sustain themselves and their families. The majority of participants reported that sexual harassment and, in some cases, sexual violence was common among women working as housekeepers, cleaners or caregivers.  One male participant explained his observations of the sexual harassment of women in the workplace:

> *"I hate it. They [Israeli employers] ask them [Eritrean women] to have sexual intercourse with them... They [employers] threaten to fire them from work.  When they threaten the women it makes them think 'how am I going to survive without work'... we don't have the right to work in Israel... she is not thinking about herself... she is thinking about keeping her job so she feels she may have to do this [sleep with employers]. It happens." (Male IDI6)*

All participants reported that one way of finding work was by standing in certain areas around Levinsky Park and on certain roads in the mornings. One male participant explained his perception of the particular risk for women of seeking informal work (*chik chak*) in this way.

> *"So when these women [Eritrean women] get here [to Israel], they go and stand in the park to wait for employers looking for cheap labor. If it's an Eritrean woman, for example, he [a potential Israeli employer] would tell her, 'Come with me I can help you find work.' They pick them up and the women go because they don't have other options. Then the Israeli would take them to work and lock them up and sexually abuse them." (Male IDI9)*

A female focus group participant confirmed:

> *"It's work and the women need jobs. If a girl waits on the street looking for a job [informal work], they [Israeli employers] take them to a remote area -- to a place where you can't even scream for help and do as they please [sexually abuse the woman]. Sometimes they tell them the job is in a house and they take them to do it there. (Women Focus Group Discussion 3, P1)*

Many participants reported that the sexual violence and exploitation can arise even if the employment relationship originally was actually for domestic services. The lack of opportunity for other employment and the absence of institutional support for work that occurs legally creates ongoing conditions of vulnerability. A male participant who witnessed the sexual exploitation of women shared his understanding of the situation:

> *"At the end it all comes down to financial security. There are two women that I know. They used to work with me. The man who employed us was Russian-Israeli. He took one girl to clean for him in another area and she went with him. He did what he did to her [raped her] and when he finished he tried to get a third woman to come home with him to clean. The other two women said no. I was there at the time so I supported the remaining women in their decision. We all got fired after that." (Male Focus Group Discussion 2, P4)*

- ***Prostitution***

Many participants reported that exclusion from the formal work sector drives some Eritrean women to engage in prostitution which is another way that provisional status exposes women to increased risk of sexual violence and exploitation. Many participants reported that Eritrean women provided sex to Eritrean and Israeli men in exchange for resources. One focus group participant explained:

> *"When men offer them [Eritrean women who become prostitutes] that kind of money, they get attracted to it. They don't think about the consequences. They focus on the money that is being offered to them. They think to themselves, 'why work all day when I can get money this way?' ...then they agree to sleep with the men... Then an unplanned pregnancy happens and another man comes to have sex with them. They end up selling their souls for money." (Women's focus group discussion 2, P2)*

A female individual participant connected Eritrean women involved in prostitution with economic and political marginalization:

> *"Yes they sell their bodies. What choice do they have? What other work do they have? They give sex to anyone that gives them money. If you escaped your country and you don't have a visa what other choice do you have? They usually begin bartending with a bit of prostitution on the side but because of the bar fights, some women shifted into full time prostitution. Honestly, like I said there are women that can't work...and so they work by selling their bodies and acquire a disease and sometimes an unwanted pregnancy happens. They go to doctors and pay lots of money to get rid of these*

*pregnancies and, in order to pay for the abortion, they prostitute themselves on top of the pregnancy. Do you understand? They have to spend the night with someone so that they can get the abortion the next day." (Female IDI2)*

### Crowded living conditions

Many participants cited crowded living spaces as yet another factor connected to economic and political marginalization which increases women's vulnerability to sexual violence and exploitation. While the social norm of living with others, the gender imbalance in the community, and the lack of known and trusted sources of social support were indicated by participants to result in many women sharing living quarters, often with men who they do not know, the majority of participants agreed that the underlying reason for shared housing was economic pressure. Many participants stated that while the sharing of spaces made life in Israel affordable, the crowded and often mixed-gender environment, in which there are usually many more men than women, often increased women's vulnerability to sexual violence. A male key informant explained his understanding of the risk:

> *"Okay, you're living with eight or ten men. A relative brings a woman to live with your group. So she's living among eight men who've been here for five years with no women at all. Sometimes the women are forced [to have sex] by one of the men. Sometimes they are not forced but the situation creates pressure. Bringing a woman into a living environment where there are eight men is a way of forcing her right? Even married couples have to live in this situation. One problem that married couples face is that one of the men living in the home may ask or pressure the wife to sleep with them while her husband is at work. Do you understand me? She may be able to protect herself and her marriage for 99 out of 100 days but there is always that chance that something can happen. Something can happen one day."(Male KI25)*

One female focus group participant described single women's vulnerability to sexual violence:

> *"To live as a single woman is very stressful. They [men] won't leave you alone unless you are married ... the single women can't afford to live alone, it's expensive to cover food and all... So she lives with a group, either with men or women. It's often very difficult to find other single women to live with so they live with men who are their relatives or who are from the same region. These women get asked for sexual favors all*

*the time, and the men force themselves on them … it's very difficult … the women are ashamed of the fact that they were raped so they won't tell. They are ashamed to say that a man from their hometown raped them." (Women's Focus Group Discussion 1, R5)*

### Domestic violence

Many participants also reported an increased risk of domestic violence, including wife-murders, which they attributed in part to the effect of political and economic marginalization of Eritrean men. Many participants noted that women are caught between relying on men for the family's livelihood and the need to protect themselves from violence:

> *"My husband, he would hit me with an electric wire and I would bleed. Once the police came and saw the blood. They [the police] said as long as he [husband] is alive he is not getting out of prison. Honestly, even though he had hit me and I lost my child [a pregnancy] I didn't want him to be in prison because I have another child. I would rather my husband help me financially but the government won't let him out. Women don't call the police because they don't expect to get murdered. You expect the fight to pass. You try and tolerate it but then it gets out of control. You understand that the men are stressed too. You pray that with time the violence will pass but it is beyond you. The circumstances of our lives are bad. The men have stress here [in Israel]. It has been almost six years since Eritreans came to this country and the government hasn't taken care of us … they don't have visas for us. We don't have rights like Eritrean refugees in other countries … there is oppression here. After washing dishes all day some men come home and accept it [their fate] … and some don't. Those men that don't say to themselves 'why aren't our rights respected like others [citizens]?' They want to go to libraries and study in schools like Eritreans who are accepted as citizens in other countries. Here it is not like that. The men are doing badly here." (Female IDI2)*

Another male focus group member connected political and economic pressures to wife-murders in the Eritrean community:

> *"I think the stress is the main problem. No Eritrean has hope in this country. For example, they [the Israeli government] don't tell you anything that is coming for you, for example whether you will be able to get papers [more permanent status] after a certain amount of time. There is no sign of improvement and so there is a lot of stress. It could be my perception but honestly most Eritreans work 12-18 hour days. If a man and a woman fight there is no time or energy to solve the problem. Are you going to rest and call for people [other community members who can mediate] to settle it? As a result these things [disputes] get more serious with time. So the main problem is the difficult situation for Eritreans in this country. I have never heard of killing your wife in Eritrea. It's my first time hearing that a man killed a woman. It's brought up by the stress, the psychologists say that too, it's the stress." (Male Focus Group Discussion 3, R1)*

## *Discussion*

The core finding of this paper is that there may be a connection between state-level policy and women asylum seekers' vulnerability to sexual violence upon arrival in their host country - the "destination" stage of Zimmerman's model (79). Zimmerman's model provides a framework for understanding that the experiences of sexual violence and exploitation are cumulative over the multiple stages of movement (79, 81-85). Zimmerman's model does not however delve into the political and economic environments in the destination country and their role in increasing risk to sexual violence (79). Using the theory of structural violence (94, 115) we were able to explore how restrictive immigration policy in Israel may have had repercussions in terms of the exigency that women have to seek necessary employment in unregulated sectors where they may be more vulnerable to sexual violence and exploitation, with little recourse to institutional support or protection. The unpacking of Zimmerman's "destination stage" through the lens of structural violence theory (94) enabled us to explore the ways in which politically-driven social inequalities contributed towards increasing women's risk of violence and exploitation.

Political and economic marginalization in Israel affected all Eritrean participants in the study. The majority of the 56 individual interview and focus group participants and one Eritrean key informant whose views are reported here claimed that Israeli policy granting them only provisional status and the resulting barriers to employment in the formal sector contributed to their marginalization within Israeli society. Political and economic exclusion rendered Eritrean women vulnerable because they lack trusted, stable and secure social support, affordable shelter, or the ability to earn a legal income to live

independently. The informal policy of direct settlement that was in effect prior to 2012, is an example of a practice that resulted in many women arriving in Tel Aviv without money, connections or shelter. The lack of refugee assistance left new arrivals dependent upon strangers for food, lodging, and employment. We found that one of the repercussions of built-in exclusion from the social welfare system was an increase in sexual violence perpetrated against Eritrean women asylum seekers.

Policies giving rise to political and economic exclusion also had repercussions for women's "structured vulnerability." The decision of the Israeli government to grant provisional status with a stipulation banning Eritreans from the formal work sector may foster the conditions that foster sexual abuse. Most Eritrean asylum-seeking women in our study worked as domestic workers which limited their choice of employment and their recourse for legal protection. For women who are day laborers or who are in search of new work, the practice of being picked up for *chik chak* may increase risk considerably. In addition to risks of sexual violence and exploitation in the workplace, economic exclusion pressured many to use sex as a means of income. Finally, we found that living in crowded spaces with predominantly male roommates can create situations in which sexual coercion occurs. Participants described marital stress arising from political and economic instability and connected that stress to greater risks of injury from spousal abuse. Participants also identified both Israelis and other asylum seekers as perpetrators of sexual violence, exploitation, and general abuse of Eritrean women in Israel. Political exclusion may have created opportunities for sexual violence and exploitation to occur and also to hinder women from accessing institutional support.

Our findings support previous research establishing that migrants are at high risk of sexual victimization at every stage of their migration experiences including the time after their arrival at the country of destination (93, 120-125, 175). Research indicates that for asylum seekers who are not afforded protection under international refugee law in their host countries, risk of abuse is considerably higher than for those who are granted official refugee status (131, 168, 174, 176). This was relevant to the experiences of all of the Eritrean asylum seekers in our study as none of them were afforded the full protections of refugee status. All participants in the study had conditional release visas (temporary protection) that banned them from working in the formal work sector.

Studies in the Middle East, Europe, Asia and Africa, have found that migrant women without the legal status necessary for formal protection in the work sector are often sexually and psychologically abused by their employers (168, 176-179). Our results reinforce these findings as women working in the informal sector indicated an increase in their risk of sexual violence by their employers. Similar to our finding that some Eritrean women asylum seekers in Israel resort to prostitution, research conducted in Europe found that marginalized African migrant women often rely on prostitution as a source of income (169). While research connecting crowded living conditions, migration and risk of sexual violence is limited, our findings suggest that this combination may influence risk of sexual violence and exploitation of asylum-seeking women. We argue that these risks are rooted in the structural violence embedded in the policies governing asylum seekers agency and their lives generally.

We also explored the impact of political and economic marginalization on intimate partner violence. Research conducted in the United States and Europe found that

the high prevalence of intimate partner violence in migrant communities is rooted in political and economic pressures affecting them (180-182). In addition to placing stress on a marriage, women who do not have legal status in a country or have other forms of non-permanent status do not receive necessary institutional support when experiencing domestic violence as they may fear for their own or their partner's detention or deportation (181, 183). Our findings illustrate a similar situation for Eritrean women with provisional status, in which political and economic marginalization both serves as a catalyst for spousal abuse as well as fuel for its continuation because women hesitate to seek help out of fear that their partners will be detained.

A major strength of this study is that it is the first of its kind to investigate Eritrean asylum-seeking women's vulnerability to sexual violence and exploitation in Israel. Qualitative data about the experiences of Eritrean women in Israel allows for an in-depth exploration of the various circumstances of vulnerability in which Eritrean asylum-seeking women find themselves and their understandings of the factors creating their vulnerability. The use of information gleaned from interviews and focus group discussions with Eritreans allowed for a comprehensive understanding of the effects of political and economic exclusion and its implications for the sexual vulnerability of Eritrean women living there.

The inclusion of men's perspectives added an additional perspective, uncommon in most studies of violence against women. Male participants provided more detailed information about the experiences of sexual violence and exploitation faced by Eritrean women living in Israel. The willingness of men to discuss these traumatic events may be related to them not having been personally abused (men may have less fear of being re-

traumatization by sharing their narratives). While the information is indirect, it complemented the information shared by the women themselves. The use of male testimonies also highlights the psychological stressors that men experience when they observe this abuse. The women themselves shifted between first- and second-person narration. This might have been a mechanism for them to distance themselves from information that could be traumatic and stigmatizing.

Eritrean men were a primary source of information, however, on the subject of violence perpetrated by fellow Eritrean men. While male participants focused their discussions of sexual violence on the violence to those perpetrated by men outside of the community (particularly en-route), they also shared about violence happening within their communities as well. In describing this violence, they often expressed a frustration and sadness at the added layer of vulnerability that Eritrean women faced. They sought to contextualize these actions within the wider context of their experiences in Eritrea, en-route to and in Israel. Male participants strove to ensure that this behavior was understood within the context of the detrimental psychological impact of adverse events prior to and throughout their migration experiences. The purpose for clarifying this nuance was to avoid the common practice of blaming "cultural norms" and deeming Eritrean men as inherently violent towards their spouses. They also emphasized that while such violence undoubtedly occurred, it was not common.

The study also has limitations. The focus on the testimonies of fifty-six participants (based on 12 interviews and 8 focus groups) may not reflect the variety of experiences of Eritrean asylum-seeking women living in Israel and it is possible that some women may not experience sexual violence or exploitation. For those who have

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experienced it, this paper may not comprehensively describe all of the possible circumstances of risk connected to their marginalization.

A potential solution to the risk of sexual violence and exploitation these women endure would be to provide asylum seekers who lack personal support systems with social support in the form of government-sponsored safe lodging. Another solution might be to allow all asylum seekers authorization to join the formal work sector, which would likely lead to economic stability and to the reduction of violence. Access to the formal work sector would also enable asylum seekers to have health insurance.  The police should be made aware of the abuses occurring in the informal work sector and penalties for perpetrators of sexual violence against asylum seekers should be enforced. Information about the importance of reporting sexual abuse to the police irrespective of the perpetrators background should be shared with the asylum-seeking community.

Our results suggest that the nature of the status granted to Eritreans in Israel has implications for the ability of Eritrean women to stabilize their livelihood and establish themselves in households free from spousal abuse or sexual pressure from other residents in-group living situations. This marginalization has implications not only for their risk of sexual violence and exploitation, but also, depending on the nationality and level of authority of the perpetrator, their recourse for legal or other institutional protection. These circumstances create an environment of impunity for the abuse of vulnerable populations within a context in which non-marginalized groups are highly protected. Areas of future research might include an exploration of factors influencing the wellbeing of male Eritrean asylum seekers who are also marginalized, but may face distinct challenges. In line with the underlying theory of Zimmerman's model, future research

could more explicitly explore whether experiences at the destination stage of the

migration cycle were compounded by experiences of sexual violence during the travel

stage.

# Chapter Five

# Manuscript Three: Barriers to contraceptive care-seeking of Eritrean asylum-seeking women in Tel Aviv-Yafo, Israel

*Abstract*

**Background**

Female migrants, including those with claims for asylum, report desiring access to quality and consistent family planning services. In the case of Eritrean women asylum seekers in Israel, provisional refugee status limits access to affordable contraceptive services to those offered at one NGO and one Ministry of Health sponsored clinic.

**Objective**

This study qualitatively explores structural barriers to contraceptive access from the perspective of the health system and male and female asylum seekers in Israel.

**Methods**

We conducted individual interviews with 25 key informants as well as 12 individual interviews and 8 focus group discussions with Eritrean asylum seekers living in Israel..

**Results**

Data analysis identified seven structural barriers each of which will be discussed in below: (1) distance to health facilities in Tel Aviv; (2) fragmentation of the health system; (3) unaffordability of contraceptive services; (4) limited supply of providers, clinic hours and medications; (5) low standard of care; (6) discrimination; and (7) social and linguistic communication barriers.

**Conclusion**

The core finding of this paper is that the political and economic marginalization of Eritrean women within the wider Israeli system may leave them with access to a fragmented health care system. Health care services were reported to be inadequate because they were neither accessible nor adequately equipped or staffed.

*Introduction*

Since 2007, an estimated 7,000 Eritrean female asylum seekers, the majority of whom are of reproductive age, have migrated to Israel via the Egyptian border (54, 157). Within Israel, gynecologists, social workers and Eritrean community members suggest that unwanted pregnancy is a significant problem in this population and that these women desire to reduce the number of these pregnancies[xxvii]. However, their access to reproductive health services is limited. As provisional refugees, asylum seekers are not covered by the Israeli national health insurance ("NHI") which is available only to citizens, permanent residents, and officially recognized refugees (50, 155, 186). As a result, Eritrean asylum-seeking women throughout Israel who cannot pay for private care rely mainly on two humanitarian clinics,[xxviii] both based in Tel Aviv (50, 186). In theory, these women should also have access to family planning services through the Ministry of Health-sponsored maternal and child health stations (Tipat Chalav); however, in practice, these services are currently unavailable due to governmental budgetary constraints.

Research conducted throughout Europe, the United States and Australia has found that marginalized women, including migrant women with claims for asylum, face structural barriers in accessing contraception (119, 187-194). Difficulties in accessing care are often coupled with a high need for contraceptive services (119, 187-194). The categories of the various systems of influence vary across models but two dynamics are consistent across all iterations of the social ecological model: (1) behavior is affected by multiple levels of influence; and (2) individual behavior both shapes and is shaped by the wider political, economic, and social environment. This paper draws upon McLeroy's version of the Social Ecological Model to categorize the layers of influence on contraceptive care-seeking behavior for Eritrean women in Israel (80).

Previous research on access to family planning for migrant women has focused on the community, interpersonal and personal levels. At the community and interpersonal levels, religious values, social norms, spousal support, and normalization of hardship can present considerable obstacles to careseeking (119, 187-200). At the personal level, knowledge of contraceptive methods, health concerns, and fears of side effects have been identified as factors influencing contraceptive careseeking (119, 187-200).

To date, no systematic studies have examined access to family planning services among Eritrean female asylum seekers or the systemic barriers to contraceptive services that Eritrean women face in Israel. This lack of research makes it difficult to understand the connection between female migration, vulnerability to unwanted pregnancies and access to contraception in the Israeli context. We address this gap by exploring the multiple factors within the Israeli health system and the larger social, economic and political context that influence access to contraceptives for Eritrean female asylum seekers.

*Methods*

This paper is based on a qualitative study that was conducted in two phases. Phase I occurred between December and April of 2013 and focused on studying barriers to contraceptive care-seeking from the health systems level perspective. During this phase, semi-structured in-depth interviews were conducted individually with 25 key informants.  Phase II occurred between April and September of 2013 and focused on Eritrean community members' perspectives on family planning and their perception of access to these services in the Israeli context. This phase consisted of 12 individual in-

depth interviews (6 women and 6 men) and 8 focus group discussions (FGDs) (total n=44).

During Phase I, 20 Israelis, one American and four Eritrean key informants were recruited from NGOs that serve the Eritrean community, government facilities, public and private clinics and service-providing organizations, and one of the main universities in the country. The interviews were conducted in English, Tigrinya or Hebrew and lasted one to two hours. Key informants were identified as having relevant experience and information by local NGO workers, university researchers, community activists, UN personnel and Ministry of Health officials (135). An Israeli research assistant fluent in Hebrew and familiar with Israeli social norms was present for all 20 interviews with Israelis. We obtained information on how Israeli immigration policy impacts access to health care for asylum seekers and on what role the Israeli health system plays in providing services to asylum seekers. We also sought to gain an etic perspective on three core topics: the experiences of Eritrean asylum seekers within the Israeli health system; the reasons for unwanted pregnancies; and the accessibility of contraception for Eritrean women. Recruitment ended after reaching data saturation when no new themes continued to emerge during data analysis (201).

During phase II, asylum-seeking participants were recruited from the Physicians' for Human Rights – Israel "Open Clinic" (134). The "Open Clinic" was identified by ethnographic mapping of locations which Eritrean asylum seekers frequent to obtain a variety of health care services. Staff was provided both with verbal information about the study and recruitment scripts (translated into Tigrinya for the participants and English for the staff to understand the study). Signs describing the study were posted in the clinic.

The first author conducted all interviews in Tigrinya in a private room in the facility after participants provided informed oral consent. Participants were six females and six males, aged 18 to 49 years.

FGDs were held separately for women and for men and lasted between one and three hours. Initial participants were recruited via snowball sampling (135) as well as purposively sampled through contacts with community activists, researchers and staff at the Physicians' for Human Rights-Israel Open Clinic (135). The FGDs were conducted in locations that were considered appropriate and safe by the participants (e.g. back rooms in participants' stores, homes and (135) NGO meeting rooms). Due to suspicion related to detainment and deportation, as well as internal political tensions within the Eritrean asylum seeking community, natural grouping methods were employed (136, 137). Thus, recruited participants formed groups of 4-8 members for discussions.

Data collection instruments for the key informant in-depth interviews began with structured questions regarding basic demographic information as well as familiarity with the Eritrean community. The unstructured component explored perceived barriers to contraceptive careseeking. The structured component of the instrument for the in-depth interviews with Eritrean community members was similar but also added questions regarding knowledge of different methods of contraception. The unstructured component of the questionnaire focused on barriers to contraceptive careseeking, vulnerability to unwanted pregnancies and on daily challenges faced by Eritrean asylum seekers in Israel. The unstructured component was flexible and was often guided by the participant. For the structured component, the focus group discussion guide included a basic demographic questionnaire, while the unstructured component explored norms regarding fertility,

unwanted pregnancy, and family planning. Qualitative interviews were digitally recorded using hand-held recorders and were subsequently transcribed directly from Tigrinya into English by a team of transcribers fluent in both Tigrinya and English.  While the coder is fluent in Tigrinya, some of the phrases and references that participants made could not be literally translated without in-depth knowledge of the Eritrean context. Also, some participants spoke in regional dialects in which the first author was not fluent.  Thus transcripts were translated into English in order to enable a more thorough analysis of the data given specific contextual references and regional dialects.  Descriptive quantitative analyses of the responses to the structured questions and qualitative analysis of both the individual and the FGD interview transcripts began during data collection and continued through June 2014.

The coding process was the same for transcripts from Phases I and II.  Open coding and memo writing was employed for the first reading of the transcripts.  Subsequently, focused coding of transcripts was conducted.  Axial coding of focused codes created the themes described in the paper.  During the coding process, written memos were used to inform the conceptual development of codes and themes (139). Textual data were coded and analyzed using Atlas.ti as well as manually. Member checking with a small sub-sample of the participants provided an opportunity to share findings with them in order to ensure that the study's results were correctly interpreted (140). Relevant demographic information regarding female IDI participants (Table 4), male IDI participants (Table 5), female FGD participants (Table 6), and key informant IDI participants (Table 7) is reported below.

**Table 4. Demographic information from female IDI participants**

|  | Participant 1 | Participant 2 | Participant 3 | Participant 4 | Participant 5 | Participant 6 |
|---|---|---|---|---|---|---|
| **Age** | 21-25 | 26-30 | 26-30 | 26-30 | 21-25 | under 20 |
| **Marital status** | Married | Married | Divorced | Single | Married | Married |
| **Educational background** | Secondary | Middle School | Secondary | Secondary | Middle School | Secondary |
| **Time in Israel** | 3 to 6 years | 3 to 6 years | 3 to 6 years | 1 to 3 years | 1 to 3 years | 1 to 3 years |
| **Partner in Israel** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Children in Israel** | 3 | 1 | 0 | 0 | 1 | 1 |
| **Occupation in Israel** | Hotel janitor | Unemployed | Janitor | Restaurant worker | Janitor | Janitor |
| **Ever use of contraception** | Yes | Yes | No | No | Yes | No |
| **Type of method** | Injectables | Injectables | None | None | Injectables | None |
| **Current use of contraception** | Yes | No | No | No | No | No |
| **Type of method** | No response | None | None | None | None | None |
| **Partner use of contraception** | No | No | No | No response | Yes (withdrawal) | No |

**Table 5. Demographic information from male IDI participants**

|  | Participant 1 | Participant 2 | Participant 3 | Participant 4 | Participant 5 | Participant 6 |
|---|---|---|---|---|---|---|
| **Age** | 31-40 | 21-25 | 21-25 | 26-30 | 18-20 | 26-30 |
| **Marital status** | Married | Single | Single | Single | Single | Divorced |
| **Educational background** | Middle School | Secondary | Secondary | College | Secondary | No formal education |
| **Time in Israel** | 3 to 6 years | 3 to 6 years | 3 to 6 years | 1 to 3 years | 1 to 3 years | 1 to 3 years |
| **Partner in Israel** | Yes | No | No | No | No | No |
| **Children in Israel** | 1 | No response | 0 | 0 | 0 | 0 |
| **Occupation in Israel** | Works in a kitchen | Works in a kitchen | Supermarket shelver | Day laborer | Unemployed | Day laborer (construction and gardening) |
| **Ever use of contraception** | No | Yes | No | No | No | Yes |
| **Type of method** | N/a | Male condom | N/a | N/a | N/a | Male condom |
| **Current use of contraception** | No | Yes | No | No | No | Yes |
| **Type of** | N/a | Male | N/a | N/a | N/a | Male |

| method | | condom | | | | | condom |
|---|---|---|---|---|---|---|---|
| Partner use of contraception | Yes (injectables) | No | | No | No | N/a | No |

**Table 6. Patterns of contraceptive use by female focus group participants**

| | Ever use of contraception by the participant | | Current use of contraception by the participant | | Current use of contraception by the participant's partner | |
|---|---|---|---|---|---|---|
| | Use? | Type of method | Use? | Type of Method | Use? | Type of method |
| **Group 1** | | | | | | |
| **P1** | Yes | Oral contraception | Yes | Oral contraception | No | N/a |
| **P2** | Yes | Counting days | No | N/a | No | N/a |
| **P3** | Yes | Counting days | Yes | Counting days | No | N/a |
| **P4** | No | N/a | No | N/a | No | N/a |
| **Group 2** | | | | | | |
| **P1** | No | N/a | No | N/a | Yes | Injectables |
| **P2** | Yes | Injectables | Yes | Injectables | No | N/a |
| **P3** | No | N/a | No | N/a | Yes | Oral contraception, injectables |
| **P4** | Yes | Condom (M) | Yes | Condom (M) | Yes | Injectables, abstinence |
| **Group 3** | | | | | | |
| **P1** | No | Abstinence | No | Abstinence | Yes | Injectables |
| **P2** | Yes | Condom (M) | Yes | None | Yes | None |
| **P3** | Yes | Abstinence | No | None | Yes | Injectables |
| **P4** | No | None | No | Abstinence | Yes | Injectables |
| **P5** | Yes | Injectables | No | None | Yes | Injectables |
| **P6** | None | None | None | None | None | None |
| **Group 4** | | | | | | |
| **P1** | Yes | Condom (M) | Yes | Condom (M) | No | N/a |
| **P2** | No | None | No | None | No | N/a |
| **P3** | No | None | No | N/a | Yes | Injectables |
| **P4** | No | N/a | No | N/a | Yes | Condom (M) |
| **P5** | Yes | IUDs | Yes | IUDs | Yes | Oral contraception, injectables, implants, IUDs, condom (M) |
| **P6** | Yes | IUDs | Yes | IUDs | Yes | Oral contraception, injectables, |

| | | | | | IUDs, withdrawal |
|---|---|---|---|---|---|
| | | | | | |

**Table 7. Demographic information from IDIs with key informants**

| Participant # | Age | Sex | Occupation | Educational level |
|---|---|---|---|---|
| | | | | |
| **KI 1** | 40-50 | Female | Health practitioner/ NGO representative | PhD |
| **KI 2** | 30-40 | Female | Social worker | MA |
| **KI 3** | 20-30 | Female | NGO representative | BA |
| **KI 4** | 31-40 | Female | Teacher/NGO representative | BA |
| **KI 5** | 26-30 | Female | NGO representative | BA |
| **KI 6** | 40-50 | Female | NGO representative/Human Rights Activist | BA |
| **KI 7** | 40-50 | Female | INGO representative | MA |
| **KI 8** | 31-40 | Female | NGO representative | BA |
| **KI 9** | 26-30 | Male | Community activist, janitor | Diploma |
| **KI 10** | 26-30 | Female | Community activist, NGO representative, caregiver | BSc |
| **KI 11** | 50+ years | Female | Health practitioner/community activist | Nursing |
| **KI 12** | 50+ years | Female | Health practitioner (gynecologist) | MD |
| **KI 13** | 50+ years | Female | Government social worker | BA |
| **KI 14** | 26-30 | Female | Community activist, janitor | Diploma |
| **KI 15** | 40-50 | Male | Physician/MOH | MD |
| **KI 16** | 50+ | Female | MOH/Health Practitioner | MD, MPH |
| **KI 17** | 40-50 | Male | Health practitioner | MD |
| **KI 18** | 50+ | Female | Health practitioner (gynecologist) | MD |
| **KI 19** | 40-50 | Female | MOH/Health Practitioner | MHA |
| **KI 20** | 50+ | Male | Private gynecologist | MD |
| **KI 21** | 50+ | Male | Health practitioner (gynecologist) | MD |

| KI 22 | 40-50 | Female | NGO representative | Certificate |
|-------|-------|--------|-------------------|-------------|
| KI 23 | 50+ | Male | Health practitioner (gynecologist) | MD |
| KI 24 | 40-50 | Female | Social worker | MPH |
| KI 25 | 31-40 | Male | Student Researcher | BA |

## *Results*

This paper summarizes data that pertains specifically to the structural barriers of McLeroy's adaptation of the Social Ecological Model. This adaptation lends itself well to exploring the role of systemic policy-rooted barriers to careseeking (public policy level of the model). While the model does not directly explore the influence of gender and economics (employment), it does assess the symptoms of these factors. For example, gender norms that affect women's contraceptive decisionmaking at McLeroy's Community Level are influenced by socially-constructed gender norms at the wider societal level. The wider category of economics as a variable is reflected in McLeroy's Public Policy Level (as banning asylum seekers from formal employment is an explicit policy in Israel) and at the organizational level (employment policy influences careseeking).

Within McLeroy's organizational level, we create a "health systems" category, arguing that it is worthy of investigation to understand the various influences hindering access to contraception. Data analysis identified seven structural barriers each of which will be discussed in below: (1) distance to health facilities in Tel Aviv; (2) fragmentation of the health system; (3) unaffordability of contraceptive services; (4) limited supply of providers, clinic hours and medications; (5) low standard of care; (6) discrimination; and (7) social and linguistic communication barriers. (See the appendix for a profile of

participants). Key informants and men quoted in the results did not personally experience the barriers to contraceptive careseeking. The Eritrean women themselves alternated between first- and second-person narration. Eritrean men's perspectives were particularly important because they allowed the researchers to uncover differences in knowledge and perspectives that would affect careseeking behavior of their female counterparts. Any indication of differences might indicate a need for tailoring of future programming that would involve men. The information reported must be read and interpreted with these different perspectives in mind.

### *Distance to health facilities in Tel Aviv*

Many participants reported that a lack of geographic proximity to health care services was a significant barrier to Eritrean women's access to modern contraception. They stated that the two clinics serving as the main sources of medical care for asylum seekers are in Tel Aviv-Yafo. For example, one participant described that *"a lot of women come to Tel-Aviv to get contraceptive services... All the information, all the services are focused here because most of the population is here also and the NGOs are here." (Female Israeli NGO representative)* Many key informant participants indicated that, although the majority of Eritreans are densely concentrated in southern Tel Aviv-Yafo, in the city's poorest and most underserved neighborhoods, several thousands of Eritrean asylum seekers live in other parts of the country. Many participants concluded that Eritreans living outside of Tel Aviv-Yafo face a significant barrier of having to travel to the city in order to access contraceptive services: *"It's a big problem! ... It's a sin making thousands of people come to Tel Aviv to get [contraceptive services] reproductive health care."*

*Fragmented health system*

Both key informant and Eritrean participants explained that affordable care was available at the two humanitarian clinics (one government-sponsored and the other NGO-sponsored) for family planning services. However, these clinics were reported by participants to be often understaffed, underfunded and limited in their capacity to provide comprehensive reproductive healthcare. As a result, many women seek these services, particularly family planning, from the Tipat Chalav (maternal-child health stations). For the reasons explained below, the Tipat Chalav have been unable to meet the family planning needs of the Eritrean population.

Ministry of Health officials explained that historically family planning services were provided at maternal and child health stations known as Tipat Chalav. More recently, health maintenance organizations (HMOs), which can only be accessed by persons covered by national health insurance, have supplanted the Tipat Chalav network for most Israeli women who prefer the more comprehensive and technologically better equipped services offered at HMOs.

The majority of Ministry of Health officials who participated in the study stated that, in reaction to the decreasing demand from Israelis who were the majority of people who use these health services in South Tel Aviv until the arrival of asylum seekers from Eritrea and Sudan, the number of government-run Tipat Chalav stations and the services provided there had been reduced in recent years. Participants employed by the Ministry of Health indicated that Tipat Chalav in Tel Aviv-Yafo, for example, had recently stopped offering family planning services pursuant to a restructuring of their services.

The remaining government-run Tipat Chalav stations remain the only option, other than the two under-resourced humanitarian clinics, for uninsured women including Eritreans who, as asylum seekers, may not access HMOs. According to one participant from Ministry of Health, the Tipat Chalav stations were justified in ending contraceptive services because of budgetary constraints and decreased demand:

> *"One hundred and fifteen women come now to Tipat Chalav and most of them are Eritreans because they don't have another choice…they don't have health insurance. We used to have fourteen Tipat Chalav [in Tel Aviv-Yafo] providing comprehensive maternal and neonatal care and family planning but over the years we stopped giving full services because so few women come. Now we only have two or three Tipat Chalav. For the past year we no longer have a gynecologist … No family planning anymore…. Now the clinics are staffed with nurses. It's difficult to continue providing family planning and other services if the number of women coming decreased in every Tipat Chalav." (Israeli female health practitioner and government worker)*

The majority of key informant and Eritrean participants indicated that seeking contraceptive services often involves trips to more than one health facility.  This is because the reduction of services at individual Tipat Chalav clinics meant that the clinic cannot provide family planning and must refer patients to private physicians who are willing to offer their services at reduced rates. This patchwork of services is both complex to navigate and more expensive than if services were provided without having recourse to private physicians, even those offering reduced rates. One participant explained that:

> *"If I'm a woman and I want contraception and I only know about [one clinic], the chance that I walk out with contraception is very, very, very small. I have to know which days it is open. I have to get there on time and be early enough that my name makes it on the list. I have to find the right person who can help me. If I do find the right clinic, I would most likely get a referral to a private gynecologist [because of their limited supplies]. The [gynecologist] appointment would probably be a couple of weeks away so I would have to, you know, remember to go to it and understand it, understand the directions of how to get there, get there on time, be able to take off of work on that particular day, and finally get to the gynecologist." (American female social worker and NGO representative)*

In summary, although the two humanitarian clinics mentioned above did provide family planning services at reasonable rates, they were insufficient to meet the demand. While the Tipat Chalav was mandated to provide family planning services to women irrespective of their legal status, budget cutbacks and the move from the government operated centers to HMOS rendered the clinics also unable to meet the demand (50). One unintended consequence of this change in governance and financing, is the systematic exclusion of non-citizens from family planning service-provision and other quality reproductive health services.

### *Cost of contraceptive services*

Many key informant and Eritrean participants indicated that exclusion from public health insurance combined with the low wages they earn in the informal sector make cost a significant barrier to contraceptive access. Key informants explained that the humanitarian refugee clinic sponsored by the Ministry of Health[ii] charges asylum seekers for medications and services, although at a much-reduced rate. Private services, while available, were reported by most participants to be unaffordable for the majority of asylum seekers. For example, one community member explained that in order *"[t]o pay and get treatment is very expensive. The money you saved for two years won't be enough to cover your medical bills." (Eritrean male community member)* Many Eritrean community participants stated that, while the majority of women work, the costs of their healthcare needs are secondary to their other financial obligations. Many explained that the money that they earn on the informal market is used to subsist in Israel, pay the debts associated with their passage to Israel, and send remittances home to family in Eritrea. One Eritrean male community member shared his perspective:

*"Even without the cost of raising children, we are struggling for our basic survival… without exaggeration an Eritrean would rather remain sick and die than jeopardize their jobs and financial security [their job security] by taking the time to seek health care."* (Eritrean male community member)

Several Eritrean and key informant participants reasoned that in such situation there is a "struggle for survival.' One Ministry of Health official reported:

*"I want to tell you that their [Eritrean women's] lives are very, very hard and [if] they don't have work, they don't have money to pay their rent and they do not have health insurance. Their own health concerns are the last things that they think about. They don't have the money to insure their babies and children whom they put above themselves." (Israeli male physician and Ministry of Health official)*

### *Limited supply of health providers, clinic hours and medications*

Almost all key informant and Eritrean participants reported that the two humanitarian clinics providing affordable medical care, including contraceptive services, to asylum seekers lack an adequate number of health providers, hours of operation, time available per patient and contraceptive devices and products. The staff and volunteers are aware of the clinics' limited capacities, which are related to their mandate (volunteer staff whose clinics rely on donated medicines) as well as their structural and budgetary setup. For example, key informants explained that both clinics are staffed by volunteer medical providers and all medications are donated. Referring in specific to family planning services, one key informant working at one of the two clinics noted:

*"[t]here is a gynecologist once a week and it's not enough. So, it can take months before they [women seeking gynecological care] get assistance." (Israeli female NGO representative)*

One male community participant described his perspective of the typical experience of a woman seeking contraception in one of the two clinics providing services for this population:

**"**[The clinic] works with a certain quota. If they plan to see 15 people [women seeking contraception] today…no matter how long the line is they only see the number of people they planned to see. The first 15 people will get treatment [reproductive care] and the rest of the people in the line won't get medical attention. So there is a problem there.*

*Even if you get in you won't get enough treatment. There is not enough medication."(Eritrean male community member)*

### Low standard of care

The majority of Eritrean participants stated that certain private gynecologists offered services at a reduced rate for the asylum-seeking population. However, they also claimed that some of these physicians provided incorrect information, incorrect prescriptions, and did not examine patients prior to administering contraceptives such as injectable contraception. For example, one Eritrean woman participant sharply criticized a particular gynecologist, calling him "a very bad doctor" and accusing him of "ruining peoples' lives":

> *"He only cares about his time and money and he injects six women at the same time without even changing gloves ... He uses a medication that is meant to be used for one person and divides it for two. He claims that he provides pregnancy test but he doesn't even check...it has happened to me. I was three weeks late and I went there and he gave me an injection...After two months I started to experience morning sickness and I was worried and I asked a friend of mine and she told me that it happens and I shouldn't worry. I went after a month to get injected and he examined me and he confirmed that I was pregnant and I asked: "how is this possible?" because he was supposed to check if I was pregnant before injecting me ...I know this lady who without even knowing that she was 4 months pregnant went ahead and got injected." (Eritrean female community member)*

### Discrimination

Eritrean women participants seeking contraception and other reproductive health services reported that they felt discriminated against by health care providers at the refugee clinic and in public health facilities. One social worker shared what she had observed while visiting an Eritrean woman giving birth:

> *"Another time, I was at a birth and the doctor [was] having a side conversation in Hebrew with a nurse [and] said: 'Oh, all of these Eritrean infiltrators, infiltrating our hospital and coming all the time for births. Why do we have so many of them? It's so annoying." (American female social worker)*

One Eritrean woman explained:

*"wherever we go, … they don't listen to us…. They call us 'kushi.' It means black and their impression is that we are worthless…They let us into this country. Why didn't they kill us if it was like this? That would have been better. We don't know where we are or who we are. I am so done I cannot speak anymore." [weeping] (Eritrean female community member)*

Community members reported that discrimination was particularly prevalent in public health facilities. They noted, the expectation of disrespect and maltreatment by the administrative and/or medical staff acts as a major deterrent to seeking reproductive health services:

*"[W]hen it comes to us [asylum seekers from Africa], they don't care whether we live or die. [Even] in case of an emergency they could keep you waiting all night… so … you would think the birth control is a luxury. Thus, you won't be motivated to ask such questions … If they don't give you answers when you are in this [emergency] situation, how could you ask them about birth control?" (Eritrean female NGO representative)*

One Israeli physician cast some light on the phenomenon of discrimination in healthcare settings by stating that it stemmed from the communication barriers and discomfort experienced by healthcare workers when interacting with asylum seekers:

*"This [maltreatment] happens because it's difficult to talk to them [the Eritrean asylum seekers]. They don't understand anything. They just consume our time. Maybe they don't have a right to stay here. Maybe they stink. Maybe they are dirty, 'I don't want to be close to them, I don't want to touch them. Maybe they have diseases.' So, we have to look at it at the perspective of the healthcare workers, which are also human beings, and they also have their own attitudes towards foreign migrants. They also have their fears." (Israeli male Public Health Physician and Ministry of Health official)*

Other issues that added to the tension between asylum-seeking patients and the staff in Israeli public health facilities were fears and stigma related to tuberculosis (TB). Key informants indicated that African asylum seekers were often suspected of carrying TB; this led some hospitals to take precautionary measures, such as requiring African persons to wear masks in health facilities so as to prevent the infection of staff and other patients:

*"To prevent the transmission of infectious disease. We also have the responsibility to protect our staff." (Israeli female health practitioner and government worker)*

However, a Ministry of Health Official contended:

*"It is not a solution ... to put a mask on every migrant who comes to the hospital. I think in most cases it is not. When they are told to put one on [based only on their skin color], it is sheer discrimination." (Israeli male Public Health Physician and Ministry of Health Official)*

An Eritrean participant reported her experience of being asked to wear a mask in a

hospital:

*"The [health care provider] made us cover our mouths because Eritreans are said to have TB ... He said Eritreans have a disease... 'who said it?' I asked and he said the Ministry of Health. I cried and I was very sad. They asked me why I was getting emotional...I told them this is the first time I am being treated this way... why? They said they found [TB] in Eritreans.... If it's found in one person does it mean the whole world has it? Eritreans are not one person it's a community ... You get scared this discrimination will happen so instead of going to the hospital you choose to do everything yourself and get better at home... " (Eritrean female community member and volunteer translator)*

### *Inability to communicate*

One of the most consistently mentioned challenges in accessing care was the

language barrier. All Eritrean female participants were native Tigrinya speakers and

many could not speak Hebrew or English. Among the six individual interviews with

women, four could not speak Hebrew and three could not speak any English. Those that

spoke English were limited in their proficiency. Patients who only spoke Tigrinya

explained being reluctant to seek care because they could not express their health needs

or advocate for themselves, and there were few if any translation services available in

clinics. Unable to communicate with their patients, providers mentioned the difficulty of

obtaining health-relevant information from patients to understand their needs:

*"Language is a huge barrier. First, to understand their way of life; the risk factors, their sexual habits, sexual life... vulnerability... If I could speak Tigrinya, this clinic would be a totally different clinic. But we cannot speak Tigrinya; [we have interpretation services] just 10 hours a week...." (Israeli female social worker)*

Another health care provider described her unease with being unable to obtain informed

consent for particular contraceptive methods:

> *"I provide IUDs if they specifically ask for it but I don't feel comfortable not being able to explain the ramifications of this form of birth control. If I could explain... then I would feel a lot better. Because then I would know that they understood what they are doing." (Israeli female gynecologist)*

Most participants indicated that the communication difficulties thus reduced the options in terms of different types of contraception available to Eritrean patients:

> *"To explain to them [gynecologists] that I'm [an Eritrean woman] looking for...' again, language becomes huge, and now you are talking about private gynecologists.... They have fewer translators, ... They have to feel comfortable prescribing to someone who they can't really communicate with which is always a problem especially with things like the Depo-Provera injection which has very important side effects to explain. If they can't explain them then they are often unwilling to prescribe it at all." (American female NGO representative)*

> *"Most of the Eritreans do not take the pills, they take the injection. They worry about how to take them [pills]... They [pharmacists] explain how to take pills to them but they don't understand. Instead of misunderstanding the directions for pill use, the women would just prefer to take the injection." (Eritrean female NGO representative)*

Many health providers stated that they often relied heavily on other Eritreans in the waiting room to translate for their female patients. Eritrean participants and health providers alike suggested that the reliance on an untrained translator, often a man from the asylum-seeking community, may influence a woman's willingness to make her contraceptive needs known to the provider. For instance, one Israeli female health practitioner and government worker reasoned that involving another community member as an interpreter created *"a serious ethical problem. There is no doubt that the person translating will affect what a women says."*

One Israeli gynecologist explained her perspective:

> *"Even the translators didn't always have all the medical language that you really need to be able to explain certain things. But I think also, just a woman speaking to a strange man about her vagina; I don't know how comfortable anybody would be." (Israeli female gynecologist)*

Key informant participants described their perceptions of women's fear of their sexual and reproductive health information being shared by members of the Eritrean community with whom they lived, worked and socialized:

> *"Do they [the clinics] have a translator? Was the translator the male nurse who I [an Eritrean woman] know from Eritrea? I'm [the Eritrean female patient] definitely not going to say I want contraception in front of him." (American female NGO representative)*

## *Discussion*

Our main finding in this paper is that the political and economic marginalization of Eritrean women within the wider Israeli healthcare system may leave them with access to a fragmented health care system. In regards to family planning, there may be an unmet need for contraceptive services among female Eritrean asylum seekers in Israel due to a number of structural barriers in the healthcare system. That is, our results show that, despite Eritrean women's desire for family planning services, the social, political and economic marginalization of the Eritrean asylum-seeker communities in Israel impacts their access to basic services. This lack of access described by participants may result in high social and medical costs including unsafe abortion and its potential dire consequences for women's health and unwanted pregnancies leading to high numbers of children in already economically strained households. In many countries in the global north, the exclusion of asylum seekers from national health insurance systems has resulted in similar negative consequences including high costs for the health system and poorer health of migrants (202, 203).

The social ecological model allowed us to articulate how certain structural factors of the state health system overlap and intersect with asylum seekers' personal lives and their access to care while simultaneously recognizing that barriers exist at the

community, household, dyadic and personal levels as well. In order to better understand political and economic reasons for Eritrean women's fragmented access to contraceptive care, we used the critical theoretical lens of structural violence. Structural violence theory provided a means to explore how political and economic marginalization within Israel generally, and from the national health care system specifically, may result in Eritrean women seeking care from two humanitarian health clinics whose ability to provide consistent and quality services is limited by their capacity (small size, volunteer staff, limited medical supplies dependent on donations).

The study reveals a number of health systems-related factors within the organizational level of McLeroy's social ecological model influencing access to contraception for Eritrean asylum-seeking women. Distance to health facilities (with a concentration of services only in Tel Aviv-Yafo), the complex patchwork of fragmented health services, cost of care, inadequacy of supplies (a shortage of staff, limited clinic hours and supply of contraceptives), perceived low standard of care, discrimination in health facilities, and a lack of cultural and linguistic translation services were all described as playing a role in whether or not an asylum-seeking woman sought care. Communication barriers between health providers and patients have been identified in other studies as a major factor influencing contraceptive careseeking in industrialized countries with high irregular migrant populations (including those people with claims for asylum) (119, 187-200). In the absence of medically-trained translators employed by public and private health facilities, providers and patients alike described attempts to bridge the communication gap by simplifying treatment options (not offering the variety of options available) or using informal translators (which may affect a woman's desire to

speak openly about her sexual health and family planning needs). We argue that these systemic barriers to careseeking for migrants are rooted in political and economic marginalization reflective of structural violence.

Our findings support previous research that has shown that marginalized groups face additional difficulties in accessing contraceptive and other reproductive health services compared to non-marginalized groups (119, 189-194). Our study found many of the same structural level barriers identified by participants in prior studies including discrimination, complexity of navigating the health system, insufficient interpretation services, cost of contraceptive careseeking, lack of insurance coverage, distance to health facilities, and availability of family planning methods and providers (119, 187-200). Our findings suggest that these added difficulties may be built-in structural mechanisms that intentionally or unintentionally hinder access to services for marginalized populations.

A finding highlighted by our study was the central role ascribed to discrimination in health facilities. Eritreans appear to experience considerable prejudice in Israel and form a stigmatized population in the country (52, 55, 60). The general suspicion Eritreans have of their health care providers and their expectation of racial, class and religious discrimination may be compounded by their experiences with these forms of discrimination outside of health facilities. Eritrean participants reported widespread discontent with the care offered to them within a fragmented and largely unregulated private and/or charity-based health care system. Participants reported an acute sense of marginalization, in the health sector and elsewhere. Finally, the present context of increasingly restrictive immigration policies in Israel (55) and the absence of consistent and reliable health-related information that participants described may cultivate suspicion

and fear and thus increase barriers to accessing healthcare. Thus the structural violence (political and economic marginalization) experienced by Eritreans in Israel may result in a social stigmatization and interpersonal tensions between Israelis and Eritreans which negatively affect Eritreans' access to healthcare.

The general xenophobic sentiment towards Eritreans may explain most asylum seekers' perceptions that discrimination was rooted in race and religious prejudices, whereas Israeli key informants perceived that differential treatment in public health facilities was not necessarily tied to race or religion, but rather to racialized fears of infectious diseases and providers' discomfort with cultural and behavioral differences. Furthermore, providers' hesitancy in prescribing contraceptive methods to Eritrean women must be understood within the context of the forced contraceptive use of Ethiopian Jewish women in the 1980s in Israel (204, 205).

Studies conducted among ethnic and racial minorities, including African women seeking asylum in the United States and Europe, have found that racial and class hierarchies influenced patients' trust in providers and the treatments that they received in health facilities (119, 189, 190, 192-195). A review of disparities in family planning in the United States found that racial and ethnic discrimination by providers of marginalized women was a barrier to careseeking (192). In the context of Israel, Israeli health providers (like all citizens) are exposed to negative discourse about Eritreans in the media (206). Similarly, Eritrean asylum seekers are aware of the structural violence and its associated negative stereotyping and the wider political, social and economic marginalization that they experience in Israel (206). Thus both groups' experiences may influence interpretation of their interactions with each other in a clinical encounter.

According to Willen and Filc, political, social and economic marginalization of non-Jewish groups, including Eritreans in Israel, is rooted in the socio-political and historical context of Israel (49, 53, 207). Israel's desire to uphold its international image by adhering to international law and provide services for provisional Eritrean refugees as group "deserving" support is argued to be in direct conflict with: 1) its pressure to maintain a Jewish demographic majority in the country; 2) its fear of becoming a destination country for more migrants seeking asylum; 3) its beneficial relationship with the Eritrean administration(51); 4) its relative inexperience with non-Jewish migration; 5) the internal challenges of integrating Jewish migrants from all over the world; and 6) the ongoing Palestinian conflict where "the right of return" is an issue of contention (40, 49, 50, 52, 53)[xxix]. The 'othering' of non-Jewish communities in Israel is argued to be used as a justification for maintaining their exclusion from services and from society as a whole (53, 207). The increasing marginalization of asylum seekers is reflected in current legislation (55) and public discourse focused on the strengthening of the Jewish character of the state (52, 208).

The study has a number of limitations. The Eritrean community members that participated in Phase II of the study were recruited at the Physicians for Human Rights Open Clinic. The method of facility-based sampling may have led to inclusion of participants who were more likely than the average Eritrean population to seek health care services. The sampling of Eritrean participants from the Physicians for Human Rights Open Clinic may also have influenced the findings as persons seeking care in these facilities have more severe health concerns as compared to those going to the other humanitarian clinic. The limited number of participants and the method of sampling of

Eritrean community participants may influence the credibility of the research findings to other migrant populations in Israel and elsewhere.

The study also has strengths including that it is the first to study access and barriers to contraception for Eritrean women asylum seekers in Israel. The findings illustrate the various structural factors that influence contraceptive careseeking. The triangulation of researchers, methods, and sources as well as the member checking of findings with a select number of participants improves the validity of the study findings. The first author conducted fourteen months of intensive fieldwork provided a more in-depth understanding of the context and population.

An additional strength was the inclusion of the perspectives of Eritrean men and key informants. While in regards to the focus of the research these were third-party voices, each group's testimonies added to women's perspectives. Key informants provided a diverse systems-level view of the 'built-in' structural barriers to careseeking and Eritrean men's perspectives were important in understanding whether there were interpersonal level dynamics hindering women from seeking care. The results of this exploration will be presented in a future paper.

The identification of specific tangible barriers to careseeking point to a need for asylum-seeking women in Israel to have improved access to family planning, such as through inclusion in the national health insurance program as citizens. Despite differences between Israel and other host countries in the global north, models for providing the basic health care to asylum seekers through the same facilities and services afforded to citizens as have been demonstrated in United Kingdom, Spain, Portugal, and France (209, 210).

It is important to note that because resources for this population often focus on pregnant women and children, Eritrean and other asylum-seeking men and non-pregnant women may experience additional barriers to careseeking. Thus, despite a likely shared general lack of access to care, there may be variability in access to care among Eritrean asylum seekers. The differential access to reproductive health care may or may not relate to their levels of need. Future research could build on the findings presented here by examining this differential access to health services and support within the asylum seeking and migrant community as a whole. This could be done by exploring the ways in which health systems prioritizes and respond to the needs of Eritrean asylum seekers depending on their perceived vulnerability and deservingness (claim for assistance and support). Understanding the layers of vulnerability and the system's response to their needs may have wider implications for improving access to care for asylum seeking and migrant groups in Israel and around the world.

# Conclusion

This dissertation is composed of three qualitative papers each of which addresses an issue in the three stages of the migration process: the journey from Eritrea to Israel, the arrival and initial settlement in Israel, and the reality of living in Israel as asylum seekers. More specifically the Chapters sought: (1) to report the connection between changes in context and risk of sexual violence during the journey from Eritrea to Israel; (2) to explain how Israeli immigration policies create political and economic exclusion that may be linked to increased vulnerability to sexual violence and exploitation; and (3) to identify health system level barriers to accessing contraception for asylum seekers in Israel.

Chapter Three details the various circumstances of risk to sexual violence experienced by women as they migrate irregularly across Ethiopia, Sudan and Egypt in order to reach Israel. The perpetrators of this violence included smugglers, traffickers, and fellow asylum seekers. All key informants who worked closely with the community, including health care providers, social workers and community activists stated that they had worked with many who had these experiences. While many participants (both key informants and community members) discussed the issue of human trafficking, it was members of the Eritrean community who explored in depth the degree of sexual violence that women endured en-route to Israel. The overwhelming majority of community participants had witnessed, experienced or heard of fellow Eritreans who were sexually abused while en-route to Israel.

Chapter Four identifies political and economic marginalization as a major contributor to sexual violence and exploitation in the workplace and violence in the home

as well.  We observed that key informants were generally open and willing to discuss the challenges facing the Eritrean community. The inclusion of Israeli government and NGO workers provided more insight into immigration policies that created system level barriers for the community.  Eritrean activists, who worked closely with the humanitarian community and the Eritrean population, offered a more in-depth understanding as to how these policies influenced lives on the ground.

We observed that some community participants were initially more fearful about discussing certain issues individually.  Male community participants often shared more details about the external political and economic factors affecting their lives, whereas women focused more on internal community issues. Focus group discussions (FGDs), while difficult to organize, were the settings in which participants most openly discussed the challenges stemming from Israeli policies as well as those coming from within the community itself.  While nearly all participants were able and willing to discuss rape en-route to Israel perpetrated by non-Eritreans, we noted that women were more likely to disclose information about sexual violence perpetrated by community members as compared to male participants.

Chapters Three and Four of this dissertation focus on the sexual violence and exploitation experienced by Eritrean women en-route to and in Israel. While the questionnaires did not ask about these issues explicitly, the IRB approved key topics that this study sought to address including: (1) the reasons for pregnancies and whether or not they are intended; (2) the ways that women who experience unintended pregnancies are viewed; and (3) perceptions of personal risk and vulnerability to unintended pregnancies. The IRB protocol also allowed analysis for the identification of issues related to data

collection/study procedures, as well as of thematic content on the conditions of unintended pregnancies among the asylum seeking population. The predefined questions found in the structured portions of the semi-structured questionnaires and focus group discussion guides were answered directly and succinctly as the responses were limited. The unstructured component, however, yielded a variety of topics and themes. In discussing unwanted and unintended pregnancies, sexual violence and exploitation was a common theme that arose. Thus, while the interviewer followed the interview guide in a pre-determined order, participants, particularly during the focus groups, often expanded the conversation to include issues that they perceived to be relevant. As is common in qualitative research, the interviewer was able to follow topical trajectories in the conversation that strayed from the guide because they were relevant to the subject of interest and to the population's experiences. Semi-structured interviews were selected as the method of data collection so as to allow participants the freedom to express their views in their own terms. This method of data collection provided the opportunity for identifying new ways of seeing and understanding the causes of unintended and unwanted pregnancies as well as the population's access to reproductive health services.

Chapter Five explores health-system (structural) barriers to Eritrean women's access to comprehensive family planning services in Israel. The majority of key informants indicated that the limited availability of affordable supplies, providers and services was a source of frustration for patients, providers and social workers alike. The majority of asylum seekers that participated in the individual interviews and FGDs had difficulty accessing consistent health care services and reported that the care that they received was often below standard. Both key informants and community participants

indicated that the status of asylum seekers lay at the root of their exclusion from the health care system and that this marginalization would in time produce poorer health outcomes as well as other social problems for both asylum seekers and Israelis alike. The seven barriers identified may suggest a need for further research in order to inform evidence-based policy recommendations for the Ministry of Health. These recommendations may help the Ministry of Health to invest in either improving existing services or devising more sustainable solutions to the inaccessibility to affordable and consistent care.

## *Voices*

In this study, we chose to include the perspectives of participants, specifically Eritrean men and key informants, who did not personally experience the events reported. The inclusion of Eritrean men and key informants is an example of acquiring narratives from third parties. The inclusion of third-party perspectives can be beneficial. Exploring the range in perspectives provides an opportunity to assess the heterogeneity of viewpoints. For example, men focused more heavily on the experiences of sexual violence perpetrated against Eritrean women by men outside of the community (both en-route to and in Israel) whereas women focused more intensely on their experiences of abuse in Israel, often perpetrated by members of their own community. Women seemed more reluctant to discuss their experiences en-route to Israel whereas men, particularly those that witnessed abuse, were open to sharing their experiences. Key informants provided a diverse array of etic perspectives when discussing the violence experienced by these women and the difficulties accessing care. For example, Ministry of Health Officials' perceptions of the barriers that women experienced in seeking family planning

differed from that of service providers (e.g. case workers, nurses, physicians) working closely with these women. This diversity of perspectives reflected their different roles, and level of interaction with the affected community.

The inclusion of third-party voices also presents several challenges. For example, third party voices are proxies for the people of who actually experienced these events. In the example of this study, Eritrean men and service providers were not directly affected by the sexual violence and exploitation nor the difficulty accessing contraception that Eritrean women experienced. They may also deliberately or inadvertently exclude or distort information. Despite the challenges of using this approach, the inclusion of third-party perspectives complemented the information that was learned from speaking with women themselves, adding dimensions to the study results.

### *Contributions of the study to migration and health*

Our main contribution to the migration and health literature is the description of the critical nexus between the political, social, and economic position of the person migrating (legal status, economic standing, nature of social support) and the contexts through which they traverse (degree of governability of territories and legal frameworks within these areas), and how this intersection can alter individual risk for sexual violence. The travel and destination phases of Zimmerman's model provided a structure for understanding the cumulative impact of sexual violence risk throughout the trajectory of movement.

In Manuscripts One and Two, Zimmerman's Model for Migration and Health provided a mechanism for conceptualizing and exploring the trajectory of Eritrean women's migration and the sexual violence they experience over the course of two stages

of the migration cycle. While Zimmerman's Model proved useful for conceptualizing the cumulative nature of adverse events at any one stage of movement, it did not provide a mechanism for understanding risks rooted in the wider political and economic framework within each category. The critical theoretical perspectives of intersectionality (Manuscript One) and structural violence (Manuscript Two) were used as lenses to explore subcategories within the travel and destination stages of movement that created variability in risk to sexual violence. We argue that each phase of migration is multi-faceted and multi-layered and that individual women's social and economic positioning in each context may influence their risk of abuse. More specifically, considering the intersections of gender, legal status, social support, and economic standing and contextual variables such as a country's adherence to international laws protecting migrants (including asylum seekers and refugees), national policies, formal and informal regional political agreements, religio-linguistic context, racial or ethnic hierarchies, the existence of civil law, produces a more comprehensive view of vulnerability to sexual violence within these different stages of movement. Previous research has called for the use of critical theoretical perspectives to understand the social determinants of the health of migrants in their destination countries (106, 110). We have found none, however, that followed a group of asylum-seeking women migrating irregularly throughout the trajectory of their movement within and across international boundaries (travel and destination stages) using the lens of sexual violence and exploitation.

I hope that this study opens the door to a conversation about the variability in irregular migrant populations. The reasons people left, the demographics of the movers, and the experiences along the way may vary. This variability should factor into the way

that their needs are addressed in their destination countries. This can be assessed in a chronological sense through the five stages of the Zimmerman cycle and with special attention to the variability of risk and context within each of these stages. There are many populations migrating irregularly whose reasons for movement differ but whose experiences and need for support are effectively the same. I hope that our findings spark research and interventions that take the heterogeneity of these populations into consideration.

Manuscript Three, discussed the barriers to contraceptive careseeking in Israel. For the purposes of this paper, we used the Social Ecological Model in order to nest systems-level barriers to contraceptive careseeking within the hierarchy of influences on women's health careseeking behaviors. This frame allowed for an exploration of the disconnect between women's desire for family planning methods and the politically and economically-rooted challenges that they face in order to access to care. While providing a useful structure and a recognition of the role of policy, the different levels of the Social Ecological Model were not "unpacked." In order to provide a more comprehensive depiction of our study population and the "built-in" systems level barriers that they faced, we applied the critical theoretical lens of structural violence.  The combination of this model and theoretical perspective enabled us to more thoroughly explore the sources of systematic inequality and its impacts on contraceptive careseeking behavior experienced by Eritrean women asylum seekers in Israel.

While previous studies have explored the structural barriers to accessing contraceptive care of asylum seeking women in host countries (191, 192, 194), they predominantly focus on economic, social (language, cultural), knowledge, discrimination

and religion as barriers (119, 189). We seek to add to the discussion on migration and access to contraception by highlighting the role of power and politics in determining access to contraceptive care for female populations that are marginalized by the systems in which they live. To date we have found no studies that have bridged the social ecological approach with structural violence in order to explore the link between status and access to contraceptive healthcare services for African asylum-seeking women in the Middle East.

While social ecological frameworks have been used to understand barriers to contraceptive careseeking among women migrants (107, 194), we have found none that combine these models with critical theoretical analysis of the wider power structures in which women asylum seekers with a non-permanent status (these studies are largely focused on women asylum seekers who have been or are soon to be locally integrated). Our paper extends beyond the typical focus on community, household, interpersonal and individual level barriers, to assess more closely the wider political and economic climate influencing access.

The combined use of public health models with critical theoretical lenses will hopefully begin the work for drawing a connection between exclusionary immigration and labor policies and the experiences of sexual violence and exploitation for asylum-seeking women en-route to and in Israel. In the broader public health literature, marginalization of women, whether political, economic, or social, fosters sexual violence, and often these women have little recourse to institutional protection and support. This research's exploration of the layers of vulnerability to sexual abuse lays a foundation for evidence-based policy changes to minimize these risks in the country of destination.

While this investigation may be limited in its ability to measure, we must have a starting point for understanding the issue. My research will hopefully inform other researchers who choose to investigate this topic area quantitatively and qualitatively. This exploration will hopefully facilitate future researchers' ability to assess the magnitude of the problem and advocate effectively on behalf of this population.

There are additional contributions to the current migration, health and human rights literature. First, this dissertation documents the flow of people from Eritrea to Israel, the nature of the journey, and the difficulties encountered at each step along the route. Secondly, using critical theory, this dissertation seeks to identify the two aspects of the violence reported: (1) the direct physical violence that these women incur and that their male counterparts witness including rape, torture, and death; and (2) the structural violence inherent to the contexts in which they live. We seek to depict the connections between the larger political and economic context and the conditions that foster the risk of sexual violence in women's daily lives. While Eritreans in Israel and populations like them have agency to create safe conditions in which to live, we argue that this agency is hindered by their social and economic positioning within the wider power structures in which they live.

### *Migration terms and protection*

Migration literature often does not acknowledge the multifaceted nature of migrant decision-making. It frequently dichotomizes voluntary economic migrants who cross international borders solely for economic gain from forced migrants who meet the criteria of the Geneva Convention and its corresponding protocol or other regional definitions. Turton argues that in reality there is no clear distinction between these two

groups (211). There is a continuum between the extremes of voluntary migration, where a person may opt to travel for a short-period of time after retirement and extreme forced migration such as being transported for the purposes of slavery (211). People's reasons for migrating are often a mix even within the same population undergoing the same external pressures. In light of these complex realities, we look to agencies like the UNHCR, whose work it is to codify these definitions in order to help us operationalize these terms and shape realities (211). These codified definitions are important because they have implications for the type of protection and services that migrants receive. Incorrectly applied, these terms may result in detrimental consequences for host states and migrants, particularly those in need of protection.

In politically charged countries like Israel, words have power. The terms used to refer to migrants in Israel reflect the agenda of a person or party and are used as tools to influence the volatile migration discourse that either challenges or legitimizes Israel's policies toward Eritreans there (50, 186, 212). This discourse molds the social and economic realities of the study population including their access to services (50, 186) (49, 212). The four most common terms that are used to refer to Eritrean migrants are "refugee," "asylum-seeker," "foreign worker" and "infiltrator" (50, 186) (49, 212).

The situation for Eritrean migrants in Israel has been complicated because Israel did not allow Eritreans to submit an application for the formal refugee determination status procedure ("RSD") until 2013, and the current mechanism for determining status is deemed biased by UNHCR (40). Instead Israel granted Eritreans "temporary protection status" with a conditional release from detention allowing them to remain in the country until the Israeli government deems it safe for them to return to their countries of origin

(58). The granting of temporary protection implies that there is a recognition that Eritreans are unable to return to their home country for fear of persecution (falling within the definition of forced migration). Temporary protection status in this context does not, however, allow them to work legally, provide access to any social services afforded to asylum-seekers under international law, and requires that they repatriate when the State of Israel decides it is safe to do so (58). Some claim that Israel has not instituted a formal refugee determination status procedure because of the large number of Eritreans currently there and Israel's fear that, if most of them qualified for *de jure* refugee status, it would affect Israel's desired Jewish demographic majority and potentially open up a discourse around Palestinian refugees (52).

The terms "refugee" and "asylum-seeker" are often used interchangeably. A "refugee" (either *de jure* or *de facto*) in Israel is a person who meets the three criteria of the *1951 Convention* and *1967 Protocol (12, 47).* A person can be referred to as a "refugee" because they have been formally assessed and legally granted refugee status *(de jure)* (12). People can be considered a *de facto* refugee if there is well-founded evidence that they would be granted individual refugee status if Israel allowed them to participate in an assessment procedure to review and recognize their claim (12). An "asylum-seeker" is someone who has fled persecution in their home country and is seeking protection in their host country (12).

While the stipulations of the temporary protection status exclude Eritreans from the services afforded to citizens, permanent residents and officially recognized refugees, this temporary protection and its subtle acknowledgement of Eritreans as forced migrants, enabled the Ministry of Health to open a humanitarian clinic named "The refugee clinic"

for Eritrean and Sudanese people in need of health services. This temporary protection also enables NGOs like the Physicians for Human Rights – Israel and others to use the terms that they believe to be appropriate for the population in order to advocate for increased protection on their behalf.  Temporary protection granted by the administration is often used as a basis for considering Eritreans de facto refugees. Their inability to access the services afforded them under international refugee law, their fear of punishment upon return to Eritrea, the inability of many Eritreans to obtain documents from the Eritrean embassy, their fear of detainment in Israel for indefinite periods of time, and no third-party countries willing to accept them all, has created a limbo status that is reminiscent of de facto statelessness for many. This reality has detrimental practical implications for their lives in Israel, and their ability to seek safety and security in other places (52).

It is argued that Eritreans who are referred to as an "asylum-seeker" or "refugee" may not all, in fact, meet the necessary criteria for individual refugee status according to the Geneva Convention and its corresponding protocol. While not every individual may have been personally persecuted by the Eritrean administration, however, research indicates that all who left the country irregularly will likely be punished upon return. Since Israel, however, does not allow Eritrean migrants' access to a fair and transparent RSD procedure, the accuracy of a label that is based on legal status is arguably irrelevant. The term "asylum-seeker" is valued because it is used to capture the initial intent of many Eritrean migrants to apply for refugee status (13, 52). Under international law, official recognition of refugee status obliges host-states to potentially incorporate these refugees into the national fabric (47). In the case of Israel, recognition of Eritrean migrants as

refugees would entitle them to almost all of the rights of citizens and permanent residents, including National Health Insurance coverage (49).

There is a very vocal proportion of the current Administration and the Israeli public who, despite no official consideration of Eritreans' claims for protection, consider them to be economic migrants (52, 212). Migrants who have left their home country solely for economic reasons are not entitled to any of these state-provided benefits (47, 186). This group often refers to the Eritrean migrants as "foreign workers" (50). Since the implementation of the updated *Anti-infiltration Law of 2012*, Eritreans have also been referred to as "infiltrators" who have allegedly migrated solely for economic reasons or with the intention of dismantling the national security of the state by supporting an anti-Israeli agenda (at best) and of being terrorists (at worst) (40, 52, 58, 63). The use of the terms "economic migrant" and "foreign worker" has tremendous implications not only for exclusion from health care services, but also for their ability to remain in the country outside of a detention facility and their protection from forced repatriation. The term "infiltrator" encourages exclusion and criminalization of their presence as a threat to national security.

For the purposes of this dissertation the term "asylum seekers" was used to acknowledge: (1) the deteriorating political, social and economic conditions in Eritrea and the intent of the majority of Eritreans who have migrated to Israel to seek asylum; and (2) the state of limbo arising out of the granting of temporary protection from deportation and the concurrent denial of access to services due to the lack of formal refugee status and recognition (50). The term irregular migration was also used in this dissertation in order to characterize the nature of their movement (crossing international

borders without documentation as is common among people seeking protection) as compared to other non-Jewish migrant groups in Israel. The combination of these two terms captures the essence of their fear of forced repatriation and the types of experiences that they incurred en-route.

### *Strengths and limitations*

The study findings were obtained from 13 months of data collection which included ethnographic research within the community, participant observation of clinics and NGOs, in-depth interviews with both key informants and community members, and FGDs with members of the community. The length of data collection allowed for the triangulation of methods and sources of data. Participants included in the study were all native Tigrinya speakers and predominantly Christian. While Tigrinya-speaking Christians comprise the majority of Eritreans in Israel, there are other groups that exist there, including but not limited to, the Saho and Bilen ethnic groups. Finally, the inclusion of Eritrean community participants was limited to men and women of reproductive age. While the majority of Eritreans in Israel are within this age range, there is a small minority of elders in the community for whom the findings may not be applicable. I was fluent in the Tigrinya language as well as accompanying social norms. This knowledge allowed me to volunteer as a translator at various NGOs and at the two humanitarian clinics providing services to the women. My knowledge of the language and customs combined with the length of time spent that I spent in the field, allowed me a more in-depth understanding of the complex historical, political and economic forces that shape the experiences of Eritrean migrants both in Eritrea and in Israel.

One limitation of this study could be the sampling of community participants for the individual interviews from the Physicians for Human Rights-Israel Open Clinic. Due to the difficulty recruiting community members to participate, we decided to use one of the two health facilities where asylum seekers seek care. It is possible that this method of sampling may have influenced our ability to gain insight into a diversity of experiences as those seeking care may have characteristics that differ from those who do not.

Despite this potential limitation, there are a number of factors that may make the research findings applicable to similar populations in other contexts. For example, the findings may be applicable to other asylum seekers who migrated irregularly with the help of smugglers (over land or sea) and who are not afforded refugee status in the industrialized countries in which they seek asylum. The political marginalization of these groups may have similar impacts on access to social services like healthcare. Some of these findings may also be applicable to other non-asylum-seeking irregular migrants who may not have claims for living in Israel or similar contexts as well. We hope that this research will provide more comprehensive information for health providers and policy makers about some of the mutable factors influencing the sexual health and reproductive wellbeing of Eritrean women living there so as to provide opportunities for improving the situation.

In order to aid in the accurate representation of the data, I discussed results and emerging interpretations with asylum seekers themselves, other researchers, International NGO workers, and NGO staff working closely with the community. With respect to member-checking, the student researcher returned to Tel Aviv for a period of three months to officially share the findings of the research with three key informants (one

gynecologist, one NGO worker, and one government worker) as well as a group of Eritrean women and one community activist. Formal and informal discussions with this select number of participants both corroborated our findings, as well as enhanced the depth and quality of the data.

Another potential limitation was the use of third-party voices as a source of data. As an indirect source of information, key informant and Eritrean men's perceptions of both sexual violence and the difficulties incurred in attempting to access contraception may be distorted. Despite this potential setback, we found the use of different perspectives illuminating. The triangulation of sources was conducted in order to meet one of the most important criteria for establishing "credibility" in qualitative work (as defined by Lincoln and Guba) (140, 213). According to their perspective, the "credibility" of qualitative studies is actualized when researchers are able to examine the multiple realities inherent to the study of a particular phenomenon (140, 213). The purpose is to capture the overlapping themes and inconsistent nuances that are both sensitive towards and reflective of real world complexities (140, 147, 213). Thus it was important to interview different parties who were familiar with the politically and economically determined conditions influencing Eritrean women's risk of sexual violence and access to services.

Key informants, the majority of whom were not a part of the Eritrean community in Israel, provided an important lens. The inclusion of case-workers, Ministry of Health officials, health care providers and domestic and international NGO officials, added a layer of depth to the study findings because they were most familiar with the health system. They also provided an important understanding of access to contraceptive

careseeking for asylum seekers as they were not directly or indirectly personally affected by the consequences of this limited access.

Eritrean men themselves did not experience the sexual violence discussed in this dissertation nor have they personally faced the barriers to accessing family planning methods. Despite being an indirect source of information however, research documents the importance of the male perspective in discussing reproductive health as men are "… important actors who influence, both positively and negatively, directly and indirectly, the reproductive health outcomes of women…" (214). Gender-based power has implications both for vulnerability to sexual violence and the "capacity of both women and men to realise their potential for health" (215, 216). As men are an integral component in understanding the risks that women endure, we felt it was critical that their perspectives be included.

## *Policy Implications*

Our findings suggest that the vulnerability of Eritrean women in Israel, and subsequent inequity in access to healthcare, may be rooted in the political and economic marginalization in which they live. In order to develop policies and interventions to ameliorate the circumstances of Eritrean women in Israel, future research must be commissioned. Additional quantitative and qualitative investigations will lay the foundation for an in-depth understanding of the political context of their home country, the individual reasons that they left home, the trajectory of their journeys, and the consequences of their legal and work status in Israel is critical. It is also crucial to connect the circumstances of risk in which these women find themselves throughout their migration experiences to the wider power structures, including the various immigration

policies in all of the countries that they traverse. A more comprehensive understanding of the direct and indirect consequences of the connection between the political and the personal is important for providing the evidence necessary for sustainable solutions. Future research that does not investigate invisible power structures may be limited in its ability to identify root level problems whose amelioration could have a profound impact.

Our findings suggest that irregular migration creates the optimal conditions for sexual violence to occur. We suggest that international organizations such as UNHCR and local organizations must work closely with the governments' of transit and host countries to devise mechanisms by which irregular migrants, including those with claims for asylum, can seek refuge without risking their safety to do so and without subjecting themselves to the predations of smugglers and traffickers.

Our research also suggested a connection between immigration policies and overcrowded living conditions and unregulated workplaces, and that this nexus may foster the level of violence migrants experience on arrival in a host county. A potential solution to alleviate these problems would be for officials from the Ministry of the Interior and the Ministry of Labor to acknowledge system-level barriers and work to address them. Another potential solution would be for the Israeli government to develop a fair and transparent refugee determination procedure in line with the standards of the Geneva Convention. Additional potential mechanisms for improving the situation would be for the Israeli government should also allow asylum seekers access to formal employment as it would enable access to health insurance and reduce the economic pressures that result in increased stress and poorer health outcomes. If this is not possible for the Israeli government to do so then the UNHCR in Israel should be given

responsibility for the care of the asylum-seeking population. In addition to changes to current immigration policy, the Israeli government could develop smaller interventions to mitigate the tensions between Israelis living in South Tel Aviv and the asylum-seeking population. As the current health system available to asylum seekers is unable to provide access to comprehensive and quality reproductive health services, the Israeli government could develop mechanisms to incorporate asylum seekers into the existing health system so as to ensure that all of their health care needs are met (e.g. using taxes paid by asylum seekers to enable them access to one of the four Israeli HMOs).

A protection gap is defined as a situation in which asylum seekers or other irregular migrants are unable to access institutional protection and support from either their host or their home states (151). Despite high recognition rates elsewhere, Eritreans in Israel have fallen into a protection gap (77, 78). Only four of the 5,573 Eritrean and Sudanese asylum seekers that have submitted applications for refugee recognition have been accepted (217, 218). By contrast, in Europe (under the definition of the Geneva Convention and its corresponding protocol) and Africa (under the OAU definition for refugees), Eritreans have over a 90% total refugee recognition rate (77). This rate remains high even in countries like Switzerland where criteria for admission have become increasingly restrictive (77). Nor do these asylum seekers have the option of returning to Eritrea where the government persecutes returnees who emigrated without consent. This fear of persecution exists for Eritreans irrespective of their initial reasons for leaving the state (whether or not they were individually persecuted). Furthermore Eritrean children born in Israel are not granted citizenship or any other status.

Ponthieu and Derderian in their article "Humanitarian Responses in the Protection Gap" argue that

> … lack of assistance or incoherent policies only aggravate humanitarian needs …. States facing such influxes must adapt migration and refugee policies coherently to avoid increased vulnerability and to uphold people's rights and human dignity (151).

Israel's policies are an example of both a lack of assistance, and even more significantly, the application of punitive measures to discourage migration there (218). Since 2012, Eritrean asylum seekers have been caught in the policy debates between the Knesset, which has passed amendments to an Anti-infiltration Law that require the detention of asylum seekers, and the High Court of Israel which to date has declared the Knesset's amendments unconstitutional (217).

Currently, Eritrean asylum seekers continue to be summoned to the Holot Detention Facility and detained in the Saharonim closed facility (55). The newly elected Minister of the Interior, Gilad Erdan, announced that Israel would begin forcibly resettling Eritrean asylum seekers to a third country in the coming week (217). The government claims that the purpose of this policy is to protect the Israeli residents of South Tel Aviv, where the majority of asylum seekers live (217). The Attorney General, Yehuda Weinstein, has agreed to this plan leaving the final ruling to the High Court of Justice (217). (The High Court has overruled two previous attempts by the Knesset to legalize indefinite detention (55, 217).) International agencies to which asylum seekers might appeal have no ability to provide protection from detention or forcible deportation because they would require Israel's consent to operate freely. In the case of the UNHCR, that consent has been largely limited (52).

There are a number of potential responses to the protection gap facing Eritreans in Israel many of which are similar to those mentioned above. First, Israel could allow the

UNHCR to take more responsibility to resolve the status insecurity of Eritrean asylum seekers in Israel. Secondly, the Ministry of the Interior could implement a more transparent and fair refugee status determination process to facilitate the protection of asylum seekers who meet the criteria of the 1951 Convention and its corresponding Protocol. Thirdly, Israel could provide Eritreans in Israel access to the formal work sector. This would enable them to have a more stable standard of living and also allow them to access to the national health insurance system and adult education in exchange for taxation. Lastly, children born to Eritrean asylum seekers (born in Israel or arriving there with their parents) could be afforded an official and more permanent status that would entitle them to free access to health care services and support for infant care and preschools.

There are a few different audiences to whom this research may be relevant. The international human rights audience may be interested as this study may help raise awareness and support advocacy for forced migrants. Perhaps it may motivate a reexamination of the type of protection that can be offered to these people, and how various actors can more effectively respond to their needs.

The research community may be interested for other reasons. The findings of this study may suggest to them that there is a need to better understand and document the health care needs of this population and others like them given their migration trajectories. Thorough quantitative and qualitative exploration may add depth and breadth to our understanding of the health concerns so that the situation can be improved.

The third audience is that of local stakeholders. The Ministry of Health and other organizations working to ameliorate the challenges facing these marginalized

communities may find this work valuable because it depicts the heterogeneity of women's needs and experiences and may offer insight into potential mutable systems level barriers that can be addressed in an appropriate, feasible and sustainable manner.

*Research agenda*

Our study explored the experiences with violence and marginalization of Eritrean women asylum seekers through the lens of reproductive health. These issues can be assessed through a number of other important lenses. Qualitatively, future research could explore the health impacts of witnessing sexual violence on men, women and children en-route to Israel. Future research could also qualitatively explore the male experiences in transit with sexual violence. Another potential study would qualitatively explore the predictors of survival for men, women and children that make the journey. This research could serve as the foundation for quantitative work assessing the magnitude of these experiences and the corresponding negative health consequences within the population.

In regards to marginalization within Israel, future research could perhaps use our findings as a basis from which to qualitatively and quantitatively explore the health concerns facing men and children in this population and the barriers and facilitators that they experience in accessing healthcare. This research could be extended to the wider irregular migrant communities in Israel. While our research discusses the difficulties in accessing family planning services in the current Israeli health system, the challenges faced in accessing other types of health care have been largely unexplored. Future research could also explore the fates of infants that resulted from the sexual violence described in our papers as it has come to our attention that many of them are left in hospitals to be taken to orphanages. Research on the health conditions of the daycare

centers where Eritrean infants are left while their parents work is another area of potential research.

The accumulation of this evidence may play a role in evidence-based policy changes. More information may offer a foundation for officials representing the various branches of Israeli government to devise sustainable and just political solutions to the challenges facing the asylum-seeking population. Ultimately additional evidence must be combined with political will in order to address the challenges experienced by Eritreans in their home country, in transit, and in Israel.

# References

## *Appendices*

### *Key informants' profiles*

- *Health care providers*

There were six practicing health care providers, half of whom were male and the other half female all of whom were over 50 years of age. They included five gynecologists and one nurse. Five of these providers were Israeli and the last was Eritrean. The providers, while they worked with the Eritrean population extensively, had no cross-cultural training. Only the Eritrean health provider spoke Tigrinya.

- *NGO workers*

There were seven workers providing services to Eritreans at various NGOs throughout Tel Aviv. These NGOs were Israeli or international focusing on health, workers rights, and advocacy. All of these workers were female and the average age of 55 years. They included social workers, volunteers, and heads of various NGO departments. Five of the six NGO workers interviewed were Israeli and one was an American. All of the NGO representatives interviewed worked intimately with the Eritrean population. None of them spoke Tigrinya.

- *Government workers*

There were five government workers included. They worked for Ministry of Health Offices that provide STD testing, District and Municipality Health Offices and in government-sponsored centers. All were Israeli or international focusing on health, workers rights, and advocacy. Four of the five were female and their ages ranged from 39-50+ years. They included social workers, public health practitioners and high-ranking MOH officials. All five of the interviewed were Israeli. Two of the five had worked with

Eritrean asylum seekers directly. None of them spoke Tigrinya.

- *International NGO worker*

One International NGO representative was interviewed for the study. The participant was and Israeli female between the ages of 40-50 years. She had worked extensively on issues related to Eritrean asylum seekers and had some contact with them.

- *Eritrean community activists*

Four community members were included. Three of the four community members volunteered their time providing grass roots support for members of their community. These services ranged from developing organizations to providing translation services. One of the activists was a student researcher at a local University. Two of the activists were male and two were female ranging from 26-31 years of age.

*Eritrean community members' profiles*

- *Eritrean community members*

There were 56 Eritrean men and women included in the study ranging from 18-49 years (44 of these men and women participated in focus group discussions). Demographic characteristics from the 12 in-depth interviews are provided here. Four of the six female participants were married, one was divorced and one was single. One of the six male participants was married and one was divorced. The remaining four were single. Five of the 6 women and one of the six men reported having children. Half of female participants reported past use of modern methods of contraception (injectables) and only one reported current use of modern methods (unspecified). Two of the six men reported past use of modern methods of contraception (male condom) and these two continued to use this method. All but one male participant reported personally experiencing or knowing someone who had experienced an unwanted pregnancy. Seven of the

participants completed their secondary education, one had completed college, and the remaining four completed middle school or had no formal education. Ten of the twelve participants were employed, two were unemployed and two had recently stopped working. Three of the twelve participants had some kind of a work contract, and all of them were women.  These three women, and one male participant had some form of health insurance (privately sponsored or through employment).  All participants had been in Israel ranging between one and six years.

*Questionnaire*
*Key informant interviews: Unintended Pregnancies among Eritrean asylum seekers*

**Interviewer name:**

_____

_____

**Interview date:** _____     **Interview location:**

_____

*Complete consent form (explaining purpose of study, confidentiality of information and voluntary nature of interview) prior to beginning the interview.*

**Module 1:  Demographic Information**

| MODULE 1: DEMOGRAPHIC INFORMATION | | | |
|---|---|---|---|
| **Number** | **Question** | **Instructions** | **Coding** |
| 1. | Nationality? _____ | Record actual nationality. | 1.  Eritrean<br>2. Israeli<br>99.  Other: _____ |
| 2. | Age?  _____ | Record actual age. | 1. >20      2. 21-25<br>3.  26-30    4. 31-40<br>5.  40-50    6. 50+ |
| 3. | Gender?  (circle one)<br>    Male  /  Female | | 1.  Male<br>2.  Female |
| 4. | Occupation<br><br>    _____ | Record exact occupation on the left and circle the category in which it falls on the right. | 1.  Health practitioner (physician, nurse, PA etc.)<br>2.  Social Worker<br>3.  NGO representative<br>4.  Government worker<br>5. Community member<br>6. Community leader<br>7. International NGO |

| | | | representative<br>99. Other:<br>_____ |
|---|---|---|---|
| 5. | Mother tongue?<br><br>_____ | *What language did the participant speak while growing up at home?* | 1. Afar<br>2. Amharic<br>3. Arabic<br>4. Bilen<br>5. Hedareb<br>6. Saho<br>7. Kunama<br>8. Nara<br>9. Tigre<br>10. Tigrinya<br>11. Hebrew<br>12. English<br>13. Fur<br>99. Other:<br>_____ |
| 6. | Other languages spoken?<br><br>_____<br><br>_____ | *List as many as the participant answers.* | 1. Afar<br>2. Amharic<br>3. Arabic<br>4. Bilen<br>5. Hedareb<br>6. Saho<br>7. Kunama<br>8. Nara<br>9. Tigre<br>10. Tigrinya<br>11. Hebrew<br>12. English<br>13. Fur<br>99. Other:<br>_____ |
| | | | |
| 8. | How many years of experience do you have working with the Eritrean asylum-seeking populations? | | 1. >1 year<br>2. 1-5 years<br>3. 5+ years<br>99. Other:<br>_____ |

| 9. | What is the highest level of education that you have completed?<br><br>_____ | *Record highest level obtained.* | |
|---|---|---|---|

| Number | Question | Instructions | Coding |
|---|---|---|---|

| 10. | What was your occupation in your home country?<br><br>_____ | Only ask if the interviewee is a member of the refugee community or an expatriate. Record occupation. | |
| --- | --- | --- | --- |
| 11. | What is the average age of women becoming pregnant in this population?<br><br>_____ | | 1. > 18 years<br>2. 18-25 years<br>3. 25-30 years<br>4. 30-35 years<br>5. 35-40 years<br>6. 40+ years |
| 12. | Does your organization deal with family planning? | | 1. Yes<br>2. No |

- *Qualitative open-ended questions*

## MODULE 2: REPRODUCTIVE HEALTH CARE SEEKING

1. What is the legal status of the women with whom you work?

2. Could you describe some challenges that these women face in their daily lives?

   a. Probe on how legal status influences their access to health care.

3. Could you describe the factors that empower women in these communities?

   a. Probe on resources that enable women to deal with the challenges of being in Israel.

4. Could you describe any challenges that you have observed in the access to family planning for these women in the health system?

   a. Probe on structural level challenges, discrimination, miscommunication

5. Could you describe any challenges that you have observed in the access of family planning for these women at the community and individual level?

   a. Probe on gender relations, community dynamics, religion, cultural practices

6. Could you describe the demand for family planning in your experience?

7. To what extent do you understand the family planning desires of this population?

8. Could you describe any challenges in accessing family planning unique to this population as compared to Israeli's or other migrants

9. Could you describe the reproductive health services available to women who were trafficked through the Sinai when they arrive to Israel?

10. To what extent do you know about  informal provision of family planning services?

    a. Probe:  Physicians involved in the provision of such care using informal/poor quality practices and also members of community providing reproductive health care

11. Could you describe how family planning provision is monitored for quality assurance?

12. To what extent do you consider unwanted pregnancies to be a concern for this population?

13. Could you describe the factors that put women at risk for these pregnancies?

14. Please describe the consequences for bringing unwanted pregnancies to term for these women and their partners and families.

    a. Probe: Social, legal and economic consequences separately.

15. Could you describe any challenges in communication between providers and patients?

16. Please describe the consequences of miscommunication that you have observed in the provision of reproductive health services.

    a. Probe on how miscommunication influences the demand for family planning

17. Could you describe a potential solution to the challenge of reproductive health care provision for these migrants?

18. Could you describe the reasons for the absence of a governmental solution to health care for the Eritrean community?

a. Probe on the evolution of the current health provision for asylum-seekers

19. Is there anything else you would like to add that you think may be helpful for me to know in learning about access to reproductive health care and/or any of the topics discussed above?

*Questionnaire: Individual interviews with Eritrean asylum seekers*

**Interviewer name:**

_____

_____

Translator present: yes or no

Translator name: _____

**Interview date:** _____    **Interview location:**

_____

***Complete consent form (explaining purpose of study, confidentiality of information and voluntary nature of interview) prior to beginning the interview.***

**Module 1:  Demographic Information**

| MODULE 1: DEMOGRAPHIC INFORMATION | | | |
|---|---|---|---|
| **Number** | **Question** | **Instructions** | **Coding** |
| 1. | Nationality? <br> _____ | Record actual nationality. | 1.  Eritrean <br> 2. Sudanese <br> 3. Ethiopian <br> 99.  Other: <br> _____ |
| 2. | Age?  _____ | Record actual age. | 1. >20      2. 21-25 <br> 3.  26-30    4.  31-40 <br> 5.  40-50    6.  50+ |
| 3. | Gender?  (circle one) <br>    Male  /  Female | | 1.  Male <br> 2.  Female |
| 4. | Occupation <br><br> _____ | Record occupation. | 1.  Health practitioner (physician, nurse, PA etc.) <br> 2.  Social Worker <br> 3.  NGO representative <br> 4.Hospitality <br> 5. Construction <br> 6. Janitorial services <br> 7. Childcare <br> 8. Day laborer <br> 6. Business owner |

| | | | 7. Student<br>99. Other:<br><br>_____ |
|---|---|---|---|
| 5. | Do you have a work contract? | | 1. Yes<br>2. No |
| 6. | Do you have health insurance through your work? | | 1. Yes<br>2. No |
| 7. | If yes, what type? | | 1. Israeli national health insurance<br>2. Private self-sponsored insurance<br>3. 99.  Other:<br><br>_____ |
| 8. | Do you have any other form of health insurance in Israel? | | 1. Yes<br>2. No |
| 9. | If yes, what type? | | 3. Israeli national health insurance<br>4. Private self-sponsored insurance<br>99.  Other:<br><br>_____ |
| 10. | Mother tongue?<br><br>_____ | *What language did the participant speak while growing up at home?* | 1. Afar<br>2. Amharic<br>3. Arabic<br>4. Bilen<br>5. Hedareb<br>6. Saho<br>7. Kunama<br>8. Nara<br>9. Tigre<br>10. Tigrinya<br>11. English<br>12. Fur<br>99. Other:<br><br>_____ |
| 11. | Other languages spoken?<br><br>_____<br>_<br><br>_____<br>_ | *List as many as the participant answers.* | 1. Afar<br>2. Amharic<br>3. Arabic<br>4. Bilen<br>5. Hedareb<br>6. Saho<br>7. Kunama<br>8. Nara |

| | | | 9. Tigre<br>10. Tigrinya<br>11. Hebrew<br>12. English<br>99. Other:<br>_____ |
|---|---|---|---|
| 12. | What city/town/rural area were you born in? | Record location. | 99. Other:<br>_____ |
| 13. | What is your marital status? | | 1. Married<br>2. Single<br>3. In a relationship<br>4. Divorced<br>5. Widowed<br>6. Other:<br>_____ |
| 14. | If married or in a relationship, is your partner in Israel? | | 1. Yes<br>2. No |
| 15. | Do you have children? | | 1. Yes<br>2. No |
| 16. | If yes, how many children do you have? | | 99. Other: _____ |
| 17. | Are your children in Israel? | | 1. Yes<br>2. No |
| 18. | What is your living situation in Israel?<br><br>_____ | If other please record living situation. | 1. Rent a room with friends/family<br>2. Rent a room alone<br>3. Rent a room with spouse/partner<br>4. Stay with friends/family<br>5. Stay with stranger<br>6. Stay with partner<br>7. Stay in shelter<br>99. Other<br>_____ |
| 19. | Do you have your own income? | | 1. Yes<br>2. No |
| 20. | How much do you make per month? | | 1. Less than 2,000<br>2. Between 2000-4000<br>3. Between 4000-6,000<br>4. Greater than |

| | | | 6,000 |
|---|---|---|---|
| 21. | Do you send money home? | | 1. Yes<br>2. No |
| 22. | How often do you send money home?<br>_____ | Record how often. | |
| 23. | If yes, what proportion of your income is sent home? | | 1. less than 10%<br>2. 10%-20%<br>3. 20-30%<br>4. Greater than 30% |
| 24. | How many years have you lived in Israel? | | 1. >1 year<br>2. 1-3 years<br>3. 3-6<br>4. 6+<br>years_____<br>_ |

| 25. | What is the highest level of education that you have completed?<br><br>_____ | | 1. No formal education<br>2. Pre-primary,<br>3. Primary,<br>4. Middle,<br>5. Secondary<br>6. Tertiary<br>99. Other:<br><br>_____ |
|---|---|---|---|

| Number | Question | Instructions | Coding |
|---|---|---|---|
| 26. | What was your occupation in your home country?<br><br>_____<br>__ | Record occupation. | |
| 27. | Did you travel alone to Israel? | | 1. Yes<br>2. No |
| 28. | What countries did you travel to en route to Israel? | | Country 1: _____<br><br>Country 2: _____<br><br>Country 3: _____<br><br>Country 4: _____ |

| | | | Country 5: _____ |
|---|---|---|---|
| | | | Country 6: _____ |
| | | | Country 7: _____ |
| | | | Country 8: _____ |
| 29. | How much time did you spend in each place? | | Country 1: _____ <br> Time (months): _____ <br><br> Country 2: _____ <br> Time (months): _____ <br><br> Country 3: _____ <br> Time (months): _____ <br><br> Country 4: _____ <br> Time (months): _____ <br><br> Country 5: _____ <br> Time (months): _____ <br><br> Country 6: _____ <br> Time (months): _____ <br><br> Country 7: _____ <br> Time (months): _____ <br><br> Country 8: _____ <br> Time (months): _____ |
| 30. | What is the average age of becoming sexually active in your population? | Record in years. | |
| 31. | What is the average age of women becoming pregnant in your population? <br><br> _____ <br> __ | | 1. > 18 years <br> 2. 18-25 years <br> 3. 25-30 years <br> 4. 30-35 years <br> 5. 35-40 years <br> 6. 40+ years |
| 32. | Please list all of the forms of contraception with which you are | Check all mentioned. | 1. Oral contraception <br> 2. Injectables |

| | familiar. | If they mention something not listed write in other category. | 3. Implants<br>4. IUDs<br>5. Female Condoms<br>6. Male Condoms<br>7. Foam<br>8. Withdrawal<br>9. Abstinence<br>99. Other: _____ |
|---|---|---|---|
| 33. | Have you ever used any form of contraception? | | 1.Yes<br>2. No |
| 34. | If so, what types? | | 1. Oral contraception<br>2. Injectables<br>3. Implants<br>4. IUDs<br>5. Female Condoms<br>6. Male Condoms<br>7. Foam<br>8. Withdrawal<br>9. Abstinence<br>99. Other: _____ |
| 35. | Are you currently using any form of contraception? | | 1.Yes<br>2. No |
| 36. | If so, what types? | | 1. Oral contraception<br>2. Injectables<br>3. Implants<br>4. IUDs<br>5. Female Condoms<br>6. Male Condoms<br>7. Foam<br>8. Withdrawal<br>9. Abstinence<br>99. Other: _____ |
| 37. | If you have a partner in Israel, are they currently using any form of contraception? | | 1.Yes<br>2. No |
| 38. | If so, what types? | | 1. Oral contraception<br>2. Injectables<br>3. Implants<br>4. IUDs<br>5. Female Condoms<br>6. Male Condoms<br>7. Foam |

| | | | |
|---|---|---|---|
| | | | 8. Withdrawal<br>9. Abstinence<br>99. Other: _____ |
| 39. | Were you educated on its use? | | 1.Yes<br>2. No |
| 40. | If so, by whom? | | 1.Health care provider<br>2. Friends<br>3. Family<br>3. religious leaders<br>4.Other community members<br>5. Spouse<br>99.Other:_____ |
| 41. | What is your preferred method? | | 1. Oral contraception<br>2. Injectables<br>3. Implants<br>4. IUDs<br>5. Female Condoms<br>6. Male Condoms<br>7. Foam<br>8. Withdrawal<br>9. Abstinence<br>99. Other: _____ |
| 42. | Have you or anyone you know experienced an unplanned pregnancy? | | 1.Yes<br>2. No<br>99. Other: _____ |
| 43. | Have you or anyone that you know experienced an unwanted pregnancy? | | 1.Yes<br>2. No<br>99. Other: _____ |

- *Qualitative open-ended questions (IDI)*

# MODULE 2: REPRODUCTIVE HEALTH CARE SEEKING

**Access to family planning**

20. Could you describe for me the availability of family planning here in Israel?

    a. Probe: where it is available, who it is meant for, what types are available, informal provision, stores that sell condoms

21. Could you describe the preferred method of contraception on average in the community?

    a. Probe: women and men separately,

22. Could you describe the reasons that this/these method/s are preferred?

23. Could you describe the quality of the family planning services that are available to you?

    a. Probe: patient-provider communication, translator, what is lacking, what could be improved

24. Could you describe the support that you have when you need contraception here in Israel?

    a. Probe: who do you go to discuss your options, who directs women to the health facilities, translation

25. From your experience, could you describe access to contraception in your home country.

    a. Probe: Are there any barriers to access? What makes it difficult? Economics? Knowledge? Availability?

26. Could you describe the process of accessing family planning and other forms of reproductive health care in Israel?

    a. Probe: Are there any barriers to access? What makes it difficult (Economics? Knowledge? Availability? Spousal support? Religion? Social norms?)? Are there different norms for married and unmarried women? Has that changed in Israel?

27. Could you describe the main difference between access to contraception and other forms of family planning here and in your home country?

28. Could you describe ways in which access to family planning services could be improved for women and men in your community?

**Unwanted Pregnancies**

1. Could you describe how your role as a man/woman in your community has changed in Israel?

    a. If yes, probe to assess how the new context has influenced relationships.

2. Could you describe the decision-making power that women have in their relationships?

    a. Probe: For example, would a woman have the power to purchase goods, where to live, whether or not to have a baby

3. Could you describe what would make a woman vulnerable to unwanted pregnancies?

    a. Probe: decision-making within a marriage, living environment, demographic imbalance, Israeli employers, other migrants

4. Could you describe the reasons that a pregnancy would be unwanted?

5. Could you describe the consequences of an unwanted pregnancy?

    a. Probe: economic, social, legal consequences for mothers and fathers separately

6. Could you describe the pros and cons of contraceptive use in your community

    a. Probe: from the perspective of women, men and children separately

7. Could you describe what women/couples/families do in light of an unwanted pregnancy?

8. Is family planning accessible through informal networks?

    a. Yes or No

    b. Probe: If so, please describe where they are found, who provides them and peoples experiences with them.

9. Could you describe any experiences that you or anyone that you know has had with the reproductive health care system in Israel?

    a. Probe: cultural and linguistic barriers to communication

10. Is there anything else you would like to add that you think may be helpful for me to know in learning about access to reproductive health care and/or any of the topics discussed above?

***Unintended Pregnancies among Eritrean Asylum-seekers***
***Interviews with Asylum-seeker***
**Moderator name:**
**Translator present:  Yes or No**
**Translator name:**
**Focus Group Discussion Location:**

*Complete consent form (explaining purpose of study, confidentiality of information and voluntary nature of interview) prior to beginning the interview.*

**FGD Guide**
*Research Question:* What are the barriers and facilitating factors to the access and utilization of contraception among Eritrean Asylum Seekers in Israel?

*Estimated Time: 1.5* hour

## Module 1: Ask of each FGD participant separately prior to the start of the group discussion

| | | | |
|---|---|---|---|
| 1. | What is the average age of becoming sexually active in your population? | Record in years. | |
| 2. | What is the average age of women becoming pregnant in your population? _____ | | 1. > 18 years<br>2. 18-25 years<br>3. 25-30 years<br>4. 30-35 years<br>5. 35-40 years<br>6. 40+ years |
| 3. | Please list all of the forms of contraception with which you are familiar. | Check all mentioned.  If they mention something not listed write in other category. | 10. Oral contraception<br>11. Injectables<br>12. Implants<br>13. IUDs<br>14. Female Condoms<br>15. Male Condoms |

| | | | 16. Foam<br>17. Withdrawal<br>18. Abstinence<br>      99.   Other: _____ |
|---|---|---|---|
| 4. | Have you ever used any form of contraception? | | 1.Yes<br>2. No |
| 5. | If so, what types? | | 1.   Oral contraception<br>2.   Injectables<br>3.   Implants<br>4.   IUDs<br>5.   Female Condoms<br>6.   Male Condoms<br>7.   Foam<br>8.   Withdrawal<br>9.   Abstinence<br>      99.   Other: _____ |
| 6. | Are you currently using any form of contraception? | | 1.Yes<br>2. No |
| 7. | If so, what types? | | 1.   Oral contraception<br>2.   Injectables<br>3.   Implants<br>4.   IUDs<br>5.   Female Condoms<br>6.   Male Condoms<br>7.   Foam<br>8.   Withdrawal<br>9.   Abstinence<br>      99.   Other: _____ |

| 8. | If you have a partner in Israel, are they currently using any form of contraception? | | 1.Yes<br>2. No |
|---|---|---|---|
| 9. | If so, what types? | | 19. Oral contraception<br>20. Injectables<br>21. Implants<br>22. IUDs<br>23. Female Condoms<br>24. Male Condoms<br>25. Foam<br>26. Withdrawal<br>27. Abstinence<br>99. Other:_____ |
| 10. | Were you educated on its use? | | 1.Yes<br>2. No |
| 11. | If so, by whom? | | 1.Health care providers<br><br>2. Female friends<br>3. Family<br>3. religious leaders<br>4.Other community members<br>5. Spouse<br>99. Other:_____ |
| 12. | Have you or anyone you known experienced an unplanned pregnancy? | | 1.Yes<br>2. No<br>99. Other: _____ |
| 13. | Have you or anyone that you know experienced an unwanted pregnancy? | | 1.Yes<br>2. No<br>99. Other: _____ |

- *Qualitative open-ended questions (FGDs)*

## Module 2: Focus group discussion

*Probes to continue conversation*: Can you tell me more about that? Does anyone disagree? Does anyone agree? Can we see a show of hands? I see you are nodding (or shaking your head) in agreement (or disagreement), what part of that statement did you agree (or not agree) with? Is there anything further on this topic that someone would like to add? What is our consensus opinion on this topic before we close it out?

<u>BARRIERS AND FACILITATORS</u>

## 1) Could you describe any reasons that women would be vulnerable to an unwanted pregnancy?

**Probes:**

- Ability to access contraceptive information or services (linguistic competency in Hebrew or English, health worker attitudes)
- Demographic composition of living spaces
- (gender imbalance)
- Type of relationship (power structure of these relationships)
- Work environment
- Economic pressures (dependence on men to help survive, financial insecurity)
- Rape
- Social expectations to marry and give birth
- Fear of detention
- Limited social support

## 2) Could you describe some of the consequences of an unwanted pregnancy?

**Probes:**

- Impact on social standing within social networks (perception of unwanted pregnancies)
- Employment
- Economic standing
- Strain on relationship (if in a relationship)
- Stigma if not in a relationship
- Psychological stress due to insecure nature of their stay in Israel
- Pressure to remain in an undesired relationship

**3) Could you describe how life in Israel is different from life at home?**

**Probes:**
- Employment (control of finances)
- Change in the male to female ratio
- Social structure (lack of familial support, absence of gatekeepers)
- Linguistic barriers
- Power dynamics within relationships

**4) Could anyone describe any barriers to contraceptive access in your home country?**
- Financial constraints
- Health infrastructure (accessibility of facilities, availability of supplies, geographic distance)
- Gender (gender expectations of pregnancy as a mark of womanhood, respect conferred)
- Social stigmatization of sexual intercourse for unmarried women

**5) Could anyone describe barriers to contraceptive access in Israel?**

**Probes:**
- Discrimination due to ethnicity
- Discrimination due to race
- Discrimination due to religion
- Discrimination due to migrant status
- Financial constraints (Costs of procurement)
- Health infrastructure (accessibility of facilities, geographic distance)
- Gender (gender expectations of pregnancy as a mark of womanhood, respect conferred)
- Linguistic barriers (miscommunication)
- Employment (stability of employment in light of pregnancy or health concern)
- Parity (does the number of children that a woman has affect her desire to access contraception?)
- Age
- Self-efficacy
    - Do I feel capable of accessing contraception?
- Contraception's benefits outweigh its risks?
- Fear of side effects (physical (infertility) and emotional
- Fear of being "found out"
- Contraception is effective?
    - Contraception a good use of funds?
- Ability to use consistently
- History of behavior: previously used contraception

    o What was last experience of contraception like and how does that affect attitudes today?
- Knowledge of contraceptive methods
- Current health status

## 6) Could you describe anything that would make access to contraceptive use easier?

**Probes:**

- Communal support, knowledge, streamlined list of service providers,

## 7) Could you describe if there are any methods that are preferable to others?

**Probes:**

- Ask why each method mentioned is preferable and why others are not
  - Taste, smell, secrecy,
- Traditional methods vs. modern methods

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# Endnotes

i "The suspension of the parliament and the constitution, the universal and indefinite military conscription policy, and in general, the system of one-man rule have all been justified by the need to counter the "Ethiopian threat" so the settlement of the border issue would eliminate the rationale for maintaining this system and would undoubtedly lead to new domestic demands for addressing the nation's many political and humanitarian problems." 19.    Kjetil Tronvoll GG. Ethiopia and Eritrea: Brothers at war no more Al Jazeera. 2012.  Scholars argue that the Ethiopian threat is a political tool used to maintain unity among the Eritrean population at home. Conflicts with neighboring countries are argued to be effective distractions from political, economic and social repression domestically.19.          ibid. 20. UN rebukes Eritrea 'shoot to kill' policy ibid.2013.

ii Scholars argue that the current situation in Eritrea is borne from a legacy of colonial rule and the EPLF's military domination in the liberation struggle in which social and political opponents were imprisoned or killed.  Scholars argue that the repressiveness of the current administration is in fact rooted in a deep fear of internal disunity in the post-independence period.13.  Connell D. Escaping Eritrea - Why They Flee and What They Face. MER 264 - Pivot, Rebalance, Retrench [Internet]. 2012 03/05/2013; (MER 264), 14.
        Reid R. Caught in the Headlights of History: Eritrea, the EPLF and the Post-War Nation-State. The Journal of Modern African Studies. 2005;43(3):467-88.

iii According to Reporters without Borders, Eritrea has ranked last place in its World Press Freedom Index 2012-2013 for six consecutive years. 26.     Borders Rw. World press freedom index 2014. online: Reporters without Borders, 2014.

iv Scholars argue that it is possible that the contested border town of Badme may likely be handed to Eritrea officially for the purposes of peace.19.          Kjetil Tronvoll GG. Ethiopia and Eritrea: Brothers at war no more Al Jazeera. 2012.

v Some argue that the Eritrean administration may not want to remove the "Ethiopian threat" because it would create challenges to the PFDJ's power and would lead to increased pressures to face the domestic demands for addressing political and humanitarian problems.14.          Reid R. Caught in the Headlights of History: Eritrea, the EPLF and the Post-War Nation-State. The Journal of Modern African Studies. 2005;43(3):467-88, 19.     Kjetil Tronvoll GG. Ethiopia and Eritrea: Brothers at war no more Al Jazeera. 2012.

vi UNHCR reports that in recent months there has been an influx of unaccompanied children between the ages of five and eight years old entering refugee camps on the Ethiopian-Eritrean border.28.          Abiye Y. Unaccompanied Eritrean minors' influx shocks UN officials 2014.

vii Scholars argue that the extension of military training, the investment in Sawa military training camps, the militarization of education at the Eritrea Institute of Technology (the country's only University because the University of Asmara, no longer exists) is reflective of the underlying militaristic nature of the administration inherited from the 30-year struggle for independence. "The government is frozen in its pristine image of a militaristic struggle for independence in which sacrifice, hardship and struggle are the core principles of the former EPLF fighters, now the governing administration's ideology. Pluralism, democracy, human rights and freedom of speech and press are considered luxuries."14.    Reid R. Caught in the Headlights of History: Eritrea, the EPLF and the Post-War Nation-State. The Journal of Modern African Studies. 2005;43(3):467-88.

viii The term "irregular migrants" refers to those migrants who have crossed international borders without documentation including, but not limited to, migrants who enter with the intent of seeking refugee status or asylum.32.          UNHCR. Asylum-Seekers. UNHCR; 2010-2014 [cited 2014]; Available from: http://www.unhcr.org/pages/49c3646c137.html.

ix "A former Military Intelligence Officer Ta'ame Akolom was arrested in January 2012 by the Ethiopian police for participating in a smuggling and trafficking trade operating in Eritrea, and in camps in Ethiopia and Sudan. He confessed that the key coordinator of the smuggling and trafficking chain was General Teklai Kifle, commander of the Eritrean Border Surveillance Unit, also known as "Manjus," a "key coordinator of the human smuggling trade out of Eritrea" (ibid., para. 141). (van Reisen et al. 4 Dec. 2013, 48) or the commander of the "Western sector" of the Eritrean military" (UN 13 July 2012, 16, para. 59).23.

State USDo. 2013 Country Reports on Human Rights Practices - Eritrea. United States Department of State, 2014, 31.        Canada CIaRBo. Eritrea and Sudan: Situation of the border region between the two countries, including military and police patrols, as well as legal crossing points; information on physical obstacles to prevent crossing, such as fences and mines; number of people legally and irregularly crossing the border (2013-May 2014). 2014.

[x]"The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."41.Crime UNOoDa. Definition of Trafficking in Persons. Vienna: United Nations Office on Drugs and Crime; 2015; Available from: https://www.unodc.org/southeastasiaandpacific/en/topics/illicit-trafficking/human-trafficking-definition.html.

[xi] Some were intercepted while en-route to or from a refugee camp, while others are abducted living in *Shagarab* (a camp populated by Eritreans in eastern Sudan).43.        Reisen ME, M; & Rijken, C The Human Trafficking Cycle:  Sinai and Beyond [Draft]. Oisterwijk: Wolf Legal Publishers, 2013.  Still others were abducted while working in nearby agricultural fields, living in border cities like *Kassala*, or even living within Eritrea itself  They were held captive in Eastern Sudan and later sold to human traffickers who ultimately sell them to the Bedouin clans involved in human trafficking[2] in the Sinai.44.      van Reisen M, Estefanos M, Rijken C. Human Trafficking in the Sinai.  Reports indicate that many groups were involved in the human trafficking chain including: members of the Eritrean and Sudanese *Rashaida* and *Hidarib* ethnic groups, Sudanese, Egyptian and Eritrean authorities, members of the Egyptian *Sawarka* Bedouin group, Israelis, and finally Eritrean and Ethiopian collaborators—some former trafficking victims themselves.  Involvement in the trade ranged from abduction and transportation of victims, to operating the camps where people were tortured in the Sinai Peninsula.43.   Reisen ME, M; & Rijken, C The Human Trafficking Cycle:  Sinai and Beyond [Draft]. Oisterwijk: Wolf Legal Publishers, 2013, 44.          van Reisen M, Estefanos M, Rijken C. Human Trafficking in the Sinai, 45.  Watch HR. Egypt/Sudan: Traffickers Who Torture. Human Rights Watch, 2014 February 11, 2014. Report No.

[xii]Egyptian soldiers patrol the border with Israel and are charged with ensuring that no one crosses without documentation. If survivors evade the bullets of Egyptian soldiers and successfully crawl under a border fence separating Egypt and Israel, then Israeli soldiers took them to a temporary camp in the Negev, where they received medical care.44.       van Reisen M, Estefanos M, Rijken C. Human Trafficking in the Sinai.

[xiii]Scholars argue that the conflict between its ideals for a Jewish democratic state and the reality of nearly 300,000 non-Jewish migrants, 60,000 of whom would like to seek asylum (and cannot be returned) are the main reason for the slow and insufficient development of a transparent domestic legal framework for refugee status determination in Israel.40.     Afeef KF. A promised land for refugees? Asylum and migration in Israel. UN High Commissioner for Refugees; 2009, 50.     Gottlieb N, Filc D, Davidovitch N. Medical humanitarianism, human rights and political advocacy: The case of the Israeli Open Clinic. Social science & medicine. 2012;74(6):839-45, 53. Filc D. Circles of Exclusion: The Politics of Health Care in Israel. 2009.  While improvements have been made in developing a response to the demand for a political asylum procedure, it is argued by human rights organizations, NGOs, many local researchers and the United Nations that, to date, Israeli procedures are insufficient and biased, and therefore breach the rules codified in the *Convention* and *Protocol*.40. Afeef KF. A promised land for refugees? Asylum and migration in Israel. UN High Commissioner for Refugees; 2009, 49.     Willen SS. Transnational Migration to Israel in Global Comparative Context: Lexington Books; 2007.

[xiv]Israel restricts access to its National Health Insurance to citizens, permanent residents and officially recognized refugees. As a result, asylum seekers depend on a patchwork of government sponsored and humanitarian health care services.49.        Willen SS. Transnational Migration to Israel in Global Comparative Context: Lexington Books; 2007.

[xv]It is argued that Israel is not allowing Eritreans to apply for a RSD because of Israel's fear that, if Eritreans qualified for *de jure* refugee status, it would affect Israel's desired Jewish demographic majority and potentially open up a discourse around Palestinian refugees.52.     Paz Y. Ordered Disorder: African Asylum Seekers in Israel and Discursive Challenges to an Emerging Refugee Regime. Working paper no. 2052011 Sep. 05, 2012.

[xvi]An international refugee law which prohibits the generic repatriation of people, generally refugees into war zones and other disaster areas to places where their lives or freedoms could be threatened.61.
Convention and Protocol Relating to the Status of Refugees. Text of the 1951 Convention and the 1967 Protocol Relating to the Status of Refugees, (2010).

[xvii]These crimes included domestic violence and carrying two cell phones without proof of ownership.55.
Maya Kovaliyov SR. From One Prison to Another: Holot Detention Facility. Tel Aviv, Israel: Hotline for Migrant Workers, 2014, 58.      Refugee Livelihoods in Urban Areas: Identifying Program Opportunities Case study Israel. USA: Tufts University, 2012.

[xviii]According to Human rights organizations a number of married men with families have also been detained.55.      Maya Kovaliyov SR. From One Prison to Another: Holot Detention Facility. Tel Aviv, Israel: Hotline for Migrant Workers, 2014.

[xix]While *Holot* was designed to accommodate 3,300 people, it has been reported that 4,100 people were summoned.55.    ibid.

[xx] 2,639 men are currently held in the facility.55.     ibid.

[xxi]According to testimonies of detainees, food, clothing and medical care in the detention facilities is limited.55.      ibid.

[xxii]According to human rights organizations, as of March of 2014, 367 Eritreans agreed to return to Eritrea.55.       ibid.  Human rights organizations state that the lower number of Eritreans willing to return is due to the impossibility of arriving in the highly regulated Asmara airport from Israel and escaping imprisonment, torture and in some cases murder as a result of leaving the country illegally.55.
ibid.  The severity of the punishment is said to depend on many factors including payment of the diaspora tax, whether or not a person formally apologized to the regime and Eritrean Embassy in Israel in exchange for clemency, and whether or not they participated in the refugee movement in Israel.68. R. F. Conversation about 1,000 asylum seekers leaving Holot. Tel Aviv, Israel2014.

[xxiii]More than ten demonstrations occurred including candlelight vigils, restaurants serving African food in solidarity, and protests in front of foreign embassies and UNHCR in Tel Aviv, the Knesset, and in back of the Ministry of Interior. Protesters conducted a three-day strike from employment, a ten-day sit-in at Levinsky Park in southern Tel Aviv, and demonstrated in front of the *Holot* facility.70.    Tikue LL. Experiences of trafficking victims. In: Gebreyesus T, editor. 2014.

[xxiv] After being taken to Saharonim, they began a two-week hunger strike.68.      R. F. Conversation about 1,000 asylum seekers leaving Holot. Tel Aviv, Israel2014.

[xxv] There are Eritreans in Israel who have chosen to realign themselves with the Eritrean administration by signing forms indicating their regret for leaving the country and pledging their allegiance to the State.  Numbers of government supporters are unknown but are considered to be a small minority by members of the community.68.     ibid.

[xxvi] Eritrea is one of the few countries in the world that requires a 2% tax payment for all members of the Eritrean diaspora irrespective of their current citizenship.  This tax is a precondition for services provided by the government ranging from obtaining and/or renewing an Eritrean passport or any other form of identification documents to sending food or any other consumer products to one's family.

[xxvii] According to the Women's Refugee Commission, unmet need for contraception is particularly high among refugees and asylum seekers,184.     Commission WsR. Family Planning. NY, NY: Women's Refugee Commission; 2014 [cited 2014 07/31]; Available from: http://www.womensrefugeecommission.org/programs/reproductive-health/family-planning. as forced migration is a risk factor for unwanted pregnancy.185.         Bartlett LA, Purdin S, McGinn T. Forced migrants--turning rights into reproductive health. Lancet. 2004 Jan 3;363(9402):76-7.

[xxviii] One clinic is sponsored by the Ministry of Health and is targeted toward the asylum-seeking population and the second is affiliated with an NGO and provides services to all uninsured populations. 50.    Gottlieb N, Filc D, Davidovitch N. Medical humanitarianism, human rights and political advocacy: The case of the Israeli Open Clinic. Social science & medicine. 2012;74(6):839-45, 155.       Filc D, Davidovich N. Health Care as a National Right? The Development of Health Care Services for Migrant Workers in Israel1. Social Theory & Health. 2005;3(1):1-15, 186.         Gottlieb N, Filc D, Davidovitch N. Migrants' access to health care, state responsibility and NGOs' role in an age of neo-liberal globalization. Inequalities in Health Care for Migrants and Ethnic Minorities.229.

[xxix]Scholars argue that the conflict between its ideals for a Jewish democratic state and the reality of nearly 300,000 non-Jewish migrants, 60,000 of whom would like to seek asylum (and cannot be returned) are the

main reason for the slow and insufficient development of a transparent domestic legal framework for refugee status determination in Israel.40.    Afeef KF. A promised land for refugees? Asylum and migration in Israel. UN High Commissioner for Refugees; 2009, 50.    Gottlieb N, Filc D, Davidovitch N. Medical humanitarianism, human rights and political advocacy: The case of the Israeli Open Clinic. Social science & medicine. 2012;74(6):839-45, 53. Filc D. Circles of Exclusion: The Politics of Health Care in Israel. 2009.  While improvements have been made in developing a response to the demand for a political asylum procedure, it is argued by human rights organizations, NGOs, many local researchers and the United Nations that, to date, Israeli procedures are insufficient and biased, and therefore breach the rules codified in the *Convention* and *Protocol*.40.  Afeef KF. A promised land for refugees? Asylum and migration in Israel. UN High Commissioner for Refugees; 2009, 49.    Willen SS. Transnational Migration to Israel in Global Comparative Context: Lexington Books; 2007.

# Resume

**TSEGA ARAYA GEBREYESUS**
tgebrey1@jhu.edu

## EDUCATION
**Johns Hopkins University Bloomberg School of Public Health Expected Graduation: May 2015**
PhD, Department International Health Social and Behavioral Interventions Program
**University of Oxford: June-August 2014**
Certificate of completion from the International Summer Program in Forced Migration
**Columbia University Mailman School of Public Health Graduated: May 2010**
Master of Public Health (MPH), Epidemiology with Global Health track
**Bryn Mawr College,** Bryn Mawr, PA **Graduated: May 2008**
Bachelor of Arts, Anthropology, **Cum laude**
Senior Thesis: *Life Stories Written on the Body: An exploration of issues of identity through the lens of cultural markers*

## LANGUAGE TRAINING
**Berlitz Language Institute,** Tel Aviv, Israel, **Spring 2013**
**Qasid Arabic Institute,** Amman, Jordan, **Summer 2012**
**Alliance Française,** Denver, Colorado, **Summer 2010**
**ALIF Arabic Language Institute,** Fez, Morocco **Summer 2008**
**American University in Cairo,** Cairo, Egypt **Fall 2006**

## EMPLOYMENT HISTORY
**Columbia University Mailman School of Public Health, Department of Health Policy & Management Fall & Winter 2008**
☐☐ Worked as a Research Assistant transcribing interviews for a Macarthur Foundation Project

**LANGUAGES** Tigrinya, Fluency; Spanish, Arabic: Advanced; Amharic: Proficiency

## ACADEMIC RESEARCH EXPERIENCE
**Independent Research:  Access to Reproductive Healthcare for Eritrean Asylum-seekers, 2012-2013**
☐☐ Advocate and medical translator for Amharic, Arabic, and Tigrinya speaking asylum seekers and migrants
**Clinton Health Access Initiative (CHAI), Ghana Summer 2011**
☐☐ Protocol development
☐☐ Consultative workshops with Ghanaian collaborators to further develop the instruments for data collection

☐☐Visits to health facilities, pharmacies and licensed chemical shops at 3 of the 5 intervention sites

☐☐ Creation of a database for data entry and training manual for data collectors

☐☐ Engaging the support of community leaders

**National Institutes of Health, Bethesda, Maryland (IRTA Fellow) Spring & Summer 2011**

☐☐ Assisted in development of an intervention designed to reduce incidence of Podoconiosis in Wolayta, Ethiopia

☐☐ Verified translation of transcripts from Amharic to English

☐☐ Two publications

**Population Council, Cairo, Egypt Summer & Fall 2009**

☐☐ Conducted analysis on reproductive health data set

☐☐ Assisted supervisor in conducting literature search on post abortion Family Planning use

☐☐ Participated in activities conducted by Population Council regional office

☐☐ Presented research findings to colleagues


## COMMUNITY ACTIVITY/VOLUNTEER

**African Refugee Development Center, Israel 2012-2013**

☐☐ Advocate and translator for Amharic, Arabic, and Tigrinya speaking refugees and migrants

**Physicians for Human Rights – Israel 2012-2013**

☐☐ Medical translator for Amharic, Arabic, and Tigrinya speaking refugees and migrants

☐☐ Presented for visiting faculty and other stakeholders

**Eritrean Refugee Livelihoods, Cairo, Egypt Fall 2009**

☐☐ Helped conduct interviews for a needs assessment paper among 100 Catholic, Pentecostal, Muslim and Orthodox Eritrean refugees in Cairo

**Group for Community Recovery, New Orleans Spring Break 2009**

☐☐ Collected in-person and telephone interviews with grandparents raising grandchildren, conducted home visits, gathered field notes, took photos and video clips

☐☐ Met with Senator Broome to discuss and work on policy reform efforts

☐☐ Helped with site renovation projects at the Grandparent's House apartment building in Baton Rouge

**Child Family Health International, La Paz, Bolivia Summer 2007**

☐☐ Supported doctors in burn unit, prenatal care unit, street outreach clinic, surgery room, and women's jail clinic

☐☐ Participated in weekly lectures on Bolivia's health care system, traditional medicines, and of diseases

**Maan Refugee Support Group, Cairo, Egypt Fall 2006**

☐☐ Helped Darfur refugees build English language skills

**Attaba School, Cairo, Egypt Fall 2006**

☐☐ Taught English to deaf Egyptian, Ugandan and Sudanese people

**Save the Children, Addis Ababa, Ethiopia Summer 2006**

☐☐ Edited health education articles promoting sexual health

☐☐ Taught English at Selam Berr middle school to AIDS orphans and some HIV+ children 6-8th grade students

## LEADERSHIP ACTIVITIES
*Major Representative,* **Anthropology Department 2007-2008**
☐☐ Organized fundraisers and conference events
*Dancer,* **Senior thesis on Domestic Abuse Fall 2007**
*Founder and co-president,* **Student Movement for Real Change, Bryn Mawr Chapter 2007-2008**
☐☐ Raised $600.00 for Ugandan AIDS orphans school fund
*Publicity Co-head/dancer,* **Mayuri Bryn Mawr's South Asian Dance team 2004-2006**
☐☐ Promoted classical dance workshops, events, and performances at Bryn Mawr, Haverford, and Columbia University
*Social committee co-head,* **BACASO (African and Caribbean Affinity Group) 2005-2008**
- Promoted In charge of planning the welcome social, meetings and planned the BACASO culture show

## AWARDS
**\*Bill and Melinda Gates Millennium Scholar\***
**\*Bryn Mawr Summer Travel Grant\***
**\*David L. Boren Fellowship (Scholarship for overseas research and language study)\***
**\*Sidney Kark Award (Awarded by the department of epidemiology at Columbia University)\***
**\*Critical Language Scholarship (Full-funding for a summer of intensive Arabic language training in Amman, Jordan)\***
**\*Alliance Française Summer Scholar\***

## PRESENTATIONS
*Guest-speaker,* Sexual violence en-route from Eritrea to Israel, Ben Gurion University, Israel, May 2015
*Presenter,* Sexual violence en-route from Eritrea to Israel, 3rd Oxford Interdisciplinary Desert Conference, University of Oxford, England, April 2015
*Presenter,* Sexual violence en-route from Eritrea to Israel, Drylands, Deserts and Desertification International Conference, Ben Gurion University, Israel, November 2014
*Guest-speaker,* The migration experiences of Eritrean refugees in Israel,
Johns Hopkins University, February 2014 and March 2015
*Video presenter*, *Perspectives*, David L. Boren Fellowship Video, November 2013
*Guest-speaker*, Access to family planning and vulnerability to unwanted pregnancies among Eritrean women in Tel Aviv, Israel, Ben Gurion University, May 2013
*Guest-speaker*, Access to family planning and vulnerability to unwanted pregnancies among Eritrean women in Tel Aviv, Israel, Physicians for Human Rights-Israel, March 2013

***Guest-speaker***, Improving availability and access to affordable Artemisinin combination therapies in Ghana,
Johns Hopkins School of Public Health, August 2011
**Presenter,** *Challenges of targeting shoe distribution to genetically high-risk children*,
National Human Genome Research Institute (NHGRI), National Institutes of Health, March 2011

## PEER-REVIEWED PUBLICATIONS

Ayode, Desta, et al. "The Association of Beliefs About Heredity with Preventive and Interpersonal Behaviors in Communities Affected by Podoconiosis in Rural Ethiopia." *The American journal of tropical medicine and hygiene* 87.4 (2012): 623-630.

Ayode, Desta, et al. "A Qualitative Study Exploring Barriers Related to Use of Footwear in Rural Highland Ethiopia: Implications for Neglected Tropical Disease Control." *PLoS neglected tropical diseases* 7.4 (2013): e2199.

## NON-PEER-REVIEWED PUBLICATIONS

Gebreyesus, Tsega. "Bodies in the Desert." *Johns Hopkins Bloomberg School of Public Health & Huffington Post* (May 2014).