



REACH OUT: PUBLICATION

Addressing gender-based violence faced by migrants and refugees in Europe: how to respond and why it is important



This report was drawn up as part of the REACH OUT project, implemented in Belgium, Germany, and the Netherlands by Médecins du Monde, and in Serbia by the Red Cross of Šid, under the coordination of Médecins du Monde Belgium. Due to the pandemic context, the sensitivity of the subject, and the situation of most beneficiaries, very few pictures of the project could be taken. Therefore, two pictures come from other Belgian projects (this will be specified with a “*”).



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FOREWORD

**Signed by Claire Bourgeois,
President of Médecins du Monde Belgium.**

The media are full of discussions of immigration and representations of exiles. The fact remains that migrants' voices are generally "spoken" by others, without them being able either to deliver their own story or to choose the displayed images from their odyssey, which is what these dangerous journeys are. Since 2020, the COVID-19 pandemic has shed light on the overexposure of women, girls, and vulnerable groups such as migrants to gender-based violence, due to shifts in social safety nets, mobility, support networks, and access to services.

Migrants' voices are generally "spoken" by others, without them being able either to deliver their own story or to choose the displayed images from their odyssey.

This publication does not try to explain the mechanisms of violence or to understand migrations. It is written at the human level, the level of men and women who are caught up in political, repressive, and violent logics trapping them in a deadly fate. This publication hopes to counter the hegemonic narratives about the virtues of border control by adding the views and experiences of migrant populations and their care providers.

Gender-based violence is a form of discrimination, a violation of human rights, and a public health issue. It can happen to anyone: women, girls, men, boys, and non-binary people. In many international legal agreements, States have committed to actively preventing gender-based violence and providing survivors with protection, care, and reparation. Such commit-

ment includes granting survivors an effective access to support services, such as psychological aid, social assistance, and appropriate health care. Under the human rights legal framework, this protection is universal. However, survivors of gender-based violence face tremendous difficulties in reporting violence and accessing support services. Intersectional factors, among them the situation of migration, further hamper the accessibility of support services for survivors of gender-based violence. Indeed, in violation of international law, migrant survivors face additional constraints in receiving appropriate care. These constraints can be explicit, when access to services is dependent on immigration status, or implicit, such as language barriers and cultural biases. Therefore, migrant populations, who are already overexposed to gender-based violence, are less likely to report the violence they experienced and seek support.

Médecins du Monde has long-term experience in working with vulnerable groups who do not have access to support services. The REACH OUT—REActing to sexual and gender-based violence against migrants and refugees through Coordinated Help, advocacy and OUTreach actions—initiative is jointly implemented by Médecins du Monde Belgium, Médecins du Monde Germany, Médecins du Monde Netherlands, and the Red Cross of Šid, Serbia. The project aims to empower migrant survivors of gender-based violence to access support services and exercise their human rights, notably by providing guidance and raising awareness about gender-based violence among institutions, governments, and civil society. This publication contributes to this goal by debunking preconceptions related to gender and migration. Those prejudices seriously hinder access to quality care for migrant survivors of gender-based violence. By reflecting upon our vision of migration and gender norms, we can all take action to support survivors' rights and contribute to a more equal and fairer world. This publication is a first step in this direction.

TERMINOLOGY

For the purpose of this document and to guarantee readability, the term **'migrant'** is used to designate applicants for international protection, refugees, and undocumented people, without distinction based on their immigration status. However, it is essential to acknowledge that migration experiences do not define the individual.

In this document, the term **'survivor'** of gender-based violence is preferred to 'victim' of gender-based violence, to emphasise the resilience and autonomy of individuals who have experienced gender-based violence, rather than their legal status. This does not deny or diminish the feelings of individuals who have experienced gender-based violence. Ultimately, the best terminology for designating persons who have experienced gender-based violence is the terminology they choose themselves.

For the purpose of this document and to guarantee readability, the term **'survivor'** is used instead of 'individual who has experienced gender-based violence'. However, it is essential to acknowledge that experiences of violence do not define the individual.

For the purpose of this document and to guarantee readability, the term **'perpetrator'** is used instead of 'individual who has committed violence'. However, it is essential to acknowledge that actions of violence do not define the individual.

EXECUTIVE SUMMARY

Can gender-based violence happen to men and boys? Does the host country always give residency to undocumented people who face intrafamilial violence? How can (national) institutions act to prevent gender-based violence against migrants? Is there any gender-based violence other than harmful practices? Each of these questions is answered based on scientific reports and filled with experiences to create a small encyclopedia addressing preconceptions on gender-based violence against migrants and refugees.

From their country of departure, during their journey, and after their arrival, migrant populations face a state of increased vulnerability with regard to their health.

This publication has been written as part of the REACH OUT project. REACH OUT, for REActing to sexual and gender-based violence against migrants and refugees through Coordinated Help, advocacy and OUTreach actions, is a project co-funded by the European Union dedicated to empowering migrant survivors of gender-based violence in accessing care and exercising their fundamental rights. The project was launched in December 2019 in Belgium, Germany, the Netherlands, and Serbia. Due to the COVID-19 pandemic, the outreach actions could be pursued but were limited. Despite the restricted implementation of REACH OUT activities, findings based on desk research and completed fieldwork provided sufficient information for writing this publication.

From their country of departure, during their journey, and after their arrival, migrant populations face a state of increased vulnerability with regard to their health. Travelling conditions, social isolation, and economic

precarity exacerbate the risk for migrants to be exposed to violence. Among other types of violence, gender-based violence is widespread at each step of the migratory pathway. Gender-based violence is a violent act directed against someone because of their gender. It relies on stereotyped gender norms and is rooted in the structural inequality between genders. Even though most gender-based violence survivors are women and girls, men, boys, and non-binary people also face such harmful acts. In 2018, 58% of migrants arriving in Europe had been subjected to gender-based violence.¹ Survivors of gender-based violence need inclusive and holistic care to deal with the consequences of gender-based violence. However, they have limited access to support services during their journey and throughout the whole process of resettlement because of legal, administrative, financial, informative, and cultural barriers. Most of those barriers rely on preconceptions related to migrants' experiences, culture, and gender norms.

Gender-based violence is a violent act directed against someone because of their gender. It relies on stereotyped gender norms and is rooted in the structural inequality between genders.

By deconstructing inaccurate perceptions, this publication intends to encourage the public to engage in the protection of basic human rights, to spread reliable information regarding migrants and gender-based violence, and to improve access to adequate care for migrant survivors of gender-based violence.

1. Lotte De Schrijver et al., "Prevalence of Sexual Violence in Migrants, Applicants for International Protection, and Refugees in Europe: A Critical Interpretive Synthesis of the Evidence", *International Journal of Environment and Public Health* 15, no.9 (September 2018).

LIST OF ACRONYMS

ANKER CENTRE	Ankunft, Entscheidung und kommunale Verteilung bzw. Rückführung – Arrival, Decision and Municipal Distribution or Return Centre
CK ŠID	Red Cross of Šid
COL 06/2017	Circulaire Commune Du Ministre De La Justice Et Du Collège Des Procureurs Généraux Relative À La Politique De Recherche Et De Poursuites En Matière De Violences Liées À L'honneur, Mutilations Génitales Féminines Et Mariages Et Cohabitations Légales Forcés - Joint Circular of the Minister of Justice and the College of Attorneys General on the Policy of Investigation and Prosecution of Honour-related Violence, Female Genital Mutilation, and Forced Marriage and Cohabitation
COMEDE	Comité pour la santé des exilé.e.s
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organisation
EU	European Union
FEDASIL	Agence Fédérale pour l'Accueil des Demandeurs d'Asile – Federal Agency for the Reception of Asylum Seekers
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
GREVIO	Group of Experts on Action against Violence against Women and Domestic Violence
IASC	Inter-Agency Standing Committee
IEFH	Institut pour l'Égalité des Femmes et des Hommes – Institute for Equality between Women and Men
IPV	Intimate Partner Violence
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual persons, +
MDM	Médecins du Monde
NAP	National Action Plan
NGO	Non-Governmental Organisation
PSEAH	Protection from Sexual Exploitation and Abuse and Sexual Harassment
REACH OUT	REActing to sexual and gender-based violence against migrants and refugees through Coordinated Help, advocacy and OUTreach actions
SOP	Standard Operating Procedures
UAM	Unaccompanied Minors
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

INTRODUCTION

In 2018, 2.2 million people migrated to the European Union (EU),² and 625,000 asylum applications were filed.³ Asylum applications primarily arose from nationals of Syria, Afghanistan, and Venezuela,⁴ all conflict-ridden countries. Among those applications, 38% of court decisions amounted to a decision granting asylum;⁵ this illustrates the significant gap between the number of people applying for international protection in the EU and the number of applications eventually granted. It is also worth noting that some migrants do not apply for asylum right after entering the EU but keep traveling across the continent through ‘countries of transit’ and towards ‘countries of destination’ where they seek to reside.

From their country of departure, during their journey, and after their arrival, migrants face increased vulnerability with regard to health. Although some migratory routes may present more risks than others,⁶ the state of migration automatically means that individuals are rendered more vulnerable. Living and travelling conditions during the migration expose migrants to violence and limit their ability to access health care centres. In countries of transit or destination, many explicit or implicit barriers based on immigration status prevent effective access to protection and care for migrant populations, which may worsen their health condition. The social isolation and economic precarity that can be triggered by the migration exacerbate the risk for migrants to be exposed to violence, whether physical, psychological, or sexual. Among other types of violence, gender-based violence (GBV) is widespread at each step of the migratory pathway.

2. “Statistics on migration to Europe”, European Commission, accessed on July 9, 2021, https://ec.europa.eu/info/strategy/priorities-2019-2024/promoting-our-european-way-life/statistics-migration-europe_en#developmentsin20192018.

3. “Asylum statistics”, Eurostat Statistics Explained, European Commission, accessed on July 9, 2021, https://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics.

4. “Statistics on migration to Europe”, European Commission, *supra* note 2.

5. It should be underlined here that given the delays and backlogs in processing asylum applications, decisions made during a year include some applications filed the years before and do not cover all applications filed in the same year.

6. See for instance L. Reques et al., “Episodes of violence suffered by migrants transiting through Libya: a cross-sectional study in “Médecins du Monde’s” reception and healthcare centre in Seine-Saint-Denis, France”, *Conflict and Health* 14, no. 12 (2020).

During their migratory journey, migrants are exposed to a higher risk of facing GBV, whether it be physical, psychological, or sexual. It was estimated in 2018 that 58% of migrants arriving in Europe had been subjected to GBV, 69% of whom were women.

GBV is defined by the Inter-Agency Standing Committee (IASC) as “any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed differences between males and females”. It is rooted in the structural inequality between genders and conflates gender norms and harmful abuse. Among others, some examples of GBV include domestic abuse, sexual exploitation, rape, sexual assault, threats and verbal assault, intimidation, and forced marriage. It is estimated by the World Health Organisation (WHO) that one in three women in the world will experience GBV in her lifetime.⁷ Although figures are scarce regarding the prevalence of GBV against males, men and boys may also face GBV, especially in conflict settings. During their migratory journey, migrants are exposed to a higher risk of facing GBV, whether it be physical, psychological, or sexual. It was estimated in 2018 that 58% of migrants arriving in Europe had been subjected to GBV, 69% of whom were women.⁸ Children are also particularly at risk: a 2018 UNICEF report indicated that 42% of the children crossing the Mediterranean were unaccompanied.⁹ Because children are also

7. World Health Organisation, “Devastatingly pervasive: 1 in 3 women globally experience violence”, *World Health Organisation Joint News Release*, 29 March 2021, <https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence>.

8. De Schrijver, L. et al., “Prevalence of Sexual Violence in Migrants”, *supra* note 1.

9. United Nations High Commissioner for Refugees (UNHCR), United Nations International Children’s Emergency Fund (UNICEF)

poorly tracked by the authorities, little data is available about their health and wellbeing.

The explicit restrictions in migrants' access to health care, which reflect governments' focus on immigration control rather than public health and human rights, are even more severe when it comes to GBV.

Therefore, GBV survivors often need medical care and/or psychological help to deal with the physical and psychological consequences of GBV. Access to such support services is hampered by many factors in both countries of transit and countries of destination. Legal, administrative, financial, informational, and language barriers prevent migrants from seeking support. The explicit restrictions in migrants' access to health care, which reflect governments' focus on immigration control rather than public health and human rights, are even more severe when it comes to GBV. The lack of systematic gender-sensitive and culturally specific training in the education of health professionals and social workers also reduces the possibility of grasping the intersectionality¹⁰ of GBV against migrant populations. This affects the quality of care GBV survivors can access. Finally, additional internalised drivers can prevent GBV survivors from seeking support, such as cultural barriers regarding health and the body, or shame associated with sexual abuse. All those factors rely on preconceptions related to migrants' experiences, culture, and gender norms.

and International Organisation for Migration (IOM), *Refugee and Migrant Children in Europe. Overview of Trends January-December 2018*, UNHCR, UNICEF and IOM (2019).

10. Intersectionality is a framework of analysis that identifies how the interaction of social characteristics—such as race, gender, class, disability, etc.—creates modes of discrimination and privileges in a society. The term « intersectionality » was conceptualised by American professor and lawyer Kimberlé Williams Crenshaw.

Acknowledging these numerous difficulties, REACH OUT, for REActing to sexual and gender-based violence against migrants and refugees through Coordinated Help, advocacy and OUTreach actions, was launched in 2019 by Médecins du Monde (MdM) Belgium, MdM Germany, MdM Netherlands, and the Red Cross (CK) of Šid in Serbia. The project was co-funded under the EU's Rights, Equality and Citizenship programme 2014-2020. It marks the continuation of a previous initiative, WE ACT, which was conducted in 2018-2020 in different European countries with similar goals. REACH OUT is in line with the EU directive 2012/29/UE which requires specialist support services to be developed by public bodies to help GBV survivors. REACH OUT aims to raise awareness about GBV faced by migrants and to empower them in accessing care and exercising their fundamental rights. The project relies on four pillars:

- ✘ **Improving the coordination between all staff providing support to migrants**
- ✘ **Training professionals and cultural mediators to strengthen their capacities to provide support to migrants**
- ✘ **Raising awareness and facilitating access to support services for migrants**
- ✘ **Enhancing communication and advocacy on GBV and migration-related topics**

These four main objectives were then translated into several activities implemented in the four countries participating in the project. However, it must be noted that the COVID-19 pandemic restricted REACH OUT activities, which—as a European project between four countries—included several coordination activities involving travel or gatherings, such as study visits to locations of implementation of the project. Those visits could not be organised in person because of border closures. Similarly, individual counselling sessions which were meant to be finished by Summer 2021 were rescheduled for Autumn 2021. Fieldwork was also mostly postponed to Summer-Autumn 2021, which limited the informational impact of the project on migrant populations. While those restrictions undermined data collection, the teams in all four countries did their best to provide services and implement the activities planned in the project. Therefore, findings based on desk research and completed fieldwork provided sufficient information for writing this publication.

CONTEXT

The publication of this report falls under the scope of the fourth objective of the REACH OUT project, which includes communication and advocacy. As mentioned above, access to support services for migrant survivors of GBV is hampered by many factors, reflecting preconceptions related to migration, culture, and gender norms. Therefore, this document aims to address four of those preconceptions through four frequently asked questions:

1. **Can gender-based violence happen to men and boys?**
2. **Does the host country always give residency to undocumented people who face intrafamilial violence?**
3. **How can (national) institutions act to prevent gender-based violence against migrants?**
4. **Is there any gender-based violence other than harmful practices?**

Each question was handled by a REACH OUT partner working in one of the countries of implementation. The first question was written by the coordination team, the second by MdM Belgium in Antwerp, the third by both MdM Germany and CK Sid, and the last one by MdM Netherlands. For each question, a general answer based on local context and desk research is first provided. Then, specific findings and activities implemented by REACH OUT are presented. Finally, further actions and recommendations are suggested. By deconstructing inaccurate perceptions, this publication intends to encourage people to engage in the protection of basic human rights, to spread reliable information regarding migrants and GBV, and to improve access to adequate care for migrant survivors of GBV.

The following section briefly presents the main regulations with regard to both migrants' rights and GBV in each country of implementation of the project.

BELGIUM

In 2019, approximately 28,000 individuals filed an application for international protection in Belgium, an 18.3% increase compared to 2018. The most important reason for this increase is the rise in secondary movements within Europe. Out of those applications, 31.4% or 5,776 individuals were granted refugee status; 5.5% or 943 individuals were granted subsidiary protection. Most originated from Afghanistan, Syria, Turkey, and Iraq.¹¹

Access to support services for migrant survivors of GBV is hampered by many factors, reflecting preconceptions related to migration, culture, and gender norms.

Once an individual applies for international protection in Belgium, the Federal State becomes responsible for them. According to the 21 November 2017 reform of the Immigration Act, applicants for international protection are entitled to medical and psychological support, as well as material assistance—housing, social, legal, and administrative support—for the whole duration of the procedure. The Federal Agency for the Reception of Asylum Seekers (Fedasil) manages the reception of applicants for international protection and dispatches them to various centres throughout the country. The reception capacity of accommodation centres in Belgium varies each year; the country supplements its structural reception capacity (around 20,000 places available) with additional capacities offered by the private sector, qualified as temporary reception capacities or “buff-

¹¹. “International bescherming”, Statistiek Vlaanderen, accessed on July 5, 2021, <https://www.statistiekvlaanderen.be/internationale-bescherming>.

er capacities".¹² Applicants for international protection and undocumented people are not integrated into the compulsory national health insurance scheme for Belgian citizens and residents. Such a parallel system leads to variations and inequalities in access, organisation, availability, coverage, and quality of care.

The authorities seem to have taken a proactive stance combating GBV beginning in 2011 with a first National Action Plan (NAP). The plan is coordinated and implemented by the Institute for the Equality of Women and Men (IEFH) and is supported by the Federal State, the Communities, and the Regions. The scope of understanding of GBV by public authorities has also expanded in recent years and decades, gradually including issues such as street harassment (2014), Female Genital Mutilation (FGM), honour-related crimes, and forced marriage (2017).¹³ Control mechanisms and policies have been implemented at both federal and federated levels. Despite those actions, migrant survivors of GBV face specific vulnerabilities. Undocumented survivors do not have automatic access to shelters and risk being expelled from Belgium when they report or file a complaint about GBV with public authorities.

GERMANY

Germany has remained the first destination country in the EU for migrants over the last five years.¹⁴ However, the number of applications for international protection has decreased by 84% since 2015, when more than 720,000 applications were filed.¹⁵

Several federated states—namely Bavaria, Saxony, and Saarland—developed their reception capabilities by relying on what is known as AnKER centres,¹⁶ opened in the periphery of cities. In these accommodation facilities, applicants for international protection wait until their application is processed. They are granted theoretical access to health care, accommodation, social and administrative help. However, the living conditions in AnKER centres have been widely characterised as inadequate, with overcrowded facilities and bad hygiene conditions.¹⁷ There is a high estimated number of cases of violence against women while reports regularly mention violations by security forces.¹⁸

Germany has adopted numerous legal provisions to work towards gender equality and to root out GBV. Two action plans designed to eradicate violence against women were drafted in 1999 and 2007 and efforts have been undertaken by federal and federated states on the issue since then. Locally based initiatives addressing GBV have also been implemented. In 2004 in Munich, the victim counselling centre of the police launched the “Münchener Unterstützungsmodell” (MUM) project, which allows for proactively directing victims of domestic violence towards appropriate support services offering counselling and care. The MUM project is ongoing and is considered a big success. A federally funded program, “Together against Violence towards Women”, was also launched on 18 February 2020. Up to 120 million euros in funding has been allocated for the period 2020–2023. Thus, the issues of GBV and migration are present on the German political agenda even though some observers¹⁹ have pointed out a lack of political will and community support to address them.

12. Federal Agency for the Reception of Asylum Seekers (Fedasil), Review 2019. *Reception, resettlement, voluntary return*, Fedasil (2020).

13. Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO), *Baseline evaluation report. Belgium*, GREVIO (2020).

14. “Immigration by age and sex”, Eurostat, accessed on August 11, 2021, https://ec.europa.eu/eurostat/databrowser/view/migr_imm8/default/table.

15. Federal Office for Migration and Refugees (BAMF), *Migration, Integration, Asylum in Germany 2019*, BAMF (2020).

16. Since 2018, newly arrived asylum-seekers in Bavaria are accommodated in so called “AnKER” centres (camps for “reception, decision-making and return”) for the duration of the asylum process. The AnKER centres are run by the federal government of Bavaria and are usually located in regions with a poor infrastructure. The social services on site are run by non-governmental welfare organisations. Many experts and human rights organisations criticize the isolation and “inhumane” living conditions in these mass facilities (See for example “Anker Centres”, Bayerischer Flüchtlingsrat, accessed on July 9, 2021, <https://www.fluechtlingsrat-bayern.de/themen/anker-zentren/>).

17. Informationsverbund Asyl und Migration, *Country Report: Conditions in reception facilities*, Asylum Information Database & European Council of Refugees and Exiles (2020), accessible at: <https://asylumineurope.org/reports/country/germany/reception-conditions/housing/conditions-reception-facilities/>

18. Ibid.

19. Umbrella Association of Migrant Women’s Organisations, *GREVIO-Shadow Report on the Implementation of the Istanbul Convention in Germany*, Dachverband der Migrantinnenorganisationen (2020), accessible at: <https://rm.coe.int/202012-damigra-grevio-shadow-report/1680a0d18c>.

THE NETHERLANDS

The composition of migration flows to the Netherlands has changed considerably since the expansion of the EU in 2004 to Central and Eastern European countries. In 2020, most migrants coming to the Netherlands came from within the EU.²⁰ According to the Dutch Council for Refugees, around 200,000-250,000 refugees currently reside legally in the Netherlands. They come from countries such as Afghanistan, Iraq, Iran, Somalia, and Syria. In 2015, the number of asylum applications peaked at 58,880. From 2016 onwards, this number decreased to approximately 30,000 a year, and has remained around that level since then.²¹

Upon arrival, applicants for international protection are received in one of the three reception centres in the Netherlands, run by the Central Institute for Reception of Asylum Seekers (COA) under the Ministry of Security and Justice. Theoretically, within the first one or two weeks following their arrival—in practice many months—people register with the police and receive legal support in submitting their application for asylum with the Immigration and Naturalisation Service. After the procedure is started, people are placed in one of the forty Asylum Seekers' Centres to wait for the result of their application. Migrants who are granted a residence permit or refugee status have access to the health care system under the same conditions as Dutch citizens.²² However, undocumented migrants with a rejected asylum claim are only entitled to emergency care and medically necessary care.²³ They cannot purchase health insurance and usually must pay for the care they receive. However, when undocumented migrants cannot afford essential care, health care providers can, under certain conditions, get a refund from the government²⁴ under the Health Insurance Act.

20. "Hoeveel mensen met een migratieachtergrond wonen in Nederland?", Statistics Netherlands (CBS), accessed on June 11, 2021, <https://www.cbs.nl/nl-nl/dossier/dossier-asiel-migratie-en-integratie/hoeveel-mensen-met-een-migratieachtergrond-wonen-in-nederland>.

21. Immigratie- en Naturalisatiedienst, Ministerie van Justitie en Veiligheid, *Asylum Trends. Monthly Report on Asylum Applications in The Netherlands*, IND Business Information Centre (December 2020).

22. Anne-Laure Macherey, Nathalie Simmonot and Frank Vanbiervliet, *Legal report on access to health care in 12 countries*, Médecins du Monde (June 2015).

23. Ibid.

24. Madelon Kroneman et al., "Netherlands. Health system review", *Health Systems in Transition* 18, no. 2 (2016).

With regard to GBV, the Netherlands has taken appropriate steps to comply with the Istanbul Convention and to include GBV prevention and protection in the national legislation. A national action plan on sexual health and sexually transmissible diseases control was launched in 2017 by the Dutch Ministry of Health. The document mentioned sexual violence and unwanted pregnancies. In 2018, the program "Violence does not belong anywhere" was presented by the Ministry of Health, Welfare and Sport, the Ministry of Justice and Security, and the Association of Netherlands Municipalities. It outlines the government's ambition to improve the training of professionals with regard to GBV. In parallel, there are 16 centres for sexual violence survivors spread across the country, accessible within less than one hour from any location, to help in reporting GBV and granting medical and psychological care. Additionally, 26 Safe Houses provide information, security, and legal advice.²⁵

SERBIA

Serbia is not part of the EU but is a country of transit for migrants who seek to reach the EU, the United Kingdom, or the Baltic countries. The temporary living situation of migrants makes it even harder to provide assistance. However, this geographical position, as an intermediate step in the migratory journey of migrants taking the Balkan route between Turkey and the EU, offers an opportunity to initiate physical and psychological care and to organise the health continuum of migrants. As of June 2021, 5,062 refugees and applicants for international protection were residing in the Republic of Serbia; 49% of all arrivals originated from Afghanistan and 28% from Pakistan, followed by Somalia, Syria, Bangladesh, and Morocco.²⁶ In March 2021, among refugees and applicants for international protection in Serbia, 83% were men, 3% were women, and 14% were children (girls and boys).²⁷

25. PROTECT – Preventing Sexual and Gender-Based Violence against Migrants and Strengthening Support to Victims, *Mapping Report on Legal Frameworks and Assistance Available to Migrant Victims of Sexual and Gender-Based Violence*, International Organisation for Migration (2019).

26. United Nations High Commissioner for Refugees (UNHCR), *UNHCR Serbia Update*, UNHCR (March 2021).

27. Ibid.

The new Law on Health Care Protection grants medical care to “persons who spent time in war or refugees, who are unemployed with a low monthly income and a residence on the territory of the Republic of Serbia” and “young unemployed persons who are not involved in education up to the age of 26”.²⁸ However, undocumented migrants remain deprived of free health care other than urgent medical care.²⁹

factors hampering the effectiveness of the judiciary in addressing GBV.

With regard to GBV and violence against women, Serbia ranked 19th out of 156 countries in the 2021 Gender Gap Index of the World Economic Forum.³⁰ As such, it is one of the five most-improved countries in the index that narrowed their gender gaps by at least 4.4 percentage points in a year. A protocol for the protection and treatment of women victims of violence was also implemented in 2014,³¹ along with four other protocols, in partnership with three UN agencies.³² A Law on Prevention of Domestic Violence was also adopted in 2017.³³ Serbia is also a signatory of the Istanbul Convention, but its implementation has been shown to be partial, in view of the limited number of shelters, the funding and maintenance of 24/7 SOS helplines, and the lack of training on GBV for employees working at the prosecutor’s office.³⁴ Studies highlighted that a significant proportion of migrants travelling through Serbia experienced violence in the country.³⁵ Finally, a review conducted by the Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO)³⁶ reported limited efficiency of the judiciary in punishing GBV. Little guidance in judiciary proceedings, limits on the beneficiaries of free legal aid, and partial application of the sanctions punishing GBV are the main

28. Katarina Randjelovic and Anja Avramovic, *New Law on Health Care*, Janković Popović Mitić (2019).

29. International Organisation for Migration (IOM), *Migration Governance Profile: Republic of Serbia. May 2018*, IOM (2018).

30. World Economic Forum, *Global Gender Gap Report 2021*, World Economic Forum (March 2021).

31. Integrated Response to Violence against Women in Serbia, *Republic of Serbia Ministry of Health – Special Protocol for the Protection and Treatment of Women Victims of Violence*, United Nations Development Program (2013).

32. Ibid. .

33. Roma Women’s Centre BIBIJA, *National Report on the Implementation of CEDAW and the Istanbul Convention in Serbia. Discrimination and Violence against Roma Women*, BIBIJA (May 2019).

34. Ibid.

35. Jelena Markovic and Marija Cvejic, *Violence against women and girls among refugee and migrant population in Serbia*, Atina - Citizens’ Association for combating trafficking in human beings and all forms of violence against women (2017).

36. Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO), *Baseline evaluation report. Serbia*, GREVIO (2019).

CAN GENDER-BASED VIOLENCE HAPPEN TO MEN AND BOYS?

The concept of GBV encompasses all violence related to socially prescribed gender roles.³⁷ Therefore, women, men, and non-binary persons may face GBV. However, it is worth noting that the structural inequality between genders entails different risk factors and causes behind violence and requires different approaches when addressing GBV against women, men, or sexual and gender minorities. Thus, although women and girls are disproportionately exposed to GBV,³⁸ men and boys can also be victims.

The concept of GBV encompasses all violence related to socially prescribed gender roles. Therefore, women, men, and non-binary persons may face GBV.

In 2005, the IASC guidelines for GBV in humanitarian crisis recognised that “men and boys may also be victims of gender-based violence, especially sexual violence”.³⁹ The 2015 updated guidelines engage more profoundly with the notion of GBV against men and boys and highlight their increased exposure to GBV due to “gender inequitable norms related to masculinity”.⁴⁰ GBV against men and boys is now explicitly mentioned in international legal and policy documents such as United Nations

Security Council resolutions,⁴¹ or more recently in the United Nations High Commissioner for Refugees (UNHCR) 2020 Policy on the prevention of, risk mitigation, and response to GBV.⁴² In 2010, the Belgian IEFH mandated a study about male and female experiences of GBV.⁴³ The study showed that 10% of the male respondents had experienced GBV in last 12 months, and 2% of them experienced intimate partner violence (IPV). Despite this recognition on paper, there is very little awareness of GBV against men and boys. As women and girls are much more often subjected to GBV and perpetrators of GBV are predominantly men, there are only a few studies on male survivors of GBV. Indeed, GBV is often equated to violence against women. The lack of available data with which to evaluate the scope of violence, in turn, hampers survivors’ access to protection, care, and reparation.

Shame and fear of being ostracised or labelled as a ‘victim’, which would indicate a failure to perform/conform to social ‘masculinities’, also discourage help-seeking behaviours.

37. See the definition in Directive 2012/29/UE from the European Parliament and the Council of the European Union, October 25, 2012. See also Inter-Agency Standing Committee (IASC), *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*, IASC (2005).

38. EU Institutions data, *Special Eurobarometer 449: Gender based violence*, Directorate-General for Communication (2016).

39. Inter-Agency Standing Committee (IASC), *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*, IASC (2005):7.

40. Inter-Agency Standing Committee (IASC), *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*, IASC (2015):11.

41. United Nations Security Council, Resolution 2106, S/RES/2016 (2013)

42. United Nations High Commissioner for Refugees (UNHCR), *UNHCR Review of Gender Equality in Operations*, UNHCR (2016): 10.

43. Institut pour l'Égalité des femmes et des hommes (IEFH), *Les expériences des femmes et des hommes en matière de violence psychologique, physique et sexuelle*, IEFH, 2010.

Though GBV against both men and women is generally underreported, GBV faced by men is even less reported than violence against women.^{44 45} There are several barriers preventing men from reporting violence, deriving from the ability to access health facilities, the trauma associated with the abuse, or social constraints. Shame and fear of being ostracised or labelled as a 'victim', which would indicate a failure to perform/conform to social 'masculinities',⁴⁶ also discourage help-seeking behaviours.⁴⁷ Those gender biases have an impact on the quality of the care provided to male survivors of GBV; during interviews conducted in Belgium, some stakeholders expressed their lack of confidence in discussing any problem related to GBV. Moreover, male survivors of GBV often do not have access to dedicated services. In the Netherlands, interviews reported that only a limited number of shelters host male survivors of GBV. In Antwerp, MDM Belgium contacted an organisation working with homeless men in Antwerp; GBV against men and boys was not a topic they addressed.

GBV against boys and men is pervasive and occurs everywhere in the world, across the whole spectrum of society. Some factors of vulnerability can nonetheless be highlighted. Men and boys are more exposed to experiencing GBV when there is a combination of several factors related to the concept of intersectionality:

Age: young men face increased risk of experiencing GBV, as their age places them in a situation of vulnerability. According to the WHO, 20% of girls and 7% of boys have been exposed to sexual abuse.⁴⁸ Interpol noted that boys are more often subjected to "grave abuse" in child pornography.⁴⁹ Unaccompanied minors who do not benefit from the protection of parents or elders are more at risk of being coerced into sexual relationships in exchange for protection.

LGBTQIA+ persons: individuals perceived as 'defying gender norms' are more likely to face GBV. Therefore, persons identifying as non-binary or trans are more likely to be targeted.⁵⁰ A recent study of sexual violence in Belgium showed that LGBTQIA+ persons were significantly more exposed to GBV during their lifetime, while 90% of survivors did not access care or support services.⁵¹

Disability: the intersection between disability and GBV is of particular concern since some forms of GBV against people with disabilities remain invisible and are not recognised due to disability discrimination.⁵² Persons with disabilities are regularly prevented from accessing care services due to many factors, including stereotypes related to disability and sexuality.⁵³

Conflict settings: GBV is more prevalent in conflict-ridden areas, where it becomes a way to humiliate and incapacitate the adversary. Men engage in combat more often, which puts them at an increased risk of being exposed to sexual violence.⁵⁴ For instance, it was estimated by the UNHCR that amongst male migrants who fled Syria, 30 to 40% experienced sexual

44. United Nations High Commissioner for Refugees, Working with men and boys survivors of sexual and gender-based violence in forced displacement, UNHCR (2012).

45. IEFH, Les expériences des femmes et des hommes, *supra* note 43.

46. The IEFH study highlighted that men were less likely to disclose experience of GBV, notably when it came to IPV.

47. 'Masculinities' relates to the position of men in a gendered order. It refers to the expected actions, roles, and behaviors of men according to patriarchal norms. The theory of masculinities, as a sub-field of gender studies, has been developed by sociologist Raewyn Connell in the 1990s. Connell notably distinguishes between four categories of masculinities: hegemonic masculinity (the ideal-type of patriarchy), complicit masculinity (supporting hegemonic masculinity and enjoying indirectly its effects), subordinate masculinity (dominated because it does not match with the social vision of masculinity, e.g., homosexual men) and marginalised masculinity (which could be hegemonic but is not due to other social factors, such as race for instance).

48. David Lisak, "The psychological impact of sexual abuse: Content analysis of interviews with male survivors", *Journal of traumatic stress* 7 no. 4 (November 1994).

48. World Health Organisation (WHO), *Global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children*, WHO Library Cataloguing-in-Publication Data (2016).

49. GAMS, Family Justice Centre, and Intact, *Violences liées au genre dans le contexte de l'asile*, GAMS (2019).

50. See for instance Human Rights Watch (HRW) and Helem, "They treated us in monstrous ways": *Sexual violence against men boys and transgender women in the Syrian conflict*, HRW (2020).

51. Lotte De Schrijver, "Sexual Violence in LGBTQIA+ persons and applicants for international protection", *Communication presented at the online seminar Beyond the Tip of the Iceberg – Sexual Violence in Belgium*, 17 June 2021.

52. Stephanie Ortoleva and Hope Lewis "Forgotten Sisters – A Report on Violence Against Women with Disabilities: An Overview of its Nature, Scope, Causes And Consequences", *Northeastern Public Law and Theory Faculty Research Papers Series*, no. 104 (2012).

53. United Nations Population Fund (UNFPA), *Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*, UNFPA (2018).

54. Chris Dolan, "Into the Mainstream: Addressing Sexual Violence Against Men and Boys in Conflict", *Workshop held at the Overseas Development Institute in London*, 14 May 2014.

violence in Syrian detention centres.⁵⁵ Cases of systematic rape, forced genital mutilation, torture with sexual character, and sexual slavery were reported. In Ugandan refugee camps, 38.5% of refugee men who had fled conflicts in the Democratic Republic of Congo reported having experienced sexual violence in their lifetime, 13.5% of them within the past 12 months.⁵⁶

Precarity: precarious economic situation, unstable legal status, and isolation put individuals in a vulnerable position with regard to GBV. Few shelters are dedicated to male or non-binary survivors of GBV and most require a financial contribution.

Situation of migration: migrants face several factors of vulnerability all along their migratory journey. The asylum application procedure itself reinforces the exposure of men and boys to GBV. Applicants for international protection must notably prove that their fear of persecution is well-founded. According to one of the interviewed stakeholders in Belgium, who works with LGBTQIA+ refugees, this requirement leads to several forms of extortion, such as threats of withdrawing testimonies so that applicants cannot obtain legal documents.

- ✘ **GBV encompasses all kind of violence related to prescribed gender roles and can consequently be faced by men and boys.**
- ✘ **GBV against men and boys is generally underreported due to its social stigma labelling survivors as failing to perform their 'masculinities'.**
- ✘ **GBV against men and boys is exacerbated by other factors such as age, being LGBTQIA+, conflict settings, and migration.**

HOW DO NGOS ACT IN THAT SITUATION? WHAT HAS BEEN DONE BY REACH OUT?

Despite the rising concern about GBV in our societies, there is a general lack of awareness of GBV against males among health professionals and the general public. Existing networks of health care providers are sometimes not equipped or prepared to deal with male survivors and few resources are allocated to specific care for men and boys. Therefore, non-governmental organisations (NGOs) should shed light on the fact that men and boys can also be victims of GBV. NGOs can also engage in data collection regarding GBV faced by men and boys to improve the understanding of such violence and formulate adequate prevention and mitigation policies. They can push for updating or developing health protocols acknowledging male survivors of GBV and make sure that health professionals and cultural mediators are trained to engage with male, female, and non-binary survivors. NGOs can also promote the inclusion of specific training in the curriculum of all care providers.

These difficulties in providing care to male victims of GBV were at the core of the REACH OUT project. The REACH OUT proposal was carefully framed in an inclusive perspective to ensure that all persons at risk/survivors of GBV could be reached. Considering the performative effect of language, particular attention was given to the words used to describe the project. The expression 'gender-based violence' was used to avoid limiting the scope of the project to violence against women or sexual violence. It was recalled in all documents and activities that GBV relies on stereotyped gender norms and can therefore be experienced by women, girls, men, boys, and non-binary people. Each activity specified that men and boys should be included. The proposal included specific outreach and psycho-social activities targeting men and boys. Those workshops focused on strategies for preventing GBV and supporting GBV survivors. They emphasised how openness about GBV contributes to justice and recovery. They also provided men and boys with relevant information about existing support services.

55. Sarah Chynoweth, *Sexual violence against men and boys in the Syria crisis*, United Nations High Commissioner for Refugees (2017).

56. Chris Dolan, "Into the mainstream", *supra* note 54.

The REACH OUT project also focused on increasing the assistance available for male survivors of GBV by conducting awareness training sessions with health professionals and cultural mediators. First, all protocols systematically specified that GBV could happen to any individual. MdM Belgium designed GBV identification cards for women, men, and non-binary people. Then, some specific workshops were held to address the issue of male survivors of GBV. MdM Germany organised a workshop about GBV and post-traumatic stress disorder dedicated to professionals working in AnKER Centres. One of the invited experts was Andreas Schmiedel, a social pedagogue at the Münchner Informationszentrum für Männer (Men's Information Centre Munich). He discussed how to support male victims of GBV. In addition, he described why male survivors of GBV face high barriers in discussing GBV-related experiences. He outlined which methods social workers can use when talking with male survivors. In the Netherlands, eight men from Syria, Afghanistan, Iran, and Somalia were trained on how to start a dialogue on GBV with their communities. A partnership was also formed with Fathers under Pressure, an NGO in the Netherlands organising dialogue sessions for men in which one of the REACH OUT cultural mediators was involved.

REACH OUT also implemented outreach activities targeting men and boys at risk of GBV. Having noticed that men were mostly not involved in workshops about GBV, MdM Netherlands organised unigendered sessions of 10 participants on neutral topics such as health, nutrition, and education. The objective was to create a trust-building atmosphere that could eventually lead to disclose experience and to engage on the topic of GBV. Similarly, in Serbia, three workshops were planned with men between the ages of 18-40. The first workshop addressed neutral topics such as access to the health care system. The second delved more into detecting signs of GBV, getting support, and helping GBV survivors to seek support. The last workshop was dedicated to methods for reporting cases of GBV. Finally, to mitigate any additional mental trauma, individual counselling sessions with unigender specialists were offered at the end of each workshop.

Implemented by REACH OUT

- ✘ **Training of health care professionals and cultural mediators on GBV faced by men and boys**
- ✘ **Outreach activitiesw targeting men and boys at risk of GBV**

Recommendations of REACH OUT

- ✘ **Data collection on GBV faced by men and boys**
- ✘ **Training of health care professionals, social workers, and public authorities on GBV faced by men and boys**
- ✘ **Advocacy towards national institutions so that legal definitions of GBV and access to support services include men, boys, and non-binary persons**

This part was redacted by the coordination team from MdM Belgium, with the expert contribution of Michel Roland, general practitioner, former president of MdM Belgium, and Professor of Public and Social Health at the Université Libre de Bruxelles.



Young man looking at the European map*
© Médecins du Monde Belgique

DOES THE HOST COUNTRY ALWAYS GIVE RESIDENCY TO UNDOCUMENTED PEOPLE FACING GENDER-BASED VIOLENCE IN AN INTRAFAMILIAL CONTEXT?

DEFINITION

According to the WHO⁵⁷ and the IASC,⁵⁸ Intimate Partner Violence (IPV) applies specifically to violence occurring between intimate partners (cohabiting, married, boyfriend/girlfriend, or other close relationships). It refers to “any behaviour within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours”.⁵⁹ This type of violence may also include the denial of resources, opportunities, or services. IPV occurs in all countries, all cultures, and at every level of society.⁶⁰ Furthermore, stressors related to the immigration process and changes in family or gender roles can trigger or intensify IPV, with psychological violence being the most commonly described.⁶¹

57. Claudia Garcia-Moreno, Alessandra Guedes, and Wendy Knerr, *Understanding and addressing violence against women. Intimate partner violence*, World Health Organisation (2012), accessible at: https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf;sequence=1.

58. Inter-Agency Standing Committee (IASC), *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*, IASC (2015).

59. World Health Organisation (WHO), *Violence against women. Intimate partner and sexual violence against women*, WHO (2014).

60. Carmen Vives-Cases et al., *Preventing and addressing intimate partner violence against migrants and ethnic minority women: the role of the health sector*, World Health Organisation Regional Office for Europe (2014).

61. Rubeena Zakar et al., “Intimate partner violence against women and its related immigration stressors in Pakistani immigrant families in Germany”, *Springerplus* 1, no. 5 (2012). See also Carmen Vives-Cases et al., *Preventing and addressing intimate partner violence against migrants and ethnic minority women: the role of the health sector*, World Health Organisation Regional Office for Europe (2014).

ISTANBUL CONVENTION

The Convention on Preventing and Combating Violence Against Women and Domestic Violence, hereafter called the ‘Istanbul Convention’, is the first comprehensive tool in Europe to set legally binding standards for preventing and fighting violence against women, punishing perpetrators, and guaranteeing survivors the availability of medical, psychosocial, and legal services, as well as safe accommodation. This treaty was signed and ratified by Belgium (2012, 2016), Germany (2011, 2017), the Netherlands (2012, 2015), and Serbia (2012, 2013), among other states. In joining the Istanbul Convention, states must align their national legislation and ascertain that all women benefit from such services, including undocumented women.⁶² Article 4, Paragraph 3 of the Istanbul Convention mentions very explicitly that discrimination based on immigration status is forbidden.

The implementation of the provisions of this Convention by the Parties, in particular measures to protect the rights of victims, shall be secured without discrimination on any ground such as sex, gender, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth, sexual orientation, gender identity, age, state of health, disability, marital status, migrant or refugee status, or other status.

62. Platform for International Cooperation on Undocumented Migrants (PICUM), *Achieving a world free from violence against all women, regardless of migration status*, PICUM (2020).

THEORY INTO PRACTICE

In 2018, Europol data estimated that around 17,235 undocumented people resided in Belgium, while other research counted 23,000 undocumented migrants in the Netherlands⁶³ and one million in Germany.⁶⁴ However, it is impossible to know the exact size of this heterogeneous population given the fact that these people are often not registered anywhere. Moreover, the definition of who is considered an undocumented migrant remains unclear when data are collected. Given those difficulties, it is even harder to quantify the number of undocumented people who experience IPV.

Additionally, the current COVID-19 pandemic has reinforced existing inequalities. The lack of inclusion of undocumented migrants in COVID-19 income and housing support schemes also enhanced their vulnerability.⁶⁵ The impacts of COVID-19 on migration include forced immobility and higher dependency on smugglers, while financial deprivation entails increased risks of accepting dangerous work for survival.⁶⁶ More generally, the closure of borders had dire consequences on the legal situation of migrants, who have been compelled to remain in place, have overstayed their visas, or have seen their regularisation procedures slowed down by the closure of offices.

Lockdowns and mobility restrictions led to a sharp increase in all forms of violence against women and girls, particularly domestic violence.⁶⁷ Stay-at-home measures strengthened mechanisms of control that isolate victims of GBV. A UNICEF report pointed out that many organisations supporting GBV survivors, including UNICEF partners in Europe who deliver GBV support services through its GBV program, have seen an increase in demand for their services.⁶⁸ All partners who took part

63. "Estimates of numbers of illegal immigrants show downwards trend", Government of the Netherlands, accessed on July 9, 2021, <https://www.government.nl/latest/news/2020/12/16/estimates-of-numbers-of-illegal-immigrants-show-downwards-trend>.

64. Phillip Conner and Jeffrey S. Passel, *Europe's Unauthorized Immigrant Population Peaks in 2016, Then Levels Off*, Pew Research Centre (2019).

65. Lorenzo Guadagno, "Migrants and the COVID-19 pandemic: an initial analysis", *International Organisation for Migration (IOM) Research series*, no. 60 (2020).

66. Mixed Migration Centre (MMC), *L'impact de COVID 19 sur les réfugiés et les migrants en mouvement en Afrique du Nord et de l'Ouest*, MMC (February 2021).

67. María-Noel Vaeza, "Addressing the Impact of COVID-19 Pandemic on Violence against Women and Girls", *United Nations Chronicle* (2020).

68. United Nations International Children's Emergency Fund (UNICEF), *Impact of Covid-19 on Gender-Based Violence. Refugee and Migrant Response*, UNICEF Europe and Central Asia Regional

in this report expressed concerns about the increased risks of IPV against refugee and migrant women and girls, as well as other forms of violence, including sexual violence and sexual exploitation.⁶⁹ This increase is likely to be an underestimate because survivors who do not have legal residence documents, do not know the health system, and/or are unaware of their rights have an even harder time seeking help and are thus rarely, if ever, identified.

ACCESS TO SERVICES AND INFORMATION

In general, being undocumented creates dependencies increasing the risk of experiencing IPV and hampering survivors from leaving situations of violence and abuse. The violent partner is in many cases the only source of information and often tells the survivor that they will be deported if they leave or file a complaint. Given their dependence, survivors often have limited to no access to medical, psychosocial, or legal services, or safe accommodation. For example, in both Belgium and Germany, absence of legal residence document seriously hampers access to shelters for survivors of IPV. Moreover, these services are not free, which makes it difficult for someone who cannot officially work to afford them. In the Netherlands, access to care or a shelter is theoretically not dependent on legal residence or immigration status. However, in practice, many providers are not aware of undocumented persons' rights and are not willing to do all the paperwork for the reimbursement of medical costs.

FILING A COMPLAINT

On top of the difficulties that survivors of IPV often encounter when filing a complaint (secondary victimisation, too few specialised staff, dismissal, refusal to draw up a report, lack of proof, etc.), undocumented people also fear persecutions such as imprisonment or deportation. In Belgium, circular COL 06/2017 was adopted in 2017 to ensure protection for survivors regardless of their origin or residence

Office (2021). (For example, in Greece, the General Secretariat for Family Policy and Gender Equality (GSFPG), which collects data on people requesting support, has seen an increase in demand for support against GBV during the pandemic. In Italy, an analysis of calls to the national anti-violence and stalking helpline showed an increase in demand during the pandemic).

69. Ibid.

Being undocumented creates dependencies increasing the risk of experiencing IPV and hampering survivors from leaving situations of violence and abuse. The violent partner is in many cases the only source of information and often tells the survivor that they will be deported if they leave or file a complaint.

status. Police officers are therefore required to protect GBV victims. However, under Belgian law, police officers must also report undocumented people to immigration authorities. It must be noted that the reality is more nuanced. Indeed, the police and judiciary institutions have been increasingly sensitive to GBV issues, which are a matter of public order. In the Netherlands, a pilot project was progressively implemented in Amsterdam, Utrecht, and Eindhoven to make it possible for undocumented migrants to report GBV without any immigration consequences.⁷⁰ However, NGO Stichting LOS⁷¹ mentioned that there were no guarantees that reporting would not have later immigration consequences for the victim and/or their network. As a result, undocumented survivors of IPV are unlikely to report violence⁷² and are often forced to remain in a violent situation.

70. Ruben Timmerman, Arjen Leerkes, and Richard Staring, *Safe Reporting of Crime for Victims and Witnesses with Irregular Migration Status in the Netherlands*, University of Oxford Center on Migration, Policy and Society (2019).

71. Rafaël Bouts, Ties Coenen, and Robbert van Dijk, *Een goede zaak: Onderzoek naar veilige aangifte voor ongedocumenteerden*, Stichting LOS (2016).

72. PICUM, *Achieving a world free from violence against all women*, supra note 62.

POSSIBILITY OF APPLYING FOR RESIDENCE BASED ON IPV

In contrast to the case of victims of trafficking—who are granted an initial temporary right of residence and shelter—there is no specific procedure for undocumented people survivors of IPV. In Belgium, they may be able to apply for a residence permit based on Article 9bis of the Alien Act, the so-called “humanitarian regularisation application”. Since there are no legally defined criteria and no deadline is set for the Immigration Department to make a decision, the procedure remains unclear. In addition, during this procedure, the person does not have access to the labour market, decent housing, health insurance, etc. In the Netherlands, survivors of IPV are eligible for international protection. However, the application process makes it extremely difficult to prove that such violence happened; people with trauma often have difficulties consistently sharing their stories. These inconsistencies are taken as evidence by the authorities that the applicants are not telling the truth. In addition, many applicants for international protection do not share their experiences of sexual violence in the first interview. They are not always aware that this information could support their application. Similarly, Germany recognises GBV, including IVP, as a ground for asylum. However, research has shown that women applying for gender-based asylum face more difficulty in getting international protection. This is due to the lack of access to legal assistance but also to the asylum hearing format, deeply influenced by gendered norms and expectations, for which applicants for international protection must provide a detailed account of the violence they experienced.⁷³ In Serbia, based on the available information CK Šid had, there is no explicit legal provision granting residence status to migrant survivors of IVP. Regular legislation dealing with survivors of violence does not include migrants in target groups.

According to Article 59 of the Istanbul Convention, survivors of IVP whose residence status is conditional on marriage or being in a relationship should be granted an autonomous residence permit in the event of dissolution of the relationship, with no exceptions. However,

73. Abraham Lamptey, “Learning from German Gender and Immigration Policy Missteps”, *The Gender Policy Report* (April 2018), accessible at: <https://genderpolicyreport.umn.edu/learning-from-german-gender-and-immigration-policy-missteps/>.

Women applying for gender-based asylum face more difficulty in getting international protection. This is due to the lack of access to legal assistance but also to the asylum hearing format, deeply influenced by gendered norms and expectations, for which applicants for international protection must provide a detailed account of the violence they experienced.

- ✘ Limited access to support, protection, and legal services; constrained possibilities for filing a complaint
- ✘ No specific procedure for undocumented persons who are survivors of IPV
- ✘ Possibility of getting residence status through a new application for humanitarian purposes or restart of the asylum application when the residence permit is conditional on being in a relationship

HOW DO NGOS ACT IN THAT SITUATION? WHAT HAS BEEN DONE BY REACH OUT?

NGOs can first raise awareness on the topic of GBV among both migrant populations and staff working with migrant populations, notably through training and information workshops. They can also enhance bridges between migrant communities and support services by working with translators and cultural mediators to ensure proper communication between all stakeholders. Finally, NGOs can implement critical advocacy actions to defend the human rights of GBV survivors independently of their residence status.

MdM Belgium conducted interviews with employees of more than 70 organisations who either regularly come into contact with migrants and/or have expertise on the topic of GBV. During these conversations, needs with regard to care for people with precarious residence status who have experienced GBV were identified. Those needs were classified into different categories, such as medical care, mental health care, abortion care, legal support, pregnancy follow-up, social support, and accommodation. Afterwards, multiple meetings were organised to strengthen the coordination between different stakeholders and to brainstorm on how to enhance care for GBV survivors. The findings of these individual and group conversations were, among others: (1) limited knowledge of certain stakeholders

in both Germany and the Netherlands, survivors of GBV who arrived through family reunification need to start a new asylum process if they divorce their partner within the three first years (Germany) or five first years (Netherlands) following arrival, even in the case of IPV. In Belgium, the right of residence obtained through family reunification may not be terminated after divorce in cases of “particularly distressing situations”, including IPV.⁷⁴ However, this provision is applied very strictly by the Immigration Department. A survivor of IPV would be asked to formally prove the violence, for instance through filing a complaint, or providing medical documents or a housing letter from a shelter. Furthermore, individuals whose family reunification application is pending or whose partner left after they filed a complaint are not protected by the provision.

As a result, undocumented people in a violent relationship find it extremely difficult to submit a residence application. Therefore, many survivors see no other option than to stay with their violent partner, at least until they are sure of their own right of residence.

⁷⁴ Law of 15 December 1980 on access to the territory, residence, establishment and the removal of aliens, article 42 quarter 1^o4.4o.

on the topic of GBV in a migration context, (2) lack of confidence regarding the identification, support, and referral of survivors of GBV, and (3) absence of clarity on the consequences of reporting violence by an undocumented survivor.

Based on these findings, a series of eight training sessions was organised for professionals working with refugees, undocumented people, and applicants for international protection, i.e., medical staff, social assistants, psychologists, reception officers, police officers, volunteers, etc. One of the training sessions focused on domestic violence and IPV. Care providers and police officers briefly discussed the complexity of filing a complaint when the survivor does not have legal residence documents. The police advised reporting the violence, whereas caregivers were more reluctant to do so since no protection could be guaranteed. It was eventually suggested that the care provider could anonymously report the violence with the consent of the survivor.

Interviewed stakeholders in Germany and the Netherlands also stressed that survivors were dissuaded from reporting IPV because they feared that such reporting would be disclosed to their partners. Therefore, information workshops organised in shelters and refugee centres focused on confidentiality. It was systematically highlighted that all staff involved—health professionals, social workers, public authorities, NGOs—are bound to non-disclosure.

Finally, to create clarity as to where undocumented migrants can go for help, MdM

Belgium developed an overview of the available services. MdM Germany also created a map of the support system existing in Munich that mentions organisations specifically handling cases of IPV. Finally, in Serbia, CK Šid organised a specific information workshop about how to report family violence and get support from Serbian institutions.

Implemented by REACH OUT

- ✘ **Training workshops on IVP for professionals**
- ✘ **Mapping out existing support services for survivors of IVP**
- ✘ **Information workshops for undocumented migrants about their rights and their possibilities for reporting IVP cases, with a focus on confidentiality**

Recommendations of REACH OUT

- ✘ **Pursue training sessions on GBV for all staff working with migrants**
- ✘ **Lobbying to national authorities so that there are no immigration consequences when undocumented migrants report a case of GBV**
- ✘ **Lobbying to fully implement the provisions of Article 59 of the Istanbul Convention**



MdM staff orienting a beneficiary*. © Olivier Papegnies

TESTIMONY

Interview with a care provider employed by MdM Belgique in Antwerp:

“During one of our patient meetings, a woman rang the doorbell. My colleagues and I immediately saw that she was badly beaten after which we immediately let her in. The young woman told us that she had been raped and beaten by her male housemate. Besides giving her the necessary medical care, we also gave her the possibility of filing a complaint. She refused because she realised she was not in the possession of legal residence documents and thus feared imprisonment or deportation. At that time, even we could not guarantee her protection. She also did not want to go to the emergency department, something we were also not inclined to send her to, since we all knew that the police would be notified here as well.

Subsequently, I contacted several organisations hoping one of them could offer her a safe place to stay. In vain, because no organisation was willing or able to provide her with shelter. On the one hand because they did not have any space left, but mainly because she did not have the right documents.

We took care of her as best as we could after which she returned to the violent situation from which she had fled earlier.

For me, as a care provider, this was the most difficult part, knowing that she was forced to go back to the person who had raped her and to the place where the violence had taken place. Only because there was no other option. The trauma that this woman had to face must have been devastating.

This whole situation is appalling, especially when a survivor of sexual violence has finally found the courage to seek help, you, as a caregiver, cannot offer the help she needs and deserves.

The next day, I contacted the police to explain the situation and to ask very specifically: “What would you do?” They responded very strongly: “If they shouldn’t be here, then they shouldn’t be here”. Afterwards, I consulted my own network, which also includes some police officers. They told me that the complaint would be filed, but that the way such a situation would be handled entirely depends on the police officer you are dealing with. This makes you, as a care provider, also reluctant to encourage undocumented people who have experienced violence to report it to the police.

For me, the ideal scenario in such a situation would be that the survivor of violence receives the adequate support to deal with her trauma and that she is protected by the people in our society who are competent to do so. At that point, the fact that she may or may not have legal residence documents should not matter.”

The ideal scenario would be that the survivor of violence receives the adequate support to deal with her trauma and that she is protected by the people in our society who are competent to do so.

HOW CAN (NATIONAL) INSTITUTIONS ACT TO PREVENT GENDER-BASED VIOLENCE AGAINST MIGRANTS?

National institutions play an essential role in preventing GBV against migrants and supporting GBV survivors. First, States are the primary actors in terms of human rights implementation. Second, many public institutions are actively involved in health care and immigration services; in the countries of implementation of the project, most refugees' accommodation centres and shelters for GBV survivors are managed by public authorities. Third, as policymakers, national governments and legislators have the power to embed GBV guidelines and procedures into the national legal framework, allowing those protocols to be sustainably implemented. Therefore, it is critical to highlight the main actions national institutions can take in the field of GBV and migrations.

Many applicants for international protection as well as recognised refugees live in state-run refugee centres. The nature and the management of these centres are crucial for ensuring adequate violence prevention and protection. Because they are usually mass facilities located in the periphery, protection from violence and access to support services are often not possible in practice. Refugee centres should be located close to existing services and transportation to those services should be accessible for migrants to ensure their right to medical services, independent legal consultation, and access to counselling centres. Centres and shelters should be built as small, decentralised accommodations, in which the residents know and can support each other. In addition, including residents in the centre management (e.g., organisation of catering/cooking, use of common rooms, organisation of social activities) would promote the empowerment of residents. People who can organise their everyday

lives are more likely to speak up for themselves and are therefore less vulnerable to GBV.

States are the primary actors in terms of human rights implementation. As policymakers, national governments and legislators have the power to embed GBV guidelines and protocols into the national legal framework, allowing those protocols to be sustainably implemented.

National institutions should also ensure that identification procedures in refugee accommodation centres are adequate and culturally sensitive. Indeed, those procedures may lead to secondary traumatisation, stigmatisation, and/or discrimination against vulnerable persons. This recommendation applies to all support services. The well-being, security, and (mental) health of people must always be treated as the highest priority when identifying and providing support to survivors. State action should never expose people to any additional risk.

Finally, institutional measures for violence

protection should include:

- ✘ **Information for all migrants about their rights to medical services, legal aid, and social counselling**
- ✘ **Information for all residents about external support services for GBV survivors (e.g., women’s emergency hotline)**
- ✘ **Guarantee of privacy and places of retreat**
- ✘ **Standardised procedures in cases of (suspected) violence**
- ✘ **Clear referral persons for GBV survivors, whose services include language mediation**
- ✘ **Standards and job requirements for all staff working in accommodation centres and/or shelters (e.g., certificate of good conduct, adequate training, and professional experience)**
- ✘ **Regular training on Protection from Sexual Exploitation and Abuse and Sexual Harassment (PSEAH) by external experts for all staff working in accommodation centres and/or shelters**
- ✘ **Regular monitoring and evaluation of the implementation of the protection from violence strategy**
- ✘ **Internal and external complaint management, with a control and sanction mechanism**

From a long-term perspective, national institutions can play another significant role by adopting legislation, protocols, and guidelines on GBV and migrations. Notably, they need to ensure the full implementation of the EU Directive 2013/33⁷⁵ and the Istanbul Convention in national legislation.

⁷⁵ The directive of the European Parliament and of the Council (Directive 2013/33/EU) from June 26, 2013, lays down standards for the reception of applicants for international protection. It contains provisions on basic medical care, accommodation and access to education and employment.

Articles 21 and 22 of the EU Directive 2013/33 determine that Member States should assess which applicants for international protection must be treated as vulnerable persons. Special needs must be considered during the entire asylum process and vulnerable persons have the right to receive adequate support. All survivors of GBV should be recognised as vulnerable persons. In addition, LGBTQIA+ persons should receive special attention since they are disproportionately often affected by GBV.

Refugee centres should be located close to existing services and transportation to those services should be accessible for migrants to ensure their right to medical services, independent legal consultation, and access to counselling centres.

Article 60 paragraph 3 of the Istanbul Convention determines that “parties shall take the necessary legislative or other measures to develop gender-sensitive reception procedures and support services for asylum-seekers as well as gender guidelines and gender-sensitive asylum procedures.” Therefore, in 2015, with the massive influx of migrants along the Balkan Route, the Republic of Serbia coordinated relevant stakeholders with the assistance of the United Nations Population Fund (UNFPA) to adopt Standard Operating Procedures (SOP) regarding GBV against migrant populations. It was quickly recognised that the people traveling through Serbia had suffered violence and trauma during their journey to Europe. As a result of various working group meetings, the Republic of Serbia created the Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies,⁷⁶ which were finalised in September 2016. The SOP are based on the guiding principles of

⁷⁶ Ugochi Daniels et al., *Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies*, United Nations Population Fund (2015).

safety, trust, respect for privacy, and non-discrimination. Through these protocols, persons reporting GBV can gain international protection in Serbia. SOP and frameworks in Serbia have been regularly updated to account for the changing circumstances in migration settings.

Similar measures have been adopted in all countries of implementation of the REACH OUT project, but many factors are preventing their effective implementation. In Belgium, the NAP to combat all forms of GBV includes training and guidelines for all stakeholders exposed to GBV disclosure. However, it was reported that relevant actors were not aware of such guidelines, which led to virtually no use of those procedures. In the Netherlands and Germany, partners acknowledged the existence of various protocols addressing GBV intended for relevant stakeholders but deplored their fragmentation and lack of coordinated application. In Serbia, the previously mentioned protocols are not binding and are not always rigorously implemented. While they are mostly known by the workers interacting with migrant populations, the lack of coordination and harmonisation between different sets of guidelines hinders their effective implementation. Moreover, most protocols at the local level are limited to domestic violence and no initiatives exist concerning the other forms of violence covered by the Istanbul Convention. Therefore, despite those guidelines, professionals lack the ability to detect GBV among persons in migrant populations.

National institutions can act within three main areas to address GBV against migrant populations:

- ✘ **The nature and the management of state-run refugee centres and shelters**
- ✘ **The adoption of protocols and guidelines on GBV prevention, detection, and care**
- ✘ **The training and coordination of public authorities in contact with migrants and refugees: health professionals, social workers, police, immigration services, etc.**

HOW DO NGOS ACT IN THAT SITUATION?

WHAT HAS BEEN DONE BY REACH OUT?

NGOs can take action in three regards: first, they can conduct activities directed at migrants in general and GBV survivors in particular to raise awareness about their rights and the support services they are entitled to. Second, they can consult and support government institutions in improving their approach to preventing GBV against migrants and refugees. Third, NGOs can act to influence national legislation on violence protection and prevention.

Many refugees are not aware of the rights laid down in international agreements—such as the Istanbul Convention or the EU Directive 2013/33/ on standards for the reception of applicants for international protection—and national law. NGOs can hold awareness-raising activities focusing on the rights of GBV survivors. Such activities include low-threshold workshops, individual consultations, and the dissemination of multilingual information through brochures, postings in refugee centres, and social media. Finally, it must be guaranteed that participants are not stigmatised, discriminated against, or even in danger of more violence because of their participation.

Secondly, NGOs can support government institutions like state-run refugee centres through consultations and training sessions. Because of their practical experience and everyday work with GBV survivors, NGOs often have an in-depth understanding of the target group. They are aware of the (structural) challenges and barriers faced by GBV survivors. NGOs can share this expertise with government institutions and sensitise them to the situation of GBV survivors. NGOs can also use this expertise to conduct training for the staff of government institutions. Such training can notably cover the identification of and provision of needs-based support to GBV survivors. Finally, NGOs can conduct training for the staff of Civil Society Organisations (CSOs), which are more strongly locally rooted and can effectively raise awareness within their environment.

Finally, NGOs can promote change in the national legislation on GBV prevention and survivors' protection. The public is often not aware of the structural challenges GBV survivors face and therefore does not take political action. Information campaigns can increase public attention to the issue. In addition, NGOs can directly reach out to decision-makers and raise their awareness of the importance of political change.

During the implementation of the REACH OUT project, several of the activities proposed above were conducted. First, measures for raising awareness of existing support services among migrants at risk/survivors of GBV were implemented. In Germany, the REACH OUT partners created a guide centralising all support services for GBV survivors in various fields (medical, psychotherapeutic, legal, psychosocial, etc.). Such coordination and harmonisation efforts make it easier for migrant survivors of GBV to identify which support services exist and are available. Similarly, in Serbia, interviewees expressed the need for a clear map of all support services and a clear referral pathway so that care providers can properly link the needs of survivors to appropriate services. During the COVID-19 crisis, the Ministry of Health at the national level and the Šid Health Centre at the local level implemented a system of coordination of medical care providers, allowing for more clarity and visibility of the support services available for survivors of GBV.

Outreach activities were also conducted; as an example, CK Šid implemented outreach activities that included seven workshops with persons residing in reception and transit centres in the Šid area. Four workshops were held with women and girls, and three workshops were held with men. In total, 71 applicants for international protection—30 men and 41 women—participated in the workshops. Participants were informed on how to report cases of GBV to the relevant institutions and which procedures to follow. Participants also discussed how to detect signs of GBV and how to approach people in a supportive way.

Second, REACH OUT implemented actions to enhance public authorities' approach to GBV prevention and detection. In Belgium, Germany, and the Netherlands, interviewed stakeholders expressed their need to know

more about existing support services for victims and GBV. They also emphasised the necessity of increasing coordination between all staff working with migrant populations. Consequently, the REACH OUT partners organised various training and coordination activities targeting professionals. CK Šid, in collaboration with the project consortium and local stakeholders (health care professionals, the Commissariat for Refugees and Migration, the Ministry of Interior, the Centre for Social Work, the Municipality of Šid, etc.) investigated the current situation with regard to GBV in Šid reception centres. Resources were mapped out through interviews with stakeholders, analysis of the current legislation and SOP, and recommendations for new protocols. Then, CK Šid developed a training program to enhance the capacities of health care professionals. The training program focused on how to report cases, the rights of migrants to receive protection, and how to provide psychosocial support.

In December 2020, MdM Germany conducted a five-hour training session for professionals working in AnKER centres in the district of Upper Bavaria. Staff from social services and centre management as well as the governmental coordination staff responsible for all AnKER centres in Upper Bavaria were invited. The training aimed to enhance mutual exchanges, improve internal procedures, and specify the responsibilities of each institution in case of suspected violence. The REACH OUT coordinator from MdM Germany discussed possible indicators of GBV and presented relevant support organisations in the region. Then,

NGOs can support government authorities in improving their approaches toward prevention of and protection from GBV. Governmental authorities can benefit from the expertise NGOs have due to their practical work with GBV survivors.

a lawyer for asylum and alien law explained the relevance of GBV experiences for the asylum process. She stressed that GBV survivors often have the right to international protection. Furthermore, she discussed the rights GBV survivors have during the asylum process and the responsibilities of public authorities in ensuring these rights.

The lessons learnt from these training sessions were that NGOs can support government authorities in improving their approaches toward prevention of and protection from GBV. Governmental authorities can benefit from the expertise NGOs have due to their practical work with GBV survivors. A multi-faceted approach including governmental and non-governmental actors should be pursued to effectively prevent GBV and protect survivors.

Implemented by REACH OUT

- ✘ Mapping existing support services and referral pathways for survivors of GBV
- ✘ Training professionals to improve coordination and existing procedures

Recommendations of REACH OUT

- ✘ To support governmental activities in state-run refugee centres and shelters
- ✘ To share expertise when drafting/improving SOP for GBV cases
- ✘ To raise public awareness on GBV so that public authorities are proactive on the topic

This part was redacted by MdM Germany and CK Šid with the expert contribution of Susanne Nothhafft, Professor of Law and Researcher at the Katholische Stiftungshochschule München.



TESTIMONIES

Abstracts of an interview with a GBV survivor in a refugee centre in Germany (a young, single woman from a Middle East and North Africa country, who lives in a refugee reception camp in a rural area close to Munich):

“The first camp was a container, and in the room, I had 8 women with me. It was a disaster. With cleaning, with toilet, they don’t have normal toilets, they have the toilets that go in the floor so I could not use the toilet even. I arrived at 1 am and I remember I couldn’t sleep that night, because it was really... I was in shock of the situation there. In this camp one security [guard] who comes from Tunisia, he pushed me. And he called me a bitch. And he was a security guy. And at that time the chief of the security came and talked to me and said we will act, and they were just letting me go so that I don’t talk to the police about it. And I haven’t talked to the police about it.

There was no social service in this camp because it’s a temporary camp and it’s only a container. But I tried to talk to them once because I received a call thinking maybe it was from my ex-husband, but they did not give it attention. [...] He [the security guard] continued to work there. And he called me a “Schlampe” in front of everybody. The whole container could hear it because the container is open. And he was screaming, and he said “next time I will pull you from your hair”. [The boss from security went to talk to me], it was just to calm me down so that I don’t call the police. And he said “you don’t want problems right now for your asylum. You don’t want people to say that you are causing problems in this place”. And then I was moved to the building [of the centre].

And in that building it was better than the container but still all the securities there. I am so sorry, but I don’t know, but everybody is hitting on you there. They think if you’re a single woman here[...] you’re an easy catch for anybody. I don’t understand why. Is it that I am seeking for asylum means I am weak? And I just want anyone to hold on to? So, I had some problems like that. [...]

You cannot lock them [the facilities]. The showers are open. If someone opens the door, you are right there where you take the shower. You cannot lock any door there. It’s crazy. Unbelievable. And I really don’t understand why. There are women in the same room, and they tell you “oh you have women security also.”[...] So, when I’m sleeping, I sleep in my tank top, so I open my eyes and I find six security in my room. One woman and five men, because my roommate’s daughter was sick. But that does not give you permission to just come into my room.”

Feedback to interview questions provided by the NGO Incijativa za Razvoj I Saradnju (Initiative for Development and Cooperation)⁷⁷

“Our experience with GBV is related to cases reported to our staff by medical staff hired by our organisation to work in migrant camps. The number of such cases is between 20 and 30 in 5 years of work with the migrant population. The most common cases were domestic violence, rape, and human trafficking. In dealing with these cases, we coordinated with relevant stakeholders in accordance with national Standard Operating Procedures. The staff is educated on a high degree of the importance of confidentiality and sensitivity towards victims. Some of the staff received training on GBV-related topics. There is a need to further improve knowledge about GBV through training. These problems are cultural, sociological, legal, and others. Some of the beneficiaries (migrants) were satisfied with the support provided (most of them) and some expressed dissatisfaction, estimating that their needs for support after dealing with violence were not serviced quickly and with quality.

Migrants have needs like other socio-economic groups, except that they have a dramatically higher degree of threat to their basic rights and needs. The degree of urgency to providing assistance is much higher than other vulnerable groups.”

⁷⁷ Excerpts taken from interviews with the management through the REACH OUT Questionnaire sent by CK Šid as part of the mapping exercise, May 2021.

IS THERE ANY GENDER-BASED VIOLENCE OTHER THAN HARMFUL PRACTICES?

While gender role and stereotypes may vary, patriarchy transcends cultures.

Considering culture as the only determinant of gender inequality obscures the various causes of unequal gender norms, gender discrimination, and GBV. It contributes to producing racist representations of culture and racializes patriarchy.

GBV IS ROOTED IN GENDER INEQUALITY AND PATRIARCHY

GBV is not unique to any country, culture, or religion. It occurs all over the world. Its causes lie in gender norms and unequal power relations, which exist in all societies. Indeed, while gender roles and stereotypes may vary, patriarchy transcends cultures.⁷⁸ Those patriarchal norms determine stereotypical binary behaviours for men and women: what society expects of men and women, what their roles,

78. J. Sidanius et al., "Social dominance orientation, hierarchy-attenuators and hierarchy-enhancers: Social dominance theory and the criminal justice system", *Journal of Applied Social Psychology* 24 (1994).

privileges, and limitations are. As a result of these gender norms, certain types of violence become normalised and justified.

A GENDERED ANALYSIS OF CULTURE

Culture can be defined as a set of symbols and meanings⁷⁹ including rituals, beliefs, and societal structures. Gender relationships are both shaped by, and shape, those structures. Therefore, gender, like culture, is a category for analysis of the way societies are organized.⁸⁰ The examination of the relationship between gendered hierarchies and culture aims to investigate gender rapports—inequalities, biases, discrimination—in a specific context while questioning the relative importance of culture and gender norms in constructing those relationships.

Considering culture as the only determinant of gender inequality obscures the various causes of unequal gender norms, gender discrimination, and GBV. On the one hand, it contributes to producing racist representations of culture and racializes patriarchy.⁸¹ Indeed, in this perception, GBV is viewed as being only a set of harmful practices. Those practices rely on social, cultural, and customary considerations that vary from one community to another. They can take various forms: honour killings, selective abortion, forced sexual initiation, genital mutilation, early marriage, breast ironing, food taboos, female infanticide, dowry, etc. Overestimating the importance of culture in shaping gender roles leads to racial-

79. Clifford Geertz, *The Interpretation of Cultures* (New York, Basic Books: 1973).

80. Audrey Heine and Laurent Licata, « Genre et culture », in *Les psychologies du genre. Regards croisés sur le développement, l'éducation, la santé mentale et la société*, ed. Vincent Yzserbyt, Isabelle Roskam, and Annalisa Casini (Bruxelles : Mardaga, 2021) : 243.

81. Ibid.: 256.

Overestimating the importance of culture in shaping gender roles leads to racialised visions of GBV as being committed only in non-Western countries by non-Western men.

ised visions of GBV as being committed only in non-Western countries by non-Western men.⁸² Most associations and organisations providing support services to survivors of GBV focus on selected forms of GBV, notably Female Genital Mutilation/Cutting (FGM/C) and honour crimes.

On the other hand, overestimating the importance of culture in shaping gender roles can lead to total relativism. Such a posture may foster the normalisation of harmful practices and contribute to maintaining gender inequality in all societies.⁸³ Finally, a universalist vision of gender norms as transversal to all cultures provides a hegemonic Western perspective obscuring other systems of oppression intersecting with gender inequality.

AN INTERSECTIONAL UNDERSTANDING OF GENDER, CULTURE, AND GBV

The fact that GBV is the product of patriarchal structures and unequal power relations does not mean that all individuals experience the same violence. GBV must be apprehended from an intersectional perspective considering other domination systems based on race, class, national origin, etc. Indeed, intersectional factors such as race, gender, being LGBTQIA+, age, disability, or being in a situation of precarity increase the exposure to GBV and hinder access to support services for survivors. Thus, it is critical to avoid essentialising survivors and perpetrators of GBV by presenting them as uniform and homogeneous categories. On

the contrary, specific needs arising from each individual's specific situation must be carefully considered through an intersectional lens. Such an approach helps to break the false assumption that GBV is only about 'culture' and is perpetrated only by non-Western men on non-Western women.

While GBV exists in all societies, the perceptions of this violence, the modes of perpetration, and the actions taken to deal with it differ. Those differences are influenced by socio-cultural determinants that affect everyone's perceptions and representations of violence. To illustrate the complexity of GBV and its numerous determinants, the WHO elaborated several non-exhaustive typologies of acts constituting GBV. The WHO identified six categories of acts constituting GBV when classifying such acts based on the context of perpetration and the nature of the violence:⁸⁴⁻⁸⁵ physical violence, sexual violence, moral and psychological violence, harmful practices, economic and social violence, and human trafficking.

Therefore, GBV cannot be reduced to harmful practices, which are just one category among others of acts constituting GBV. GBV is experienced by migrant populations at each step of their journey. First, GBV can be a reason for leaving their country. Notably, situations of instability and armed conflict increase the prevalence of GBV.⁸⁶ Second, living and travelling conditions along the migratory path both expose migrants to GBV and limit their ability to access support services. In 2018, 58% of migrants arriving in Europe had been subjected to GBV.⁸⁷ Third, in countries of transit and/or destination, reception conditions and restrictive immigration procedures reinforce the vulnerability of migrants to GBV. The recent 2021 UN-MENAMAIS study showed that 84% of applicants for international protection in Belgium had experienced GBV in their lifetime, among whom 61% in the last twelve months.⁸⁸

82. Christelle Hamel, « La sexualité entre sexisme et racisme : les descendantes de migrant·e·s du Maghreb et la virginité », *Nouvelles Questions Féministes* 25, no. 1 (2006).

83. Heine and Licata, "Genre et culture", *supra* note 80 : 257.

84. Julia Branchat and Constance Duplessy, *Prévention et réponses aux violences liées au genre. Guide Méthodologique*, Médecins du Monde (2010).

85. Etienne G. Krug et al., *World report on violence and health*, World Health Organisation (2002).

86. See for instance the United Nations Security Council Resolution 1325, which recognised for the first time, the differential impact of conflicts on women and girls, and called for a gender-specific approach to conflict management.

87. Lotte De Schrijver et al., "Prevalence of Sexual Violence in Migrants", *supra* note 1.

88. Lotte De Schrijver, "Sexual Violence in LGBTQIA+ persons and applicants for international protection", *supra* note 51.

The lack of unigender facilities, the over-representation of migrants in precarious jobs, and the lack of access to support services, including the justice system, perpetuate this vulnerability.

The distinct forms of GBV are produced by different gender vulnerabilities, exacerbated by discriminatory border regimes and unequal access to resources and supporting networks.

The distinct forms of GBV are produced by different gender vulnerabilities, exacerbated by discriminatory border regimes and unequal access to resources and supporting networks.⁸⁹ Focusing on harmful practices dismisses all the other forms of GBV and limits the accessibility and the quality of support services for survivors. Therefore, it is critical to adopt an intersectional perspective to fight against GBV while rejecting cultural essentialism. Such a posture acknowledges the plurality of each individual's identity and allows survivors' needs to be met according to this multi-faceted and self-defined identity. Considering GBV as resulting from intersectional vulnerabilities embedded in asymmetrical gender norms allows for comprehensive access to protection, care, and reparation for all survivors of GBV.

- ✘ GBV lies in gender norms and power relations; it happens all around the world.
- ✘ The perception of GBV, its modes of perpetration and the actions taken to deal with it differ with regard to many factors, notably sociocultural determinants. GBV must be apprehended from an intersectional perspective considering other systems of domination, such as race and class.
- ✘ Harmful practices are one category among others of GBV

It is critical to adopt an intersectional perspective to fight against GBV while rejecting cultural essentialism.

⁸⁹ Evangelia Tastsoglou, Xanthi Petrinioti, and Chara Karagianopoulou, "The Gender-Based Violence and Precarity Nexus: Asylum-Seeking Women in the Eastern Mediterranean", *Frontiers in Human Dynamics* 3 (2021).

HOW DO NGOS ACT IN THAT SITUATION? WHAT HAS BEEN DONE BY REACH OUT?

NGOs can contribute to changing attitudes towards GBV in different ways. Notably, they can:

- ✘ **Spread the message that GBV occurs everywhere, can happen to anyone, is a violation of human rights, and is never acceptable, regardless of one's origin, culture, or religion.**
- ✘ **Spread the message that every human being has the right to be protected from GBV. This requires informing the communities about their rights and the available support services through culturally sensitive materials about GBV in different languages.**
- ✘ **Organise training for health care providers and other professionals working with migrants on the causes and the consequences of GBV. Such training should question their views on gender, migration, and GBV.**

To combat all forms of GBV, it is important to engage with migrants, health professionals, and public authorities on this issue. The REACH OUT partners have therefore conducted various informational activities.

First, they engaged in outreach activities toward migrant communities. In all countries of implementation, small-scale information workshops helped to start building a relationship of trust. They were first held on neutral topics to discuss issues such as the local health care system or raising children in two cultures. Those neutral topics then became entry points for discussing gender roles and stereotypes that perpetuate or promote GBV. In the Netherlands, workshops highlighted key messages for survivors: “GBV can happen to anyone”, “it is never the survivor’s fault”, and “help is available”. Those workshops, along with the cultural mediation available, provided survivors with a supporting network for sharing their experiences in their own language without running the risk that this would be disclosed to their partner, family, or community.

In Munich, MDM Germany launched the project “Spread the Word”: the partners identified women living in refugee centres in Bavaria to become ‘multipliers’. This program had a two-fold objective: to gain information on the situation in refugee camps and to empower refugee women in exercising their human rights through better information and socio-counselling. The multipliers maintained a relationship of trust with other refugee women and could refer them to appropriate support services when they needed to. They also disseminated relevant information through WhatsApp and printed newsletters. Multipliers created a bridge between women applying for international protection, institutions, and support services.

Second, the REACH OUT partners proposed training sessions about GBV and migration. In Munich, all training sessions started by defining GBV and investigating its root causes, namely gender inequality, fixed gender norms, and patriarchal societal structures. It was systematically highlighted that GBV was not specific to any country, culture, or religion. Similarly, in Serbia, all training sessions included discussions on culture and GBV and emphasised that GBV cannot be equated with harmful practices.

During those training sessions, many participants were concerned about how to provide inclusive and culturally sensitive care services. In the Netherlands, the REACH OUT partners invited culturally sensitive professionals and interpreters to discuss the exact meaning of all terms related to GBV and how to work in a culturally sensitive way. MDM Netherlands also selected 30 men and women from migrant communities and trained them to become cultural mediators. They came from countries such as Syria, Sudan, Eritrea, Afghanistan, Iran, and Somalia, and many of them had a refugee background. As they are familiar with both the culture of the country of origin and the country of destination, they fulfil a bridging function by building trust with members of their community in their own language.

This group of cultural mediators followed a three-day training course to discuss issues such as culture, causes and consequences of GBV, intimate/unspoken topics, and available care in the Netherlands. Additional meetings were also organised with representatives from Sexual Assault Centres and police officers. They

provided cultural mediators with insights into the functioning of those institutions. These organisations, in turn, understood the critical role of cultural mediators in guiding survivors toward regular support services.

Implemented by REACH OUT

- ✘ Training of cultural mediators, care providers and public authorities
- ✘ Information workshops to raise awareness about all forms of GBV

Recommendations of REACH OUT

- ✘ Organise regular dialogue sessions between cultural mediators and migrants
- ✘ Ensure the presence of cultural mediators when discussing GBV with service providers to avoid misinterpretation and oversimplification

This part was redacted by MDM Netherlands, with the expert contribution of Marian Tankink, Ph.D., Medical Anthropologist, Researcher & Trainer on Gender, Violence and Mental Health.



Training sessions for cultural mediators © Médecins du Monde Netherlands

TESTIMONIES

Testimony from Elie Shamoun, social worker and cultural mediator in the Netherlands

“As a cultural mediator, I talk to people and listen to their stories. I help victims of sexual and gender-based violence to get in touch with support services and care providers, so that they can get the care they need. Also, as a man, I can draw attention to men who have experienced GVB.

Thanks to this work, I am learning a lot and can develop further as a social worker. I can't make things better in Syria, but here much more is possible. My goal is to learn, to develop myself further, and to assist and help victims of GBV. It will be difficult to reach people and make subjects related to violence and sexuality discussable. Currently, we are living a world with great tensions and conflict which make people's lives more difficult. Despite these conditions, it is the time to take up the challenge [...]. Through the Project REACH OUT cultural mediators are given an opportunity to play an important role in raising awareness about GBV among refugee communities.”

Testimony from Haweya Jama, cultural mediator in the Netherlands

“I am Haweya Jama from Somalia, and I am 48 years old. I have been working at MDM Netherlands for the Reach Out project since early January this year.

Once a week I come to the community centre in Amsterdam where many refugees come to learn the Dutch language. MDM Netherlands is also present here with the Zorgcafé to have conversations with refugees and to build up trust so that they are willing to share their deepest problems with you. I really enjoy doing that because step by step you get closer to the person. Women also share their complaints that may be caused by being circumcised. I know and can see that many women walk around with pain and problems every single day. I am happy that I can support them in finding the right support in the Dutch health care system.

In Somalia it is a cultural custom to circumcise girls. It is impossible not to do so because then you are excluded from the community. [...] Therefore, the Reach Out project is very important and supports us in making this subject open for discussion. Many women do not dare to talk about female genital mutilation and are not always aware that this is prohibited in the Netherlands. Moreover, health care professionals do not know how to talk about this subject. The taboo really needs to be broken and that is why I am telling you my story!

I have been circumcised myself and to this day I experience daily pain. I gave birth to three children. Two children were born in the Netherlands under the supervision of a gynaecologist. During childbirth, colleagues were called in out of 'curiosity' to learn what a circumcised woman looks like. No one actually mentioned it nor asked how it was for me or how they could help me. But, after 26 years, I found out that there is a clinic in Amsterdam for women who have been circumcised. They referred me to the outpatient clinic for trans-genders and I am now on the waiting list for surgery. Because of corona the surgery has been postponed for a year, but I am hopeful, and I look forward to the day when I can live without pain.”

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HUMAN RIGHTS

JUSTICE

EQUALITY

