Understanding access to professional healthcare among asylum seekers facing gender-based violence: a qualitative study from a stakeholder perspective

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Abstract

Background: When it comes to gender-based violence (GBV), migrant women and girls represent the most vulnerable group. GBV can happen at any stage of migrants' flight and/or during asylum process. It has severe consequences on their life and health. Victims therefore need timely access to healthcare. This study explores the context GBV victims are faced with when they seek refuge in Switzerland. The study focuses on the organizational framework and the current strategies handling medical and psychological support. It identifies access barriers and maps needed support within the health system.

Methods : Qualitative methodology was used where we conducted five semi-structured focus groups and three interviews with sixteen stakeholders involved in the asylum process and health care professionals. We analysed the data using framework analysis.

Results : Study participants noted lack of confidence from the GBV victims in the legal and in the healthcare system as major barriers to disclosure of GBV. Since only GBV exerted before fleeing the home country gives the right to asylum, they also pointed out that victims do not disclose GBV that took place after they left their home country. Language was identified as a barrier to disclosure as well as healthcare access. Continuity of care at the moment of transfer from federal to cantonal accommodations is another issue that was deemed critical. Study participants felt that health professionals must be trained to identify GBV victims. First-contact caregivers available to these victims were deemed as the most competent professionals that could act as a "GBV coordinator".

Conclusion : In Switzerland, access to healthcare is guaranteed to all asylum seekers on a legal and structural level. Yet, health seeking by GBV survivors is hindered by major factors such as (lack of) confidence in the legal system, trust building in health providers and a breach in continuity of care during the asylum process. Trust building in legal institutions, health structures and professionals should be enhanced to facilitate disclosure and strengthen resilience. This includes a healthcare system with competent professional, support with language, cultural needs and seamless continuity of care beyond cantonal borders.

Background

Gender-based violence (GBV) is a human-rights violation shown to be associated with long-term health effects (Yount, 2017; CEDAW, 2017). GBV affects 35% of women worldwide (WHO, 2013). The most reported is sexual assault, although GBV also includes physical, emotional and psychological violence, sex trafficking, forced prostitution, harmful practices like genital mutilation, and forced marriage (UNHCR, 2013; WHO, 2013). Intimate-partner violence, as a form of GBV, is highest in the Eastern Mediterranean region (37.0%) and South-East Asia (37.7%). In high income countries the rate of GBV is up to 23.2% (WHO, 2013). In Switzerland, it is reported that one out of five women has experienced psychological or physical domestic violence at least once in her life (Flury, 2010).

GBV has severe consequences on the life and health of the survivors such as psychological suffering (e.g. anxiety, depression, alcohol misuse, smoking) and negative physical outcomes (e.g. injury, disease, shock, infection or chronic diseases like high blood pressure, disabilities) (State Secratariat for Migration, 2017; UNHCR, 2013; Flury, 2010). GBV can lead to disease related mortality (e.g. injuries, AIDS, unsafe abortion) or even homicide and suicide. Early intervention can improve depression, anxiety, post-traumatic stress syndrome and functional impairment (WHO, 2013; Women's Refugee Commission, 2016; UNHCR, 2013; Tol, 2013).

During emergency situations including fleeing one's country, sexual violence is the most immediate form of GBV (UNHCR, 2015). Some recent studies describe prevalence of GBV on migration routes or in humanitarian settings (UNHCR, 2015; Inter-Agency Standing Commitee, 2015; Directorate-general for internal policies, 2016; UNFPA, 2016). Furthermore, studies report that GBV may also happen in asylum reception facilities that are meant to offer protection to the most vulnerable populations (Keygnaert, 2014; Oliveira, 2018; Hémono, 2018). However, it often remains neglected and underreported due to fear of stigma, shame and victimization (UNHCR, 2011; Directorate-general for internal policies, 2016; UNHCR, 2015). A report of the World Health Organization (WHO) underlined the limited and uneven coverage of services needed by survivors and limited availability of trained health workers (WHO, 2016). Although GBV is underreported worldwide, it is estimated that more than 67% of migrant women and girls from Syria have been victims of at least one kind of GBV (UNHCR, 2015; WHO, 2016; Directorate-general for internal policies, 2016; Inter-Agency Standing Commitee, 2015; UNFPA, 2016). This is an astounding figure necessitating careful and more detailed investigations because, during humanitarian crises, women and girls represent the most vulnerable group and have a right to be protected (UNHCR, 2015; Directorate-general for internal policies, 2016).

Switzerland is among the many host countries that receive asylum seekers but only one report exists that discusses access to healthcare in this context (State Secretariat for Migration, 2017). This report underlines the need to address asylum seekers' psychological distress once they have been transferred from a federal asylum center (first accommodation center) to the final destination. There is no specific mention about healthcare services for GVB victims (State Secretariat for Migration, 2017). Yet early intervention proves to be effective in reducing psychological and physical consequences on the short and long term (Tol, 2013; Women's Refugee Commission, 2016). There are several reasons why care needs of this group often remain unnoticed and unaddressed. First of all, women survivors of GBV are often unaware that services are available or do not seek them fearing shame and blame (Inter-Agency Standing Commitee, 2015; Oliveira, 2018; Hémono, 2018). Furthermore, they lack the necessary language proficiency to access healthcare (Ackerman Rau, 2014; Gehri, 2016). On the part of health professionals, they may not always have the competencies to recognize the specific needs and may lack training and knowledge to identify vulnerable individuals or groups (Inter-Agency Standing Commitee, 2015). Barriers must therefore be minimized on both sides to ensure careful and correct access to needed care. To our knowledge, no research has been carried out about GBV-strategies in host countries.

The 2030 Agenda for Sustainable Development, implemented in Switzerland (Federal Department of Foreign Affairs, 2018), sets out 17 Sustainable Development Goals with 169 targets. In particular, Goal 5 aims to achieve gender equality and empower women and girls, focusing on the elimination of all forms of discrimination and violence against them (United Nations, 2015). The Convention on the Elimination of Discrimination against Women (CEDAW) Committee, in the periodic report of Switzerland, highlights the positive aspects in undertaking legislative reforms like the Federal Act on Measures against forced marriages in 2013 and the adoption of Article 124 of the Criminal Code, prohibiting female genital mutilation. Yet, the visibility and the implementation of the Convention across cantons (i.e. states) and communities has not been sufficiently addressed (CEDAW, 2016). Furthermore, it is "still concerned about underreporting of GBV in Switzerland, low prosecution and conviction rates, resulting in impunity for the perpetrators, the lack of a national action plan and the insufficient number of shelters" (CEDAW, 2016). One major issue in Switzerland is the political framework associated with 26 states. Cantonal differences cause disparities in funding for shelters and a lack of support for NGOs working with the victims. The CEDAW Committee therefore recommended Switzerland enhance its efforts combating GBV, increase its reporting and adopt a national action plan to strengthen services and develop independent studies by scientific experts as well as representatives of women's NGOs. The committee further recommended to ensure that medical professionals become more aware of the cultural and linguistic barriers and that female medical staff should be available (CEDAW, 2016).

In 2002, the Swiss Federal Office of Public Health (FOPH) launched the National Program on Migration and Health (2002-2007, 2008-2013, 2014-2017). The report underlines as causes of health inequality migration-related factors such as traumatic experiences, exposure to violence, poor healthcare in the country of origin and discrimination, uncertain residence status and poor knowledge of the national languages (FOPH, 2013). Furthermore, the report identifies socio-economic situation, lack of knowledge and poor health literacy as causes of healthcare access barriers. The main objectives of the program are to lower disparities in access to healthcare, enhancing migrant-oriented health promotion and prevention, education of healthcare staff and intercultural interpreting (FOPH, 2013). The report about healthcare in federal asylum centers contains some guidelines about how to approach different health related problems, but none specifically targeted at victims of GBV (State Secretariat for Migration, 2017).

Study purpose

Switzerland is a country with 8.5 million people, 25.1% of which are deemed to be of a migrant background (Federal Statistic Office, 2019). This number includes asylum seekers as well. An asylum seeker is a person seeking safety from persecution or serious harm in the country other than his or her own country (IOM, 2019). Asylum seekers are protected in a temporary manner in accordance with the 1951 United Nations Convention. Relating to the Status of Refugees, through the Asylum Act of the Federal Council (Federal Council, 2019). In 2018, Switzerland received 15,255 new asylum applications, 15.7% less than in 2017 (2016: 27,207; 2017: 18,088). Asylum seekers stem from Eritrea (n=2825), followed by Syria (n=1393), Afghanistan (n=1186), Turkey (n=1005) and Georgia (n=873) (State

Secretariat for Migration, 2019). Further, Switzerland was processing 62,050 asylum applications, of which 39.4% were women (State Secretariat for Migration, 2019).

Healthcare professionals in Switzerland must therefore be aware of, and address thoroughly, the care needs of GBV victims in this population and offer access to care for all types of health consequences. A few studies have been carried out in Switzerland exploring asylum seekers within the healthcare system (Interface, 2017; Ackerman Rau, 2014; Gehri, 2016). However, none have discussed the experiences of female asylum seekers who have faced GBV. It is therefore a task of all involved stakeholders, including social workers and healthcare professionals, to screen for GBV in a sensitive way with a focus on appropriate communication and to obtain reliable data while protecting the confidentiality of victims. The aim of this study is to analyze the *context* that asylum seekers, who are GBV victims, face when seeking professional help in Switzerland. On the one hand, the study focuses on the organizational framework and the current strategies handling healthcare support, and on the other hand, it tries to identify access barriers and maps needed support.

Methods

Qualitative methodology has been chosen because of the explorative nature of the study. We employed semi-structured interview guides for our focus-groups (FG) and individual interviews (I). The study was conducted in a border canton of Switzerland, one of the main entry points for asylum seekers. We decided to capture the experiences of stakeholders and not of GBV victims seeking asylum in Switzerland because we deem the topic to be sensitive and difficult, with the risk of re-traumatizing the participants. In light of no clear direct benefit to the GBV victims as participants and the language barrier, there was no good reason to risk harm by capturing their views using an interpreter. Moreover, as seeking the perspectives of professional stakeholders better fitted the study aim, we decided to include them as our study participants.

Participant recruitment

The study participants included stakeholders who are providing different types of care and services for asylum seekers including GBV survivors. Since we wanted to analyze the *context*, we interviewed stakeholders who work with asylum seekers during the various stages in the asylum process, starting from arrival at the entry point to Switzerland to the first federal accommodation center until the moment the asylum seeker has been transferred to a canton. We distinguished two levels of professional workers: (1) **Institutional level**: Governmental

offices, NGOs with governmental mandates, universities; and (2) **healthcare level**: Physicians, nurses, first-contact caregiver and intercultural interpreters (see Table 1). The type of data collected (FG or I) was dependent on the professional setting of the interviewed person (team-work or individual).

Table 1: Study Participants

Government and Institutes		**Number (characteristics) of participants**
Focus Group 1	State Secretary of Migration	3 (non-HCP)
Focus Group 2	Federal Asylum Center	3 (2 HCP, 1 non-HCP)
Focus Group 3	NGO 1; NGO 2	2 (non-HCP)
Focus Group 4	University researcher	2 (non-HCP)
Healthcare professionals		
Focus Group 5	Physicians	3 (HCP)
Interview 1	Physician	1 (HCP)
Interview 2	Intercultural interpreter	1 (non-HCP)
Interview 3	First-contact caregiver	1 (non-HCP)
Total		**16**

FG = Focus group; I = Interview; HCP = Healthcare professional; non-HCP = non-Healthcare professional

Participants were selected by snowball sampling and approached either by phone or by email. All contacted persons accepted to participate in the study. In total, 16 stakeholders participated in five focus groups and in three individual interviews. The age of participants ranged from 32 up to 65 years. Thirteen of them were women and three were men. The focus groups were homogeneous regarding the participants' professional background except FG 2, which included a non-healthcare professional, a nurse and a physician. In the result's section, we use the distinction between healthcare professionals (HCP) and non-healthcare professionals (non-HCP) to guarantee anonymity of the participants. No further identifying information than that is given.

All data collection took place in the native language of the canton. Data collection stopped when it was clear to the interviewer that no new information was being gathered and that there were no other participants that could be contacted who fit the study purpose.

Data collection and analysis

Data collection was carried out by the first author, a general physician and public health worker, who had experience with qualitative research. There was no professional involvement with the participants at the time of the study. The interviews took place at the workplace of the participants between October and November 2016. All the focus groups and interviews (except one interview) were audio taped and transcribed ad verbatim. Only one participant (HCP, I1) asked to switch off the recorder to feel more comfortable to report sensitive facts but allowed the interviewer to take notes. The interviews followed a semi-structured guide with questions that aimed to gather specific information on the disclosure of survivors, strengthening the resilience of GBV victims, and preventing GBV, further on health problems (physical and mental), the communication of symptoms and coping strategies. New inputs that emerged during an interview or focus group led to new themes to investigate. The interviewer therefore adapted the contents in the following focus group or interview considering these new aspects. The duration of the focus groups was between 40 and 60 minutes and the interviews between 45 and 85 minutes. A total of 440 minutes of data were recorded.

Data analysis was done by two coders on Microsoft Word. A 5-step-framework analysis by Ritchie and Spencer (1994) was used: (1) familiarization with the data, (2) identification of thematic framework, (3) indexing or coding, (4) charting and mapping, and (5) interpretation (as described in (Bowling, 2014; Gale, 2013)). After familiarizing with the interviews, we identified major themes at the level of individual and structural (legal and healthcare system) aspects. These included lacking confidence in the legal and healthcare systems, communication related barriers, the concerns related to continuity of care, as well as sociocultural background and coping strategy of the GBV victims. Further, we indexed identified codes, charted as keywords and mapped them within the four themes. The authors

agreed on the categorization of the keywords into different themes and during the result-writing phase, all authors agreed to the interpretation of the results presented in the text.

The cantonal ethics committee reviewed the study and deemed it exempt as it was outside of Switzerland's Human Research Act. However, written informed consent was obtained from all participants after they were informed about the study orally and in writing.

Results

Confidence in the legal system and healthcare system

Confidence was noted as a strongly individual factor that needs to be addressed through targeted political and structural interventions. For the study participants, a GBV victim's lack of confidence in the legal and in the healthcare system represented a major barrier to disclosure and a hurdle to accessing healthcare facilities. The participants noted that the asylum seekers' lack of confidence was due to their undecided political status in the host nation and the uncertainties resulting from the migration process. A non-HCP participant (FG1) noted: "*They come out of illegality and suddenly they should trust people and the state and believe us when we say that they live legally in our country*". Another participant stated that *"almost all young women who transited through Egypt, have an IUD [intrauterine device]. I can recognize that it is not from here because the thread is different. They have all been to a clinic in Egypt. Some of them know, but many of them don't know about the IUD"* (HCP, FG5). Although traumatized victims must be able to trust the host country's legal system, study participants further said that "*they [the asylum seekers] often are unaware of their rights or are frightened of the [legal] system*" (non-HCP, FG1).

Disclosure of GBV is a very intimate decision and needs preparedness on the part of the victim. Several participants pointed out that to be able to work with GBV victims they have to disclose sensitive details, or they have to be identified as victims. A barrier to disclosure was the fact that GBV experienced on the migration route does not affect the political status.

"GBV during migration route does not give the right to asylum. If they don't want to stay here [the host nation they are either in or they are travelling through), they don't tell you about [this]. (…) Only GBV that has been reported in the country of origin and that is a reason for flight is important for asylum decisions" (non-HCP, FG1).

Therefore, participants reported "*early disclosure is dependent on the moment and type of GBV and its influence on the recognition of the asylum status*" *(non-HCP, FG1)*. They further concluded that *"often an unclear political status, [i.e. whether they will be recognized as asylum seekers or become a "non-entry decision"], prevents early disclosure of GBV" (non-HCP, FG1)* and that *"GBV victims must be able to trust the person and have confidence in the system to disclose their experience and its health consequences" (non-HCP, FG1).* There is also a risk that *"some asylum seekers falsely report about GBV experience to get*

political status" (non-HCP, FG1). Officers who carry out the first interviews with asylum seekers systematically screen for human trafficking to distinguish true from falsely reported GBV. They screen only for human trafficking, other types of GBV have to be reported by the victims themselves. Further, one physician stated that *"It's not during the first visit, but after three or four months that I follow them during pregnancy that they start to have confidence and to talk about their experience"* (HCP, FG5).

During the interviews, study participants talked about the need of a professional figure that is able to build trust with the asylum seekers, establish their confidence with the legal and healthcare systems, which would eventually encourage GBV disclosure and help with ensuring continuity of care beyond cantonal borders.

Communication, language and intercultural interpreters

Many participants agreed confidence and GBV disclosure are strongly related to the ability to communicate one's concerns. The existence of a language barrier from the part of the refugees who lack competence in the local language was very clear to them. Furthermore, participants also reported that victims may have a different way of expressing themselves. HCP (I1) relayed, *"She [a female asylum seeker from a sub-Saharan country] said she had a stomachache, but, instead, she meant that she was pregnant".*

Related to this was the lack of language competencies to seek care for themselves and the need to use translators. Some stated that victims seek aid of younger family members who may be more adept in the local language, which also means that the latter are faced with situations that are not of their age (e.g. *"Mother says there is no blood"* which was supposed to mean that her mother is pregnant. (HCP, FG5)). Furthermore, regarding language dissonance between care receiver and care provider, one participant revealed the lack of knowledge among professionals in the hospitals concerning how to seek language support.

"There is a lack of knowledge [among health professionals] about how to call a translator or an intercultural interpreter. So sometimes they use phone services. In emergency situations, patients use internet translators [Google translator]" (non-HCP, FG3).

All the participants underlined the importance of female interpreters. In hospital settings, there is a list with employees who speak different languages. One physician stated that "*you cannot send a technician to the delivery room to translate. When she [the asylum seeker] is in labor and there is this man, she does not want to open her legs. I have to force her to give birth… It's … like another violence to her"* (FG5). *Supporting the need for female interpreters, as a competency that is available in the healthcare system, another participant further added, "I sent a couple with domestic violence history to a physician who was from the same country and spoke the language. But the physician took the side of the men! He basically approved the violence!"* (HPC, FG5).

Participants noted that financial support for the interpreters was not clear, which raises doubts about their availability. It was reported that intercultural interpreters can represent a bridge to address the language barrier and that they can be an aide in the trust building process between doctor and patient. A participant (non-HCP, I2) highlighted that *"[An interpreter is] like a voice, [he/she does] translate what they tell [him/her], but can also interpret because [they] know the culture behind."* Importantly, it was also underlined that the interpreter must be able to disappear from this triad and help to establish a trustful relationship between the doctor and the patient.

“Not all the professionals know who pays them [the interpreters]. Now they often use a 24-hour phone service. But we need interpreters. It's not enough to translate, you need somebody who is able to interpret” (non-HCP, I2).

Continuity of care

As most asylum seekers were transferred from the federal asylum center to another cantonal accommodation within three months, participants expressed the challenge of building trust in such a provisional situation. In their case, a large diversity between the cantonal healthcare systems impeded a uniform availability of healthcare. This diversity implied additional work to find appropriate care facilities to address GBV victims.

“Sometimes I sit down with them and we do a research on internet together to find the right professional support in the canton they are transferred to. But there is a lack of continuity and of information inside the system” (non-HCP, I3).

Different linguistic regions in the country complicated the continuity of care. Further, there was a lack of transmission of paper-based information, which meant that the victim must disclose herself for a second time.

“There should be, although there is much sensibility about data security, transmission of information from one accommodation center to another. The NGOs in the new canton should receive information of a GBV victim to offer good treatment and protection. There should be a network.” (non-HCP, I3)

Such lack in continuity, in their opinions, leads to a breach in confidence between the victim and the system, and their renewed exposure to the trauma of telling the details of GBV. An example given by one of the participants highlights how this continuity of care was harmed. One participant specifically cited as an example a pregnant asylum seeker who was transferred to another canton during the third trimester of pregnancy. Time is needed to build confidence in the system and in the healthcare professional and once that is built, actions that result in change of healthcare professionals are counterintuitive.

“I followed her during the pregnancy, and we established a good patient-doctor relationship. Then she has been transferred to another canton just two days before delivery. She had to adapt to a completely new environment with different people and a different language – why couldn’t they transfer her after the delivery?” (HCP, FG5).

Sociocultural background and coping strategy

Participants felt that although the system offers several healthcare services to the victims, the moment of disclosure depends on individual factors such as sociocultural background, knowledge about GBV, stigma, coping strategy and legal protection. The diversity of sociocultural background of women asylum seekers shows different patterns of coping strategies. For example, they stated that some migrants, mostly Syrian women, are embedded in a strong family or larger social structure that offers a parallel care system. That is, their coping strategy is to talk about their experiences with other female family members, *"Syrian women have their "clan" - they are embedded in a structure. They help each other. Eritreans instead, as we notice, are scattered" (HCP, FG2).*

Moreover, one participant pointed out that Eritrean migrants are very young and often leave their home country alone or in small groups, which puts them at major risk of GBV.

“Eritrean girls know what happens on the route. But they have no (life-) experience. They think somebody [Allah] will protect them, it would not happen to them. They are naive when they leave their country" (HCP, I1).

The fear of stigmatization by the community from the home country and the victim’s sociocultural background was deemed to influence their willingness to disclose, to avoid the issue or to delay help seeking. A non-HCP from I2 revealed *"In their country, if you see a psychologist, you have a problem in your head. That’s why they don’t want to seek for psychological support. That’s very stigmatizing...".* Another participant reported GBV victims’ avoidance: *"They say: I’m in Switzerland now, I don’t want to speak about these things, I just want to forget" (HCP, FG5).*

Discussion

Study participants stated that individual factors related to a lack of confidence in the legal and the healthcare system hinder disclosure of GBV. From our study findings, it is hence clear that lack confidence is a major barrier to overcome and therefore, building confidence must be of high priority. The legal system must assure credibility and strengthen the victim’s rights. Whereas the healthcare system must offer a high standard of professionalism and ethics. Only the interface between building confidence from the side of the legal and the healthcare systems will empower the GBV victim to trust and overcome fear of stigmatization to thereby disclose necessary information, which is in her best interest. Participants further noted linguistic competence as a barrier to communicate GBV experiences and underlined the important role others play (younger family members and interpreters) to overcome this barrier. Finally, an issue that study participants highlighted as very relevant to the political and the

healthcare system was the transfer of asylum seekers from federal asylum centers to cantonal accommodation which disrupts the continuity of care, thereby making GBV an issue that risks not being raised or evaluated or simply forgotten about.

The legal and organizational context in Switzerland applicable to asylum seekers who are victims of GBV offers only partial protection. This is evident as our study participants underscored that GBV victims disclose what happened to them only if the GBV experience could positively change their right to asylum. As a consequence, women who have experienced GBV on the route would not disclose this experience because the stigma and fears related to this traumatic experience are higher and stronger than any willingness to talk about. Information and trust enhancing strategies, including laws providing protection in these situations, would strengthen confidence among GBV victims. In line with our findings, it is also highlighted in the literature that victims do not disclose GBV during the route because their aim is to reach their destination as soon as possible (UNHCR, 2015). For this reason, there is a need for mechanisms in the host countries to detect and address GBV in a timely, sensitive and confidential manner. In Switzerland, professionals who carry out the initial asylum interviews do screen for specific GBV such as human trafficking. However, victims of other kinds of GBV must disclose themselves. The moment of disclosure is subjective and depends on the confidence the victims have in the legal and healthcare systems. For this reason, a systematic screening in different phases of the asylum process could give the opportunity to the GBV victims to disclose themselves at the opportune moment. Further, our study participants noted that victims are primarily concerned about their asylum status and thus do not see the significance of disclosing their GBV experience during their asylum process. As victims are more likely to seek services from relevant healthcare institutions once the asylum status is confirmed, a rapid asylum process is therefore helpful.

A access to healthcare in the Swiss asylum context does not provide, because of a short stay, specific psychological support in federal asylum centers. This kind of support is offered once the asylum seeker has been transferred to a cantonal accommodation where long-term treatment can be initiated (State Secretariat for Migration, 2017). However, GBV victims need an early multi-faceted approach to address physical and psychological consequences of GBV

(UNHCR, 2011; UNHCR, 2015). Our study points to the important role that first-contact caregiver can play in federal asylum centers. These professionals are in the best position to build trust on an individual level. For this reason, it could represent a first moment for disclosure and identification of GBV victims and act as a “GBV coordinator” (UNHCR, 2015). It is also important to guarantee financial support for such professionals and appropriate structures for confidential GBV screening approaches.

Similar to other studies, our participants also identified language as a main barrier to access healthcare (Interface, 2017; Gehri, 2016; UMC, 2014; Hémono, 2018). Misunderstandings in communication (e.g. “stomach ache“ meaning pregnancy) as well as use of family members or co-nationals as translators (e.g. family member, hospital staff) reveal the value of providing well-trained intercultural interpreters. Although interpreters reduce communication barriers, they represent a third person hindering the doctor-patient trust building process. Furthermore, female interpreters might be more suitable to handle cases of female victims (UNHCR, 2013; Hémono, 2018). In 2018, 60.5 % of asylum seekers received asylum status in Switzerland (State Secretariat for Migration, 2019; State Secretariat for Migration, 2018). Since it is likely that the majority of asylum seekers will remain in the country, language courses would enhance communication, and promote integration and confidence in Swiss authorities and the healthcare system (State Secretariat for Migration, 2018). As a consequence, GBV victims would be more prepared to disclose their experience and seek the care that they need. In this, our study’s findings are in line with other international reports (Directorate-general for internal policies, 2016).

Until these vulnerable victims can express themselves, interpreters (preferably female) are indispensable. That these interpreters are much needed and critical in ensuring access to healthcare has been underlined in several Swiss studies (Interface, 2017; Ackerman Rau, 2014; Gehri, 2016; FOPH, 2013) as well as worldwide (UNHCR, 2013; Women's Refugee Commission, 2016; Hémono, 2018). There is a clear need for good training of intercultural interpreters. Professional recognition would strengthen their position in the healthcare community. Ensuring a financial and legal framework that guarantees their independence is a prerequisite for allowing them to act as the true voice of the victim. Although there are

different programs running to strengthen the importance of intercultural interpreters (FOPH, 2013), greater dissemination of information about intercultural interpreters among other health workers would be important. Putting in place such measures and informing people widely about them (e.g. in leaflets in the home languages of the migrants) would add to the trust building process that is necessary in the healthcare setting and is in line with the Swiss concept of access to healthcare in the asylum context (State Secretariat for Migration, 2018; FOPH, 2013).

On a structural level, lack of continuity of care represents a major issue in following and providing necessary healthcare when an asylum seeker is transferred from a federal asylum center to an accommodation in another canton. Although the process at the moment of transfer is clear, paper-based information does not seem to arrive at the destination. Instead, this lack of continuity provokes a loss of confidence in the system and the development of new self-protection coping strategies by the victim. The implementation of an electronic information exchange platform that is currently being spearheaded in the country could prove helpful for asylum seekers and the involved caregivers as it would enhance the seamless transmission of information and, thus, continuity of care.

Related to the transfer of asylum seekers to other cantons, those who are pregnant should benefit from special "maternity protection". They might be offered the possibility to give birth in an environment where they have established a patient-doctor-relationship during pregnancy. This would strengthen bonding with the new-born, enhance confidence in the new state, and thereby favor better integration. In addition, financial support guaranteed by the involved authorities would help to build a network inside the healthcare system beyond the cantonal borders.

Furthermore, health professionals (general practitioners, gynecologists, pediatricians, psychiatrics, psychologists, nurses and others) providing care to this group need to be aware of the sociocultural background of migrant populations, the different types of GBV as well as the exposure risk in the home country, on the migration route, and in the host country. Hospitals as the first care seeking point for migrants offer special training to their

professionals and have built a network of "Migrant friendly hospitals" (Saladin, 2009), later named “Swiss Hospitals for Equity Network” (FOPH, 2013). In Switzerland, different universities and NGO’s offer courses in transcultural competence in health (HUG, 2018; Croix-Rouge Suisse, 2018), which are good sources for health professionals to educate themselves to better care for their patients. On a primary care level, specific conferences about transcultural competencies and migrant health would be suitable to diffuse this knowledge to a broader population of healthcare professionals (State Secretariat for Migration, 2018; WHO, 2013; Interface, 2017). A special certificate in transcultural medicine would underline the importance of the issue, give an incentive to health workers to attend the training and enhance trust in the vulnerable population. Each canton could offer this training to professionals working in specialized centers caring for migrants. Additionally, the creation of a network of "Migrant friendly Doctors" or “Swiss Doctors for Equity Network” would ensure, among physicians in possession of such a certificate, continuity of care overcoming cantonal borders. Special reimbursement codes to reflect the more complicated and time-consuming care these populations need would underline these competencies and give additional incentives. Professionals with this special training could highlight their competencies and services to attract patients from this group (Gehri, 2016; Flury, 2010).

As described in different reports, a culturally appropriate multi-pronged approach should be applied in GBV prevention and response (UNHCR, 2015). In line with these reports, the findings of our research show that promotion of prevention strategies on an individual, community and societal level help strengthen resilience in the vulnerable population and provide the opportunity to work with as well as educate potential perpetrators. This would help potential GBV victims to become more resilient, to know about their rights and to be informed about services that they can avail. Potential perpetrators must be made aware of the legal consequences of any form of GBV including sexual harassment, domestic violence and traditional harmful practices. Integration programs would underline the importance of physical integrity and prevent violence carried out based on gender.

In sum, these results allow us to understand the actual context of the healthcare system, the barriers to healthcare access as well as the strategic challenges. The federal and cantonal

authorities should prepare themselves to ensure that those who are vulnerable and in need of care receive the necessary support from their host nation. Based on the findings and the discussion presented, we have summarized strategies that will improve GBV victims' healthcare seeking behavior (Table 2). These strategies can also lead to better health outcomes and decrease avoidable or even higher costs related to the secondary morbidities that affect not only the women who have faced GBV but also their dependent children. Moreover, efficient measures would empower GBV victims, help them to become more resilient and become promoters in the prevention of further GBV in and outside of Switzerland.

Table 2: Strategies to support victims of GBV

1	**Disclosure, identification and trust**	Implement different moments for screening procedures during the asylum process. Building confidence in the legal and healthcare systems through the role of a first-contact caregiver. This professional should build trust to encourage disclosure, ensure access to healthcare and coordinate continuity at the moment of transfer. Systematically introduce this professional in all federal asylum centers.
2	**Legal protection and prevention measures**	Engage leadership, strengthen legal protection and offer judicial protection services. Education of GBV victims, potential perpetuators and the population about local laws. Put in place prevention measures on individual, community and societal level organizing workshops, trainings an information to strengthen resilience. Engage all the stakeholders involved in the asylum process.
3	**Training and financial support for healthcare workers**	Enhance knowledge about sociocultural background of different migration groups and provide adequate training and certification of health workers (e.g. “Swiss Doctors for Equity Network”). Guarantee financial support to intercultural interpreters.
4	**Financial support**	Dedicate financial support (cantonal and federal) that would help all the implicated professional groups (medical, paramedical, interpreters, NGOs, GBV Coordinator).
5	**Continuity of care**	Build a network of competent professionals and build an electronic information exchange platform to ensure a seamless continuity of care beyond cantonal borders.

Limitations

The qualitative methodology represents a limitation because of the subjective nature of its interpretation, despite ensuring that more than one researcher read and analyzed the data. It is also important to note that the results of this qualitative study are not generalizable to the experiences of stakeholders working within the asylum system or the diversity that exists among asylum seekers in the country. Furthermore, the participants included in the research are professionals and not GBV victims themselves. Although there is much value to obtaining

information from persons directly involved and with closest experience, in light of the study goal and the barriers associated with studying GBV victims (e.g. lack of direct benefit, language, recruitment challenges), we found professionals an appropriate choice. GBV victims, who are in the asylum process, may not disclose themselves easily and they would disagree to talk about this particular experience. Importantly, it is ethically difficult to justify a revival of their trauma for research purposes. We did not deepen legal aspects, because this study aims to investigate the actual situation and eventual gaps in the healthcare system. Finally, the small sample size could be an additional limitation, but this is linked to the exploratory nature of the study and because recruited the most important representatives from every step of the asylum process.

Conclusions

In accordance with its international obligations derived from the 1951 Convention on the status of refugees and from International Human Rights law, Switzerland has the obligation to guarantee basic financial (aide social or aide d'urgence) and healthcare services (art. 80 asylum Act). In addition, healthcare personnel have professional and ethical obligations to provide adequate care for vulnerable groups independently of their legal status (resident, refugee, asylum seeker, prisoner etc.). The healthcare system is tasked with ensuring a good quality of care to these residents. A knowledgeable and well-prepared healthcare system is important to provide much needed care for GBV victims, starting from their first disclosure to specific treatments that begin on their arrival and continue until their final destination. It is important to establish an appropriate organizational framework that protects the victims and works to ensure their best health outcomes. This includes a healthcare system with competent professionals and a seamless continuity of care beyond cantonal borders. Strengthening integration services and programs available for asylum seekers would help them enforce their capability to address their own care needs. Finally, it is important to put in place early interventions to decrease long-term consequences of GBV because doing so will have positive outcomes not only for the individual concerned but also may even reduce costs to the entire healthcare system. Further research is needed to establish ethical and professional guidelines.

Abbreviations

GBV: Gender-based violence

CEDAW: Convention on the Elimination of Discrimination against Women

WHO: World Health Organization

UNHCR: United Nations High Commissioner for Refugees

UNFPA: United Nations Population Fund, formerly United Nations Fund for Population Activities

WRC: Women's Refugee Commission

IOM: International Organization for Migration

PTSS: Post-traumatic stress syndrome

OHCHR: Office of the High Commissioner of Human Rights

NGO: Non-Governmental Organization

FOPH: Swiss Federal Office of Public Health

FG: Focus-groups

I: Interview

HCP: Healthcare professional

non-HCP: non-Healthcare professional

UMC: Ufficio del Medico Cantonale

HUG: Hôpitaux Universitaires de Genève

EHR: Electronic Health Record

Declarations

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Author's contributions

Conception and design: MRS, Acquisition of data: MRS, Analysis and interpretation of data: MRS, TW, BSE, SD. Drafting of the manuscript: MRS, TW, BSE, SD. Critical revision of the manuscript for important intellectual content: BSE, SD, TW, MRS, Supervision: TW, BSE, SD. All authors read and approved the final manuscript.

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Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available. They are available from the corresponding author on reasonable request.

Ethics approval and consent

The cantonal Swiss Ethics committee has decided that there is no need of an ethical approval because of involvement of stakeholders. Every participant signed an informed consent after have received written and oral information about the study. Anonymity and the possibility to interrupt or to stop taping was guaranteed to all participants.

Consent for publication

Study participants agreed to take part in this study and were aware that the results would be published but their identity would not be identifiable to the readers.

Competing interests

The authors have no actual or potential no competing interests.

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