Hidden Violence is a Silent Rape:

Prevention of Sexual & Gender-Based Violence against Refugees & Asylum Seekers in Europe: a Participatory Approach Report

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Designed by Yousif Chati Abadi

Ines Keygnaert, Ruth Wilson, Koen Dedoncker, Hilde Bakker, Marijke Van Petegem, Najla Wassie, Marleen Temmerman

ICRH-Ghent University

Kennis en advies voor maatschappelijke ontwikkeling

For all Refugees, Asylum Seekers and Undocumented Migrants in Europe

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International Centre for Reproductive Health (ICRH)
Ghent University
De Pintelaan 185 P3
B-9000 Gent (Belgium)
www.icrh.org

CONTENTS

CHAPTER 1: A DAPHNE PROJECT 3

1.1 INTRODUCTION 3
1.2. PARTNERSHIP 3
1.3 PROJECT AIMS, METHOD & BENEFICIARIES 7
1.3.1 Aims & method 7
1.3.2 Beneficiaries & stakeholders 7
1.4 DESK STUDY 9
1.4.1 Overview of stakeholders 9
1.4.2 Prevention tools 10
1.5 FIELDWORK 10
1.6 PREVENTION TOOL 12
1.7 AWARENESS RAISING 15
1.8 EU SEMINAR 19

CHAPTER 2: PARTICIPATORY RESEARCH RESULTS 23

2.1 THE CONCEPTUAL FRAMEWORK 23
2.1.1 Socio-ecological perspective on health & Desirable Prevention 23
2.1.2 Community Based Participatory Research 25
2.2 SOCIO-DEMOGRHAPHIC PROFILE OF RESPONDENTS 27
2.3 SEXUAL HEALTH PERCEPTION 31
2.3.1 Information on sexual health in home country: frame of reference 31
2.3.2 Personal definition of sexual health 34
2.3.3 Criteria of girls turning into women and boys into men 36
2.3.4. Determining factors in sexual health 37
2.4 SEXUAL AND GENDER-BASED VIOLENCE VICTIMIZATION 38
2.4.1 Description sexual and gender-based violence cases 38
2.4.1.1 Identity of the victims 38
2.4.1.2 Types of gender-based violence victimization 39
2.4.1.3 Consequences of the victimization 41
2.4.1.4 Identity of the perpetrators 43
2.4.2 Definition of sexual violence 43
2.4.3 Risk factors of victimization 44
2.5 PREVENTION 45

2.5.1. Preventive factors on micro/meso/macro level 45
2.5.2 Definitions of prevention tools 47
2.5.3. Participation in prevention by respondents 48
2.6 CONCLUSION 48

CHAPTER 3: SEMINAR PROCEEDINGS 53
3.1 INTRODUCTION TO THE SEMINAR 53
3.1.1 Background 53
3.1.2 Purpose 53
3.1.3 Outcomes 54
3.2 SEMINAR PROGRAM 54
3.3 CONFERENCE PRESENTATIONS DAY 1 56
3.3.1 Opening speech and introduction to the Seminar 56
3.3.2 Chairperson's introduction 57
3.3.3 Overview of EU policy and the situation of refugees, asylum seekers and undocumented migrants in Europe today: key issues 58
3.3.4 Key health issues of refugees and asylum seekers 63
3.3.5 Presentation of the Participatory Research Project by Community Researchers 72
3.3.6 Presentation of Research Results 86
3.3.7 Panel: Project Partners and Community Researchers 95
3.3.8 Conference presentations Day 2 103

CHAPTER 4: SEMINAR RECOMMENDATIONS: A CALL FOR ACTION 137
4.1 INTRODUCTION 137
4.2 SUMMARY RECOMMENDATIONS (as presented on February 15th) 138
4.3 RECOMMENDATIONS ON LAW, RIGHTS & POLICE 140
4.4 RECOMMENDATIONS ON SEXUAL EXPLOITATION 141
4.5 RECOMMENDATIONS ON HEALTH CARE AFTER SEXUAL& GENDER-BASED VIOLENCE 142
4.6 RECOMMENDATIONS ON MALE ABUSE(D) 143
4.7 RECOMMENDATIONS ON EMPOWERMENT IN PREVENTION 144
4.8 RECOMMENDATIONS ON COMMUNITY PARTICIPATION IN PREVENTION 145
4.9 RECOMMENDATIONS ON INTERCULTURAL HELP-LINES IN PREVENTION & CARE 146
4.10 RECOMMENDATIONS ON AWARENESS RAISING IN PREVENTION 147

APPENDICES 149

APPENDIX 1: PARTIPANTS LIST SEMINAR HIDDEN VIOLENCE IS A SILENT RAPE, 14th & 15th of February 2008, Het Pand, Ghent, Belgium 149

APPENDIX 2: CAFÉ CONTACT PARTICIPANTS 154

APPENDIX 3: STAKEHOLDERS LIST BELGIUM- NETHERLANDS-UK 155

APPENDIX 4: ARTICLE IN WHO MAGAZINE ENTRE NOUS 168

EXECUTIVE SUMMARY

Cairo, September 1994, International Conference on Population and Development, the objectives are clear. In order to achieve equality and equity between women and men, and to ensure that all women as well as men, are able to exercise their human rights and participate fully in all areas of life, 179 governments acknowledge that all couples and individuals have the right to attain the highest standards of sexual and reproductive health and make decisions concerning their sexual health free of discrimination, coercion and violence. To this end, these governments endorse that countries should take full preventive, protective and rehabilitative measures to eliminate all forms of exploitation, abuse and violence against women and adolescents while paying special attention to protecting the rights and safety and meeting the needs of those in potentially exploitable situations. Documented and undocumented migrant women, refugee women and refugee children are specified as such[1].
European Member States ratify this action plan. One year later, during the Fourth World Conference on Women in Beijing, the definition of gender-based violence is expanded. It now comprises any act of physical, sexual and psychological violence in the family, community or perpetrated or condoned by the State that results in, or is likely to result in, physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life or in situations of armed conflict[2]. Furthermore, specific groups of women are recognized to be particularly vulnerable to gender-based violence. It concerns women belonging to minorities: the elderly and the displaced; indigenous, refugee and migrants communities; women living in impoverished rural or remote areas, or in detention.
European Member States endorse this action plan too, as well as many other international agreements that recognize gender as a determinant of health and gender-based violence as a major public health issue, a violation of human rights and in some cases as a crime against humanity. At the same time as goals are set to end gender-based violence, the European Union intensifies its efforts to evolve into a coherent political territory. Along with this development, new European asylum and neighbourhood policies are formulated[3]. However, the impact of these policies on the protection and health of asylum seekers, refugees and undocumented migrants within the Union territory as well as on the borders still remains to be seen.

The project “Hidden Violence is a Silent Rape” aimed to promote the sexual and reproductive health rights of refugees, asylum seekers and undocumented migrants by contributing to the prevention of sexual and gender-based violence against these vulnerable groups in Europe. The main goals were threefold: first to develop a prevention tool which could be used by

1 Programme of Action adopted on the International Conference on Population and Development, Cairo, 5-13 September 1994, UNFPA, 2004, IVA: 22-26 & 88-92.

2 Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response, 2003, UNHCR, 7-18

3 Uçarer EM. Managing Asylum and European Integration: Expanding Spheres of Exclusion? *International Studies Perspective*, 2001, 2: 288-304.

refugees and asylum seekers on the one hand and by intermediary organizations on the other; second to raise awareness about sexual and gender-based violence against refugees in Europe among the broad public and the authorities, and finally to do all this in a participatory way, to empower women and to equally involve men.

With EC Daphne funding, this project was steered by Belgian (Coordinator: ICRH-University Ghent, Partners: Zijn, Nederlandstalige Vrouwenraad), Dutch (MOVISIE, Pharos) and British (Tandem:) research bodies and organizations active in the field of gender-based violence, women rights and health of refugees. Applying the "Community Based Participatory Research" method, the project was conducted in close partnership with a large "Community Advisory Board", consisting of representatives of the communities, policy makers, intermediary organizations and researchers. Moreover, fourteen female and eight male refugees or asylum seekers from Iranian, Iraqi, Afghan, former USSR, Somali, Roma or Kurdish origin collaborated as "Community Researchers".

Between January and mid-April 2007, the community researchers conducted 250 in-depth interviews with their peers in Belgium and in the Netherlands. The interviews addressed four topics: socio-demographic profile, sexual health, victimization of sexual and gender-based violence and prevention of sexual and gender-based violence. From the 250 conducted interviews, 223 met the validity criteria to be incorporated in the analysis. This corresponds with 133 female, 88 male and 2 transsexual respondents, and 132 respondents in Belgium and 91 in the Netherlands. For the qualitative part, we used the Framework Analysis Technique to sort, code and constantly compare the answers. We applied the socio-ecological model on health and the concept of Desirable Prevention to interpret the findings. SPSS was used for the analysis of quantitative results. All results were discussed and interpreted with the partners, Community Researchers, respondents and the Community Advisory Board.

The general profile of the respondents was one of high-educated women and men in their reproductive age, who have little or no close relatives accompanying them and who are struggling with the enforced set-back in their possibility to participate actively in society. They generally related sexual health firstly to overall physical and mental well-being, secondly to a respectful approach to sexual relationships and sexuality, thirdly to safe and satisfying sexual life and finally to family planning and fertility. Furthermore, they were convinced that one is genuinely responsible for her or his own sexual health.

An overwhelming majority of the respondents revealed to be more than familiar with several types of gender-based violence. Among the 223 respondents, 57 didn't know anybody who had been victimized since his or her arrival in Europe. 166 respondents answered they did, and they described 332 cases of gender-based violence. 206 cases are to be categorized as emotional-psychological violence, 188 cases as sexual violence, 157 cases as physical violence, 112 cases as socio-economic violence and 47 cases as traditional harmful practices. According to the 223 respondents, prevention of sexual and gender-based violence against refugees, asylum seekers

and undocumented migrants in Europe can be done on three levels. On the personal or micro level prevention should focus on behavioral change and on the enhancement of social capital. On meso or socially interactive level, prevention should focus on the enhancement of social capital and the access to health care and services. On the macro or societal level, prevention should firstly enhance general knowledge of sexual health and awareness of sexual and gender-based violence risk and preventive factors. Secondly the overall legislative framework should be adapted in order to be more preventive and thirdly, the system of residence status and rights should be changed in order to enhance the refugees, asylum seekers and undocumented migrants' possibilities to enjoy rights and to participate actively in the host society. The utmost majority of respondents are willing to participate in prevention of sexual and gender-based violence against refugees, asylum seekers and undocumented migrants in Europe.

Taking these research findings, scientific literature and international recommendations into account, we developed a prevention tool together with the Community Researchers, the Community Advisory Board and respondents. The beneficiaries of the prevention tool are refugees, asylum seekers and undocumented migrants on the one hand and intermediary organizations and service providers on the other. The tool enhances knowledge and networking.

Many awareness raising activities took place throughout the project. The participatory approach in this project, the research results and the prevention tool were presented at the European Seminar: "Hidden Violence is a Silent Rape: Prevention of Gender-based Violence against Refugees in Europe", on February 14th & 15th of 2008 in Ghent, Belgium. Policy and practice recommendations were discussed and formulated as a Call for Action.

This report describes extensively all phases and actions in the project undertaken. We introduce the project, its aims, methods and beneficiaries in Chapter one with an overview of the different actions. In Chapter two, the results and the analysis of the Community Based Participatory Research are reported. Chapter three and four reflect the proceedings and recommendations of the Hidden Violence is a Silent Rape Seminar.

In conclusion, from the arrival on European territory onwards, young female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several types of gender-based violence. Even though a differentiation in the vulnerability of these minorities is urgently needed, they too have the right to the highest attainable standard of health and the right to live without violence. In order to prevent further victimization, structural changes on public policy level should go hand in hand with real comprehensive and participatory approaches to multi-disciplinary and multi-stakeholder interventions creating an empowering synergy between the individual, interpersonal, organizational, community and public policy level. We hope that this project and this report may contribute to the further realization of these prevention needs.

“You see someone who ran away with his family to live in freedom and at the same time you see all his hope, his life and future taken away from him.”

Iranian refugee

“Hidden Violence is a Silent Rape” Seminar

"I was alone in our room in the camp nearby Antwerp. Oscar, the lover of my mother entered. I was sad so he gave me a tablet to make my head bright he said. He went away, and after a while I became very cheerful. He came back and raped me. I was 18. I threw up along the bedside. The sheets were covered with blood. My mother entered and saw the blood, the vomit and me. She hit me. After that, Oscar fucked me and my mother whenever he wanted to. He let his friends in the camp fuck us too. We were not the only ones, there were other girls in the camp who were subjected to that, but nobody dared to react out of fear of being deported afterwards. I became pregnant, but I didn't know from whom. I tried to abort my child with alcohol and other means, I lifted heavy things. Nothing worked so I asked a friend to penetrate my uterus with an awl. I lost a lot of blood and was transferred to a hospital. They asked a lot of questions in that hospital, but I kept quiet and cried non-stop. The doctor told me: after this torture you cannot get any children any more. That is the worst thing that could happen to me! After this, we had to be transferred to another camp. The moment I received my residence papers, I took my stuff and walked away from my mother. I met a girl at the station. We talked, we became friends and lovers. She helped me to get back to school in Ghent. We had to work hard as a prostitute to earn money to eat, to study and to pay our room. But that's all over now. Now I can work with my hands and make a faire living without abusing my whole body."

Young Female Ukrainian Refugee, living in Belgium since 2003

CHAPTER 1: A DAPHNE PROJECT

1.1 INTRODUCTION

"Uncertainty, we are suspended and don't see any future"
Kurdish Asylum Seeker

This report describes the result of a two year close collaboration of approximately 300 refugees, asylum-seekers, undocumented migrants, scientists, service providers, organizations and policy-makers in Belgium, the Netherlands and the UK.

The project was initially called: "Development of a Prevention tool to Combat Violence against Refugee Women & Girls in Europe: a Participatory Approach". In communication with the different stakeholders, it turned into "Prevention of Gender-based Violence against Refugees in Europe: a Participatory Approach". But as a consequence of one of the striking quotes in the in-depth interviews, it soon became commonly named as: "Hidden Violence is a Silent Rape".

"Hidden Violence is a Silent Rape" started April 4th of 2006 and ran until April 3rd of 2008. The main goals were threefold: first to develop a prevention tool which could be used by refugees and asylum seekers on the one hand and by intermediary organizations on the other; second to raise awareness about sexual and gender-based violence against refugees in Europe among the broad public and the authorities, and finally to do all this in a participatory way, to empower women and to equally involve men.

In this chapter we describe how the aims and objectives were realized and taken far beyond our expectation. This could not have been achieved without the support of a large partnership. For this reason, we will firstly throw a light on the partners and beneficiaries before we amplify the actions taken.

1.2. PARTNERSHIP

Funded by the EC Daphne Program, this project was steered by six Belgian, Dutch and British research bodies and organizations being active in the field of gender-based violence, women rights or health of refugees. Together they constituted the "**Steering Committee**". They are:

INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH (ICRH) is the coordinating partner in this project. ICRH is an international research group at the Ghent University in Belgium. The main objective of ICRH is to improve sexual and reproductive health in its broadest sense. ICRH recognizes sexual and reproductive health as a basic human right of all men and women throughout the lifecycle. ICRH aims to contribute to the promotion, protection and fulfillment of these rights by adhering to the Program of Action of the International Conference on Population and Development of 1994. As an international, scientific and multidisciplinary centre, ICRH is an expert in sexual and reproductive health research, training and service delivery, and does this in an engaged, catalyzing, dynamic and pro-active way. Within ICRH, Ines Keygnaert, a Sexual & Gender-Based Violence Researcher, is the person who coordinated this project. She can be contacted at ines.keygnaert@ugent.be. Website: www.icrh.org

MOVISIE (TransAct) is the main partner in the Netherlands. TransAct was a centre of expertise for gender issues in health care and the prevention of sexual violence with a special focus on migrants. TransAct offered advice, courses and training, and information for counselors, institutions and policy-makers. During the project, TransAct merged with 5 other organisations and changed its name to "MOVISIE: Knowledge and Advice for Societal Development". The mission of MOVISIE is to promote the participation and independence of citizens. We do this by supporting and advising professional organizations, volunteer organizations and government institutions. Five themes are central to our work: Social cohesion, Volunteer effort, Domestic and sexual violence, Vulnerable groups, and Informal care. Hilde Bakker, a Senior Policy Adviser, is the person who represented MOVISIE in this project. She can be contacted at: hilde.bakker@movisie.nl .Website: www.movisie.nl

NEDERLANDSTALIGE VROUWENRAAD (NVR, Dutchspeaking Women Council): At the beginning of our project, there was a main partner in the UK being Refugees Arrivals Project (RAP). RAP assisted refugees from their arrival in London throughout their process. They had expertise with vulnerable groups, policy development and awareness raising. Due to the winding-up of this organization, RAP pulled out on the project on the 30th of November 2006. A new main partner had to be found. The Nederlandstalige Vrouwenraad expressed their interest and the EC Daphne Desk approved the replacement. The NVR is an umbrella organization for some forty women's organizations in Flanders with various philosophical and ideological backgrounds, reflecting cultural diversity. These are professional, political and socio-cultural as well as independent associations. The NVR aims at promoting gender equality for women and men, irrespective of age, origin, sexual preferences, and religious convictions, physical and mental abilities in a multicultural society. In this respect they are aware of both gender differences and disparities between women themselves. Their endeavors for a gender equal society are in line with the existing international instruments, both treaties and declarations, regarding women's rights and human rights. The NVR has three main activities: informing and sensitizing, providing a platform for concerted actions and debate and lobbying. The NVR was represented by Kim De Weerdt, Marijke Van Petegem and Rita Van Gool. Nvr.rvangool@amazone.be www.vrouwenraad.be

ZIJN vzw is the Belgian associated partner. ZIJN vzw is a small organization for prevention and sensitization of violence and abuse in a domestic context. Zijnvzw does this through training, education, actions, campaigns, networking, advocacy and support for scientific research on violence. With these activities, ZIJNvzw aims at enhancing better understanding, behavioral change as well as moral awareness of domestic violence. Furthermore, ZIJNvzw aims at being an added value to the curative sector. Koen Dedoncker, a Policy Adviser, is the person who represented ZIJNvzw. He can be contacted at: vorming.zijn@amazone.be Website: www.vzwzijn.be

PHAROS is the Dutch associate partner. Pharos is a centre of knowledge and advice on health issues of refugees, asylum seekers and rejected asylum-seekers. Pharos is widely known for their training of service providers on refugee-related topics as prevention of violence. Pharos was firstly represented by Patricia Schell and then by Najla Wassie, both Senior Prevention Workers.
Najla can be contacted at: n.wassie@pharos.nl Website: www.pharos.nl

TANDEM: is the associate partner in the UK. Tandem: is led by **Ruth Wilson**, who has more than 15 years' experience in research and communications in the voluntary and public sectors. Ruth has expertise in social research, project management, evaluation, writing and editorial work. She was recently involved in a research project on sexual health of refugees in the UK, sexual violence included. She wrote a manual about this for the Department of Health. Ruth can be contacted at: ruth.wilson@tandem-uk.com Website: www.tandem-uk.com

The Steering Committee was extended by people who have major professional expertise in one or several topics related to the project. They were considered a **MONITORING GROUP OF WISE (WO)MEN**. They joined the steering committees held in Belgium and had monitoring meetings with the project coordinator who reported their input to the other partners involved.
This monitoring group consisted of the following persons: 1) Dr. Mia Honinckx is Director of The Medical Reception at Fedasil, the Belgian Asylum Agency; 2) Prof. Dr. Nicole Vettenburg is Professor in criminology and social sciences with 25 years of expertise in juvenile delinquency.
She is widely recognized for her concepts on vulnerability and desirable prevention; 3) Prof. Dr. Rik Pinxten is Professor in anthropology and head of the department of Comparative Sciences of Culture at Ghent University. He published widely on the anthropology of knowledge and the comparative study of religion and identity; 4) Marleen Bosmans is Political Scientist at ICRH, researching sexual and reproductive health rights of refugees in humanitarian settings; 5) Prof. Dr. Patricia Claeys was the Coordinator of ICRH, specialized in cervical cancer and with longstanding experience in coordinating a multidisciplinary team working on sexual and reproductive health projects throughout the world; 6) Prof. Dr. Marleen Temmerman is Professor of gynecology, Head of the Department of Obstetrics-Gynecology at the Ghent University Hospital as well as the director of ICRH.

Applying the “Community Based Participatory Research” method, the project was also conducted in close partnership with **COMMUNITY RESEARCHERS**. Fourteen female and eight male refugees or asylum seekers from Iranian, Iraqi, Afghan, former USSR, Somali, Roma or Kurdish origin living in Belgium or the Netherlands were selected of many more candidates and trained as “Community Researchers”. They collaborated in every single phase of the project.

The Community Researchers are: Alfiya Abikenova, Hanifa Akram, Jailani Alekozai, Ramin Bahrami, Martin Balogh, Eva Baloghova, Darina Bruggen, Havan Faris, Hossein Ghazi, Takhir Iminov, Stella Ismail, Esra’a Khalaf, Lamia Khalil, Larisa Kurdyukova, Sousan Mohammadkhani, Baharak Pourmirzajan, Mahtab Safaipour, Chiman Saleh, Parwin Shahbazy, Natalia Shulga, Makhset Tobakoulov and Bashir Yusuf.

Furthermore a large “**COMMUNITY ADVISORY BOARD**” of stakeholders was addressed to participate and support this project. This Community Advisory Board consisted of representatives of the communities, policy makers, intermediary organizations and researchers in Belgium and the Netherlands. Meetings with the Community Advisory Board (CAB) were held at decisive moments in the project: e.g. the planning of the in-depth interviews, the interpretation of the results, the development of the prevention tool and the final seminar. They were part of several awareness raising activities and/or contributed to the content of the prevention tool.

The CAB comprised of the following stakeholders (in alphabetical order): Chris Bens, Hand-in-Hand; Marleen Bosmans, ICRH-Ugent; Ivana Bozikovic, ICRH-UGent; Jan Breyne, OOOC De Morgenster; Ria Cabus, Werkgroep Vluchtelingen Gent; Marianne Cense, Rutgers Nisso Groep; Joke Claessens, Vluchtelingenwerk Vlaanderen; Karl-Filip Coenegrachts, Stafdiensten Stad Gent; Sibile Declerq, Kinder & JongerenTelefoon; Greet De Kesel, Dienst Minderheden Provincie Oost-Vlaanderen; Ariane Den Uyl, VluchtelingenWerk Nederland; Ilse De Vuyst, Kom-Pas Gent; Anna-Maria De Witte, PINA Antwerpen; Thomas Demyttenaere, Sensoa; Ellen Druyts, Medimmigrant; Gerdie Eiting, Stichting 45-De Vonk; Nadia El-Mahi, ICRH; Hanneke Felten, MOVISIE; Karin Geerts, VLOS; Sigrid Hildebrandt, El Ele; Christophe Janssen, ING; Kristin Janssen, MOVISIE; Anne Kesteloot, Geweldcoördinatie Provincie Oost-Vlaanderen; Nienke Kiekens, Lokale preventie Stad Gent; Ir. Simone Kortbeek, MOVISIE; Geert Matthys, Odice; Gerda Nienhuis, Pharos; Henry Oris; Barbara Rayée, Sociale Dienst UZGent; Dr. Kristien Roelens, UZGent; Steven Rommel, Samenlevingsopbouw Oost-Vlaanderen; Alain Slock, CAW Artevelde; Liliane Somers, Rode Kruis Vlaanderen; Ruud Van de Velde, Dienst Asiel-en Vluchtelingenbeleid Stad Gent; Jelly van Essen, Stichting 45- De Vonk; Katty Van Gaeveren, Hand-in-Hand; Godelieve Van Geertruyen, Dienst Minderheden Provincie Oost-Vlaanderen; Anneleen Van Malderen, Sociale Dienst UZGent; An-Sofie Van Parys, UZGent; Leen Van Zele, Dienst Gezondheid Stad Gent; Chantal Vandekerckhove, Geweldcoördinatie Provincie Oost-Vlaanderen; Katia Vandendriessche, Dienst Gezondheid Stad Gent; Ann Vanheule, Dienst Asiel-en Vluchtelingenbeleid Stad Gent; Sarah Verdonck, Fedasil; Maureen Verhaegen, El Ele; Aïcha Qualit, VluchtelingenWerk Midden-Nederland.

1.3 PROJECT AIMS, METHOD & BENEFICIARIES

1.3.1 Aims & method

"Hidden Violence is a Silent Rape" aimed to promote the sexual and reproductive health rights of refugees, asylum seekers and undocumented migrants by contributing to the prevention of sexual and gender-based violence against these vulnerable groups in Europe.

The main goals were threefold: first to develop a prevention tool which could be used by refugees and asylum seekers on the one hand and by intermediary organizations on the other; second to raise awareness about sexual and gender-based violence against refugees in Europe among the broad public and the authorities, and finally to do all this in a participatory way, to empower women and to equally involve men.

Starting from the premise that sexual health and health related behaviour is determined by the interplay of a complex set of contextual stressors, health promoters and genetic endowment[1] and that effective prevention of sexual and gender-based violence best be achieved by stimulating synergy among the individual, interpersonal, organizational, community and public policy level[2]; we applied Community-Based Participatory Research (CBPR) as the overall method for our project. CBPR in public health specifically focuses on social, structural and physical environmental inequalities[3]. CBPR is a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process. The goal of CBPR is to improve health and well-being through taking action, including social change[4]. We considered this participatory research approach as the most appropriate for the aims and goals at stake.

1.3.2. Beneficiaries & stakeholders

Applying CBPR in full meant that we had to mobilize and sensitize a large group of stakeholders, being refugee and asylum seeking communities, policy makers, intermediary organizations and researchers. We considered the first group to be our main beneficiaries. In order to make the goals of the project tangible, we had to set out criteria for the inclusion of these beneficiaries. The first criterion was clear: above all we wanted to involve and empower refugee and asylum seeking women. On the other hand, one of the objectives was to equally

1 Krieger J, Allen C, Cheadle A et al. Using Community-Based Participatory Research to Address Social Determinants of Health: Lessons Learned From Seattle Parners for Healthy Communities. *Health Education & Behavior*, 2002, 29(3):361-382, p 368

2 DiClemente RJ, Salazar LF, Crosby RA et al. Prevention and control of sexually transmitted infections among adolescents: the importance of a socio-ecological perspective-a commentary. Public Health, 2005, 119:825-836, p 831

3 Israel B., Schulz A.J, Parker E., Becker B. (2001) Community-Based Participatory Research: Policy Recommendations for Promoting a Partnership Approach in Health Research, Education for Health, Vol. 14 no.2, 2001, pp 182-197, p 182.

4 Viswanathan M.; Ammerman A.; Eng E; and colleagues (2004) Community-based Participatory Research: Assessing the Evidence, AHRQ Evidence Report/technology assessment no 99, No 04-EO22-2, July 2004, pp 109, p 22.

involve men. Moreover, voices rose that vulnerable men increasingly become victims of sexual and gender-based violence. Thus, we decided to adopt a distribution of about 60% female and 40% male participants.

However, soon another problem arose while setting criteria when seeing our beneficiaries through a legal status point of view. Many asylum seekers get a negative advice and become undocumented migrants. Being undocumented enhances vulnerability significantly. Due to legal reasons, incorporating them as active participants was not possible. Nevertheless, we did not exclude them from participating in the in-depth interviews.

We then considered the most numerous communities of refugees and asylum seekers in Belgium and the Netherlands and narrowed this down to the communities living in the province of East-Flanders in Belgium and the "Randstad"-region in the Netherlands. This resulted in the inclusion of beneficiaries from Iranian, Iraqi, Roma, Kurdish, Somali, Afghan and former Soviet origin.

These criteria were applied for the inclusion of the community researchers and the respondents. For reasons related to our conceptual framework and the prevention outcome, we set two additional criteria for the latter group. They were included if they were a refugee, asylum seeker or undocumented migrant in their reproductive age (between 15 and 49 years old with a special focus on young people between 15 and 29 years old); being her/himself a survivor of sexual or gender-based violence or having a peer/close relative who is a survivor since her/his arrival in Europe. We aspired to interview at least twenty people per community with the distribution as mentioned above.

As for the prevention tool and the awareness raising activities, we addressed all refugees, asylum seekers and undocumented migrants living in the partner countries.

The other stakeholders of intermediary organizations, service providers, policy makers and researchers were invited to participate in the Community Advisory Board.

> *"You can't do anything because you're not a human being"*
> *Kurdish Undocumented Migrant*

1.4 DESK STUDY

In order to get a clear view on the existing prevention tools and recommendations as well as on the main stakeholders in Europe, a desk study was conducted.

1.4.1. Overview of stakeholders

At the first steering committee we discussed what the goal of the overview of stakeholders should be. We decided that the target group of this stakeholder information should be the beneficiaries of the project by giving them an overview of where they can find the necessary information, counseling and shelter. During the different steering committees, we discussed several ways in which we could present the stakeholder information. A lot is out on the internet and duplication was not our goal.

ICRH first made a first overview of stakeholders in East-Flanders and invited them to become partner in the Community Advisory Board. About 30 organizations and policy makers became involved. MOVISIE presented a first overview of Dutch stakeholders at the second steering committee (November 2006). This draft was made in Dutch and gave an overview of where a refugee/asylum seeker/undocumented migrant can turn to in case of sexual health or violence. This stakeholder information was given to the respondents participating in the in-depth interviews. In Belgium there exists a stakeholder file called "Violence, what now?" and this folder was given among others to the respondents in Belgium.

ZIJN/NVR presented an overview of Belgian stakeholders at the 4th steering committee (May 2007). The conclusion was that the different levels of policy, prevention and care in Belgium hampered the possibility to give a clear overview of the right stakeholders. When contacted, only very few of them appeared to work directly for/with the beneficiaries. We decided at this fourth steering committee to incorporate the stakeholder information into the prevention tool. This was done according to the different themes in the prevention tool.

Tandem: made an overview of stakeholders in the UK. ICRH made an overview of stakeholders in the other European Member States and invited them as guest speakers presenting their general expertise or their good practices in the workshops and at the café contact of the EU Seminar in February 2008.

The list of the Hidden Violence is a Silent Rape Seminar participants can be consulted in Appendix 1. The overview of the stakeholders in Belgium, the Netherlands and the UK classified according to the prevention tool themes can be found in Appendix 3.

1.4.2 Prevention tools

ICRH firstly investigated existing prevention strategies and theories and developed a conceptual framework which was proposed and agreed upon at the first steering committee. Furthermore, we inquired on existing tools and found some hundred of them. A prevention tool file was developed in order to screen prevention tools on their identity, target group and different prevention dimensions.

This attempt of screening quickly revealed that there are very few tools for prevention of sexual and gender-based violence against or among refugees, asylum seekers and undocumented migrants. Most of the available tools do not consider the specific characteristics of the beneficiaries or the specific aspects of the European context. Screening on the dimensions of Desirable Prevention turned out to be too ambitious as definitions of the prevention were very vague, if already given.

Notwithstanding these facts, ICRH made an overview of recommendations formulated in the existing tools and guidelines for prevention. The first part addressed general recommendations from a rights-based and multi-sectoral approach and an in-depth explanation of the socio-ecological model. The second part gave an overview of good practices in prevention of violence against women, violence against adolescents/youth and of violence against refugees, asylum seekers and undocumented migrants. Finally, the third part showed evidence of three different best practice approaches in prevention of violence, being: male involvement, participatory approach and the cultural/artistic approach. These recommendations were taken into consideration when the prevention tool was developed.

1.5 FIELDWORK

The fieldwork comprised of different phases. The first phase consisted of the identification of Community Researchers. First, the inclusion criteria for beneficiaries were set. Based on these criteria potential Community Researchers were identified. To this purpose several meetings were held with Community Advisory Board Members, presentations at different fora were given and a leaflet addressing potential candidates was disseminated.

In Belgium, the recruitment of community researchers was undertaken by ICRH by the end of September 2006. From more than 20 candidates, 13 community researchers were selected. They are 8 women (3 Ex-Soviet Union, 2 Roma, 1 Kurd, 1 Iranian, 1 Iraqi) and 5 men (2 Ex-Soviet Union, 1 Roma, 1 Kurd, 1 Iranian). In the Netherlands, MOVISIE started the recruitment in November 2006 and finished in January 2007. 10 community researchers were identified. They are 6 women (2 Kurds, 2 Iranian, 1 Somali, 1 Afghan) and 4 men: (2 Kurds (1 Iraq, 1 Iran), 1 Somali, and 1 Afghan). One of the Dutch community researchers dropped out during the in-depth interviews.

In a second phase the community researchers were trained to be able to conduct in-depth interviews and to participate as full partners in this project.. The training covered the same topics in Belgium and the Netherlands. The following six parts were addressed: project goals, underlying theory and methodology, doing research, psycho-social education, extensive interview exercises and relaxation. The training in Belgium took place from the 20-24th of November 2006, in the Netherlands: from 10-12th & 16-18th of January 2007. The community researchers evaluated the content of the training as very well, except for the duration of the training, the resilience training in Belgium and the cross-cultural communication in the Netherlands.

After the training, the community researchers got a voluntary contract at ICRH or MOVISIE. However, the contracting of community researchers was seriously hampered by laws and ever changing regulations on voluntary work, asylum, unemployment services and legal permission. Consequently, this extensive administrative process belated the start-up of the fieldwork to the beginning of January. After an extensive administrative procedure, all the Belgian community researchers obtained approval of RVA (state service of labor) and a contract of volunteer at the University of Ghent with full access to the university facilities. In the Netherlands it also took some time before MOVISIE obtained the approval of the Bureau of Work and Income to contract the Community Researchers as Volunteers. There should be noted that all these rules and procedures strengthen the exclusion of the beneficiaries in our society, which creates an extra barrier to their empowerment and active citizenship.

At the first steering committee there was decided that we would do first in-depth interviews with beneficiaries, and that the focus groups would be conducted afterwards for the interpretation of the preliminary results with the Community Advisory Board, and for the pilot-testing of the prevention tool. The questionnaire, interview guide and informed consent was developed and tested with the community researchers and the CAB in Belgium. The community researchers translated them into their languages. This translation was back-tested by the community researchers in the Netherlands during the training. The questionnaire consisted of 2 main parts: a socio-demographic part with closed questions and a second part with open-ended questions on sexual health, violence, risk factors, preventive factors, suggestions for prevention tools and participatory aspects.

The community researchers conducted some two hundred and fifty in-depth interviews. The interviews were recorded when the respondents allowed doing so, the community researcher made notes during the interview and made a translation of the interview in Dutch or English afterwards. This information was collected and sent to ICRH. Only the interviews where all these documents matched and having a signed informed consent were considered valid. 223 met the validity criteria.

ICRH did the full analysis and presented the preliminary results already at the fourth steering committee in May 2007. These results were also presented to the community researchers and

Community Advisory Board. Between May and July 2007, four focus groups (3 in Belgium and 1 in the Netherlands) with these stakeholders were held. We asked them for their interpretation of the preliminary research results and shared opinion on prevention tool criteria. In November 2007, another four focus groups (3 in Belgium, 1 in the Netherlands) were held with the same stakeholders to pilot-test the prevention tool. All partners participated in the focus group monitoring.

A concise report of the final research results was made and presented by ICRH at the Hidden Violence is a Silent Rape Seminar, and put on the ICRH & MOVISIE website. Where relevant the differences between Belgium and the Netherlands were given. You can find a detailed description of the conceptual framework and the research results in Chapter 2 of this report.

> *"After having done the interviews in our own language we had to translate them all into Dutch or English. Sometimes I could not find the right word in Dutch having the same meaning as in Russian. So I worked on this together with my son. Of course I did not let him read the worse parts but this way I was also able to communicate with my 16 year old son and talk to him about sexual health. Otherwise I may have been afraid to talk to him and my nine year old daughter. I had to explain to her that sexual violence exists, and that some people might want to harm. If you look at it in terms of figures it is a little cold, dry, but behind these figures there is real pain, and when these people start opening up to you, you can't just turn your back on them and say thank you for the interview. We can't abandon them, they need our help."*
> *Nathalia Shulga, Russian Community Researcher in Belgium*

1.6 PREVENTION TOOL

At the fourth steering committee in May 2007, ICRH gave a presentation on scientific literature, tools and recommendations regarding prevention of sexual and gender-based violence. A brainstorm on the goals, criteria, outline, format and the development of the tool was held. This was done based on the preliminary results of the research, on the presentation on best practices and literature, and the expertise and experience all partners have with developing tools for this target group and/or prevention of violence.

This information was taken to the focus groups with the Community Researchers and the Community Advisory Board. As described above, four focus groups were held to investigate shared ideas and opinions on the concept of the prevention tool. A report was made of all the feedback given, the meetings held and the criteria formulated. This was presented at the intermediary steering committee at the end of August 2007 at which we discussed and refined the concept of the prevention tool.

Following the suggestion of the community researchers we decided to develop a prevention diary consisting of:

- An introduction
- 12 months -> 12 themes -> 12 extractable theme cards + 1 extra card “support or joker”
    - These cards must be attractive, colorful and present one of the quotations of the respondents
    - If possible we make a game of these cards (for example a puzzle)
    - If wanted one can use these cards to send or give it to some body else
- Information on the themes on a few pages following the theme card in 9 languages behind the card (2 pages in Dutch; a summary in other languages)
- Weekly Overviews on 2 pages with international days and religious feasts and such mentioned
- A few pages with extra information on addresses, calendar 2009, notebook, birthday book, phone numbers,…
- a small bag/map at the back with preprinted address cards

We decided to set up a competition among our beneficiaries to design a few attractive cards for the 12 theme-cards and for the poster and invitation. Guidelines were written and widely disseminated in Belgium and the Netherlands. Several CAB members put the call for participation in the design competition on their websites or announced it in their newsletters. The jury of the postcard design was composed of the project partners, experts and community researchers who did not take part in the competition.

The jury was held at 24th of October in Belgium and in the Netherlands at the end of November. There were 22 eligible designs. All participants got a personal letter with the results and a copy of the prevention tool. All designers were mentioned in the colophon of the prevention tool. Out of a list of quotes, specific ones for the joker cards were chosen and translated by the community researchers. The support cards consist of 2 quotes for women/men too.

Guidelines for the writing of the theme texts were developed. Several partners, CAB members, community researchers and experts wrote and/or reviewed the twelve theme texts. The content of the theme texts were reviewed in four loops. They were translated into nine languages of the beneficiaries participating in this project. Given that the translations were only finished at the time of major Christian and Muslim feasts in December 2007, the community researchers did not have sufficient time to review the translations well before going into print. This had an effect on the quality of the translations done.

We integrated an intercultural calendar by mentioning religious and major political dates of the communities involved in our project and international UN/EU/human rights by day.

A concise overview of the address lists of Belgian & Dutch stakeholders were incorporated per theme at the back of the tool as decided upon for the stakeholder desk study. Some are lacking. All addresses received two agenda, in Belgium. Furthermore, a birthday calendar, an overview of school holidays in Belgium and the Netherlands, empty note pages, empty pages for addresses/phone numbers, a personal data page, a page indicator, a calendar of 2008 and one of 2009 were added upon request of the community researchers. As the community researchers stated during the concept and pilot phase that network cards were good to have and as this could enhance the social networking, we integrated five network cards per tool.

ICRH and MOVISIE made prototypes of the prevention tool which were pilot-tested with the CAB & CRS. 3 focus groups in Belgium were held, one in the Netherlands. The outcome of the focus groups and pilot-testing was used to change/adapt the different prevention tool parts. All contributors are mentioned in the Colophon.

Several tenders of printing and lay-out bureaus were sent to NVR who coordinated the final phase in the development of the tool. The design of the cover was done by Baharak Pourmirzajan, one of the community researchers in Belgium.

Thanks to additional funding from the Dutch Ministry on Public Health, Well-being and Sports, we were able to print more copies than initially foreseen. 26.000 copies were printed. The first copies were presented and disseminated at the Hidden Violence is a Silent Rape seminar. In each of the two main partner countries 12.700 copies were disseminated closely after the Seminar, mainly to newly arriving and present asylum seekers in the reception centers but also to refugees and undocumented migrants. In the other European Member States some 600 copies were disseminated. The tool is entirely downloadable from the ICRH website. A hard copy (ISBN 978-90-781-2816-8) can be ordered at ICRH. The other partners made a link to the ICRH site.

The prevention tool turned out to be a prevention diary with a lot of information. It addresses a different subject each month. These subjects are not only considered important by refugees, asylum-seekers and undocumented migrants that worked with us on the research project. But the service providers, organizations, policy-makers and scientists also think they are important. So it became a prevention diary for all of us. But this diary is a kind of pilot diary. The next version can be improved with the help of the users. Because we would like to evaluate this version and to develop an improved one, we explicitly asked for the opinion of the users in the guidelines of the diary.

Some people reacted that the diary turned out to be a bible, not being very handy to put in your pocket as initially planned. However, several of the community researchers and respondents do no consider it too big, they just admire it that it has become a serious book. One they are proud of. Moreover, for many beneficiaries e.g. for Roma, this information is new in their languages.

1.7 AWARENESS RAISING

> *“The stories are shocking,” said Anne Van Lancker, a Belgian socialist member of the European Parliament who attended last week’s meeting. “It is unbelievable that this is also happening in reception centres. Many [European Union] member states take the minimum standards for maximum standards.”UNHCR News Stories February 18th 2008*

Awareness raising was considered one of the core goals of this project. All partners contributed to the different awareness raising activities. At the third steering committee, an awareness raising plan was developed and agreed upon, setting out different activities addressing different stakeholders. All awareness raising actions in the plan were implemented.

Awareness raising campaign			
Target audience		**Objective**	**Action**
1. Communities	*participating refugee communities	*to know the existence of the tool, how to use it and it goals	*Leaflet about prevention tool
	*other refugee communities	*information about their rights	*internet communication
	*refugee organisations	*to know where to turn to	*on foreign Tv/radio-programme
2. Authorities	*local	*to acknowledge the necissity of violence prevention	*lobbying
	*regional	*to be aware of their responsibility	*strategic meetings
	*national	*to undertake a commitment	*policy recommendations
	*European	*to inform about the existence and use of prevention tool	*press conference
	*WHO/ UNFPA		*involvement in EU seminar
3. Intermediary organisations/ services	* beneficiaries agencies	*to inform about the project, its goals and actions	*lectures, publications in magazines, newsletters, websites
	*CAB members	*to become partner in the CABs	* lectures and meetings
	*health care + welfare	*to inform about the existence and use of prevention tool	*Invitation and participation Seminar
	*gender, violence, emancipation	*to invite them to further collaboration	*press conference
	*minorities	* to make them inform the target groups	*media coverage
	*faith groups		
	*policy		
4.General public	*general adult	*to inform about the project, its goals and actions	*media coverage
	*general youth	*to acknowledge the necissity of violence prevention	
	*schools	*to inform about the existence and use of prevention tool	
	*journalists		
5. Funders	*authorities	*funding missing budget	* scientific articles
	*private funds	*funding future projects on this topic	*seminar
			*research result reports

At the first steering committee we decided to develop several leaflets in digital and own printed versions:

- Announcement project & call for recruitment community researchers in Dutch
- Call for Community Advisory Board members in Dutch
- Informed Consent for respondents in Dutch, Arabic, Farsi, Romani, Russian, Sorani, Somali with info on project & participation research
- Leaflet on project and seminar presentation in Dutch, also disseminated during given lectures
- Call for participation design competition tool in Dutch

- Invitation folder EU Seminar in Dutch-French-English: 330 hard copies + a mailing to some 4000 persons. The announcement and invitation was also put on the websites of partners and CAB-members and mentioned in newsletters.
- Letter to designers participating in the competition to invite them to the seminar and to inform them on the results of the competition
- Respondents were invited through the network of the CRs in Belgium, 2 came to the seminar

In addition to the leaflets 100 posters to invite beneficiaries to participate in the design competition were disseminated in Belgium and the Netherlands. Another 150 posters announcing the Seminar were also disseminated in both the main partner countries.

Different media covered the Hidden Violence is a Silent Rape project:
- Article in the Flemish newspaper “De Morgen” after the presentation of the preliminary results at a Scientific symposium in October 2007
- Article in WHO magazine Entre Nous n°66 pp 12-13, addressing EU policy makers
- Press release in Belgium and the Netherlands
- Press conference the day before the Seminar in the seminar meeting venue
- 3 interviews were radio broadcasted: February 14th Radio 1 Wereldnieuws interview with Ines Keygnaert, Radio Vlaardingen 27th of February and KRO “Dingen die gebeuren”on the 5th of March with Hilde Bakker.
- The Iranian Islamic Broadcasting was present at the press conference and did several interviews.
- We were informed about the apparition of 10 articles in Belgium, the Netherlands and the UK NL, EU covering the seminar and/or the research results. An overview of these press articles were handed out at the last steering committee.

As a result of this media coverage, the 2 responsible Ministers in Belgium were asked questions in the federal parliament about their opinion on the research results and what they were going to do about it.

UNHCR – Report says young refugees suffer abuse after arrival in Europe – Windows Internet Explorer

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Two of the report's researchers at the meeting in Ghent. © *Nederlandstalige Vrouwenraad/Rita Van Gool*

UNHCR News Stories

Report says young refugees suffer abuse after arrival in Europe

BRUSSELS, Belgium, February 18 (UNHCR) – A study conducted in Belgium and the Netherlands has found that young female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several types of gender-based violence.

The survey, entitled "Hidden Violence is a Silent Rape," was presented at a well-attended international seminar organized last Thursday and Friday by the University of Ghent's International Centre for Reproductive Health, which coordinated the research. UNHCR staff attended the meeting and chaired a workshop.

A team of 13 female and eight male refugees and migrants conducted the groundwork, interviewing 233 refugees, asylum seekers and undocumented migrants hailing from Afghanistan, Iran, Iraq, Somalia and the former Soviet Union as well as the Roma and Kurdish communities.

They found that a majority of those interviewed had either suffered from some form of gender-related violence since arriving in Europe or knew of other people who had been abused. These people all remained vulnerable because of the lack of information and a social network as well as their uncertain status during the asylum procedure.

Among the respondents, 57 said they did not know anybody who had been victimized since his or her arrival in Europe, but 166 said they did and they described 332 cases of gender-based violence. Of this number, 87 respondents (39 percent) said they were personally victimized, while 229 of the cited victims were known to a respondent.

The report categorized 206 cases (62 percent) as emotional-psychological violence, 188 cases (56.6 percent) as sexual violence, 157 cases (47.3 percent) as physical violence, 112 cases (33.7 percent) as socio-economic violence and 47 cases (14.2 percent) as traditional harmful practices.

The cases of sexual violence were broken down into sexual intimidation (89 cases), sexual abuse (40

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Furthermore, different relevant stakeholders were addressed through other awareness raising activities:

- ICRH gave 9 lectures for service providers in collaboration with Community Researchers and in some occasion with the other Belgian partners. Several hundreds of service providers were reached in this way.
- 1 Lecture & publication for an scientific audience given by ICRH at "ICRH Symposium Sexual and Reproductive Health Research: Making a difference", October 2007. There were 200 participants.
- 1 Lecture of 1 Community Researchers for service providers in November 2007
- All organizations and service providers mentioned in the stakeholders list of the prevention tool received 2 copies of the prevention tool as well as an explaining note.
- At the EU seminar quotes were exhibited on different posters in different colors, + 5 passages from interviews. They were put all over the meeting venue.
- Furthermore, the partners and community researchers wore T-shirts with 2 quotes of the respondents on it throughout the seminar.
- All partners put relevant documents or links to the ICRH website on their website.
- Three hundred copies of the final report (ISBN: 978-90-382-1327-9) are published and disseminated to the Seminar participants, the Community Advisory Board members, the Community Researchers and relevant policy makers. The final report is also available on CD-rom as well as downloadable from the ICRH website.

1.8 EU SEMINAR

At the third steering committee in January 2007 we made a preliminary invitation list for key note speakers and participants as well as a preliminary program for the two days. The final date and meeting venue was decided upon at the 4th steering committee in May 2007. As the budget had a major shortage to cover all expenses of this EU seminar, extra funding was sought and obtained from the Belgian National Lottery Fund.

The Hidden Violence is a Silent Rape seminar was a two-day seminar, held at the 14th and 15th of February 2008 in Het Pand, in Ghent, Belgium. After an introduction on the health & legal situation of refugees and asylum seekers in Europe, the project and the final research results were presented and discussed.

In the afternoon, eight workshops with good practices from different EU stakeholders was held. In total 16 good practices were presented. Policy, service and practice recommendations were formulated per workshop according to the guidelines. At the second day attention was shifted towards prevention. An introduction was given on Desirable Prevention and the prevention tool was presented and disseminated. Finally, a summary of the workshop recommendations were presented as a Call for action to a panel of national and European policy makers.

Throughout the seminar networking was stimulated. A “Café Contact” gave the participating organizations the possibilities to present their good practices, tools and manuals and to network on this. You can find an overview of the Café Contact participants in Appendix 2. Furthermore, participants could visit two exhibitions which were set up at different locations where the participants had to pass by. There was one exhibition with quotes, interview passages and the post cards designs as well as the Migration in Jewels in Migration exhibition. Finally the workshops, the seminar dinner and reception offered the opportunity to exchange views and experiences and to set up new partnerships.

Hundred fifty persons participated in the Hidden Violence is a Silent Rape Seminar. The seminar was positively evaluated by all stakeholders. You can find a detailed description of this seminar in Chapter 3: Seminar Proceedings and Chapter 4: Seminar Recommendations: A call for action.

"Sexual health is dead in my body."

Kurdish Asylum Seeker

"Hidden Violence is a Silent Rape" Seminar

"I know a 22 year old Afghan girl. At the German border her parents were sent back, but she could apply for asylum in Germany. She was rejected and had to leave the country. So she came to the Netherlands and applied for asylum again. But with the same result: negative answer. She didn't know what to do or where to turn to, so she married a Dutch guy. Very soon she was forced to have sex with men in order to bring money home and hand it over to him. She was threatened by her husband. He told her that if she didn't sell sex to other men, he'd kill her. For four years she sold her body and gave the money to him. The moment she had her residence permit, she told her husband she no longer wanted to work as a prostitute, he didn't agree, so she went to the police. They arrested him. He told her that he would take revenge on her the moment he'd be free. She still has a lot of psychological problems."
Young Female Afghan Refugee, living in the Netherlands

CHAPTER 2: PARTICIPATORY RESEARCH RESULTS

2.1 THE CONCEPTUAL FRAMEWORK

2.1.1 Socio-ecological perspective on health & Desirable Prevention

Sexual and gender-based violence is globally recognized as a major public health issue, a violation of human rights and in some cases as a crime against humanity. Being rooted in the broader socio-cultural, political and economic fabric of society, it frequently occurs in diverse populations and settings transcending cultural, ethnic, or economic boundaries.

Gender-based violence can be of physical, emotional-psychological, socio-economic, socio-cultural or sexual nature. In addition to important negative effects on the well-being and the participation in society of the survivor, gender-based violence may have significant consequences on the survivors' sexual, reproductive, physical and psychological health.These consequences are the most severe in youth. Other particularly vulnerable groups to sexual violence are considered to be women and refugees.

Increasing empirical evidence suggests that health and health related behaviour is determined by the interplay of a complex set of contextual stressors, health promoters and genetic endowment[1]. Stressors include social, cultural, economic and physical environmental factors such as poverty, discrimination, inadequate housing, socially disintegrated communities, material deprivation, income inequality, oppression, and unemployment, lack of social support and lack of education.

These stressors are all ill-health factors which minorities as immigrants, asylum seekers, refugees and undocumented migrants in Europe face on a daily basis. These are also ill-health factors which counterparts are recognized as basic economic, social, cultural, civil and political human rights. But realization of these rights is far from self-evident when the possibility to do so is completely intertwined with the legal status one has or has not. Refugees have obtained an official residence permit. This status assures access to health care services and entitles them to realize most rights notwithstanding the multiple financial, cultural, physical and psychological barriers they might encounter when trying to do so. Asylum seekers are still in the insecure process of achieving such a status or having it denied. This has significant implications for their access to health care as well as for the fulfilment of the above-mentioned rights.

1 Krieger J, Allen C, Cheadle A et al. Using Community-Based Participatory Research to Address Social Determinants of Health: Lessons Learned From Seattle Parners for Healthy Communities. *Health Education & Behavior*, 2002, 29(3):361-382, p 368

From a socio-ecological perspective on health and violence, these stressors are identified on multiple levels including individual, interpersonal, organizational and community levels as well as public policy. Within each level the targets of change and possible prevention and intervention strategies are extensive. However, the central premise of this socio-ecological model is that none of its levels should function in isolation from the others. Thus, effective prevention programmes can best be achieved by stimulating synergy among the several levels that comprise the model[2].

According to the concept of Desirable Prevention, prevention is defined as: "Initiatives which anticipate risk factors in a targeted and systematic way" and Desirable Prevention as: "Initiatives which anticipate risk factors in a targeted and systematic way are desirable if they, in order to enhance or protect the health and wellbeing of the target group, antipicate risk factors ever earlier, are maximally offensive, have an integrale approach, work in a participatory way and have a democratic nature[3]"

This consists with research findings which suggest that all prevention and intervention strategies for survivors of sexual violence should be based on principles that include cultural competence and empowerment[4]. Furthermore, involving the community in evaluating its own needs and determining the most suitable actions of change would by far be the best way to assure the necessary matchmaking between research and the needs of the affected groups[5]. Some authors argued that focusing only on the structural impediments to actions of change would certainly be short-sighted, and a more comprehensive approach would be to recognize the barriers as well as the high levels of community resiliency and capacity for social change[6]. Models for Social change are concerned with increasing community problem-solving ability to redress power imbalances between oppressed or disadvantaged groups and the larger society. These models emphasize the need for a comprehensive approach to violence prevention that integrates community support systems[7].

Moreover, substantial evidence demonstrates the relationship of social support to physical and mental health and suggests the value of interventions with those who may be socially isolated. Because isolation is so often a tactic of abusers and because research participants are already isolated by virtue of language ability and immigration status, research results suggest that coming together with other survivors who share their language and culture for mutual support

2 DiClemente RJ, Salazar LF, Crosby RA et al. Prevention and control of sexually transmitted infections among adolescents: the importance of a socio-ecological perspective-a commentary. Public Health, 2005, 119:825-836, p 831

3 Vettenburg N.; Burssens D.; Melis.B.; Goris P.; Van Gils J.; Verdonck D. & Walgrave L. (2003) Preventie gespiegeld. Visie en instrumenten voor wenselijke preventie. Uitgeverij Lannoo, Tielt, pp 120.

4 Campbell & Campbell (1996)

5 Frasier P.Y.; Belton L.; Hooten E.; Campbell M.K., De Vellis B. & coll.(2004) Disaster Down East: Using Participatory Action Research to Explore Intimate Partner Violence in Eastern North Carolina. Health Education & Behavior, Vol.31(4): pp 69S-84S.

6 Mosavel M.; Simon C.; van Stade D.; Buchbinder M. (2005) Community-based participatory research (CBPR) in South Africa: Engaging multiple constituents to shape the research question. Social Science & Medicine 61 (2005) pp 2577-2587

7 Maciak B.J.; Guzman R.; Santiago A.; Villalobos G.; Israel B.A. (1999) Establishing LA VIDA: A Community-Based Partnership to Prevent Intimate Violence Against Latina Women. Health Education & Behavior, Vol. 26(6): pp 821-840

is of major importance[8]. Finally, many authors argued that community involvement isn't only increasing individual and community capacity; it as well leads to greater participation rates, increased external validity and decreased loss of follow-up of the research[9].

"It helped me get to know myself better. In our country sexuality is taboo you don't talk about it, but we tried and it turned out to be very interesting. I learned a lot and it really helped me to continue with my life and in my job it has made me a stronger person. I can talk to these people, I know what the problems are, I am more open, for me it has been a positive process. Now I know that I am able to talk to people about these subjects, before I couldn't. I was shocked when I saw these women who are struggling because I had no idea that it was so difficult, that relations between men and women are so difficult in my country. It is such a broad topic, I could talk about it for hours but what I could say now is I have a lot more information now than before. Thank you!"
Mahtab Safaipour, Kurdish Community Researcher in Belgium

2.1.2 Community Based Participatory Research

Taking these research findings into account and starting from a socio-ecological framework on sexual health and sexual and gender-based violence; and the one of Desirable Prevention on prevention, we thus use a triangulation form of qualitative, applied and formative research method, being Community-Based Participatory Research (CBPR). CBPR in public health specifically focuses on social, structural and physical environmental inequalities[10]. CBPR is a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process. The goal of CBPR is to improve health and well-being through taking action, including social change[11].

Community Based Participatory Research has multiple benefits for all stakeholders. Firstly, it creates bridges between scientists and communities, through the use of shared knowledge and valuable experiences. It emphasizes co-learning about issues of concern and, within those, the issues that can be studied with this method are reciprocal transfer of expertise, sharing of decision making power, and mutual ownership of the products and processes of research. This collaboration further lends itself to the development of culturally appropriate measurement instruments, thus making projects more effective and efficient. Secondly, CBPR establishes a mutual trust that enhances both the quantity and the quality of data collected. Finally, the

8 Krieger J., Allen C., Cheadle A., Ciske S., Schier J.K., Senturia K., Sullivan M.(2002) Using Community-Based Participatory Research to Address Social Determinants of Health: Lessons Learned From Seattle Parners for Healthy Communities. Health Education & Behavior, Vol. 29 (3): pp 361-382 (June 2002)

9 Viswanathan M.; Ammerman A.; Eng E; and colleagues (2004) Community-based Participatory Research: Assessing the Evidence, AHRQ Evidence Report/technology assessment no 99, No 04-EO22-2, July 2004, pp 109

10 Israel B., Schulz A.J, Parker E., Becker B. (2001) Community-Based Participatory Research: Policy Recommendations for Promoting a Partnership Approach in Health Research, Education for Health, Vol. 14 no.2, 2001, pp 182-197, p 182.

11 Viswanathan M.; Ammerman A.; Eng E; and colleagues (2004) Community-based Participatory Research: Assessing the Evidence, AHRQ Evidence Report/technology assessment no 99, No 04-EO22-2, July 2004, pp 109, p 22.

ultimate benefit to emerge from CBPR is a deeper understanding of a community's unique circumstances and a more accurate framework for testing and adapting best practices to the community's needs.

Applying the "Community Based Participatory Research" method, the project was conducted in close partnership with a large "Community Advisory Board", consisting of representatives of the communities, policy makers, intermediary organizations and researchers. Meetings with the Community Advisory Board were held at decisive moments in the project: e.g. the planning of the in-depth interviews, the interpretation of the results, the development of the prevention tool and the final seminar. They were part of several awareness raising activities and contributed to the content of the prevention tool. Moreover, fourteen female and eight male refugees or asylum seekers from Iranian, Iraqi, Afghan, former USSR, Somali, Roma or Kurdish origin were trained as "Community Researchers". They collaborated in every single phase of the project.

Between January and mid-April 2007, they conducted 250 in-depth interviews with their peers in Belgium and in the Netherlands. Respondents were sampled according to the following criteria: being a female or male refugee, asylum seeker or undocumented migrant from Iranian, Iraqi, Afghan, former USSR, Somali, Roma or Kurdish origin in her or his reproductive age (15-49), living in the Province of East-Flanders in Belgium or in the Randstad in the Netherlands.

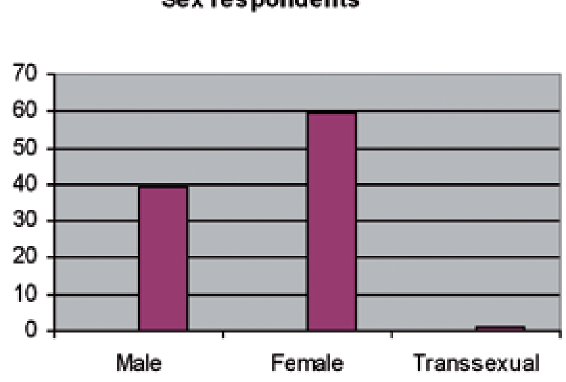
Potential respondents were found through services and organizations being member of the Community Advisory Board, the Red Cross reception centers in East-Flanders, the network of the Community Researchers and that of the respondents. Once identified, respondents were being informed about the goals of the in-depth interview and the objectives of the project. They had the opportunity to choose whether to participate or not and to withdraw at any moment of the interview. The participating respondents signed an informed consent. The questionnaire consisted of 4 main parts. The first part was on socio-demographic data (closed questions), the second on sexual health, the third on victimization of sexual and gender-based violence since their arrival in Europe and the fourth part addressed prevention of sexual and gender-based violence (all open questions).

From the 250 conducted interviews, 223 met the validity criteria to be incorporated in the analysis. This corresponds with 133 female, 88 male and 2 transsexual respondents, and 132 respondents in Belgium and 91 in the Netherlands. MOVISIE collected the interviews conducted by the Dutch Community Researchers, ICRH the ones from the Belgian Community Researchers. ICRH – Ghent University did the full screening and analysis. For the qualitative part, we used the Framework Analysis Technique to sort, code and constantly compare the answers. We applied the socio-ecological model on health and the concept of Desirable Prevention to interpret the findings. SPSS was used for the analysis of quantitative results. All results were discussed and interpreted with Community Researchers, respondents and the Community Advisory Board.

2.2 SOCIO-DEMOGRHAPHIC PROFILE OF RESPONDENTS

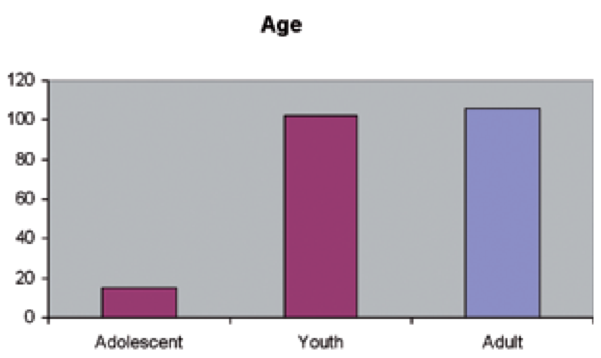
We started the in-depth interviews by asking socio-demographic questions to get a better view of who the respondents are, where they live, what status they have, what level of education and what professional background.

Of the 223 respondents, at the moment of the in-depth interview (January 2007-mid April 2007):

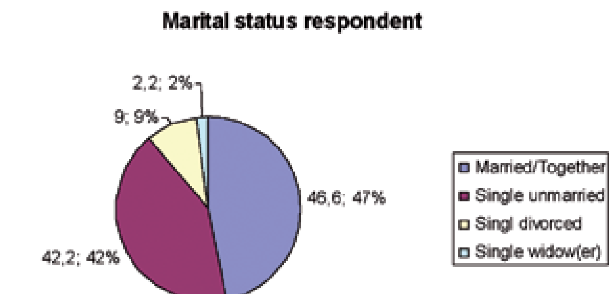


- **Sex**: 133 respondents (59,6%) were women of which 80 were living in Belgium and 53 in the Netherlands. 88 respondents (39,5%) were men of which 50 were living in Belgium and 38 in the Netherlands. 2 respondents were transsexuals (0,9%) and they both lived in Belgium.

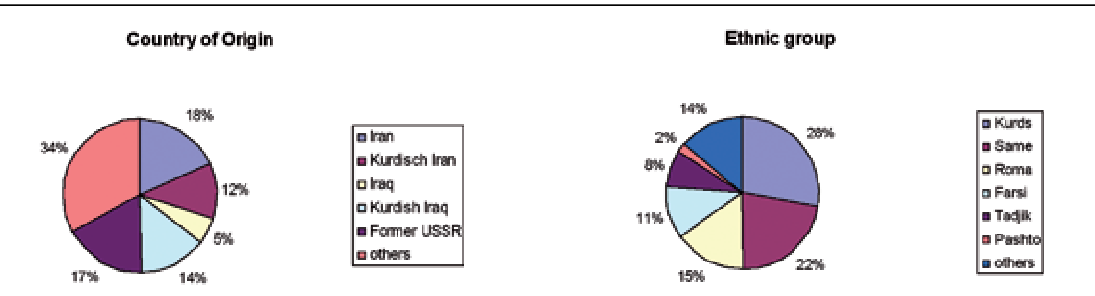
- **Age**: 106 respondents were above the age of 30 and 117 respondents under the age of 30. 15 were adolescents (6,7%, 13-18 years), 102 were youth (45,7%, 19-29 years) and 106 respondents were adults (47,4%, + 30 years). The majority of the interviewed women (57,9%) were less than 30 years old, and the majority of the men were more than 30 years old (56,8%). The two transsexuals were between 19 and 29 years old. Youth was more interviewed in Belgium (59,1%) than in the Netherlands (45,1%).



- **Marital status**: 46,6% was married or living together with her/his partner. 54,4% was single: unmarried (42,2%), divorced (9%) or a widow(er) (2,2%). This is about the same for female and male respondents. From the respondents in the Netherlands there were slightly more people living with her/his partner or being married (49,5%) than from the respondents in Belgium (44,7%).



- **Country of origin**: 18,4% or 24 female and 17 male respondents came from Iran. 11,7% or 16 female and 10 male respondents came from the Kurdish part of Iran. 5,4% or 12 female respondents came from Iraq and 13,9% or 21 female and 10 male respondents came from the Kurdish part of Iraq. 17,5% or 39 respondents (25 women, 12 men, 2 transsexuals) came from the former USSR. 15,2% or 34 respondents (23 women and 11 men) came from Slovakia, 10,8% or 24 (10 women and 14 men) came from Afghanistan. 6,3% or 14 male respondents came from Somalia and 2 female respondents from the Check Republic.



- **Ethnic group**: 62 (27,8%) respondents identified themselves as Kurds (Sorani, Kalhor, Bakhtiari), 49 (22%) said to have the same ethnic background as the country of origin, 34 responded to be Roma, 25 to be Farsi, 18 to be Tadjik and 4 to be Pashto. Others said they were Ingushetian, Karathaevka, Russian (other than country of origin), Ukrainian, Armenian, Iranian/Turkish, Arabic, Reer Hamar, Lor, Chechnyan or Gilak.

- **Current nationality**: 148 respondents had solely the same nationality as their country of origin. 58 respondents had the Dutch nationality, 13 the Belgian nationality and 4 were stateless.

- **Religion**: 79,8% of the respondents said to believe. This is about the same for both sexes and both countries of research. The majority of them is Muslim (96 persons or 53,9%) or Christian (68 persons or 38,2%). 64,6% of the Muslims lived in the Netherlands and 95,6% of the Christians in Belgium.

- **In Belgium/the Netherlands since**: 30 (22 female and 8 male) respondents didn't answer this question. 83 (50 female and 33 male) respondents were living here since more than 7 years (5 arrived before 1990, 29 between 1990-1994, 49 between 1995-1999). 89 (48 female and 39 male) respondents arrived between 2000 and 2005. 13 (6 female and 7 male) respondents arrived in 2006 and 8 (7 female and 1 male) respondents in 2007. 71,2% (94) of the respondents in Belgium arrived in 2000 or later compared to only 18,7% (16) of the respondents in the Netherlands.

- **Residence Status**: At the moment of the interview 51,1% of the female and 39,7% of the male respondents were refugee with a permanent residence status (total: 103 or 46,2%). This corresponds with 66% of the respondents in the Netherlands and 32,6% of the respondents in Belgium. 36,8% of the female and 48,9% of the male respondents were asylum seeker with a temporary residence status (total 92 or 41,3%). This corresponds with 53,1% of the respondents in Belgium and 24,2% of the respondents in the Netherlands. 12% of the female and 11,4% of the male respondents were undocumented migrants (total: 28 or 12,5%), this equals 14,3% of the respondents in Belgium and 9,9% of the respondents in the Netherlands.

- **Current housing**: At the moment of the interview 31,8% of the respondents lived in an apartment, 30,9% in a house, 8,5% in a studio, 3,6% in a room and 21% in a reception centre or reception initiative. 2 persons were homeless and 3 lived in the accommodation of her/his family. This is about the same for both sexes.

"We had to live with several families together in one apartment,
we were very sticky"
Iranian Refugee

- **Children in care**: 46,6% had no children, 15,2% had one and 22,4% had two children in care. 32 respondents of which 22 were living in the Netherlands and 10 in Belgium; had more than 3 children in care. Male respondents have a higher percentage of having no children in care (54,5%) compared to the female respondents (40,6%).

- **Accompaniment**: 29% of the respondents (= 27 women and 38 men) said to live in this accommodation without any other person older than 18 years old, 32,2% said to share this with one other person +18, 17,9% with 2 and 14,3% with 3 to 5 persons older than 18, and 6,3% said to share this space with more than 6 people. 43,9% said to live there without any children, 22,9 said that one child shared this living space, 18,4% with two, 11,2% with 3 to 5

and 3,5% with more than 6 children. Women tend to have more accompaniment (79,7% at least one +18 person and 64,7% at least one child) then men (56,8% at least one +18 person and 44,3% at least one child) This is about the same for Belgium and the Netherlands.

- **Highest attained level of education**: 40,8% of the respondents have higher education (higher: non-university 20,6% and higher: university 20,2%). This is 48,1% of the female respondents and 30,2% of the male respondents. 44,4% (40,6% of the female and 48,9% of the male) respondents have secondary school as the highest level of education obtained. 11,2% followed only primary school. 1,8% didn't go to school. (1,7% answered "other") This is about the same for Belgium and the Netherlands.

- **Language skills**: 97,8% speaks, 85,2% reads and 79,4% writes her/his mother tongue fluently. 45,7% speaks, 44,8% reads and 36,3% writes Dutch fluently. 41,3% says to speak, 41,3% to read and 44,8% to write Dutch but with difficulties. Women tend to answer more that they speak, read and write Dutch fluently than men. This is also the case for respondents in the Netherlands compared to respondents in Belgium: speak Dutch fluently B: 34,8%-Nl: 61,5%; read Dutch fluently B: 34,1%-Nl: 60,4%; write Dutch fluently B: 25%-Nl:52,7%.

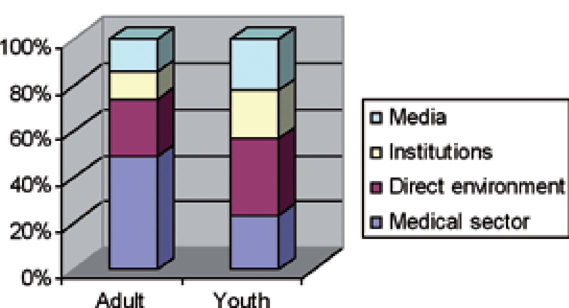
- **Daily activities in the country of origin**: 101 (51 female and 50 male) respondents had a paid job (45,3%). 88 (59 female and 27 male) respondents were students (39,5%). 12 (6 female, 6 male) respondents were on the job market (5,4%). 14 (12 female, 2 male) respondents were responsible for the household (6,3%). 4 did voluntary work (1,8%) and 4 were still a child in their country of origin. This is about the same for the respondents in Belgium and the Netherlands.

- **Daily activities in the host country**: at the moment of the interview 50 (28 male and 22 female) respondents had a paid job (22,4%). 47 (36 female and 11 male) respondents were students (21,1%). 44 (22 female, 18 male, 2 transsexual) respondents were on the job market (19,7%). 25 (23 female and 2 male) were responsible for the household (11,2%), 16 (11 female, 5 male) respondents did voluntary work, and 44 (20 female and 24 male) respondents could not work because their status didn't permit working (15,7%) or their health didn't permit it any longer (4%).The difference between the respondents in Belgium and in the Netherlands is that a higher percentage of the respondents in Belgium was on the job market (B:27,3%-Nl: 6,6%), was responsible for the household (B:17,4% - Nl: 9,9%), and could not work due to legal status or health (B: 21,2%- Nl:17,6%). 29,7% of the respondents in the Netherlands had a paid job compared to only 17,4% of the respondents in Belgium.

2.3 SEXUAL HEALTH PERCEPTION

2.3.1. Information on sexual health in home country: frame of reference

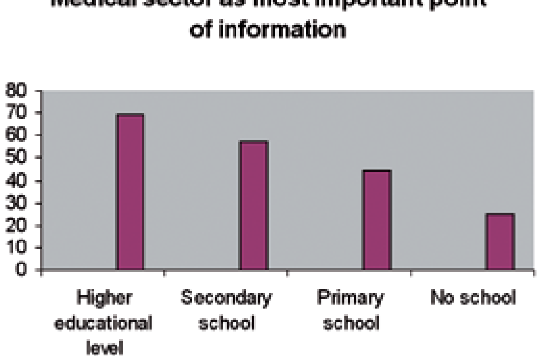
- **General:** 60,1% of the respondents said that in their home country adults turn to the medical sector for information on sexual health, 30% to the direct environment, 14,8% to institutions and 17,5% to media. 40,8% of the respondents nuanced their answer and of those doing this (91 respondents), 81,3% said that there was not really a place or a person where you could turn to in order to have information on sexual health in the home country, or that is was a big taboo. 56,5% of all respondents said that their answer counted for women and men, and 35,9% said there was a difference, the others didn't know. The most mentioned differences were that men turn to men and women to women (24,7%).



According to the respondents, this is not the same for youth. 43,% of the respondents said that youth turn to the direct environment for information on sexual health, 30% to the medical sector, 28,7% to the media and 26,9% to institutions. 42,2% of the respondents nuanced their answer by saying that there was no place or person for youth (58,5%). Others (12,8%) questioned the level and the correctness of information youth got on sexual health.

- **Medical**: For both sexes as well as for the two transsexuals in both countries of research, the medical sector is the most evident place to turn to as an adult, but the percentage of male respondents answering that adults turn to medical professionals is somewhat higher than the percentage of female respondents (M:62,5%- F: 57,9%). This is also more agreed upon among respondents in Belgium than among respondents in the Netherlands (B:68,2% - Nl: 48,4%) Respondents above the age of 30 mentioned the medical sector much more than the ones under the age of 30 (+30: 68,9%- -30:52,1%). For all the origins of respondents but one, the medical sector is the first point of information: for both Kurdish respondents from Iraq and Iran it is not. Taking the highest level of education of the respondents into account, we see that the higher the education, the higher the percentage of respondents

answering medical sector as the most important point of information on sexual health: 69,2% of the respondents with higher education level, 57,6% of the ones with secondary school education, 44% of the ones with primary school education and 25% of the ones who didn't go to school.



Within the medical sector the general practitioner is the most popular for both sexes (52,2% of all the respondents answering medical sector, 54,5% for the female ones and 50,9% of the males), followed by an outpatients' clinic (26,1%), a gynecologist (23,9%), urologist (11,2%) and a general health centre (9,7%). For the female respondents a gynecologist (31,2%) was more important than the outpatients' clinic (19,5%) and for the male respondents it is the other way around (38,2% outpatients' clinic -14,5% gynecologist). Going to a general practitioner and a gynecologist for information on sexual health is the most important to both respondents above and under the age of 30 mentioning the medical sector(GP -30:55,7%- +30:49,3%) (Gy -30:26,2% - +30: 21,9%). Going to an outpatients' clinic however, is more popular among respondents above the age of 30 (+30: 35,6%) than respondents under the age of 30 (18%) mentioning the medical sector.

	Female (%)	Male (%)	Total (%)
General practitioner	54,4	50,9	52,2
Outpatients' clinic	19,5	38,2	26,1
Gynaecologist	31,2	14,5	23,9
Urologist			11,2
General health centre			9,7

According to the 67 respondents (30%) mentioning the medical sector as a point of information on sexual health for youth, 53,7% mentioned the general practitioner, 25,4% the outpatients' clinic and 7,5% the gynecologist.

- **Direct environment**: Adults turning to their direct environment comes for both sexes on the second place, but female respondents are more turning to their peers than the male respondents. (F:39,1%-M:17%) Here, the percentage of respondents in the Netherlands is higher than the percentage of respondents in Belgium (Nl:33%-B:28%) Young respondents mentioned the direct environment more (34,2%) than respondents above the age of 30 (25,2%). For Kurdish respondents, the direct environment is the most important for information on sexual health (50,8%). This is also the case for respondents who didn't go to school (50%). From the respondents who answered that direct environment is a point on information on sexual health (67 respondents); the most important were family (74,6%) and friends (67,2%). The female respondents mentioning direct environment answered in 57,7% of the cases friends and 41,4% of the cases family. For male respondents mentioning direct environment this is both 40%. From the 43% respondents saying that youth turn to their direct environment, in 66,7% of the cases they go to their friends, and in 54,2% to their family.

- **Institutions**: Turning to institutions is about the same for female and male respondents (F:15%- M:14,8%) but is slightly more answered among the respondents in Belgium than the respondents in the Netherlands (B: 15,9%-Nl: 13,2%) This is the same for respondents under and above the age of 30 and among all origins. This is about the same for all levels of education except for respondents with primary school (8%) or no education (0%). Among institutions school/university is the most important (57,6%) followed by religious institutions (18,2%). For female respondents mentioning institutions 65% answers school/university and 20% religious institutions, for male respondents this is 46,2% for school/university and 15,4% for religious institutions. School/university as a point of information on sexual health is more important among the respondents in Belgium answering institutions (71,4%) compared to the ones in the Netherlands (41,6%).

  From the 26,9% of the respondents saying that youth get information on sexual health from institutions, 83,3% gets the information at school/university and only 8,3% from religious institutions.

- **Media**: Using the media as an information tool is more answered among the female than the male respondents (F: 19,5%-M:13,6%). This also goes for the respondents in Belgium compared to the ones in the Netherlands (B:20,5%-Nl: 13,2%) This is the same for respondents under and above the age of 30. Media as an information tool on sexual health is the most popular among Iranian and Kurdish respondents. The use of media doesn't differ much among the different levels of education.

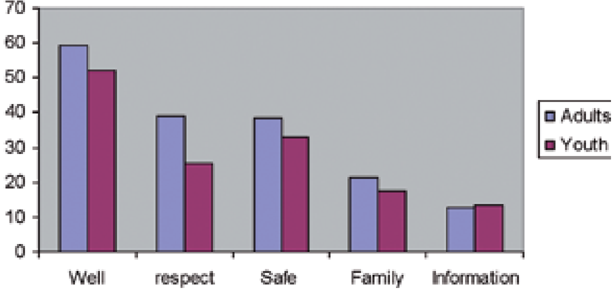
  For the total of the respondents mentioning media as an information point on sexual health, the three most important are: books 46,2%, internet 33,3% and TV 27,3%. For the female respondents mentioning media the top 3 is: books 61,5%, internet 30,8% and TV 19,2%. For the male respondents mentioning media the top 3 is: internet 41,7%, TV 33,3% and books

16,7%. Internet is about equally important to all levels of education; TV is more important to respondents with a lower education (75% of the answering respondents with primary and no education together- 11,4% of the answering respondents secondary and higher education together), and books more important to respondents with secondary school and higher education (40%- 0% primary and no education). Among the 28,7% of the respondents mentioning media as a point of information on sexual health for youth, 54,7% said that they find information on the internet, 42,2% said books and 21,9% said TV.

2.3.2 Personal definition of sexual health

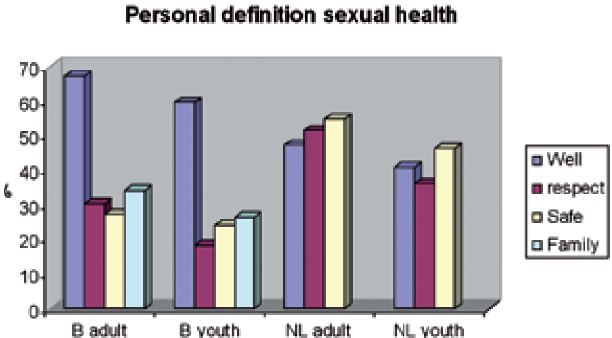
"In Iran they say you get blind if you masturbate,
here they say it's good for your health"
Iranian Refugee

General: Respondents gave nearly the same order of interpretations of sexual health for adults and for youth. 59,2% related sexual health of adults to general well-being, 39% to a respectful approach of sexual relationships and sexuality, 38,6% to a safe and satisfying sex life, 21,5% to family planning and fertility and 12,6% to have access to information and care. For youth, 52% of the respondents related sexual health to general well-being, 33,2% to a safe and satisfying sex life, 25,6% to a respectful approach of sexual relationships and sexuality, 17,5% to family planning and fertility and 13,5% to having access to information and care.



However, there is a difference between **respondents in Belgium and the Netherlands**. For the respondents in Belgium sexual health of adults is firstly related to general well-being (67,4%), then to family planning (34,1%) and thirdly to a respectful approach of sexual relationships and sexuality (30,3%) A safe and satisfying sex life comes right after with 27,3%. For youth the top 3 is: well-being: 59,8%, family planning 26,5%, safe and satisfying sex life 24,2%. A

respectful approach takes the fourth place with 18,2%. For the respondents in the Netherlands a safe and satisfying sex life (54,9%) is more important for adults than a respectful approach (51,6%) and than a general well-being (47,3%). For youth the top 3 of sexual health definition in the Netherlands is: a safe and satisfying sex life 46,2%, a general well-being 40,7% and a respectful approach 36,3%.



Taking into account whether the **respondents are youth or adult themselves**, we can say that they think the same of each other and that this description is not so far away from what they think about themselves. Young respondents (-30 years old) said that sexual health of adults is firstly related to a general well-being (61,5%) then to a safe and satisfying sex life (34,2%) and thirdly to a respectful approach to sexual relationships and sexuality. Adult respondents (+ 30 years old) said that sexual health of adults is firstly related to a general well-being (56,6%), then to a respectful approach (46,2%) and thirdly to safe and satisfying sex life (43,4%).

Young respondents said that sexual health of youth is firstly related to a general well-being (55,6%), secondly to a safe and satisfying sex life (35,9%) and thirdly to having access to information and care (23,1%). Adult respondents gave the same order about youth as youth gave about the adults: general well-being 48,1%; safe and satisfying sex life 30,2%, respectful approach 29,2%.

Of the respondents answering **general well-being** as being part of the definition of sexual health (132), most of them defined this as not having an STD/STI (43,2%), secondly as being physically as well as mentally healthy (33,3%), and thirdly as being physically healthy (11,4%)

Of the respondents answering **safe and satisfying sex life** as being related to sexual health (86), they described this firstly as being completely comfortable with having sex (47,7%), secondly with using contraception (30,2%), thirdly with enjoying sex (17,4%) and fourthly with having sex on a regular basis (16,3%).

Among the respondents saying that sexual health is related with **respectful approach to sexuality and sexual relationships** (87), the description most given was having sex only from

the moment you are married and within the marriage (24,1%), closely followed by being conscientious about risk behavior and limits of yourself and your partner (21,8%) and thirdly by having one and steady partner.

Of the respondents relating sexual health to **family planning and fertility** (48), 50% defined this as being able to deliver children, 33,3% as being fertile and 16,7% as having healthy children.

Having access to information and care as being related to sexual health (mentioned by 28 respondents) was mostly described as having enough information on what sexual health is (57,1%) and as knowing what the risks of having sex can be (42,9%).

2.3.3 Criteria of girls turning into women and boys into men

When asked how one could make a distinction between adults and youth for the female and male sex, the following criteria were set. For both girls turning into women and boys turning into men the same top 3 of criteria were given: general well-being, age and respectful approach to relationships and sexuality.

For girls this was 58,7% or 131 respondents who said that this depended on their general well-being. 41,2% of these respondents defined this as being mentally mature, 25,2% defined this as being able to take up responsibility and the same percentage defined this as when girls got their first menstruation. 26,9% of the respondents (60) said that this had to do with age. For 31,7% of them this meant in between 15 and 17 years old, and for another 31,7% this meant from the aged of 18 onwards.

25,6% (57) said that this depended on their respectful approach towards relationships and sexuality and the utmost majority (79,9%) related this with being married. 6,7% (15) related this with family planning and described this as having the feeling of motherhood after having delivered the first child, being able to become a mother and being able to become pregnant. 4,9% of the respondents (11) related this to a safe and satisfying sex life.

For boys turning into men, 48% or 107 respondents said that this depended on their general well-being. 45,8% of these respondents defined this as being mentally mature, 33,6% as being able to take up responsibility and 18,7% related this with having had his first wet dream. 31% related this to age (70). For 39,6% of those respondents this was from the age of 18 onwards, for 21,4% between the age of 15 and 17 and for 20% from 19 to 20 years old.

22,9% or 51 said this depended on their respectful approach towards relationships and sexuality. 72,5% of them related this to being married. Eventually they related turning into a man to safe and satisfying sex life factors (13,9%) and 9% or 20 respondents to family planning.

2.3.4. Determining factors in sexual health

We asked the respondents if and how an individual could take care of her/his own sexual health and which other external factors could have a positive or negative impact on their sexual health.

- **Personal responsibility in taking care of one's sexual health**: 54,3% or 121 respondents (66 in Belgium and 55 in the Netherlands) thought that by assuring to have a safe and satisfying sex life one could have a good sexual health. The descriptions most given were using a condom (59,5%) and using contraception in general (23%). 49,3% or 110 respondents (79 in Belgium and 31 in the Netherlands) said that one could assure one's sexual health by having a general well-being. In 60% of the cases, this was described as personal physical care & hygiene.

  47,5% or 106 respondents (68 in Belgium and 38 in the Netherlands) answered that having access to information and care was a determining factor in sexual health. They defined this in most cases as being informed on sex, sexual risks and sexual health (64,2%) and in 54,7% as seeing a medical professional on a regular basis or at least when problems occur.

  30,9% or 69 respondents (40 in the Netherlands and 29 in Belgium) said that in order to have a good sexual health, one needed a respectful approach to relationships and sexuality. In 21 cases this was described as having one sex partner, in 13 cases as knowing the sex partner beforehand and in 12 cases, considering the health status of the sex partner before having sex.

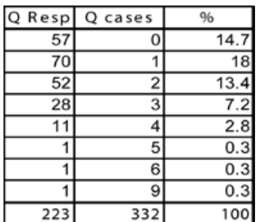
- **External determining factors in sexual health**: 68,2% or 152 respondents said that in addition to personal responsibility, there were external factors which could influence one's sexual health in a positive or negative way. The extent to which sexual health is debatable and having sexual education at school were mostly mentioned as external positive factors. Negative factors mentioned were stress, too much work and the asylum procedure. Double factors which could have a positive or a negative impact on one's sexual health were defined as friends, upbringing and one's financial situation.

2.4 SEXUAL AND GENDER-BASED VIOLENCE VICTIMIZATION

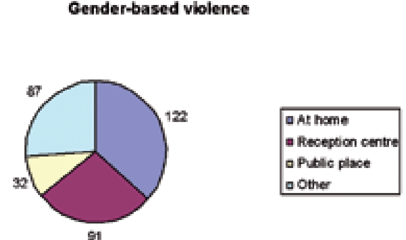
"He taught me to be a woman: with porn and forced group sex"
Russian Refugee

General: Coming to the part on victimization of sexual and gender-based violence we asked the respondents whether they knew a very close peer of them (also being a refugee, asylum seeker or undocumented migrant) who was victimized of gender-based violence in general and more specific of sexual violence since her/his arrival in Europe. This gave them the opportunity to answer in a third person if they wished so and us the opportunity to know if they also knew other close persons who were victimized. If they did know a peer, the identity of the victim and the perpetrator was asked for.

Among the 223 respondents, 57 didn't know anybody who had been victimized since his or her arrival in Europe. 166 respondents answered they did, and they described 332 cases of gender-based violence. 36,7% or 122 cases were committed in the home of the victim, 27,4% or 91 cases in the reception centre and 9,6% or 32 cases in a public place. If reasons for victimization were mentioned, in 18,5% of the cases (20) it considered an intercultural relationship, in 16,7% of the cases (18) it regarded a denial of asylum request, in 10,2% (11 cases) it regarded a refusal of sex or financial problems and on the fifth place came uncertainty due to the asylum procedure (9,3% or 10 cases).



Q Resp	Q cases	%
57	0	14.7
70	1	18
52	2	13.4
28	3	7.2
11	4	2.8
1	5	0.3
1	6	0.3
1	9	0.3
223	332	100



2.4.1 Description sexual and gender-based violence cases

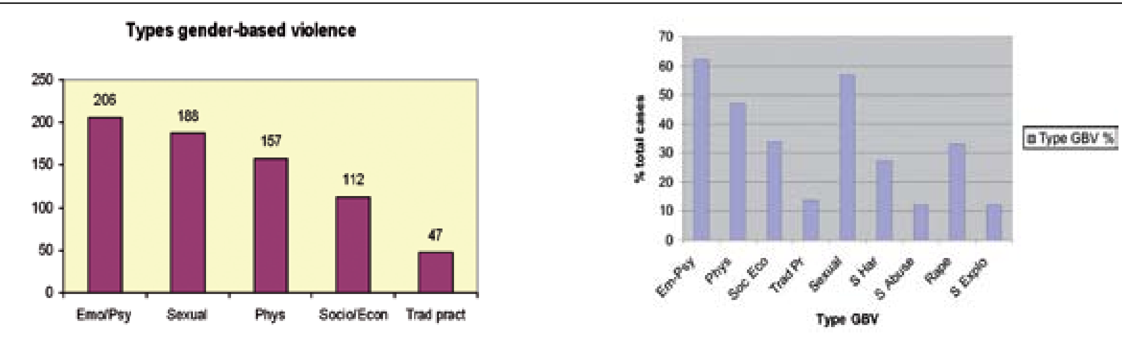
2.4.1.1 Identity of the victims

87 respondents or 39% of the respondents were personally victimized, this correspondents with 22,4% of the violence cases. 229 victims were an individual peer of the respondent (69% of the cases) and in 16 cases (4,8%) the victims were a group of people. They described this individual peer or peer group in 144 cases (43,4%) as an acquaintance like their neighbor or peer in the reception centre, in 68 cases (20,5%) as a friend and in 27 (8,1%) cases as a family member.

68% or 226 victims were women and 28% or 93 were men, 0,6% or 2 victims were transsexuals, the sex of the 10 other victims wasn't specified. The utmost victims belonged to the same ethnic group as the respondent (259 cases or 78%) 26 or 7,8% were of another ethnic group and 47 weren't specified. 175 victims (52,7%) were younger than 30 years old (17 a child, 51 an adolescent and 107 a young person) at the moment of the victimization and 131 (39,5%) were more than 30 years old. 132 victims for 39,8% were an asylum seeker in Europe at the moment of the victimization, 130 (39,2%) were a refugee and 30 (9%) were an undocumented migrant.

2.4.1.2 Types of gender-based violence victimization

62% or 206 cases are to be categorized as emotional-psychological violence, 56,6% or 188 cases as sexual violence, 47,3% or 157 cases as physical violence, 33,7% or 112 cases as socio-economic violence and 14,2% or 47 cases as traditional harmful practices. Among sexual violence we can make a distinction between sexual harassment 26,8% (89 cases), sexual abuse 12% (40 cases), rape/sodomy 33,4% (111 cases) and sexual exploitation 12% (40 cases).



- **Physical violence:** Among the 157 cases of physical violence, 46,8% (73 cases) were victimized of a single and non-life-threatening form of physical violence , 6,2% (24 cases) of a multiple and non-life-threatening form, 2,8% (11) of a single life-threatening , 7,7% (30 cases) of a multiple life-threatening form and 4,6% (18 cases) of murdering.

"Hitting is better than talking.
What he said hurt me more than getting slapped.
Sometimes being hit is easier to cope with than psychological torture."
Kurdish Asylum Seeker

- **Emotional-Psychological violence**: The three most mentioned forms of emotional-psychological violence are: emotional-psychological violence related to the asylum procedure (22,9% or 47 cases), confinement (22,4% or 46 cases) and humiliation (21% or 43 cases). These forms are followed by threat (15,6% or 32 cases), relational/family violence (9,8% or 20 cases), and an worsening combination form (5,9% or 12 cases) and verbal abuse (2,4% or 5 cases). Respondents in the Netherlands (68,1%) tended to report more cases of emotional-psychological violence than respondents in Belgium (38,6%).

- **Socio-economic violence**: The three most mentioned forms of socio-economic violence are: denial of legal aid or obstructive practice related to the asylum procedure (57,1% or 64 cases), denial of services and opportunities (22,3% or 25 cases) and discrimination/ racism (19,6% or 22 cases). 0,9% or 1 person was victimized on the basis of his sexual orientation. For socio-economic violence also, respondents in the Netherlands (41,8%) tended to report more cases of socio-economic violence than respondents in Belgium (18,9%).

- **Sexual violence**: Among sexual violence we can make a distinction between sexual harassment 26,8% (89 cases), sexual abuse 12% (40 cases), rape/sodomy 33,4% (111 cases) and sexual exploitation 12% (40 cases). The percentage and the number of respondents reporting sexual violence cases is higher in Belgium (41,7% or 55 respondents) than in the Netherlands (38,5% or 35 respondents)

Form of Sexual Violence		Number of cases	%
Sexual harassment	***89***		
Verbal invitation sex		46	53,5
Invitation+ threat		14	16,3
Porn		10	11,6
Sexual abuse	***40***		
Feeling up		14	35
Combination		13	32,5
Pinching		6	15
Rape/Sodomy	***111***		
Forced sex		35	32,4
Multiple/frequent		29	26,9
Single form		21	19,4
Gang rape		13	12
Sexual exploitation	***40***		
Transactional sex		19	47,5
Forced prostitution		8	20
Abuse of power		7	17,5

Sexual intimidation was mostly described as a verbal invitation to sex (53,5% or 46 cases), a combination of an invitation and a threat (16,3% or 14 cases) and thirdly as having to watch porn or being watched naked (11,6% or 10 cases).

> *"I had to watch him masturbating. This made me nervous, which he found very funny"*
> *Russian Refugee*

Sexual abuse was mostly described as feeling up (35% or 14 cases), as a combination of abuse forms (32,5% or 13 cases), and thirdly as pinching (15% or 6 cases).

> *"If I wanted an ice-cream, I had to lick the head of his soldier first"*
> *Russian Refugee*

Rape/sodomy was mostly described as forced sex in a relationship (32,4% or 35 cases), secondly as multiple or frequent rape (26,9% or 29 cases), thirdly as a single form of rape/sodomy 19,4% or 21 cases) and fifthly to a gang rape (12% or 13 cases).

> *"The boy had to work in an escort agency in Amsterdam,*
> *to pay back his journey to Holland"*
> *Kurdish Undocumented Migrant*

Sexual exploitation was mostly described as transactional sex (47,5% or 19 cases), forced prostitution (20% or 8 cases) and abuse of power (17,5% or 7 cases).

- **Harmful traditional practice**: in 68% of the cases it was honor-related violence (32 cases); in 27,7% of the cases it was forced marriage (13 cases) and in 2 cases (4,3%) it was a child marriage. More harmful traditional practices were reported in the Netherlands (14) than in Belgium (3).

> *"When the father heard that his daughter was raped, he killed her.*
> *He couldn't face his fellow citizens anymore after this terrible thing"*
> *Afghan Refugee*

2.4.1.3 Consequences of the victimization

68% of the victims (226 cases) had emotional/psychological effects of the victimization, 56,3% (187 cases) had socio-economical consequences, 44,6% of the victims (148 cases) had physical consequences of the victimization, and 18,1% (60) had to deal with sexual or reproductive consequences of the victimization.

> *"Fear, nightmares we all know it. My children can't support loud voices or noise.*
> *They are very kept to themselves. They forgot the meaning of the word "joy".*
> *Iranian Asylum Seeker*

- **Emotional-psychological & social consequences**: 121 cases of the 226 mentioned (53,5%) were described by the respondents as depression or as "being a psychological wreck". In

78 cases (34,5%) the victims were dispirited. In 52 cases (23%), the victims dealt with insecurity feelings. In 46 cases (20,4%) it concerned anxiety or fear. 13 victims had a mental illness (5,8%). In 45 cases the victims isolated themselves and didn't trust anybody anymore (19,9%). In 43 cases the violence had a negative effect on the victim's relation with her/his partner (19%). In 39 cases the violence had an effect on the victims relation with her/his child(ren), like being separated from them, neglecting them, or the children put in an institution (17,3%). 29 cases the victims were condemned by and expelled from their family or community (12,8%). Other consequences mentioned were sleeping disorders, shame, guilt, anger, frustration, hatred,…

"I called the police but they said: "Nothing happened,
the moment something has happened we will come!"
Kurdish Asylum Seeker

- **Socio-economic consequences**: In 24 cases the police was called but in 35 cases victims didn't put charge against the perpetrator out of fear or because they didn't know their rights. In 18 cases the perpetrator was arrested and in 44 cases the perpetrator ran free. 20 victims had no work or had to stop working because of the violence afflicted upon them. 24 victims fell behind in education because they were not allowed to school or dropped out because of the victimization. 31 victims lost everything including residence papers. Of 24 victims the respondents gave as a consequence that they could not participate actively in society. 18 victims did not receive any help for their psychological problems. And 18 victims had to switch from reception centre after the victimization.

- **Physical consequences**: 32,4% or 48 cases of the physical consequences mentioned (148 cases) had a fatal outcome: the victims either died of the immediate consequence of the violence or by having successfully committed suicide after the violence. 12 other persons tried to commit suicide after the victimization but did not succeed. 19,6% was severely injured (29 cases) and 13,5% had to be hospitalized (20 cases). Other consequences mentioned were unconsciousness, bruises, bleeding, being exhausted, heart problems, gastrointestinal problems, loss of weight, and several other physical complaints.

"My ass was a raw chunk of meat"
Russian Undocumented Migrant

- **Sexual and reproductive consequences**: For 25 victims the consequence of the victimization was that the violence continued. 22 victims had sexual disorders. 15 victims had an unwanted pregnancy, 2 had a miscarriage due to violence and 3 had a forced abortion. 2 other victims became HIV positive after the victimization.

2.4.1.4 Identity of the perpetrators

175 perpetrators acted as an individual (52,7%), 156 committed the violence in group (47%) and two respondent said to be a perpetrator themselves. 241 perpetrators were male (72,6%), 20 female (6%), in 5 cases the perpetrators were both male and female and of 65 perpetrators the sex was not specified by the respondent. In 107 cases the perpetrator was of the same ethnic group as the victim (32,2%) and in 61 cases (18,4%) the perpetrator was of another ethnic group than the victim. In 103 cases (31%) the perpetrator was specified to be a Belgian or a Dutchman.

The bulk of the violence was perpetrated by adults: 219 cases (66%). 37 perpetrators (11,1%) were young people and 6 were adolescent when they committed the violence. In 70 cases the age of the perpetrator was not specified by the respondent. Taking the residence status into account, the biggest group of perpetrators were autochthons (Belgians/Dutchmen:113 cases or 34%), 68 were an asylum seeker (20,5%), 56 a refugee (16,9%) and 4 were an undocumented migrant (1,2%).

In 102 cases (30,7%) the perpetrator was the current or ex-partner of the victim. In 87 cases (26,2%) this violence was committed by persons in charge or authorities. 13 of these 87 cases were committed by service providers in the asylum procedure (reception centre or public centre of social welfare) According to the respondents in 42 of these 87 cases this violence was committed by the government of the host country or the Minister in charge. Other persons in charge mentioned were police officers, teachers, smugglers, the lawyer, the boss, et cetera. In 53 cases (16%) the violence was perpetrated by family members, in 11 cases (3,3%) by friends, in 49 cases (14,8%) by acquaintances as peers in the same reception centre, neighbors or friends of the family. In 40 other cases (12%) the perpetrators were unknown to the victim.

2.4.2 Definition of sexual violence

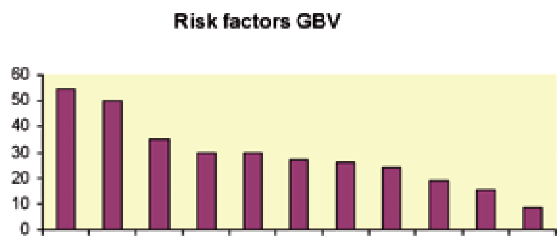
37,7% of the respondents defined sexual violence as un unwanted sexual act or sexual act without consent. They described this mostly as “a violation of someone’s rights”, “using power or violence to get something done by people” or “passing personal limits of other people”.

12,6% of the respondents defined sexual violence as sexual intimidation and described this as “verbally abusing someone”, “getting sexual comments”. 26,9% said sexual violence was sexual abuse, and described this mostly as “unwanted violent sexual contact”, “unwanted feeling up”, “coerced sexual acts” and “forced kissing”.

37,2% said that sexual violence was rape our attempt of rape. They described this as “rape”, “enforce sex with violence”, “sex without the consent of women” and “sex without being able to give consent” 2,2% related sexual violence with sexual exploitation and described this as “forced marriages”, “sex for food, work or papers”

2.4.3 Risk factors of victimization

Asking the respondents about what factors had an influence on becoming a victim of sexual and gender-based violence, we got the following answers:



On the first place came bio-psychosocial factors as important risk factors: 54,7% (122 respondents). This was closely followed by the lack of a social network (50,2%) (112 respondents). The third most important risk factor mentioned was economic hardship (35%) (78 respondents) and the fourth position was shared by the residence status and the lack of knowledge and information (29,6% or 66 respondents). Coincidence was mentioned by 27,4% of the respondents, mental health by 26,5%, 24,2% mentioned gender factors (65 respondents), cultural norms and values (18,8%), physical environment (15,2%), and general law (8,5%).

Among bio-psychosocial factors the most mentioned descriptions were drug/alcohol addiction (38,2%), choice of clothes (26,2%), verbal and non-verbal attitude (23%), being alone on the streets at night (18%) and being naïve (11,5%). Having a lack of network as a risk factor was mostly described as having no safety network/nobody to turn to (28,6%), to trust other people to fast (25%) and having bad examples as friends or parents (23,2%). Economic hardship factors were especially described as having a bad financial situation (48,7%), poverty (30,8%), taking risks to earn some money (15,4%).

Lack of knowledge and information as a risk factor was mostly described as a lower level of education (37,9%), not knowing the language and culture of the host country (30%), a lack of sexual knowledge (22,7%), upbringing (18,2%), lack of knowledge of self defense (15,2%) and lack of knowledge of one’s rights (13,6%). Among residence status factors having an influence on victimization, the respondents firstly mentioned having no legal residence permit as a major risk factor (49,2%), secondly the unprotected status of refugees, asylum seekers and

undocumented migrants (46,2%) and thirdly the fact of not having rights as an asylum seeker or undocumented migrant.

Mental health as a risk factor was above all described as being down (40,7%), having no self confidence (27,1%), being mentally ill (23,7%) and having not a lot of brains (13,6%). Among the gender factors the most mentioned descriptions were: being weaker as a woman (52,3%), when girls are too free and when women are beautiful (together 15,4%).

2.5 PREVENTION

General: Coming to the part of prevention we first asked the respondents what and whom has an influence on prevention: what can a person do to prevent victimization of sexual and gender-based violence, what can other persons do and which other things could help in prevention? We categorized their answers in the same way as the risk factors. Furthermore, we asked which suggestions they have for prevention tools for adults and for youth. Finally we asked whether they would like to participate in prevention of sexual and gender-based violence against refugees, asylum seekers and undocumented migrants in Europe, and if yes, what they would like to do.

2.5.1. Preventive factors on micro/meso/macro level

- **Micro level:** We firstly considered all preventive factors on the micro level, this is the level of the potential victim as an individual. The three most mentioned factors were bio-psychosocial factors as biology/behavior (48,9% or 109 respondents), followed by having knowledge and information (88 respondents or 39,5%) and having a social network (62 respondents or 27,8%).

  The bio-psychosocial factors were mostly described as: avoid risks (21,1%); be careful, also in relationships (15,6%); choose well the clothes you are wearing (15,6%); avoid drugs and alcohol (15,6%); be clever and defend yourself (both 6,4%). Having knowledge/ information was most often described as: inform yourself and upbringing (both 18,2%); sexual education (11,4%), working together in prevention of violence (10,2%). Having a social network was defined as avoiding relationships with unknown persons/bad friends (30,6%), choosing your friends carefully (27,4%), not trusting unknown people (11,3%).

  Furthermore they mentioned factors of mental health (38 respondents or 17%), having access to health care & services (31 respondents or 13,9%), coincidence (13,5% or 30 respondents), physical environment (22 respondents or 9,9%), cultural norms and values (14 respondents or 6,3%) and gender (2,2% or 5 respondents).

Mental health factors were described as being self-confident (36,8%), knowing your own limits (23,7%), having a strong mind (21,1%) and firstly respect yourself before you respect another (13,2%) Having access to health care & services was defined as notifying the police (74,2%), looking for help/aid of clever people (19,4%), looking for legal aid (16,1%). Coincidence factors were defined as you can not prevent violence from happening (16,7%) or it is very difficult to prevent it (13,3%). Physical environmental factors were described as: avoiding criminal districts or dangerous places (59,1%), trying to live in a safe environment (31,8%) and not going out alone (50%). Cultural norms and values were described as being faithful (42,9%) and to live according to the communities' rules (28,8%).

MICRO	Nr of resp	%	MESO	Nr of resp	%	MACRO	Nr of resp	%
Bio/behavior	109	48,9%	**Social**	118	52,9%	**Info**	96	43%
Info	88	39,5%	**Info**	112	50,2%	**Legislation**	90	40,4%
Social	62	27,8%	**Access health care**	37	16,6%	**Status**	46	20,6%

- **Meso level**: The meso level is the level in which we consider the individual in relation with her/his partner, family, friends, peers and other people. According to the respondents, the most important preventive factors on the meso level are: having a social network (118 respondents or 52,9%), having knowledge/information (112 respondents or 50,2%) and having access to health care and services (37 respondents or 16,6%).

  On the meso level, having a social network was defined as: giving support and trust to the victim (33,9%), knowing people who react when violence occurs (25,4%) and social and parental control (16,9%). Having knowledge/information was described as general information & education (both 21,4%), sensitization & advice of parents on risks (both 20,5%), talking about sex & risks (12,5%) and finally making violence debatable (12,5%). Having access to health care and services was being defined as: inform the police and services (40,5%) and calling for aid (24,3%).

- **Macro level**: The macro level is the level in which we consider the interaction between the individual, her/his social relations and the society and its laws, policies, facilities and institutions as a whole. The respondents answered that on the macro level, provision of knowledge/information is the most important (43% or 96 respondents), then the overall legislative framework (40,4% or 90 respondents) and thirdly the residence status and rights going hand in hand with the status (20,6% or 46 respondents).

2.5.2 Definitions of prevention tools

Asking the respondents what kind of prevention tool or prevention practice should be developed for adults and for youth, the same order of preferred actions or tools was given. First of all, a prevention tool should enhance knowledge and provide information (54,7% or 122 respondents) According to the respondents who answered this, this could be done through sensitization (15,6%), education on sexual health, risks and sexual and gender-based violence (13,9%) giving training to refugees about their rights (12,3%).

Secondly, the overall legislative framework should be adapted in order to be more preventive (77 respondents or 34,5%) Respondents suggested this could be done through assuring a better protection against violence by the government (19,5%), enforcing the law against violence (19,5%) and enhancing the public safety (14,3%).

Thirdly, the system of residence status and rights should be changed in order to enhance the refugees, asylum seekers and undocumented migrants' possibilities to enjoy rights and to participate actively in the host society. The respondents said this could be done by giving refugees, asylum seekers and undocumented migrants the right to work (29,7%) through shortening the asylum procedure (23,4%) and through assuring that refugees, asylum seekers and undocumented migrants know well their rights and duties (20,3%).

Type of Preventive Action	% of Respondents
Information	54,7
Sensitization	15,6
Education	13,9
Training	12,3
Legislation	34,5
Protection	19,5
Law	19,5
Safety	14,3
Status	
Right to work	29,7
Shorter procedure	23,4
Rights and duties	20,3

This top 3 is followed by 3 preventive tools or actions which were given the same importance by 53 respondents or 23,8%. They said that enhancing social networks of refugees, asylum seekers and undocumented migrant would be a preventive factor for 23,8% of the respondents (53). They described this as making that parents and children are good friends (15,1%), enhancing

networks among the same age groups (13,2%), by organizing meetings in which people can share their experiences and feelings (11,3%) and by empowering people's self-confidence (11,3%).

Enhancing access to health care and services was described as having organization to which a refugee, asylum seeker or undocumented migrant can go feeling at ease (26,3%), having services which are safe and trustworthy for refugees, asylum seekers and undocumented migrants (22,6%) and psychological assistance to refugees, asylum seekers and undocumented migrants (15,1%)

Working with cultural norms and values could be preventive for 23,8% or 53 respondents. For 24,5% discrimination should be tackled, for 22,6% this could be done through using the press, for 13,2% by giving information to autochthons of the host country about refugees, asylum seekers and undocumented migrants (13,2%). When asked whether these tools and actions would work for both women and men 88,8% or 198 respondents answered yes. For youth they specified that the tools and actions should be adapted to their own language and culture.

2.5.3. Participation in prevention by respondents

When we asked participants whether they would like to participate in prevention actions or in the development of prevention tools, 71,3% or 159 respondents said yes. When asked what they would like to do, 79 respondents said collaborating in providing information, like sharing her or his own experience, give education or advice and disseminate information. 40 respondents said that they would like to collaborate in networking. When asked how we could reach them, 78 respondents said via the community researcher. Others gave their phone, e-mail or post address.

2.6 CONCLUSION

"I live in an unlivable situation"
Somali Undocumented Migrant

In conclusion, from the arrival on European territory onwards, young female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several types of gender-based violence. According to the 223 respondents participating in this participatory research project, prevention of sexual and gender-based violence against refugees, asylum seekers and undocumented migrants in Europe can be done on three levels.

On the personal or micro level prevention should focus on behavioral change and on the enhancement of social capital. On meso or socially interactive level, prevention should focus on the enhancement of social capital and the access to health care and services. On the macro or societal level, prevention should firstly enhance general knowledge of sexual health and awareness of sexual and gender-based violence risk and preventive factors. Secondly the overall legislative framework should be adapted in order to be more preventive and thirdly, the system of residence status and rights should be changed in order to enhance the refugees, asylum seekers and undocumented migrants' possibilities to enjoy rights and to participate actively in the host society. The utmost majority of respondents is willing to participate in prevention of sexual and gender-based violence against refugees, asylum seekers and undocumented migrants in Europe.

"You need healthy people to have a healthy society"
Afghan Refugee

"I had no papers and no money, so I only had one option: to be his slave."

Russian refugee

"Hidden Violence is a Silent Rape" Seminar

"I didn't have any papers but worked as transvestite in a club. One evening a man said I was very juicy and invited me to perform on his birthday party. There were about 40 men or more, most of them had taken drugs. Me too. They started to dance and to undress. They tied me up and I had to watch them masturbating. They rubbed me with liquor and syrup and licked my body. This was awful! That bunch of naked men with burning eyes, they started to fuck me all, it didn't stop. When I opened my eyes they had thrown me away in a park in Ghent. I had to go to the doctor because my anus was as a raw chunk of meat and my penis was blue. After a while I heard I have AIDS, from whom I do not know, the only thing I know is that I'm going to die. I feel terrible because I cannot work to pay my medical bills."
Undocumented transsexual migrant,
died of AIDS in Belgium shortly after the interview

CHAPTER 3: SEMINAR PROCEEDINGS

Written by Ruth Wilson & Vivienne Brown

3.1 Introduction to the Seminar

3.1.1 Background

From the arrival on European territory onwards, young female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several types of gender-based violence. This is one of the conclusions that can be drawn from a community-based participatory research project that has been conducted in Belgium and the Netherlands. The aim of the project is twofold: to develop a prevention tool which can be used by refugees and asylum seekers themselves, and to raise awareness on this topic through participatory research.

With EC Daphne funding, this project is steered by Belgian (ICRH-University Ghent, Zijn, Nederlandstalige Vrouwenraad), Dutch (MOVISIE, Pharos) and British (Tandem) research bodies and organisations active in the field of gender-based violence, women's rights and health of refugees. It has been conducted in close partnership with 21 community researchers and a large community advisory board.

3.1.2 Purpose

During the Seminar 'Hidden Violence is a Silent Rape: Prevention of Gender-Based Violence against Refugees and Asylum Seekers in Europe" the partners presented the process and outcomes of the project to a wide range of stakeholders from across Europe. The aim was to highlight the innovative participatory approach; the research results and to launch the prevention tool.

The seminar also set out to formulate policy and practice recommendations. It did this through eight workshops with speakers representing different areas of good practice, from many different European countries. These recommendations were then discussed with a panel of policy makers on European, national and regional level.

3.1.3 Outcomes

The recommendations formulated at the Seminar represent a commitment by the 150 participants to take seriously the health of refugees, asylum seekers and undocumented migrants in Europe, and to further develop policy and practice that prevents gender-based violence.

The research report, the Seminar Recommendations and the prevention tool are being widely disseminated, and can be downloaded from www.icrh.org The partners will work to raise the profile of the publications, and will promote the recommendations.

3.2 Seminar Program

Thursday, February 14th, 2008 - Het Pand, Ghent, Belgium

09.00 – 09.30	Registration & Welcome drink *(Kapittelzaal – ground floor)*
09.30 –11.00	PLENUM I *(Conference Room: Refter – ground floor)*
09.30	Welcome speech: Prof. Dr. Marleen Temmerman, ICRH Director
09.40	Introduction to seminar: Sigrun Jorissen, Vice-president of Nederlandstalige Vrouwenraad (NVR, Belgium)
09.50	Context introduction: - Refugee overview EU & policy: Katrine Camilleri (JRS, Malta, Nansen Refugee Award 2007) - Refugee health: Loes Van Willigen (Consultant Health & Human Rights, the Netherlands)
10.35	Presentation project: Esra'a Khalaf, Havan Faris, Bashir Yusuf (Community Researchers)
11.00 – 11.30	Coffee & tea break *(Kapittelzaal – ground floor)*
11.30 –12.30	PLENUM II (*Conference Room: Refter – ground floor)*
11.30	Chair
11.35	Presentation research results: Ines Keygnaert, ICRH Researcher
12.00	Panel with partners and community researchers: Mahtab Safaipour, Ramin Bahrami, Natalia Shulga & Takhir Iminov (Community Researchers), Koen Dedoncker (vzw ZIJN), Najla Wassie (Pharos), Hilde Bakker (MOVISIE), Marijke Van Petegem (NVR), Ruth Wilson (Tandem), Ines Keygnaert (ICRH)
12.35 – 13.30	Lunch *(Kapittelzaal – ground floor)*

13.30 –14.45 WORKSHOPS PART I

Workshop 1: Law, Rights & Police *(Conference room: Zaal Rector Blancquaert – 3rd floor)*
Chair: Aintzane de Aguirre (UNHCR, Belgium)
Speakers: Katrine Camilleri (Jesuit Refugee Service, Malta) & Tanja Windbüchler (Intervention Centre Domestic Violence, Austria)

Workshop 2: Sexual exploitation *(Conference room: Oude Infirmerie – 2nd floor)*
Chair: Patricia Kennedy (University College of Dublin, Ireland)
Speakers: Pieter Lauwaert (Payoke, Belgium) & Dovile Rukaite (Women's Issues Information Centre, Lithuania)

Workshop 3: Health care after SGBV *(Conference room: Refter– ground floor)*
Chair: Peter Decat (ICRH, Belgium)
Speakers: Angela Burnett (Medical Foundation for Care of Victims of Torture, UK) & Kristien Roelens (University Hospital Ghent, Belgium)

Workshop 4: Male Abuse(d) *(Conference room: Priorzaal – 1st floor)*
Chair: An-Sofie Van Parys (University Hospital Ghent, Belgium)
Speakers: Ben Serkei (MOVISIE, Netherlands) &
Guy T'sjoen (University Hospital Ghent, Belgium)

14.45 – 15.15 Coffee & tea break *(Kapittelzaal – ground floor)*

15.15 –16.30 WORKSHOPS PART II

Workshop 5: Empowerment in prevention *(Conference room: Refter– ground floor)*
Chair: Kristin Janssens (MOVISIE, the Netherlands)
Speakers: Albena Koycheva (Bulgarian Gender Research Foundation) &
Jan Breyne (OOOC De Morgenster, Belgium)

Workshop 6: Community participation in prevention *(Conference room: Zaal Rector Blancquaert – 3rd floor)*
Chair: Ines Keygnaert (ICRH, Belgium)
Speakers: Cristina Florescu (OFRR, Romania) & Antonio Salceda de Alba (Hospital Punta de Europa, Spain)

Workshop 7: Intercultural help-lines in prevention & care *(Conference room: Oude Infirmerie – 2nd floor)*
Chair: Marianne Cense (RNG, Netherlands)
Speakers: Sibille Declerq (Kinder- en Jongerentelefoon, Belgium) & Rusen Canpolat (Terrafem, Sweden)

Workshop 8: Awareness raising in prevention *(Conference room: Priorzaal – 1st floor)*
Chair: Bieke Machiels (Fedasil, Belgium)
Speakers: Ildikó Szász (Menedék, Hungary) &
Ingrid Stals (Police Antwerp, Belgium)

16.30 - 17.00 Closure: Simone Kortbeek, director MOVISIE *(Conference Room: Refter – ground floor)*

17.00 – 18.30 Café Contact: Exchange of good practices and tools *(Conference room: Kapittelzaal – ground floor)*

19.00 Seminar dinner for invited guests

Friday, February 15th, 2008 - Het Pand, Ghent, Belgium

09.00 – 09.30	Registration & Welcome drink *(Kapittelzaal – ground floor)*
09.30 –10.45	PLENUM III *(Conference Room: Refter – ground floor)*
09.30	Summary Day 1 & Programme Day 2: Prof. Dr. Marleen Temmerman, ICRH Director
09.40	Desirable Prevention: Prof. Dr. Nicole Vettenburg, (Ghent University)
10.00	Presentation of prevention tool & panel: Hilde Bakker (MOVISIE), Koen Dedoncker (vzw ZIJN), Baharak Pourmirzajan (Community Researcher), Marijke Van Petegem (NVR), Ines Keygnaert (ICRH)
10.45 – 11.15	Coffee & tea break *(Kapittelzaal – ground floor)*
11.15 –12.45	PLENUM IV *(Conference Room: Refter – ground floor)*
11.15	Presentation policy recommendations: Ruth Wilson, (Tandem Com,UK)
11.30	Panel policy makers chaired by Gie Goris (Chief editor Mo Magazine, Belgium): - Anne Van Lancker (Member of the European Parliament, sp.a, Belgium) - Prof. Dr. Marleen Temmerman (ICRH Director, Senator, Belgium) - Blanche Tax (European Affairs Officer, UNHCR, Europe) - Paola Pace (Research Officer, IOM, Switzerland)
12.30	Closure: Prof. Dr. Marleen Temmerman, ICRH Director
12.45 – 14.30	Performance “Migration in Jewels in Migration” & walking dinner

Throughout the Seminar there were two exhibitions. The first one was with quotes and excerpts of the conducted in-depth interviews as well as the designs of the prevention tool post-cards. The second one was the “Migration in Jewels in Migration “ exhibition from Villa De Bondt.

3.3 Conference Presentations Day 1

3.3.1 Opening speech and introduction to the Seminar

Prof. Dr. Marleen Temmerman, Director, ICRH; Full Professor Ghent University; Senator, Belgian Federal Government

Good morning. It is my pleasure to welcome you all to this Seminar on prevention of sexual and gender-based violence.

First a short introduction – I am a medical doctor, a gynaecologist by training and founder and director of ICRH at the Ghent University. I have also become active in politics: I am a Senator, which gives me the opportunity to try to translate some of the recommendations that research and action groups make.

ICRH is coordinating this project and runs similar research and prevention projects and has partners across the world. We are involved in a project on violence against pregnant women in Belgium for instance but also in projects in East Congo where rape is used as a weapon of war. In the project we present today we focus on violence against vulnerable people in Europe: refugees, asylum seekers and undocumented migrants.

Violence against them remains often hidden, and when there is a hidden problem, it is important to bring it upfront and translate it into dimensions and figures, in other words: to research it. And in this project this meant not only to research it in a quantitative way but also in a qualitative way working with a community-based participatory approach in Belgium and the Netherlands. And it did not stop with the research part, we also developed a practical tool which can contribute to the prevention of sexual and gender-based violence against them.

The whole project we are marking at this seminar is the responsibility of six partners in three countries: the Dutchspeaking Women Council (Nederlandstalige Vrouwenraad (NVR)), ZIJN and ICRH from Belgium; Two Dutch partners: MOVISIE and Pharos. And from the UK: Tandem Communications.

The project started in April 2006, and ran for two years. It is coming to an end now. It has been sponsored by the EC Daphne Fund – a funding programme within the European Commission that focuses mainly on projects against sexual and gender-based violence, violence against women and children. The EC Daphne funding for this project was limited, so the seminar has been co-funded by Belgian Lottery Fund- and the prevention tool is co-funded by VWS from the Dutch Ministry for Health, Wellbeing and Sports.

I hope you all have an interesting seminar, a seminar which can add another important step in the prevention of sexual and gender-based violence. I am happy to give the floor to our chairperson Mrs Jorissen, Vice president of the Dutchspeaking Women Council.

3.3.2 Chairperson’s introduction

Sigrun Jorissen
Vice president of Nederlandstalige Vrouwenraad (NVR)

Good morning and thank you Mrs Temmerman.

I am a member of the Dutch speaking Women Council, de Nederlandstalige Vrouwenraad. We are a partner in this project to explore the prevention of gender-based violence against asylum seekers, refugees and undocumented migrants, so I am here as moderator of the day. I am not going to say much: we are an umbrella organisation of 40 female organisations in Flanders, we have been working since 1905 and have been developing policy recommendations concerning the themes of violence and refugees.

Our first speaker is going to provide context and an introduction to the issues that we shall be exploring in more detail through the seminar. She is Katrine Camilleri, a lawyer based in Malta, who has been working for 10 years with refugees, helping with legal advice, and that is why she is here. She received the Nansen Refugee Award in 2007.

3.3.3 Overview of EU policy and the situation of refugees, asylum seekers and undocumented migrants in Europe today: key issues

Katrine Camilleri, Jesuit Refugee Service, Malta; Nansen Refugee Award 2007

Key issues in the EU policy and situation of refugees, asylum seekers and undocumented migrants in Europe today is an extremely vast topic. It is impossible to cover in the time allocated, even if I were to restrict myself to the most important issues.

I have therefore chosen to focus on just three issues which I consider to be extremely pressing and urgent.

- The ever increasing focus on immigration control and its impact on protection;
- The ever-increasing use of detention;
- The fact that large numbers of migrants are forced to live in destitution.

I should state at the outset that I am not an expert on EU policy nor do I have first hand knowledge of the situation on the ground in the countries across Europe. My experience is linked to the situation in a very particular corner of the EU, where the reality is extremely different to that in most other countries; this no doubt influences my decision on what constitutes a 'key' or fundamental issue.

But I believe that the issues I have selected are relevant not only to the Mediterranean but to other parts of the EU. I will start my presentation this morning with something that an asylum seeker from Eritrea, who was detained in one of Malta's centres for irregular migrants, told us. I have chosen to do this not only because it's a good way to make a point, but also because it is very important to remember that although we are talking about policies, situations and issues, in the ultimate analysis this is all about people and the impact that laws, policies and practices have on their lives.

> He said: *"Before we were slaves by force. Now we are coming by ourselves to be slaves."*
> Anday, an Eritrean asylum seeker in Malta

Chilling words, particularly when you think that this is an asylum seeker's description of his predicament and that of his fellow asylum seekers. Possibly some might feel that his comment is unjustifiably harsh – after all, we do our best. But perhaps it is good to ask why he is claiming that today's migrants are like the slaves of old. Whether it is true that they have totally lost control over their lives and their future.

Access to territory

Anday is just one of the many thousands of migrants, uprooted by war, persecution, poverty, deprivation, lack of opportunity, oppression and human rights violations, who came to Europe in search of security and the chance to live with dignity.

The vast majority of the asylum seekers we are meeting in Malta – like many of those who arrive in Europe through its Southern borders – have undertaken an extremely dangerous journey: they have travelled thousands of miles through the Sahara desert, possibly one of the most harsh and bleak terrains in the world, and then the sea, often in small or unseaworthy boats.

Not all of them need protection, so they would not be considered 'genuine' refugees. Yet, speaking to migrants held in Malta's detention centres, it is clear that all without exception believe that they had no choice but to leave.

In the words of one asylum seeker from Congo:
"If you are safe in your country you cannot leave. Those who are safe stay in their country. To cross many countries – to cross the desert, to cross the Mediterranean Sea – is not safe because you can be killed for your money; you can drown in the rough seas… We took these risks only because we are human beings trying to find freedom."
Francois, an asylum seeker from Congo detained for almost 19 months between 2004 and 2006

And, if we were to be honest, we would acknowledge that, for many asylum seekers, the only way they can reach a place of freedom and security is by travelling and entering illegally. Even if they managed to obtain a passport, no State would issue them with a visa to enter to seek protection.

On the contrary, in recent years the focus of EU immigration policy has shifted increasingly towards immigration control. States are putting in place ever more stringent border control measures, not only within their own territory but also in third countries, through immigration liaison officers, interception activities and carrier sanctions, intended to prevent irregular migration and combat international criminal activity and security threats.

It is clear that states have a right to control irregular migration. However, in practice, the lack of legal channels to access protection means that asylum seekers are being increasingly forced to use the same channels as irregular migrants to gain access to a territory where they can seek protection. As a result they are also subject to the same restrictive border controls.

During their journey, migrants are at the mercy of the elements and, possibly more frightening, of the powers that be, whose main concern, it seems, is to keep them out. It matters little that a significant proportion of the migrants trying to enter the EU may need international

protection[1], that they will face serious harm if sent back home. Their individual needs are forgotten as states focus on protecting their borders and stemming the flow of uninvited migrants.

All too often, particularly during the summer months, migrants are left stranded, making desperate calls from sinking boats, clinging to tuna pens or crowded on board the vessel that rescued them from certain death, while states wrangle over who should take them in.

At times the crew of merchant vessels who save migrants in distress and bring them to shore, against the will of the state concerned, face criminal proceedings for aiding and abetting illegal immigration, as happened in the case of the Cap Anamur.

In an attempt to coordinate border control more effectively and avoid “humanitarian tragedies”, Frontex, the EU border agency, conducted patrols off Malta and Spain last summer. It was reported that during the first phase of the Nautilus II operation off Malta alone, more than a thousand lives[2] were saved and more than 700 irregular immigrants were intercepted. The Hera III mission off Spain reportedly intercepted a further 1,500 irregular immigrants trying to reach southern Europe[3].

These statistics beg the question: what happened to the migrants intercepted? Were any migrants sent back to their point of departure during these operations? If so, was any effort made to determine whether they were in need of international protection before they were refused access to EU territory? Were they forced to turn back to a place where they would be able to obtain protection if they needed?

Listening to the testimonies of asylum seekers in Malta’s detention centres, one cannot but be concerned about the fate of any migrants who were forced to turn back. Most of them transited through countries bordering the EU, having lived there for months or, at times, years, before deciding to move on in search of protection.

They speak of a life characterised by fear and insecurity, facing discrimination and hostility from the local population and constantly at risk of imprisonment and deportation. A number of them were imprisoned for weeks or months in terrible conditions, because of their irregular migration status, and some were actually deported. Women are particularly subject to exploitation and abuse not only throughout the journey but also during their stay on countries of transit.

They insist that it is impossible to obtain effective protection there, particularly in those countries that have not yet signed the 1951 Convention.

1 On average since 2002 nearly 48% of applicants received protection.
2 Times of Malta, Wednesday September 19, 2007
3 http://ec.europa.eu/avservices/services/showShotlist.do?out=PDF&lg=En&filmRef=53533

It should be stated, in fairness, that countries bordering the EU must deal with huge numbers of migrants both residing in and transiting through their territory. This has been acknowledged by the EU, which has pledged support for these countries to combat illegal immigration. Many times, for example, in the case of the bilateral agreement between Italy and Libya, such support has taken the form of building detention centres, providing equipment, setting up joint patrols and financing deportations[4].

Such solutions are destined to fail as they ignore the reasons why people are moving. As long as people are unable to live with dignity in their country they will move in search of something better. More effective border controls will simply mean that their journey will be harder and more risky, but it is unlikely to stop them from moving.

Moreover, they completely ignore the fact that a significant number of people need protection – that they will face harm if sent back home. Although this is clearly not about migrants, refugees and asylum seekers within EU territory, it is very much about the impact of policies, measures and controls implemented by EU MS on the quality of protection. It is also very much about some, though clearly not all, of the people who are coming to the EU in search of asylum. About where they are coming from and what they have been through – which inevitably shapes who they are and impacts on their physical, mental and psychological health.

Detention

Those migrants who make it to shore are often forgotten yet, many times, their troubles are far from over.

Although the content and scope of international protection is far from uniform across the EU, MS apply rules (the Dublin regulations) that severely restrict the asylum seeker's choice about where to seek asylum, although in fact they have every reason to pick and choose given the different standards applicable in different countries.

The application of these rules causes significant difficulties and hardship for asylum seekers in Europe and further limits their ability make choices about their life and their future. Some believe that it has also contributed to a significant increase in the number of asylum seekers who choose not to apply for asylum.

Migrants who do apply for asylum are faced with a confusing array of laws and regulations, which they often find very hard to understand. This could be due to various reasons – language barriers, lack of proper information, or the fact that they come from countries where structures and procedures are totally inexistent.

4 EP Delegation to Libya – European Parliament – News – Press Service – 08.12.2005, on bilateral agreement to fight illegal immigration between Italy and Libya

Matters are often made worse by the fact that they have a deep seated mistrust in all things official as a result of their experiences in their countries of origin and in countries of transit. Asylum seekers' stories are subject to extreme scrutiny by officials working within the asylum process, who have the thankless task of trying to assess credibility, often in the lack of any tangible evidence. Unfortunately many of them fail the test.

> *"To be rejected is so hard… it makes you think that what you are and what you are saying is just not understood… You are rejected because they didn't believe you."*
> *F., an asylum seeker from Congo detained for almost 19 months between 2004 and 2006*

While credibility assessments are more than legitimate, perhaps it would be useful to ask whether the standards we are imposing and the criteria we are using to assess credibility are realistic.

Another major issue is detention, which in many states has become an accepted means of immigration control. At times it seems as if the fundamental right to personal liberty has been turned on its head and there is an almost unquestioned assumption that detention is the only option available.

Migrants often languish in detention for months, awaiting deportation or a final decision on their asylum application. More often than not, migrants are detained in conditions which fail to meet internationally accepted standards, in over-crowded detention centres, which lack the basic necessities and fail to guarantee an acceptable standard of living. At times these put migrants and asylum seekers, at risk of further harm and make them vulnerable to abuse.

Research conducted by the Jesuit Refugee Service (JRS) and partner organizations from the 10 MS that acceded to the EU in May 2004 shows that often detainees are extremely isolated and are unable to obtain essential information or access basic services including legal assistance. This inevitably has a negative effect on the asylum procedures.

Often migrants may be detained for very long periods of time (Malta), however the said research indicated that often national legal systems often fail to provide sufficient guarantees of protection from arbitrariness, such as regular review of the decision to detain and, for migrants deprived of their liberty, the courts are often both legally and practically inaccessible.

In addition to being objectionable on human rights grounds, detention is also an issue of major concern because of the hardships it causes to people who, in many cases, have already suffered so much.

Destitution

Even migrants and asylum seekers living in the community often face extreme hardship. The situation is far worse when they have no legal status, however research conducted by JRS Europe

in seven countries indicates that destitution is experienced by a wide variety of migrants with different legal status. These include asylum seekers at appeal stage of the procedures, rejected asylum seekers and irregular migrants.Often, these migrants either cannot or do not want to return home.

As a rule destitute migrants have little or no access to public goods and services, in terms of healthcare, employment, housing, financial support and material assistance such as food and clothing. In most cases destitute migrants cannot work legally and they are often wholly dependent on the charity of family members, NGOs, religious organizations and community networks for their survival. This has a very detrimental effect on both the physical and psychological health of the migrants concerned. Moreover the impossibility of earning a livelihood legally makes people extremely vulnerable to exploitation and abuse.

Conclusion

The fact that Europe is receiving what it perceives as large numbers of migrants, perhaps many more than it wants, cannot justify a lowering of accepted standards of protection, and a failure to respect freely assumed legal obligations in terms of international law.

European and international law obliges us to ensure that people are not, directly or indirectly, sent back to a place where they will face persecution or other serious violations of their human rights. They oblige us to ensure that all those within our effective jurisdiction who need protection are able to obtain it. They also oblige us to receive migrants and asylum seekers in a manner which respects their human dignity.

In the ultimate analysis, the measure of our commitment to human rights must surely be how we treat those among us who are most vulnerable and powerless; those who have no vote and, often, no voice.

3.3.4 Key health issues of refugees and asylum seekers

Loes Van Willigen
Consultant Health and Human Rights, The Netherlands

Ladies and gentlemen, dear colleagues, let me first congratulate the project leaders of Hidden Violence is a Silent Rape with the choice, aim and title of their project.

When I was invited to speak at this significant seminar my thoughts went amongst others to Zarah, a young Koptic woman from Egypt, who consulted me in the 1980s, when I was practicing as medical doctor for refugees. Zarah sought asylum in the Netherlands because of intimidation and threats by Muslims in her home town. Her family had an important position in the Koptic church. Her mother died when she was young; her father died one year before

under very suspicious circumstances. When she arrived in the Netherlands she did not know where to turn to. An Arab speaking man she met in the centre of Amsterdam offered to bring her to the immigration service and the Dutch Refugee council, but in exchange he forced her to have sex with him.

After being housed by the Dutch Refugee Council, she consulted me about various health problems, such as headaches, belly aches, problems with sleeping and nightmares. Little by little she related her first experiences in Amsterdam. She said that she felt dirty and she showed low self esteem. She told me that she avoided making contact with anyone and felt very lonely. In addition, she was very concerned about her brother who she left behind in her home town. He often appeared in her nightmares, wounded and sometimes dead.

Over a couple of months she returned to me for counselling, and I found her the address of a Koptic church, where she received consolation and support. Slowly, she started to regain control over her life, and her health problems diminished. When with lots of relief she informed me that her brother had joined her in exile, we decided to finish our regular conversations.

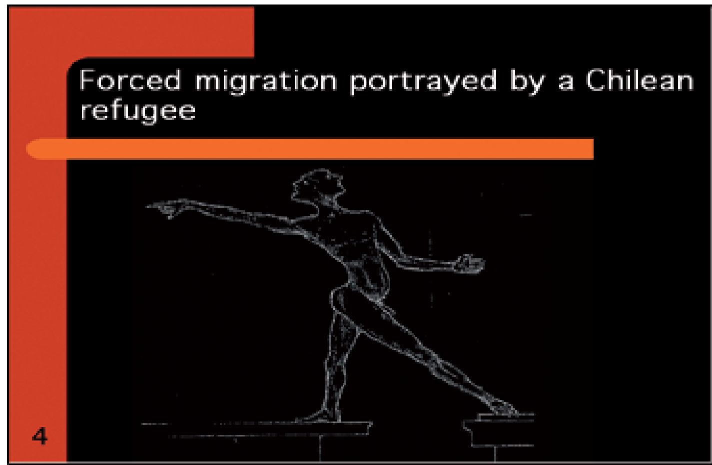
Many refugees like Zarah can hardly 'speak about the unspeakable' and express their pain and suffering in physical and psychological problems. In the following, I will give a global outline of those problems in relation with the violent backgrounds and social situation.

First, I will sketch the general backgrounds of refugees and asylum seekers, then I will describe their most common health problems and I will finish with a discussion.

Since the earliest societies, people like Zarah, have left their homes because of war, persecution and social unrest. Many refugees literally have been driven away from their homes by bombings, shootings, under threat, sometimes after execution or rape of their family members, and/or destruction of their house. Others felt forced to seek refuge because of persecution, intimidation, arbitrary arrest, imprisonment, torture, sexual violence, disappearances of next of kin and other forms of human rights violations. And lastly there are people, who do not see any way of continuing life in their country of origin, and expect to find a better future elsewhere.

Often, to escape from their country refugees have to make a dangerous journey over sea, or through mountains and the desert. In addition, as a consequence of the deterrent and restrictive asylum policies in the EU, in many cases refugees have to put their faith into the hands of human smugglers, forgetting the necessary travel documents and arranging the journey, often for high sums of money and with the risk of being deceived. Others, and in particular minors, fall or are put in the hands of human traffickers, who exploit them in forced labour or sexual slavery.

Therefore, above all forced migration can be characterised by suffering, pain and loss - loss of family, friends, social position and well-known structures. Furthermore, the uprooting and adaptation to the new environment causes a mostly stressful acculturation process. As Benedetti wrote: *"to reorganize your life in exile is not starting at zero, as so often is stated, but at minus two, minus twenty, minus hundred."*



However, forced migration can also be characterized by the head of Janus, as this picture of a Chilean refugee expresses: one face looks to the past and the other to an unknown, uncertain, but also a challenging future. Asylum seekers must obtain refugee status through a procedure

that they often experience as incomprehensible. Here the interests of the host country and the asylum seeker are opposed: the asylum seeker wants rest, safety and support, the government of the host country first wants to see proof that the asylum seeker has a right to these basic certainties.

In many countries, asylum seekers are not allowed to work or study during the asylum determination process. In reception centres there is often a lack of privacy and safety as well as possibilities for meaningful activities. Furthermore, in their countries of origin most refugees were part of and could rely on an extended family. In the host country they miss their relatives and a social network. This means that many of them live in isolation.

Frequently, when granted asylum, refugees are unable to find employment, or are forced to do work which is below their level of education. Diplomas of higher education of their home countries are often not recognized. Further education possibilities are limited. Moreover, family reunification with relatives left behind in their home country is often hampered by bureaucratic regulations and financial limitations.

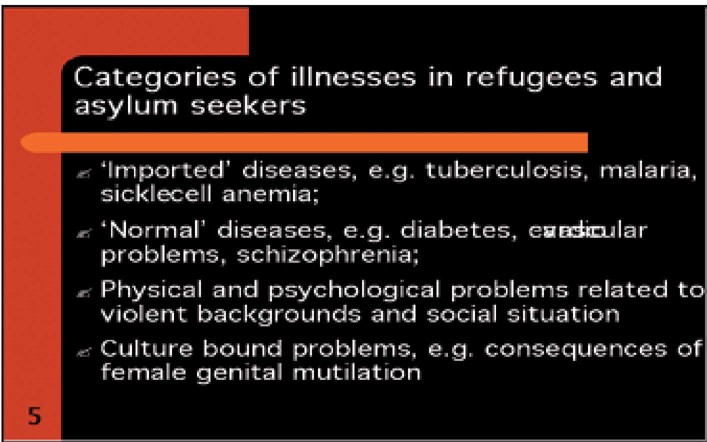
In addition, the violence refugees have fled does not stop at our borders. Through reports in the media and letters from home, as the case history of Zarah showed, refugees continue to be confronted by the repression and war in their native country. Feelings of doubt and guilt may be reinforced by positive or negative news.

Furthermore, in the last decade, asylum seekers are depicted in the media as bogus refugees, adventurers and parasites of our social system, and in particular since 9/11, xenophobia and racist tendencies in our societies have increased. This affects both asylum seekers and refugees who are residing in our countries for a longer period of time.

A quote of an Iranian woman living in the Netherlands:

> *"In the eyes of the Dutch people I am a burden; I am living with their tax money. They often say: 'why should my taxes be spent on foreigners?' You see this in their eyes. [...] As a foreigner, I could easily be blamed for all the problems."*

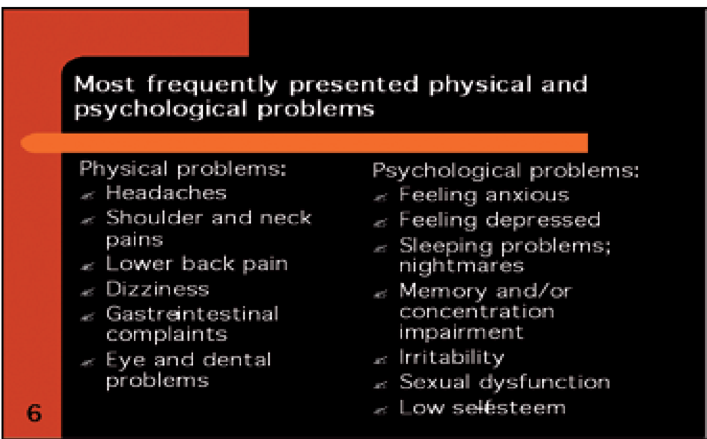
The backgrounds of refugees are thus complex. Refugees who all experience to a greater or lesser degree severe stress as a result of a sequence of violent experiences, forced migration and acculturation are not only victims of armed political conflicts in their country of origin, but also the object of national and European debate.



The health problems of refugees and asylum seekers can be divided into four categories:

- 'Imported' diseases, e.g. tuberculosis, malaria, sickle-cell anaemia;
- 'Normal' diseases, e.g. diabetes, cardio-vascular problems, schizophrenia;
- Culture bound problems, e.g. consequences of female genital mutilation
- Physical and psychological problems related to their violent backgrounds and social situation

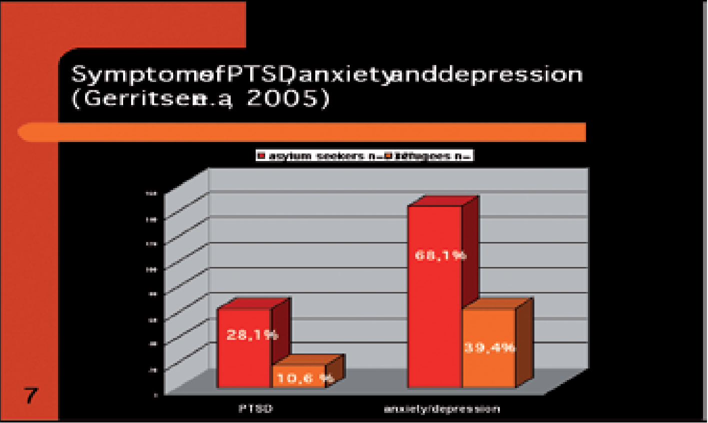
A recent epidemiological study among Afghan, Somali and Iranian asylum seekers and refugees in the Netherlands by Gerritsen and other authors showed that on average they have poorer health than native Dutch citizens.



The most frequent physical problems presented by refugees and asylum seekers are characterized by pain, such as headaches, shoulder and neck pains, and lower back pain. Other physical complaints include, for instance, dizziness, gastro-intestinal complaints, and dental and eye problems. Often, a clear diagnosis cannot be made.

The most common psychological problems are feeling anxious and/or depressed, sleeping problems and nightmares, memory and concentration impairment, irritability, sexual dysfunction and low self-esteem. In general these physical and psychological problems can be considered as 'normal human reactions to abnormal inhumane situations', or in other words as symptoms of a normal coping process of shocking and stressful experiences.

A certain percentage of asylum seekers and refugees present the symptoms of a psychiatric disorder, such as a Post-traumatic Stress Disorder (PTSD) and a Major Depressive Disorder, often in combination. In a meta-analysis of 20 surveys on the mental health of refugees Fazel and others found an average prevalence of PTSD of 9 % and of a major Depressive Disorder of 5 %. It should be noted, however, that methodologies and samplings of those 20 studies varied considerably.



In the Dutch study of Gerritsen and others, 28 % of 232 interviewed asylum seekers and 10,6 % of the 178 refugees had symptoms of a PTSD and 68 % of the asylum seekers and 39 % of the refugees had symptoms of depression and anxiety. It should be noted that the asylum seekers in this study lived on average 3 years in a reception centre, awaiting a decision on their asylum request.

Various studies in the Netherlands and abroad have shown that asylum seekers and refugees who suffered torture and or a high number of other violent events in their country of origin have a higher risk for a PTSD than others. Besides, in the study of Gerritsen and others, more post-migration stress and less social support was associated with PTSD and depression and anxiety symptoms.

Postmigration stress factors mentioned by asylum seekers in study Gerritsen e.a. (2005)

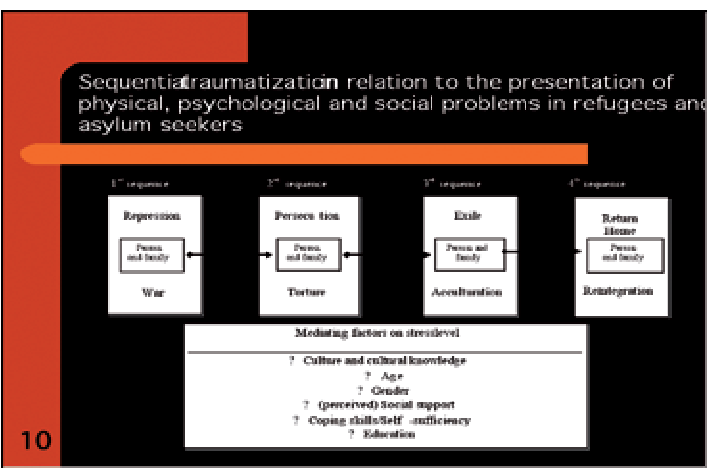
- Frustration and insecurity about the asylum procedure
- Worries about relatives left behind
- Boredom and lack of meaningful activities
- Lack of privacy and other housing related problems
- Loneliness
- Loss of social position
- Communication and language problems

8

The post-migration stressors most frequently mentioned by the asylum seekers in the study of Gerritsen and others were frustration and insecurity about the asylum procedure, worries about relatives left behind, boredom and lack of meaningful activities, lack of privacy and other housing related problems, loneliness, loss of social position etc.

In international literature, other mentioned factors related to the health of asylum seekers and refugees include unemployment, lengthy separation from family members, feelings of alienation and discrimination. Often, the psychosocial problems become circular: for instance, irritability and sleeping problems may lead to problems between spouses, which have an effect on the behaviour of children, etc.

In other words, physical and psychological problems of asylum seekers and refugees can be related to their shocking experiences in the country of origin and or during flight, but may be aggravated and caused by their living conditions during the asylum determination process and the social situation connected to life in exile as well.



After Keilson (1979; 1992), the succession or sequence of experiences of asylum seekers and refugees can be divided into four sequences, namely the first sequence, the period in which either the repression or war in the native countries begin; the second sequence, the period in which the refugee him/herself has personally undergone forms of persecution and violence; the third sequence, the period after arrival in the host country. i.e. the phase of uprooting, asylum procedure and acculturation; and, in the case that refugees return to their native country, the fourth sequence in which they have to reintegrate into the society of their origin.

Especially in the first phase of the third sequence, after arrival in the host country, refugees are particularly vulnerable, as a result of their previous experiences and uprooting. As a case in point the case history of Zarah. Moreover, the initial experiences of refugees in the host society have a strong influence on subsequent experiences and thus on the severity of stress related to those experiences.

A variety of, partially culturally determined, personality and environmental factors influence how the experiences are interpreted, and thus their impact on the refugee. Also, these factors have influence on the way how the experiences are coped with and on their consequences. In general, each culture has its own idioms of distress and coping styles. However, often those coping styles are inadequate in a different environment.

In the 1990s, in international literature, a sometimes heated discussion started about the application of concepts as trauma and PTSD on non-western people who experienced shocking events. Opponents to this application consider these concepts as western social constructs that individualize the suffering and pain of refugees, reduce them into psychiatric categories, and reify their life-world. A controversy rose between the so-called trauma model, that, putting it in 'black-and-white', assumes that all persons who experience shocking events are victims and potentially patients of health care, and the psychosocial model that considers them survivors and potentially healthy.

Various authors have pointed out that the majority of refugees, despite their experiences before and after forced migration, appear to regain control over their own existence with or without the support of volunteers or their own social group, provided that the context in which they live offers them the necessary opportunities. Medicalisation of the problem, treating refugees and asylum seekers as victims and/or as pitiful, only threatens to increase their dependence and powerlessness.

A quote of an Iranian woman in the Netherlands:

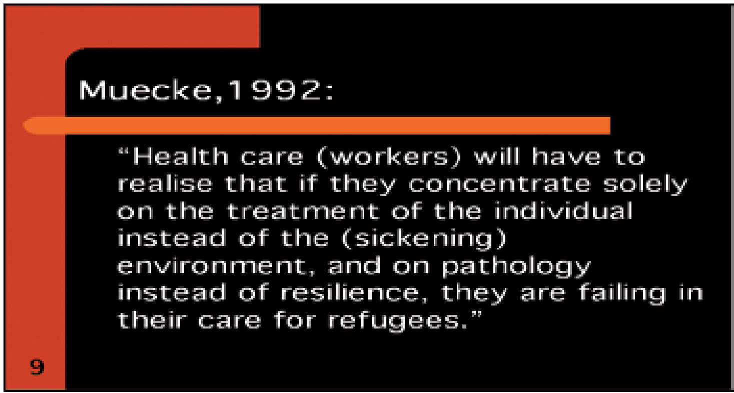
> *"In the beginning I liked it when people asked me where I came from. I thought to myself: 'how nice that they want to know more about us'. Then you explain about your past and then they say: 'oh, how pitiful'. Then I thought to myself 'how come pitiful?' My story is not pitiful at all. […] In their eyes the things I did in Iran and the things I have done here are not important at all; the only way they see me is as a pitiful person. [. . .] To be honest, in the beginning I wanted to cry most of the time because of this patronizing attitude."*

In general, asylum seekers and refugees explain their problems not only in terms of the violence experienced in their country of origin, but also, and in particular, in terms of their social situation. For social problems many refugees seek help within their own circle rather than in health care services. In many countries of origin, health care is consulted only for illness and insanity; existential and social problems are often appraised differently and require for other strategies.

A quote from a Somali woman:

> *"But about mental problems and illness that I learnt here, I never heard that in Somalia. In Somalia I have never seen someone who is ill because of stress or fear. Maybe Somalia was an open country. People have their own family and they have more contact. I think in Somalia they don't have stress."*

Ladies and gentlemen, dear colleagues: of course, health problems resulting from experiences of violence and or the social situation in the host society should be identified in time, in order that adequate support or therapy is offered. However, as I hope I have shown, the causes of the specific health problems of asylum seekers and refugees are mostly of social-political nature. Thus, preventive measures will have to be foremost in this area.



As Muecke wrote: “Health care that is exclusively directed towards treatment of the individual instead of the sickening environment, and towards pathology instead of resilience, is inadequate in the care of refugees.”

Since asylum seekers and refugees are particularly vulnerable directly after arrival in the host country, in my view, preventive measures, including reduction of post-migration stress factors and reinforcement of own coping abilities should be taken as early after their arrival as possible.

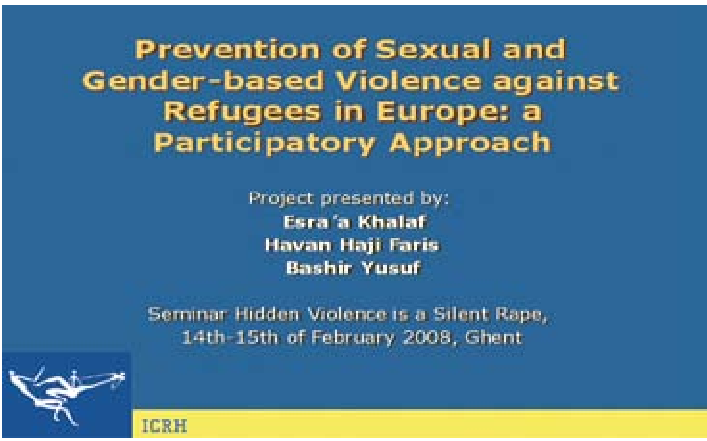
As UNHCR wrote, refugees are, by necessity, strong and resourceful people. All of them must start over - often from nothing - to rebuild productive, meaningful lives for themselves and their families. They deserve a safe and peaceful life.

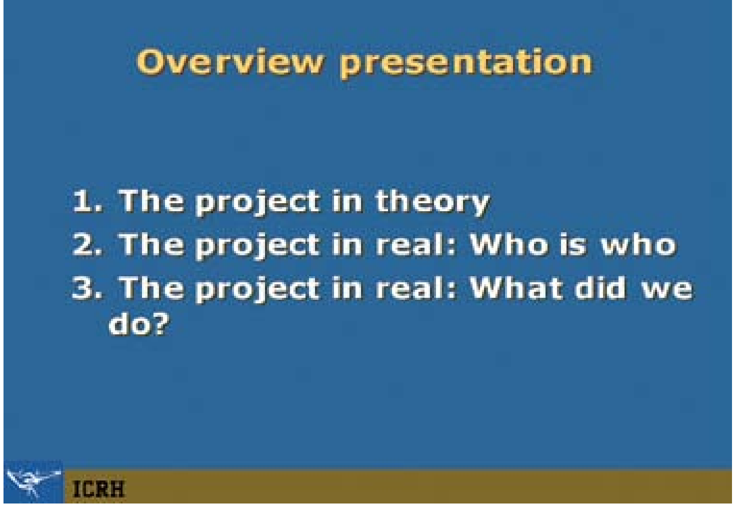
I hope that the project and this seminar will contribute to that.

3.3.5 Presentation of the Participatory Research Project by Community Researchers

Esra'a Khalaf, Havan Haji Faris, Bashir Yusuf

We are: Esra'a Khalaf, Havan Haji Faris & Bashir Yusuf 2 community researchers from Belgium and 1 from the Netherlands. We will present the project "Prevention of Sexual and Gender-based Violence against Refugees in Europe: a Participatory Approach"





1. The project in theory

1. Objectives
2. Method
3. Method applied on our project

ICRH

1.1 Objectives of the project

1. To develop a SGBV prevention tool which can be used by refugees & intermediary organisations
2. To raise awareness about SGBV against refugees among general public & authorities
3. To implement the project in a participatory way, to empower women and to involve men

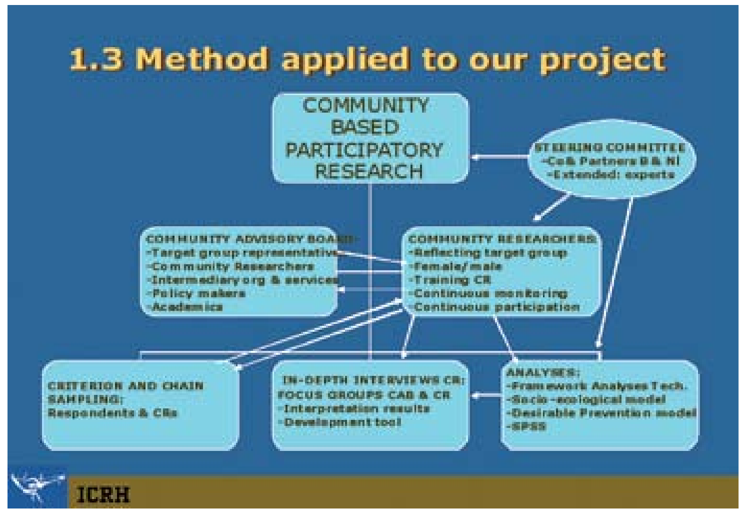
ICRH

1.1 Objectives of the project

4. In Belgium, The Netherlands, UK
5. April 4th 2006 - April 3rd 2008
6. With EC Daphne funding

ICRH

As an overall method we used Community Based Participatory Research. Ines will explain you in the next presentation what the 5 principles are and how this method is applied to our project.

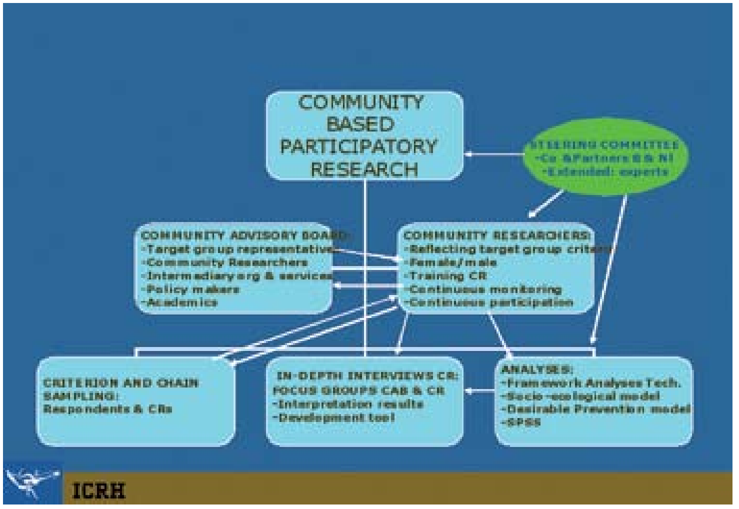


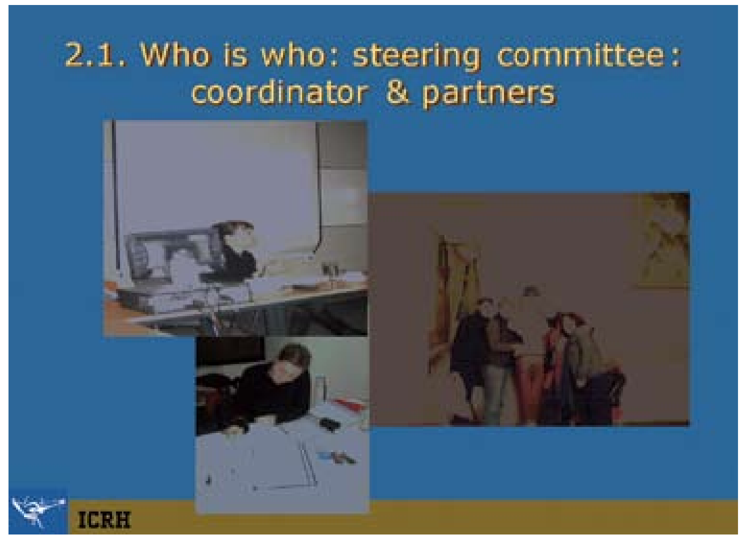
Now we come to what our project really consists of. First we'll give you an overview of who is who in the steering committee, the community researchers and the community advisory board.

2. The project in real: Who is who?

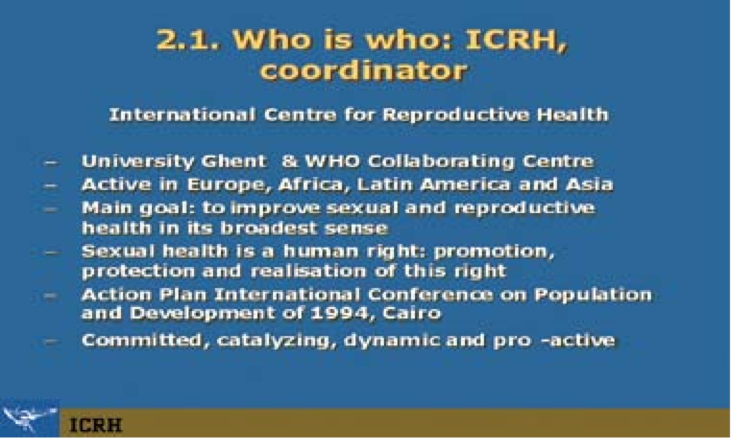
1. Steering Committee
2. Community Researchers
3. Community Advisory Board

ICRH





The coordinator is Ines Keygnaert from ICRH, you see her on the left top side. On the picture on the right you see the partners Koen Dedoncker from Zijn, Ruth Wilson from Tandem Com, Hilde Bakker from MOVISIE and Najla Wassie from Pharos. On the picture underneath you see Marijke Van Petegem from the Dutchspeaking Women Council.



2.1 Who is who: Partners

- Movisie (Nl): domestic and sexual violence with a special focus on migrants and refugees
- Refugees Arrivals Project (UK): had to wind up, exit project
- Nederlandstalige Vrouwenraadvzw (B): Umbrella organisation of about 40 women organisations in Flanders
- Pharos (Nl): Knowledge centre in health of refugees and rejected asylum seekers
- Zijnvzw (B): Flemish ngo for prevention of domestic violence
- Tandem Communications (UK): Research and Communication centre on health and sexuality of refugees

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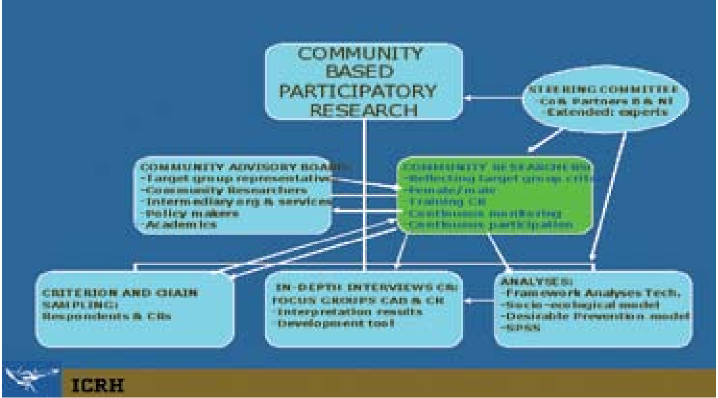
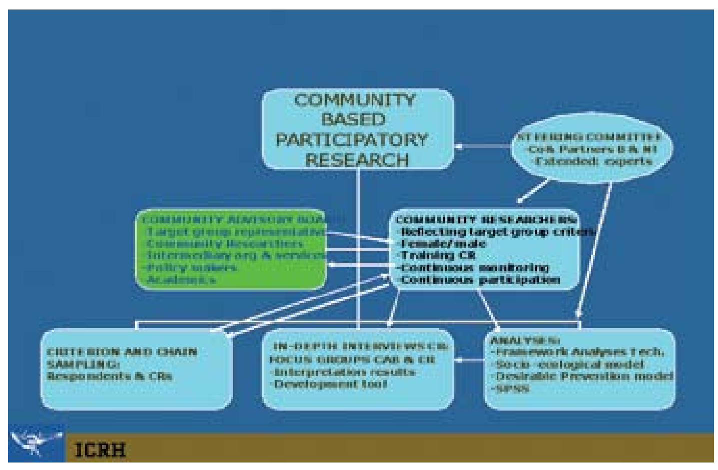
Secondly we have the community researchers, who are a reflection of the target group and who were trained to become community researchers and crucial partners in the project.



These are all the names of the 23 community researchers, 13 in Belgium and 10 in the Netherlands. So you see we are 9 men and 14 women.

Thirdly we have our extensive Community Advisory Board



2.3 Who is who: Community Advisory Board

- 5 Representatives of refugee communities :
  Werkgroep Vluchtelingen Gent, Hand in Hand, VLOS, ...
- 23 Community Researchers in B & Nl
- 27 Intermediary organisations & service providers:
  Fedasil, Red Cross Reception Centres, Stichting 45-De Vonk, Medimmigrant, Kom-Pas, Vluchtelingenwerk Midden-Nederland, CAW Artevelde, Odice, Sensoa, Vluchtelingenwerk Vlaanderen,...

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2.3 Who is who: Community Advisory Board

- 10 Policy makers:
  - Health service, Asylum service, Prevention service, ... from City of Ghent
  - Violence coordination cell, service of Minorities,...from Province of East-Flanders
- 7 Academics :
  - ICRH
  - Experts in steering committee

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3. The project in real: what did we do?

1. **Desk study**
2. **Recruitment & training Community Researchers**
3. **Interviews & Analyses**
4. **Development tool**
5. **Awareness raising**
6. **Seminar**
7. **Publications**

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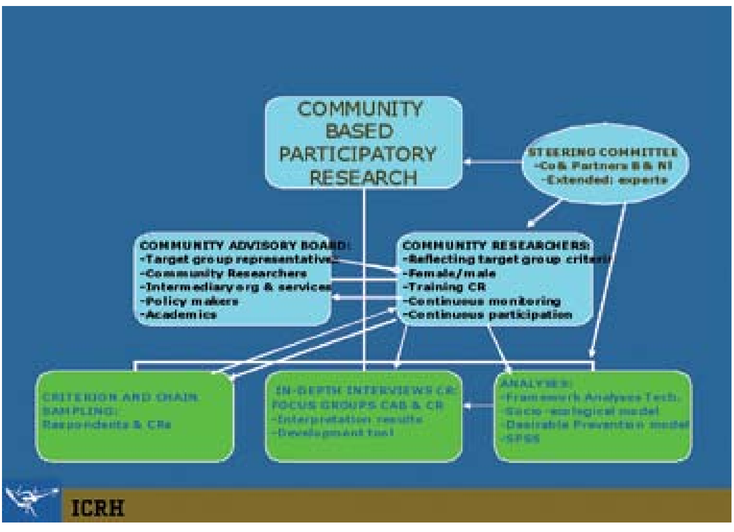

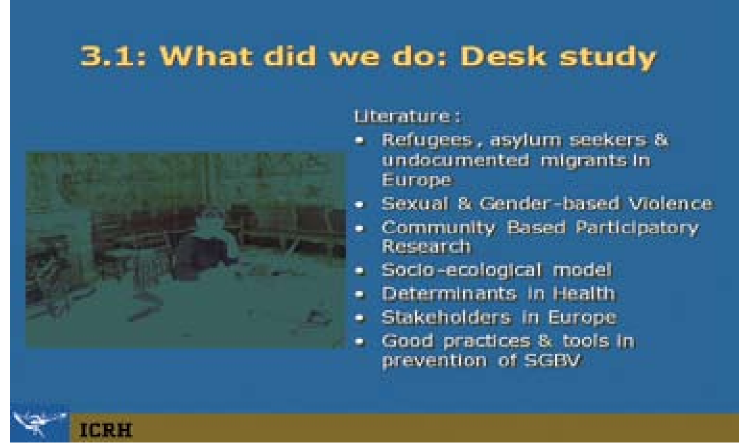

First of all, Ines did a desk study on the following topics and kept on doing that throughout the project, keeping us all on the scientific and methodological track.

From the summer of 2006 onwards the community researchers were recruited.
On the right hand you can see an overview of the origin and sex of the community researchers.
On the left hand you see the criteria the community researchers had to match.
The community researchers were found through help of the Community Advisory Board and networking of Ines and Hilde and firstly identified community researchers.

3.2 What did we do: Recruitment Community Researchers

- Sampled through criteria :
  - Female/male
  - Refugee/asylum seeker
  - Of Iranian, Iraqi, Kurdish, Roma, Somali, Afghan, former USSR origin
  - Social capital
  - Open mind
- Found through:
  - Help CAB
  - Networking

CR n=23	Female	Male
Iranian	3	2
Iraqi	1	1
Kurds	3	1
Roma	2	1
Somali	1	1
Afghan	1	1
F USSR	3	2
Total	14	9

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3.2 What did we do: Training of Community Researchers

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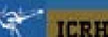
Right after the identification and recruitment of community researchers, a training took place. Here you can see community researchers doing the training in Belgium. We like to thank the City Council of Ghent who supported this training by providing the meeting venues and refreshments.

3.2 What did we do: Training of Community Researchers

Programme:

- Project goals, aims, method & timetable
- Sexual & Gender-based Violence
- Rights-based & gender-based approach
- Prevention
- Communication: intercultural, non-verbal, verbal
- Resilience training & cool down exercises
- Psycho-social education in interviewing
- Questionnaire & informed consent
- Extensive exercises in-depth interviews

40 hours in B: November 2006, in Nl: January 2007



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In total the training equaled 40 hours of education. The training in Belgium took place in 5 consecutive days in November of 2006 and in the Netherlands in twice 3 days in January 2007.

3.3 What did we do: Interviews & Analyses

1. **Sampling criteria of respondents:**
- Refugees, AS & undocumented migrants in B & Nl
- Women & men,Age : 15-49, focus 15-29 years
- 7 communities:
  - B: Ex- USSR, Iranian, Iraqi, Roma, Kurds in East - Flanders
  - Nl : Somali, Afghan, Iranian, Iraqi, Kurds in Randstad
- Per community:
  - 20 respondents, 10 women/ 10 men (60%: -30y)
- Voluntary participation: informed consent
- After interview: gift with brochures Sexual Health & Violence, condoms, voucher, hygiene & make-up

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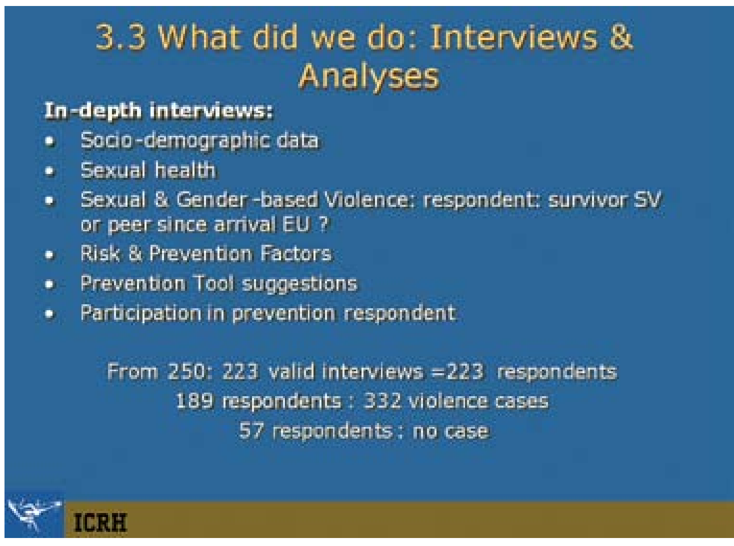
Right after the training we started conducting in-depth interviews.
These were the sampling criteria of the respondents:
They had to be refugees, asylum seekers or undocumented migrants living in Belgium or the Netherlands. They could be a woman or a man within their reproductive age (14-49 years old) and we tried to focus on young people (15-29 years). They had to be from the following communities and living in East-Flanders in Belgium or in the Randstad in the Netherlands. Per community we tried to have 20 respondents. Respondents were explained about the goals of the in-depth interviews and were free to participate or withdraw at any moment of the interview. Respondents who participated signed an informed consent and got a gift after the interview.

We asked questions about the following topics. The outcome is that from the 250 conducted interviews, 223 met the validity criteria, so we have 223 respondents, and of those 223 respondents, 189 were victimized themselves or knew a close peer who was victimized since their arrival in Europe.57 respondents didn't know any peer who was victimized. In the presentation on the research results, Ines will give all details about the outcome.



When the interviews were screened, analyzed and interpreted in focus groups with the Community Advisory Board, we started to develop the prevention tool.

Here you see several pictures of "the making off", being Baharak showing her design of the cover; Ines and her parents making prototypes; On the left down side you see some members of the jury of the design competition; Ines testing different parts of the tool, asking for feedback and finally Marijke getting through the proof reading.

We still have to keep it a secret what the tool has become, tomorrow we will show you a detailed version of the making off , and what you can do with it. And of course, you will all get a copy!

3.6 What are we doing: Seminar

Hidden Violence is a Silent Rape: Prevention of Sexual and Gender-based Violence against Refugees in Europe.
14th-15th of February 2008
Het Pand, Ghent

1. Presentation project, results, tool
2. Situation Analysis: SGBV against refugees
3. Workshops with EU good practices
4. Networking with EU colleagues
5. Prevention of SGBV: goals & Call for Action

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3.7 What will we do: Publications &...

1. Seminar Proceedings
2. Final report project, results & evaluation
3. Scientific publication
4. Articles in press

5. New project proposals
6. Continue to raise awareness & to take actions to Prevent Sexual & Gender-based Violence against Refugees, Asylum Seekers & Undocumented Migrants in Europe

ICRH

Many thanks to

Respondents

Community Researchers

Community Advisory Board

EC Daphne Fund,
National Lotery & VWS

You

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3.3.6 Presentation of Research Results

Ines Keygnaert, ICRH, Belgium

Prevention of Gender -based Violence against Refugees, Asylum Seekers & Undocumented Migrants in Europe

Presentation Research Results

Keygnaert Ines

EU Seminar "Hidden Violence is a Silent Rape ",
14th & 15th of February 2008,
Het Pand, Ghent

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1.1 Background

1. ICPD 1994, Cairo:
   - Sexual Health: free of violence= human right
   - Special attention in prevention: women, youth, refugees & undocumented migrants
2. EU Member States ratified:
   - ICPD Action Plan +
   - Gender: determinant of health
   - GBV major public health issue, violation human rights & crime against humanity
3. EU policy:
   - European Asylum & Neighbourhood policy
   - Lacking coherence

ICRH

1.2 Objectives of the project

1. To develop a SGBV prevention tool which can be used by refugees & intermediary organisations
2. To raise awareness about SGBV against refugees among general public & authorities
3. To implement the project in a participatory way, to empower women and to involve men

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Starting from an ecological framework point of view on sexual health and sexual and gender-based violence, we use a triangulation form of qualitative, applied and formative research method, being Community-Based Participatory Research (CBPR). CBPR in public health focuses on social, structural and physical environmental inequalities[5]. CBPR is a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process. The goal of CBPR is to improve health and well-being through taking action, including social change[6].

Community Based Participatory Research (CBPR) has 5 principles:

1. The first is that there should be participation of the broad target group, community researchers and a community advisory board in all phases of the project.

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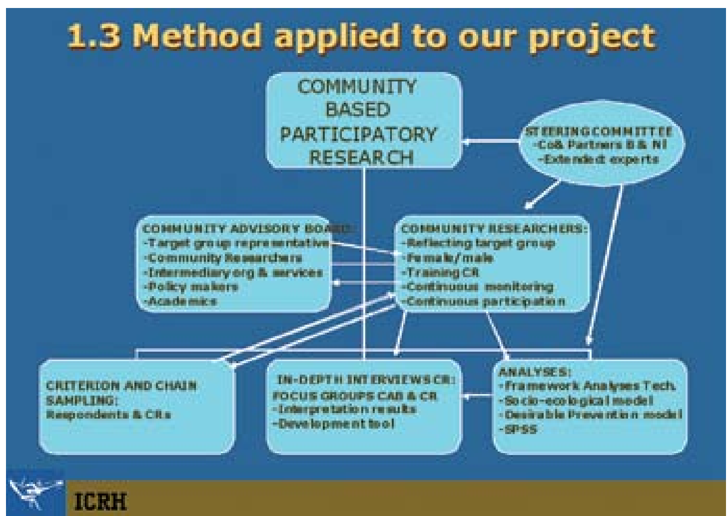
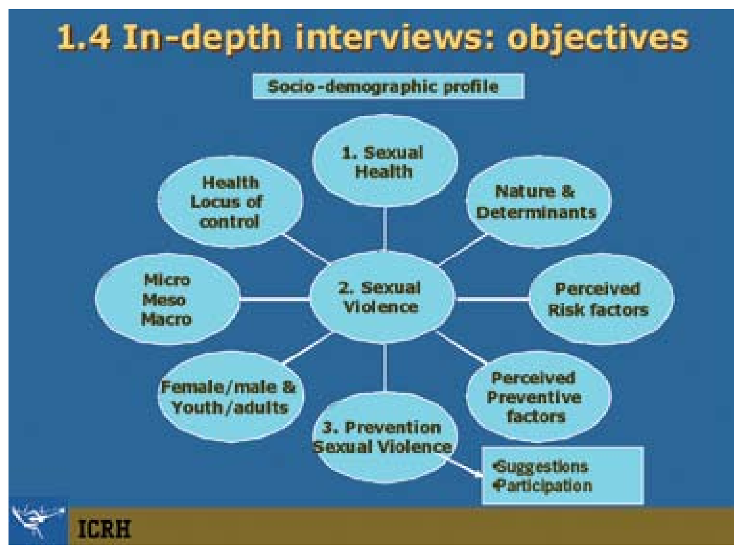
5 Israel B., Schulz A.J, Parker E., Becker B. (2001) Community-Based Participatory Research: Policy Recommendations for Promoting a Partnership Approach in Health Research, Education for Health, Vol. 14 no.2, 2001, pp 182-197, p 182.

6 Viswanathan M.; Ammerman A.; Eng E; and colleagues (2004) Community-based Participatory Research: Assessing the Evidence, AHRQ Evidence Report/technology assessment no 99, No 04-EO22-2, July 2004, pp 109, p 22.

2. According to CBPR a community is not viewed as a setting or geographic location, but rather as a social entity with a sense of having things in common and shared fate like living in the Netherlands as an asylum seeker for example, or providing health services to refugees, or doing research on sexual violence. So the target group is seen as a community, but the researchers too, and by doing this project one becomes part of a new community: being partners in this project.
3. The third principle is the one of co-learning, this means that every partner in this project has an added value and everybody's knowledge and experience is valuable to learn from
4. Empowerment is the fourth principle: again from all partners not only from the target group or beneficiaries
5. The end goal is real sustainable structural and personal change in the health and wellbeing of the beneficiaries





We first conducted 250 in-depth interviews with refugees, asylum seekers and undocumented migrants from Iranian, Iraqi, Afghan, former USSR, Somali, Roma or Kurdish origin who met the inclusion criteria as explained by the community researchers in the former presentation. After having introduced the project and having obtained informed consent, we first asked them questions related their socio-demographic profile, relevant for determinants in health. Secondly we tried to get an idea on what their frame of reference was on sexual health and what kind of health locus of control they had. Thirdly we inquired on sexual and gender-based violence victimization since their arrival in Europe. Finally, we asked them what they perceived as risk and preventive factors and what they suggested as prevention actions. We concluded by asking the respondents if they wished to participate in the realisation of their ideas and if so, how we could reach them. Throughout the interview we constantly checked their answers for both women and men and for youth and adults. They elaborated the differences or congruencies.

Two hundred and twenty three interviews met the validity criteria for incorporation in analysis. This corresponds with 133 female, 88 male and 2 transsexual respondents, and 132 respondents in Belgium and 91 in the Netherlands. The general profile of the respondents is one of high-educated women and men in their reproductive age, who have little or no close relatives accompanying them and who are struggling with the enforced set-back in their possibility to participate actively in society.

2.1 Socio-demographic profile

Respondents f/m per origin	Iranian	Iraqi	Kurds	Roma	Somali	Afghan	f USSR	Total
F (B)	10	10	10	25	0	0	27	82
F(Nl)	13	2	28	0	0	10	0	53
M (B)	17	0	10	11	0	0	12	50
M (Nl)	0	0	10	0	14	14	0	38
Total	40	12	58	36	14	24	39	223

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2.1 Socio-demographic Profile

n=223

Sex: 60% women (133), 39% men (88), 1% transgender (2)

Age: 53% under age of 30 (58% f & 43% m)

Marital status: 54,4 % single, 45,6% married/living together

Religious: 80%: Christian, Moslim

Current Nationality: 25 % Nl, 6 % B, 70% CO

Status: 12,5 % undoc, 41 % temporary, 46% permanent

ICRH

2.1 Socio-demographic Profile

n=223

Housing : 21 % AC, 31% house, 32 % appartment

Company: A: 29% none, 51% 1 - 2; C: 44% none, 41%: 1 - 2

Education: 41% higher, 44% secondary, 11 % primary

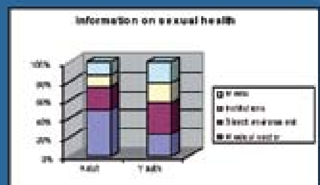
Occupation CO: 45% paid work, 40% students

Occupation B/Nl: 22% paid work, 41% unemployed (21/20), 21% students

ICRH

2.2. Sexual health

n=223



Health locus of control:

Internal: (n)

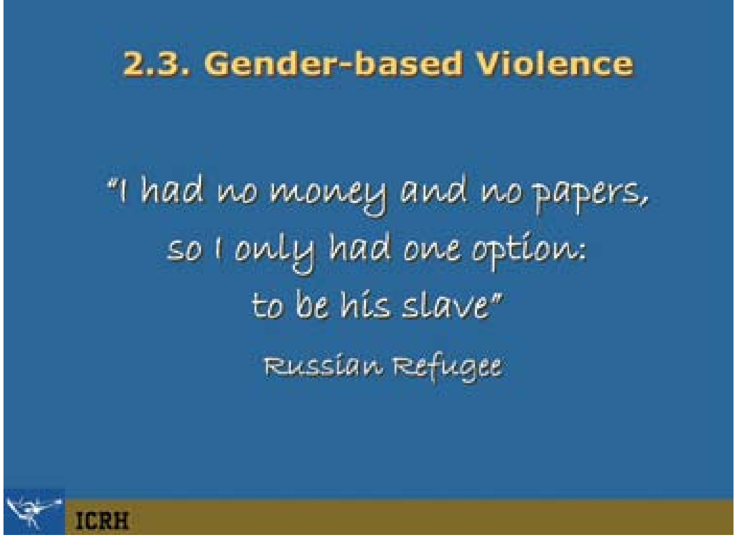
- 121: Safe & satisfying
- 110: Well-being
- 106: Info & care
- 69: Respectful

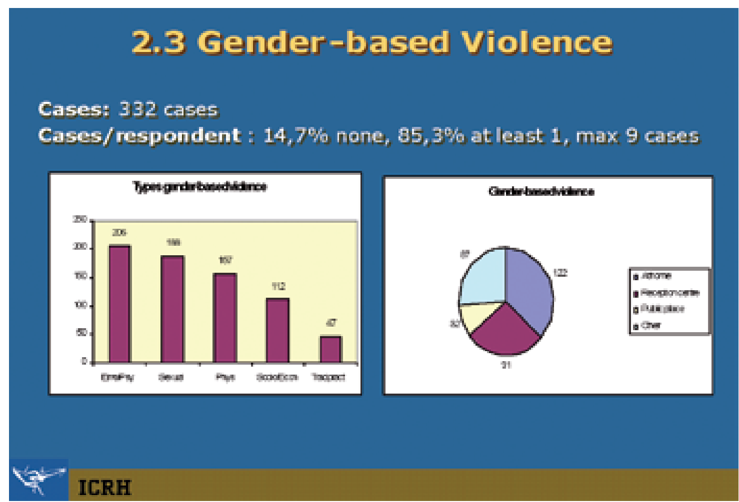
External: (n) 152 +

- Positive: Info & education
- Negative: Stress, asylum
- Double: family & friends,

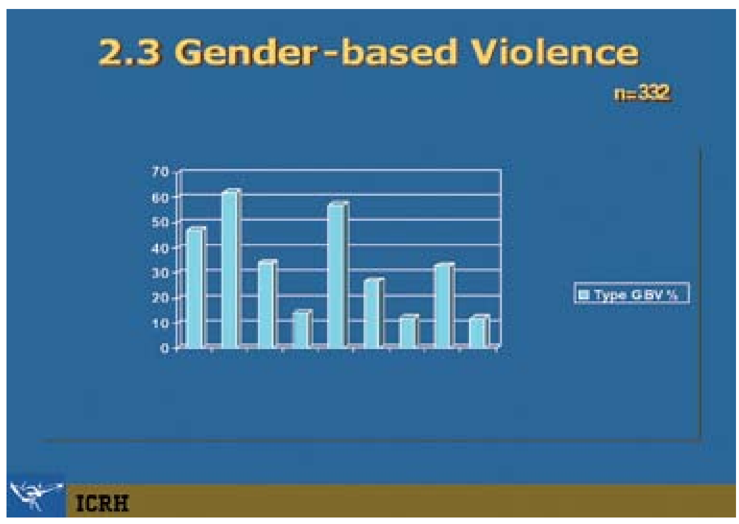
ICRH

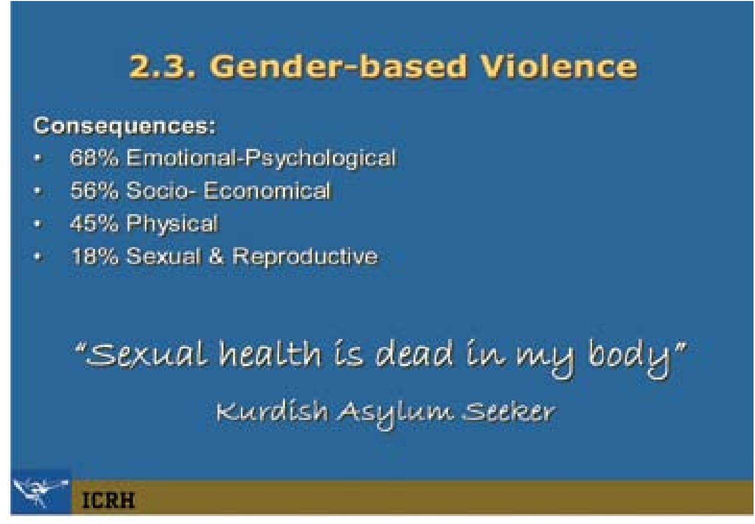
The majority (60,1%) of the respondents said that in their home country in order to have information on sexual health, adults turn to the medical sector first and then to their direct environment (30%). Youth go to their friends and family first (40%) before turning to the medical sector (30%) or the media (28,7%). According to the respondents in Belgium, an adult is sexually healthy if she/he is generally well (67,4%), if she/he is able to raise a family (34,1%) and thirdly if she/he has a respectful approach to sexual relationships and sexuality(30,3%). For the respondents in the Netherlands having a safe and satisfying sex life (54,9%) is more important than having a respectful approach (51,6%) or being generally well (47,3%). Furthermore, the respondents are convinced that one is genuinely responsible for her or his own sexual health and that one should act upon that.

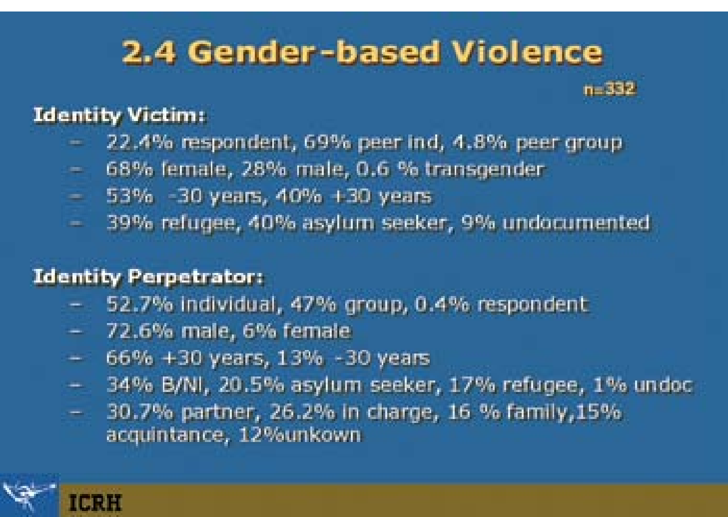




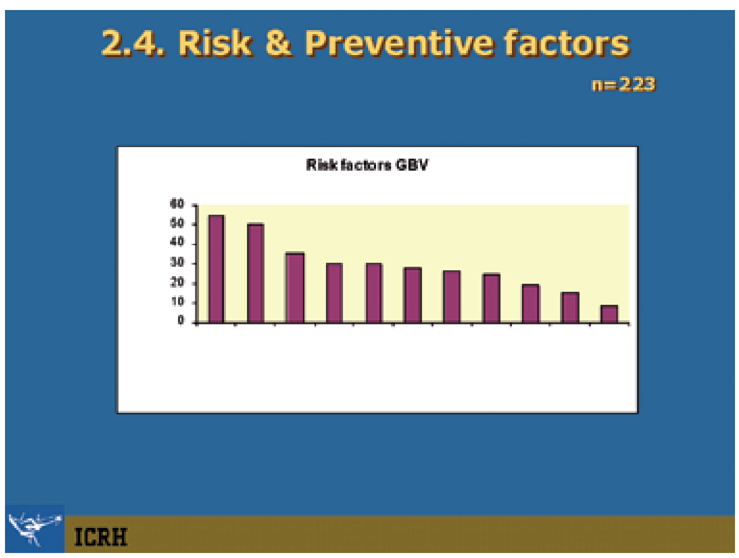
An overwhelming majority of the respondents revealed to be more than familiar with several types of gender-based violence. Among the 223 respondents, 57 didn't know anybody who had been victimized since his or her arrival in Europe. 166 respondents answered they did, and they described 332 cases of gender-based violence. 62% or 206 cases are to be categorized as emotional-psychological violence, 56,6% or 188 cases as sexual violence, 47,3% or 157 cases as physical violence, 33,7% or 112 cases as socio-economic violence and 14,2% or 47 cases as traditional harmful practices. Among sexual violence we can make a distinction between sexual intimidation 26,8% (89 cases), sexual abuse 12% (40 cases), rape/sodomy 33,4% (111 cases) and sexual exploitation 12% (40 cases).







Eighty seven respondents or 39% of the respondents were personally victimized, this correspondents with 22,4% of the violence cases. 229 victims were an individual peer of the respondent (69% of the cases) and in 16 cases (4,8%) the victims were a group of people. 175 perpetrators acted as an individual (52,7%) and 156 committed the violence in group (47%). 241 perpetrators were male (72,6%), 20 female (6%). The bulk of the violence was perpetrated by adults: 219 cases (66%). Taking the residence status into account, the biggest group of perpetrators were autochthons (Belgians/Dutchmen: 113 cases or 34%). In 102 cases (30,7%) the perpetrator was the current or ex-partner of the victim. In 87 cases (26,2%) this violence was committed by persons in charge or authorities. 13 of these 87 cases were committed by service providers in the asylum procedure. In 53 cases (16%) the violence was perpetrated by family members, in 11 cases (3,3%) by friends, in 49 cases (14,8%) by acquaintances as peers in the same reception centre, neighbors or friends of the family. In 40 other cases (12%) the perpetrators were unknown to the victim.



The risk factors for victimization identified by the respondents correspond mainly with bio-psychosocial factors (54,7%), a lack of a social network (50,2%), economic hardship (35%), the residence status and the lack of knowledge and information (both 29,6%). Preventive factors were categorized on an individual (micro), socially interactive (meso) and societal (macro) level. According to the respondents, the most important factors on micro level were bio-psychosocial factors as biology/behavior (48,9%), followed by having knowledge and information (39,5%) and having a social network (27,8%). On meso level, the most preventive factors are having a social network (52,9%), having knowledge/information (50,2%) and having access to health care and services (16,6%). On the macro level, provision of knowledge/information is the most important (43%), then the overall legislative framework (40,4%) and thirdly the residence status and rights going hand in hand with the status (20,6%).

2.4. Risk & Preventive factors

n=223

MICRO	Nr of resp	%	MESO	Nr of resp	%	MACRO	Nr of resp	%
Bio/ behavior	109	48,9%	Social	118	52,9%	Info	96	43%
Info	88	39,5%	Info	112	50,2%	Legislation	90	40,4 %
Social	62	27,8%	Access health care	37	16,6%	Status	46	20,6 %

Prevention tools:
1. Knowledge & information: sensitization, education, training
2. Legislative framework: protection, law, public safety
3. Status: right to work, shorten procedure, rights & duties

71,3% respondents want to participate in prevention of SGBV

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Asking the respondents what kind of prevention tools or actions should be developed, the same order of preferred actions or tools for youth and adults were given. First of all, a prevention tool should enhance knowledge and provide information (54,7%) Secondly, the overall legislative framework should be adapted in order to be more preventive (34,5%) Thirdly, the system of residence status and rights should be changed in order to enhance the refugees, asylum seekers and undocumented migrants' possibilities to enjoy rights and to participate actively in the host society. 71,3% or 159 respondents said to be willing to participate in prevention actions or in the development of prevention tools.

3.3.7 Panel: Project Partners and Community Researchers

Panel members:
Ines Keygnaert, ICRH, Belgium
Marijke Van Petegem, NVR, Belgium
Koen Dedoncker, vzw ZIJN, Belgium
Hilde Bakker, MOVISIE, Netherlands
Najla Wassie, Pharos, Netherlands
Mahtab Safaipour, Community Researcher, Belgium
Ramin Bahrami, Community Researcher, Belgium
Natalia Shulga, Community Researcher, Belgium
Takhir Iminov, Community Researcher, Belgium
Bashir Yusuf, Community Researcher, Netherlands

Question: I would like to hear more about the community researchers' experience.

Ramin Bahrami: My personal experience is that in the beginning it was very difficult to get interviews because talking about sexual activity is something difficult for every person. I talked to Muslims and maybe they are more sensitive, so to bring them to this point takes a lot of time, you have to be very tolerant, and that was a very new experience for me. So to talk to people about sexual violence that was very new, some did not know the meaning of the word violence, they think that sexual organs depend 100 per cent on human body and they never think about sexual health or sexual violence. So you needed a lot of time to explain about the project and its goals. So that was an absolutely new experience, and it was very new information. I learned a lot myself and it was very nice.

Natalia Shulga: After having done the interviews in our own language we had to translate them all into Dutch or English. Sometimes I could not find the right word in Dutch having the same meaning as in Russian. So I worked on this together with my son. Of course I did not let him read the worse parts but this way I was also able to communicate with my 16 year old son and talk to him about sexual health. Otherwise I may have been afraid to talk to him and my nine year old daughter. I had to explain to her that sexual violence exists, and that some people might want to harm. If you look at it in terms of figures it is a little cold, dry, but behind these figures there is real pain, and when these people start opening up to you, you can't just turn your back on them and say thank you for the interview. We can't abandon them, they need our help.

Bashir Yusuf: Today I had tears in my eyes when Catherine Camilleri was speaking. What she was telling is what I heard from the refugees and asylum seekers who I interviewed. They left their homes, they were expecting to get a better life here, but that was not materialised. But suffering was there, they use drugs and alcohol to ease the pain. Many who never ever touched alcohol are now alcoholics. Being here as an asylum seeker, for ten years in a centre… There

is no place to go back to. No home to go back. The experience I have come with, the Somalis say we had better died, but there is no home to send them back to. The experience is very shocking, and needs attention. And hopefully with the recommendations from this research there will be some relief.

Takhir Iminov: I would first remark that we are also former refugees, some of us do not have an official status yet, but when I started this project Natalia and I had been living in Belgium for about eight years and I thought I had forgotten my experience. When I went to the asylum centres to do interviews, I got this old pain, I shake when I think about it, when you talk to these people you can tell that they are clutching at you that they see you as their last straw and you say I am sorry all I can do is listen to you. So I hope with all of my heart that this project will not just end with our nice presentations of figures and stats and that there is real change. I have children of my own and when I heard how children are abused it is really hard, as a man, to hear this. Most people come to Europe looking for the promised land, but they sometimes end up in a situation that is worse than before. In your country you know that you will not get any help, you are on your own, but here you think Europe is safe there is help, but in my experience it is hypocrisy, it is not like that.

Mahtab Safaipour: It helped me get to know myself better. In our country sexuality is taboo you don't talk about it, but we tried and it turned out to be very interesting. I learned a lot and it really helped me to continue with my life and in my job it has made me a stronger person. I can talk to these people, I know what the problems are, I am more open, for me it has been a positive process. Now I know that I am able to talk to people about these subjects, before I couldn't. I was shocked when I saw these women who are struggling because I had no idea that it was so difficult, that relations between men and women are so difficult in my country. It is such a broad topic, I could talk about it for hours but what I could say now is I have a lot more information now than before. Thank you.

Question: I am very grateful that you dare to talk about sexuality with refugees because it is not first priority. I want to ask, is there any link between violence and sexual diversity? We are talking mostly about women/men relations. I know that a lot is going on in camps regarding sexual diversity.

Ines Keygnaert: We have several accounts of men and boys being victimized in our interviews, but only two respondents said something about their sexual orientation. They were transgender persons. We didn't foresee this in the beginning. We agreed that female community researchers would interview females and the male community researchers would interview male respondents. At a certain moment a Russian community researcher called me and said: "I am only doing interviews with women, right?", and I said yes. 'But I have two potential respondents who say they are women but I think they are men'. So we agreed that she could interview them, because we are not to judge the gender of the respondents. They both survived very severe victimization. Shortly after the interview though, one of them died of AIDS, which was a result of a gang rape afflicted upon him here in Ghent.

Question: I'd like to commend the project, the researchers and participants.
We've noted that male survivors of rape, gay or heterosexual, often prefer to be interviewed by women because they can find it hard to disclose to men. I wanted to ask if you had a way of offering the participants immediate support because you say many became distressed. I was interested that you had two perpetrators and I wondered how that responded and influenced findings. And how have policy makers and service providers responded?

Hilde Bakker: Your first question – we organised in Netherlands to have some social and psychological support for respondents and community researchers, its very important because its part of their recent history as well. Centre 45 is closely linked to Pharos. It has a special department working with victims of violence and torture and war. We gave a list of local addresses after each interview, and own language help lines, but I don't know if they really use this kind of help. We notice that in Belgium it is much harder to organise this kind of support.

Ines Keygnaert: We asked support of several mental health services. Most of them said not to know how to deal with refugee trauma's, and were very reluctant to cooperate in this. One Centre for Mental Health Care agreed to have one psychologist accessible for respondents participating in this project without being put on the waiting list. In general there is very little in people's own language, to get help you need an interpreter.

As for your question regarding perpetrators, we did not ask respondents if they considered themselves to be perpetrators. Two came up with it spontaneously. A lot of people said they did not want to participate, so we think we should work more with perpetrators and have another prevention tool for this. With regard to policy makers – we had several awareness raising activities with a very good response. There were several policy makers in the Community Advisory Board from the regional and local government. But we asked Ministers to speak to the Seminar tomorrow, and they didn't accept our invitation. So we hope that with the recommendations made here we can continue to lobby.

Question: Could you tell me in what way were children and minors represented in your work. Causes, prevention etc, is that different for children?

Ines Keygnaert: In the research report you can see an analysis regarding age, and how they responded with regard to others, including youth. They said there should be much more information for young people through education, including through sport or classes etc, more mainstream with specific attention to sexual health and violence. We had cases of minors too.

Ramin Bahrami: A final comment. I just want to make a little remark about the children. One of my respondents, I was packing my stuff, the 18 year old told me here the 10 year olds are seducing adult men. They already themselves have sexual relations with adults for free. How bad is it that those children in their psychology don't see that is not normal? So I think there is a lot of work to do.

Workshops: see Chapter 4 Seminar Recommendations: A Call for Action

Closing comments, Day 1
Chair: Sigrun Jorissen, Vice President of NVR
Welcome back. Everyone has been working all afternoon, and there are lots of formulations for policy recommendations coming from the workshops. We shall be reviewing these, and there will be a summary presentation tomorrow. But now, Simone will give an overview of the day and the experience of MOVISIE.

Final presentation, Day 1
Simone Kortbeek, Director, MOVISIE, also on behalf of Pharos

I am grateful for the opportunity to talk to you on behalf of MOVISIE and Pharos about an issue that has been high on the agenda of both our organizations for many years. Although this is today's final word, I am sure it will not be the last thing said about 'hidden violence'.

First, let me briefly introduce MOVISIE and Pharos, two Dutch organizations which work together in their quest to prevent violence against refugees. MOVISIE is the Netherlands expert centre on social development. It is a large non- profit institute and a major player in the field of domestic and sexual violence. Our work consists of collecting and profiling knowledge, facts and figures, good practice and methodologies, and opening this up for professionals, volunteers and government bodies.

Pharos is the standing knowledge center in the Netherlands, specialized in the field of health care for refugees and migrants. It strives to improve the health of refugees and newcomers, to reduce possible health disadvantages, and to make the healthcare system more accessible for this group. Pharos is also the national knowledge centre on 'Prevention of Female Genital Mutilation

Domestic and sexual violence are 'secret' forms of violence. They happen behind closed doors or when the victim is alone and vulnerable. In 2003 Pharos, MOVISIE and COA (COA is responsible for reception of asylum seekers) have been co-operating in a project to prevent domestic violence in reception centers. We interviewed 190 women and girls who lived in shelters and asylum centers. The conclusions were very worrying: many women felt unsafe or had experienced gender based violence. Forced sex, prostitution, abuse and intimidation were more common than we dared to think.

Our conclusion and advice to the authorities-in-charge, was clear and practical:

- give women command of their own space in the centers: give them their own kitchens and bathrooms – this improves safety and (also important) a general feeling of safety thanks to more privacy.
- we advised to empower these women by training them to stand up for themselves

- we need to make the women familiar with our system of help and care, so that they know where to go when something happens
- we should inform the staff about risk factors and how to recognize risky situations, and help them eliminate these by practical means such as guards, locks and monitoring.
- we should also teach them how to encourage and enable women to help each other: so that they form their own alliances with other women in the centers. This also empowers the shelter staff: it helps them to help these women.

In addition, MOVISIE produced a method to make sexual and domestic violence part of the "inburgeringprogramma": the familiarization procedure to introduce Dutch society and culture to migrants and refugees. We also collected numerous interventions for women and domestic violence: building empowerment under the MOSAIC project. An important element in this project is the exchange of experiences. Most of the advice of the research in the reception centers was taken to heart, and the situation in centers improved, but a follow-up of this evaluation research has never been done.

However, we still get signs of unsafe reception centers:

- Recently we heard about prostitution in the neighborhood of a center.
- Protection of children is not yet guaranteed. In the past medical staff reported a lot of child abuse.
- There are a lot of abortions and teenage pregnancies.
- Unaccompanied minors are very vulnerable. Research pointed out that 10% of the boys and 40% of the girls reports experiences of sexual violence.

We do not know if these are pre- or post flight experiences, but because of the high number of pregnancies amongst young unaccompanied asylum seeking girls, we still are very worried about this group.

Recently Pharos was involved in research concerning undocumented women.
44% of these women reported sexual violence, 51% abortion and 58 % problems with contraception. Female Genital Mutilation (FGM) is also a very serious problem. It occurs in the Netherlands as well as in the rest of Europe. In the Netherlands we have a well developed policy on preventing FGM. Pharos works together with refugee groups in the fight against FGM and trains professionals to play their part and act responsibility on this. However European policy is needed in this field.

New data, same problem

Looking back on this, it is no shock to see the results of the new research that was presented to us today, and that looks at a much broader group of refugees and undocumented migrants. I say it is no shock because we did expect it. We are dealing with a very vulnerable group under a lot of stress. But of course in reality it is very shocking, that people who have fled from dangerous situations find themselves again under danger and violence in the places and centers, where

we all said they would be safe. The community researchers have already told us this morning that something will have to change. How difficult it was to get the stories of the refugees and asylum seekers: most of them had never before talked about their problems in this field.

Violence take place during the flight, during the arrival stage (by staff or other refugees) and in the family itself (domestic violence). To develop an effective prevention strategy it is important to know when and were the violence took place. It is the same hidden violence that we see here: intimidation, sexual violence, assault, etc. It has been happening for many years and only now is becoming visible, thanks to the brave work of 23 interviewers, who themselves were refugees and asylum seekers. Many cases are confirmed or clearly reported. See also the quotes on the posters. The community researchers have formed an important bridge to reach these people.

It is brave work they did, because it is painful and shameful. It is painful to hear the stories of abuse and assault. It is painful to hear of abuse by the staff of the reception centers, by immigration officers and so-called helpers. It is also shameful because there is also a lot of violence among the group itself.

It is also hidden violence because asylum seekers, refugees and undocumented migrants are not in a position to complain:

- They feel dependant on the institutions and are afraid it might have a bad influence on their asylum procedure
- People without papers are afraid they might be kicked out of the country if they go to the police after.
- Single women or single mothers have no protection and are afraid to be kicked out of the communities.
- Undocumented women and their children can often only survive by looking for male protection. This guarantees them a place to live but usually at the cost of accepting violence or sexual favors.
- Also the social-cultural taboos around sexuality in some communities, coincide with a sense of shame, which may hinder victims to speak.

And maybe refugees think it is not very polite to show grieve and complaints to a host… maybe they feel they should be grateful to the host country.

Part of all this violence is caused by asylum procedures itself. Although the procedures in the Netherlands are generally shorter now, many refugees experience even greater problems. In a shorter time span, not enough consideration can be given to the “real story” of the violence, including all health details. Asylum seekers in Holland have to tell their whole story within 48 hours. Victims of sexual and other forms of violence often are not able to tell all the details of their story in such a short time. In general the whole asylum and immigration procedure is still a very stressful and frustrating process that can take many months. One of the Community Researchers expressed it like this:

> *"The undermining situation of asylum seekers, the institutional violence, is the mother of all problems refugees face".*

Future steps: Role of MOVISIE and Pharos
MOVISIE and Pharos want to provide advice and be frontrunners in how to make it safer for this group. As MOVISIE we were very honored to be invited by ICRH to participate in this project as the project leader in The Netherlands. In this, we worked together with Pharos. MOVISIE and Pharos, will put safety for asylum seekers and undocumented migrants back on the agenda.

For us this new research puts us back on track: this gives us the data we need to look again at procedures and shelters and trigger the responsible institutions and government bodies to improve and also tell them HOW to improve.As MOVISIE and Pharos we intend to improve the safety situation of asylum seekers, refugees and undocumented migrants in collaboration with you, the community researchers, by activities on different level:

On a political level:

- Creating a lobby to put this issue back on the political agenda and target the responsible government bodies. Pharos and MOVISIE will speak with the responsible members of the government on this.

On the institutional level:

- We want to make sure the outcomes of this research are known and used (and this is about healthcare, psychological and legal help): The trauma of these people did not end when they left their home ground: they are still victim of abuse and intimidation as we speak.
  If health and shelter institutes want to give effective support they should be aware that the violence has not stopped! We will inform health-workers and shelter-organizations and offer them training on this topic. Reorganization of the health system for refugees and asylum seekers will create the possibility for more focus in improving the medical help.

- Staff at shelters and reception centers should be more aware and receive more training in noticing possibly dangerous situations, in risk analysis and early identification of violence. They should be more receptive to the possibility and problems of continuing violence. It is necessary to evaluate improvements and keep monitoring the situation on safety. We will strongly advise the ministry of justice to do so.

On the level of asylum seekers, refugees and undocumented migrants:

- It is our job to inform them about our social structures: where they can report violence and where they can get help.
- We will continue to offer them training and empowerment, to stand up for themselves and learn what they themselves can do to make them less vulnerable. They should

also understand that the prevention of violence is a human right, it is their human right.
- We will offer newcomers training on sexual health and rights and we will go on improving our methods in this field.
- In all this we will continue to work together with refugees and professionals in the prevention of FGM.

Part of this is also implementing the prevention tool that was presented today:
We will make sure it reaches them:
- in the reception centers for people who are still in the procedure,
- it will reach the refugees with a status in the naturalization/introduction courses
- and it will go to the undocumented migrants and people without papers through organizations working especially for them.

In reaching this group the community researchers can play an important role.

What we have to do is this:
To get the commitment of the government and institutions involved in supporting these vulnerable groups. And of course we have to find money to organize this.
Inhabitants and organizations are invited to co-operate with us. We like to continue the collaboration with the community researchers trained. Our work will be focused on activities in the Netherlands, but of course Pharos and MOVISIE are very much prepared to participate on a European level.

As refugees often travel between different European countries I think it is important that we fight for this in the EU. This project and this seminar is a very good start. A start to improve the situation and policy of refugees on a European level.

I hope to meet you all again in a future seminar where we present the positive results of these activities in all the European countries! I wish you good luck and success!!
Thank you for your attention!

Café Contact
See Appendices for a list of the organisations that displayed books, newsletters, posters, leaflets and other information about their work on sexual and gender based violence.

3.3.8 Conference presentations Day 2

Summary and programme
Hilde Bakker, MOVISIE

Good morning on the second day of the seminar. We were busy yesterday exploring a lot of issues and problems that asylum seekers and refugees face in healthcare and experiences of violence. We did serious work yesterday and the workshops have provided recommendations for the panel to consider after the coffee break.

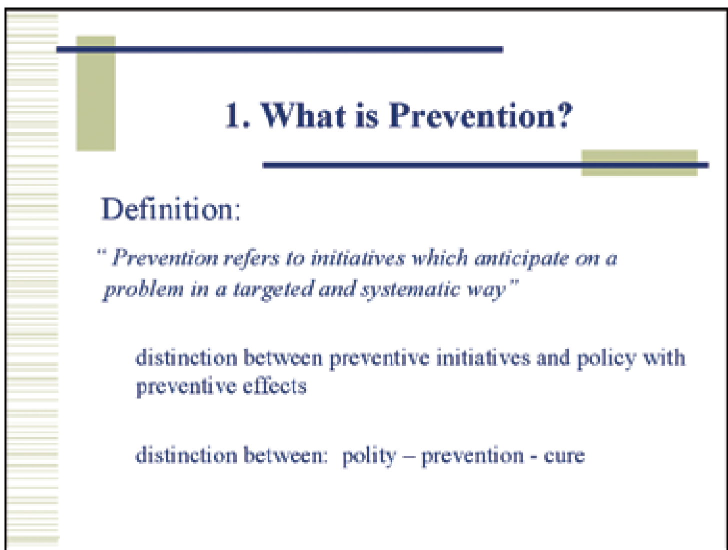
This morning the focus is on prevention, as this is one of the main goals of the project. We have had a lot of input from Professor Dr Nicole Vettenburg on working on this subject. Prof Vettenburg is globally recognised as an expert in prevention. After her introduction we'll present our prevention tool: many of you haven't seen this, and we hope that you find it positive. After the break we will present the workshop recommendations as a Call for action to our panel of policy makers. Finally we will conclude with a dance performance which is part of the exhibition Migration in Jewels in Migration by Villa De Bondt and a walking dinner.

Now Professor Vettenburg will tell us more about 'Desirable Prevention'.

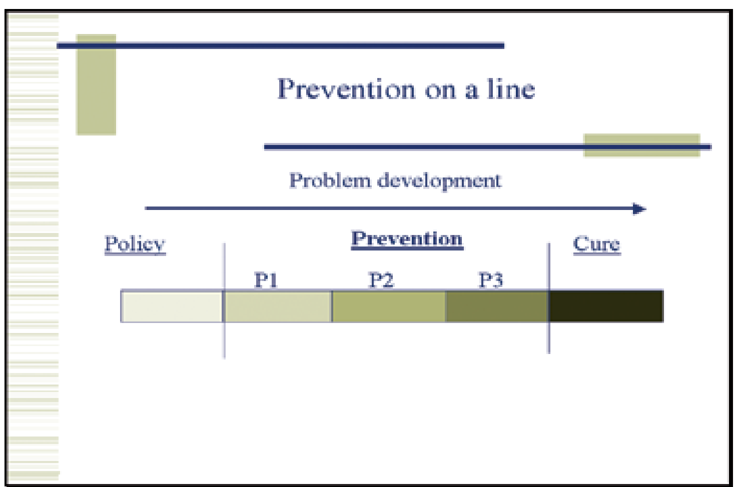
Introduction to Desirable Prevention
Prof Dr Nicole Vettenburg, Ghent University

Good morning. I will explain something about prevention and more particularly desirable prevention. A few years ago Ines contacted me about the model of prevention that we have developed. Ines thought it would be good to apply it to her project, and now here I am with people much more expert than me in issues to do with asylum and migration. I know something about the theory and practice of prevention but with regard to social work rather than refugees and asylum seekers.

The aim is to motivate you and give you a task, a challenge – you can put the prevention model in your day to day practice. If I would ask each of you to give a definition of prevention, I will hear a definition per person, each with a different emphasis or priority. I do it every year with the students. When you look at society, the notion of prevention is used for a lot of things. For instance, better school climate can prevent violence, or you can try to prevent global warming, and so on. People say that prevention is better than curing. But is it? It depends on what kind of prevention, who has the power, what is its aim. So prevention is always related to values, and when we started to research it was very difficult to get a working definition. After two weeks we made a distinction between what is prevention, and in what way we want to work on prevention. The "what" and the "who".



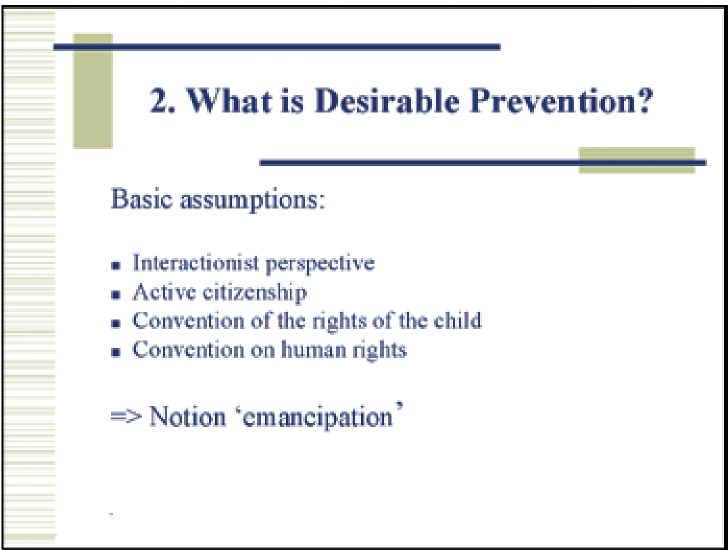
Each word is important. For instance, school is not a prevention initiative because it has another aim - to learn, to educate. But school has a preventative effect. It is important you are clear what you aim to prevent. The difference between prevention and cure is important. Cures are also preventive, but for prevention we go further, we are more specific in advance.



Individual and general prevention

Individual Prevention		General Prevention
×	Initiative	×
×	Systematic	×
×	Problem	×
×	Anticipate	×
×	Targeted	×
×	Individualised target group	⊗

For instance a young migrant begins with lots of negative experience, and this means they may commit violence. So the youth worker puts him in the squad of the football team, with the intention of preventing problem behaviour. When you see all the migrants on the football team you don't know who will benefit, and then you are working in a general way. So individual prevention has the same elements, only the target is different.



A problem is an outcome of an interaction between a person and a society. So it is crucial to work on both sides - in interaction and as a permanent learning process. All these assumptions are in development of the notion of emancipation. It has an individual and a social aspect that are both in development. The aim is to make emancipation of every citizen possible.

Desirable prevention

" Initiatives which anticipate a problem in a targeted and systematic way are describe as 'desirable' when they,

- attempt to anticipate increasingly earlier on risk factors
- are maximal offensive
- develop an integrated approach
- work in a participating manner
- have a democratic character"

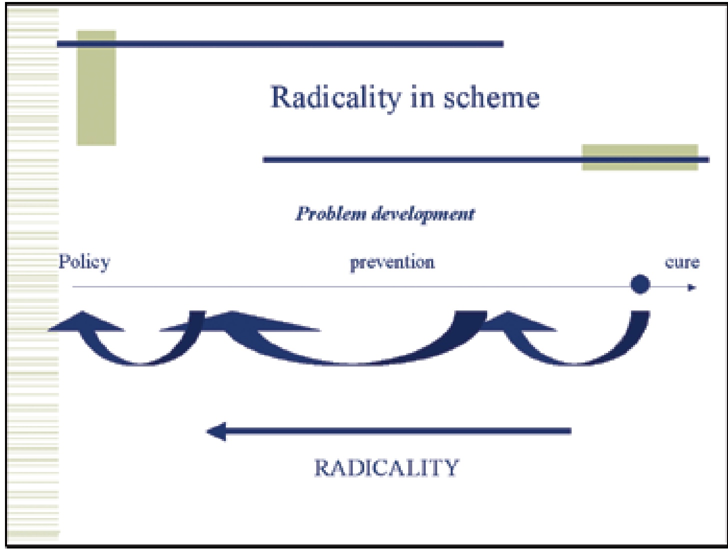
Five dimensions

1) radicality (stage in problem development)
2) offensivity (defensive – offensive)
3) integrality (person – context)
4) participation
5) democracy

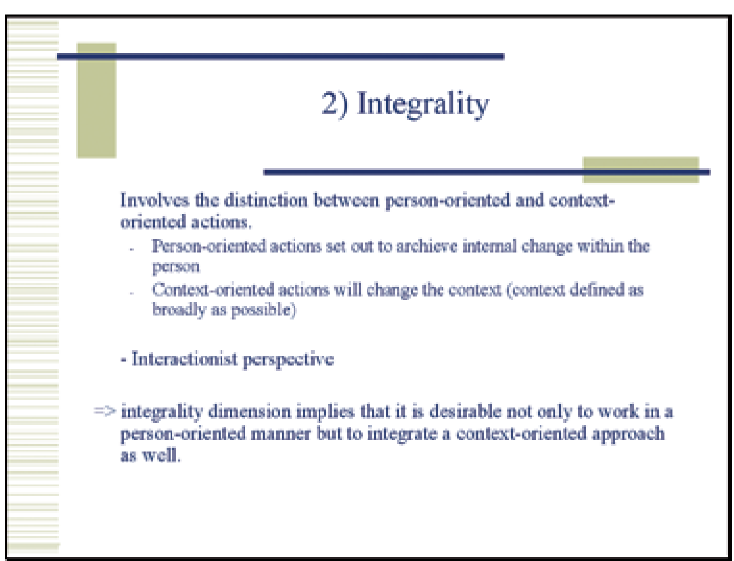
1) Radicality

Refers to the "problem development" stage.
Actions can be undertaken in the early stages of a problem or when it has already reached a further development stage.

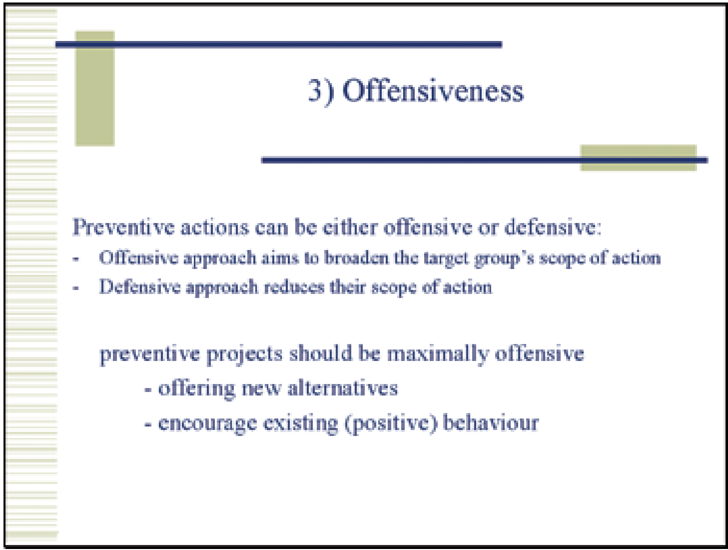
=> stop the problem as early as possible.



You have to focus on the reason underlying the development of the problem. For instance, yesterday, the research results showed lots of information about causes. This is very important because it links to how we can prevent problems. Then it is important to communicate the knowledge and experience we gain from this, to share it with agencies that could intervene at an earlier stage. We need to act ahead of the development of the problem. In social work they say, 'we don't have time to do this kind of work', but it is very important if we don't want to have these problems 20 years on.

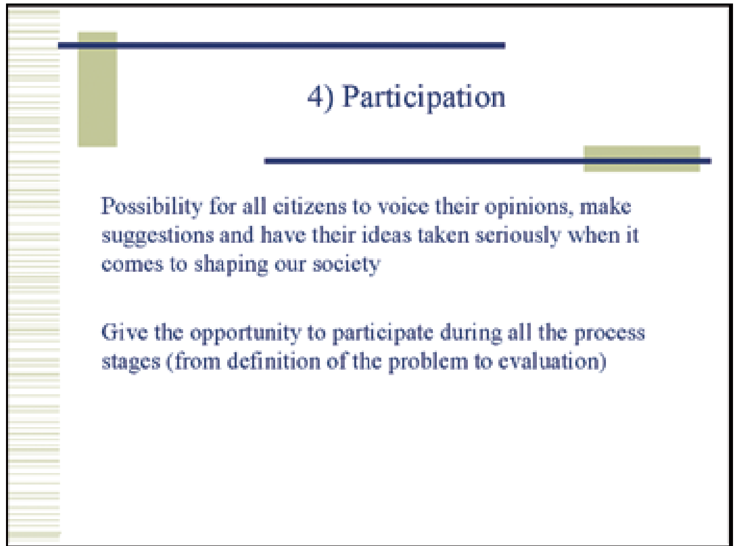


Person oriented – a lot of activity focuses on the person.
Context-oriented – could be family, school, institution, services etc
Which is better? We say you can do only person oriented, you must always see if there is a context way and that is the priority.

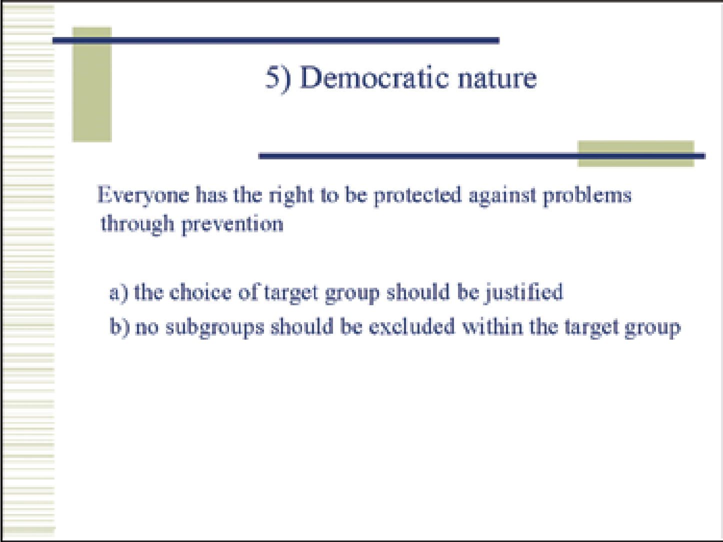


The 'offensive' approach will say that the aim is to broaden the target group's scope of action. In some circumstances it is not possible to be maximally offensive because there is too much danger. You need to encourage positive behaviour. For instance, there was lots of information yesterday about giving information to people about their rights. The further you are along the line of problem development, the harder it is to be offensive. It is very important to be early on the line of problem development, so you can be more offensive.

Defensive action is about controlling, reducing the problem.



Participation can be direct or indirect. For prevention, it must be the most direct way possible. For this, it is necessary that we have information that is not too indirect.

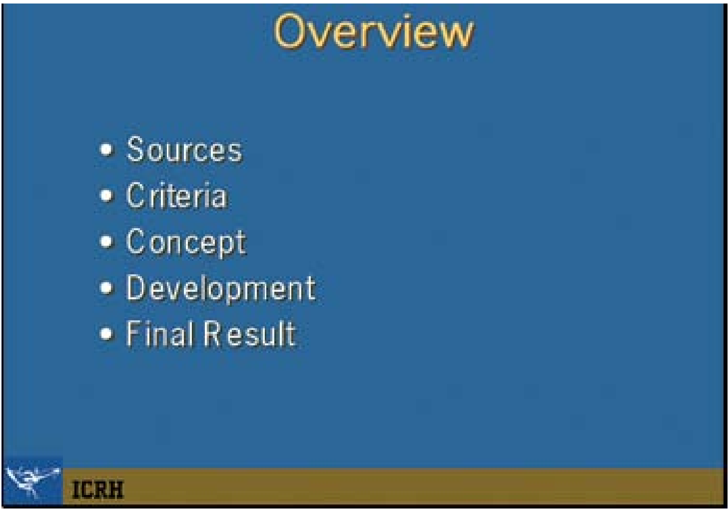


It is unethical if some groups are excluded from prevention action for whatever reason. This is easier to say than to do. So you need to give good arguments as to why you work with certain groups. When then target group is defined, then do not exclude sub groups, for example, people with disabilities, people who are illiterate.

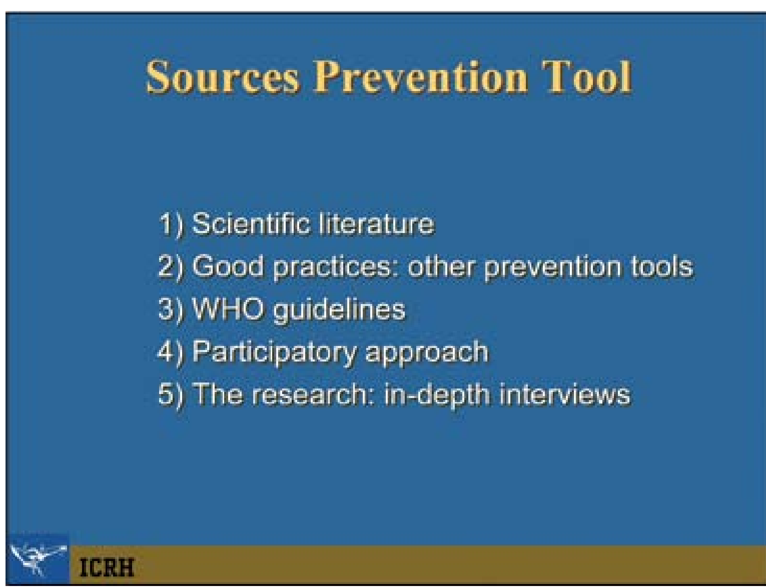
This is briefly the model we have developed. You can use it to reflect on your work every day. It is a model for participation. Thank you very much for your attention.

Presentation of prevention tool and panel
Hilde Bakker (MOVISIE), Koen Dedoncker (vzw ZIJN), Baharak Pourmirzajan (CR), Marijke Van Petegem (NVR).

Hilde Bakker: We will take you through the various stages in developing the prevention tool.



We used a number of resources to develop this tool, including Prof. Dr. Vettenburg's desirable prevention theory. We made an overview of existing tools and of what scientific literature and guidelines as the one from WHO and UNHCR state in order not to duplicate work, and to get some good ideas.In Belgium and Netherlands we found that there are several of tools on preventing violence against, but there was nothing specifically for preventing violence against refugees.It was important to use the input of community researchers, the community advisory board, and the input from the respondents' interviews.



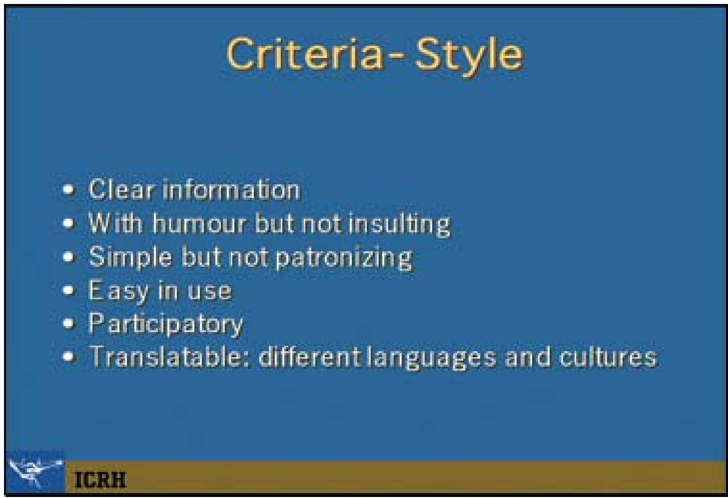
We developed some criteria about the target group, the content and the style, to which the tool should conform.

Criteria - Target Group

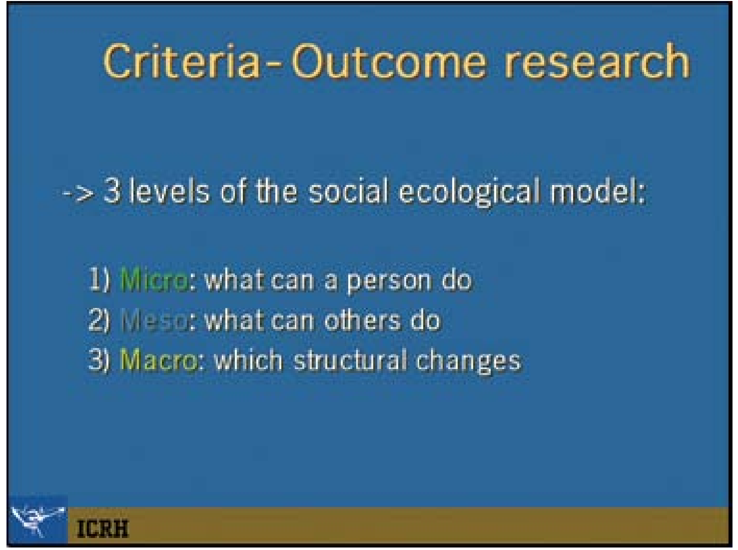
- Every new-coming refugee, asylum seeker & undocumented migrant
- Main target group: between 20-29 years
- Men & women
- Potential victims & offenders
- Target group research: Roma, Kurds, Afghan, Iranian, Iraqi, Somali, people from the former USSR
- Intermediary organisations & service providers

Criteria - Content

- Participatory
- Empowering
- Interculturally acceptable
- Risk reduction
- Breaking Taboos
- Rights -and Genderbased approach



Ines presented the results of the research and we considered what the respondents suggested for preventing gender violence. What do they need? We considered prevention on three levels.



Micro

Having knowledge en information about:

- Their rights as a refugee
- The host country
- Sexual health
- Sexual Violence
- The prevention of sexual violence

ICRH

Meso

- Knowledge about safe relationships
  - How can you trust a person?
  - How can you avoid sexual violence?
- Support network in general
- Network with people of host country
- Information & Education
- Making violence debatable
- Participation in society
- Psychological help

ICRH

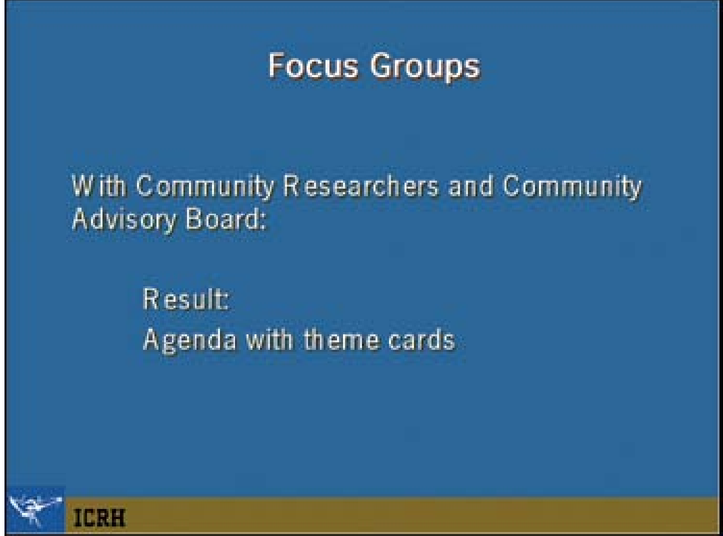
Macro

About the legal status & rights:

- A shorter asylum procedure
- Clarity of standards
- Perspective
- Not be treated like criminals or animals
- Access to:
  - education
  - work
  - health care
  - society participation
- Skills of staff in reception & detention centres
- Safety measures

ICRH

Koen Dedoncker: All this information had to be translated into a practical tool…



Why an Agenda?

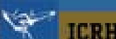
- To put violence against refugees 'on the agenda'
- As an introduction to Europe: working with agenda's
- Accepted to have it with you always
- Useful information & addresses always at hand
- To note appointments with doctor, lawyer, etc,
- To stimulate networking

ICRH

Development (1)

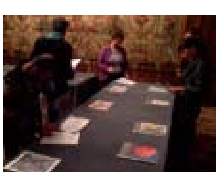
- Theme Cards

  * Choice of themes
  * Designer contest with jury



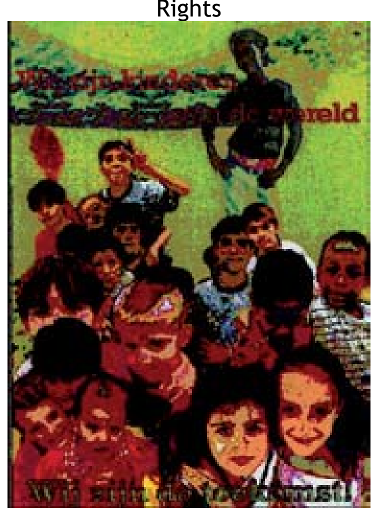
ICRH

Here are some pictures from the designer contest with the jury.



We ended up with 12 different themes:

Rights

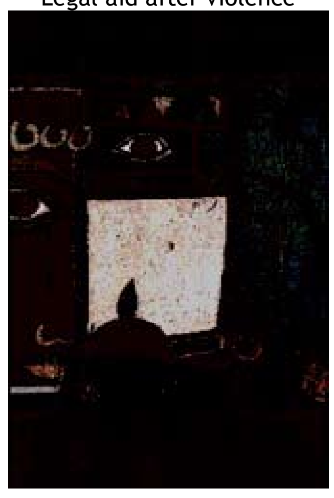


Social Network

Relationships

Reproductive and Sexual Health & Risks

Legal aid after violence



Partner violence

Sexual Harassment

Sexual Violence

Sexual exploitation

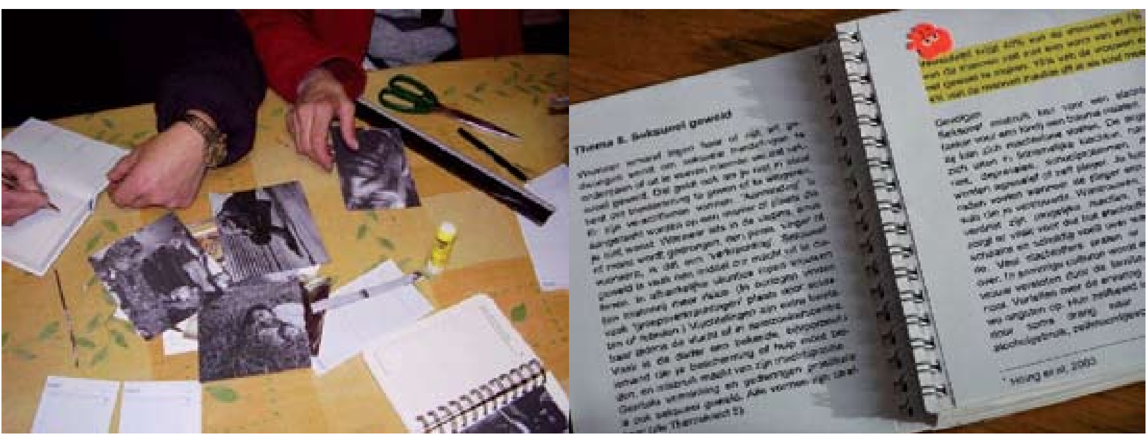
Help for offenders

Victim support

Honour-related violence

Once we had the themes, we made a prototype.

Making of the prototype

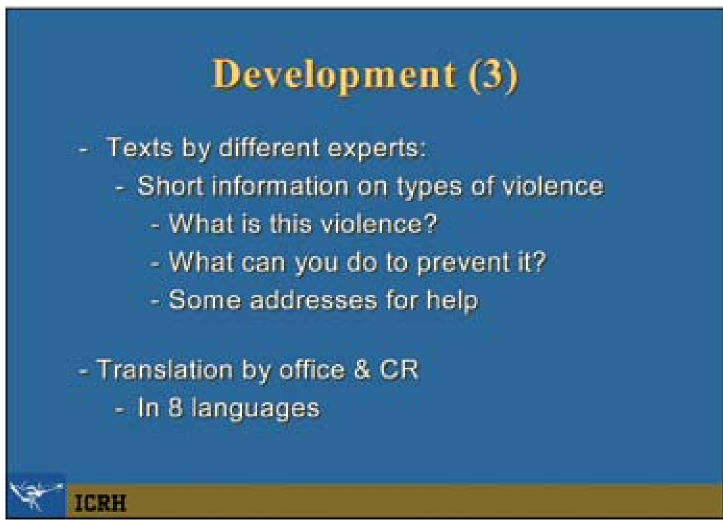


The prototype was tested by community researchers, the community advisory board, and the respondents, to see if anything needed changing.

Pilot testing Community Researchers

Pilot testing Community Advisory Board

Once fine tuning done, we started writing text to accompany themes. This was done by partners and several members of the Community Advisory Board. The translation was mostly done by Community Researchers.

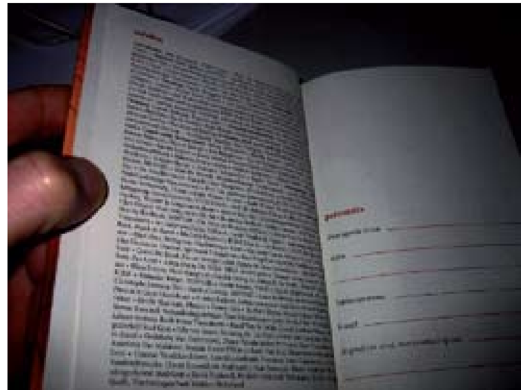


Marijke and Ines did the proofreading. Then came the layout and the printing,done by Lannoo.

Layout

Print

Marijke Van Petegem: We took some pictures of different parts of agenda. This is the acknowledgements and the space for the owner's personal information. There are a lot of acknowledgements, but we did not want to miss anybody out. The personal information is like in any agenda.



The introduction and manual section is about how to use the agenda. It includes information about the project, so the target group understands where this agenda has come from. They will know that other refugees, asylum seekers and undocumented migrants also worked on this. The manual is useful to explain all the different parts of agenda.

There is 1 illustration for each month. Each illustration has a quote from the interviews on the other side, and the quotes relate to that particular theme. The agenda is in 9 languages. The community researchers did a lot of the translations themselves.

Theme cards with quotes, texts and translations

The calendar is for 2008. It is already February now, and so we decided to start the calendar on 14th February 2008, starting with this seminar as to say: from this seminar onwards we will take sexual and gender-based violence against refugees, asylum seekers and undocumented migrants seriously as well as the prevention of it. The calendar ends on 13th February 2009. There are intercultural dates and festivals relevant to the target group.

There is a list of useful addresses for Belgium and the Netherlands, a 2009 overview and school holiday dates, a Birthday calendar, and blank pages for contacts, helping the target group build up their own social networks.

List of addresses

Overview 2009 and School Holidays

Birthday Calendar

Blanco pages for contacts

There are 16 removable postcards. There are the 12 themes, 2 support cards (one for women, one for men), and 2 “joker” cards with quotes in different languages. You can give them away, post them to friends, or use them in group discussions.

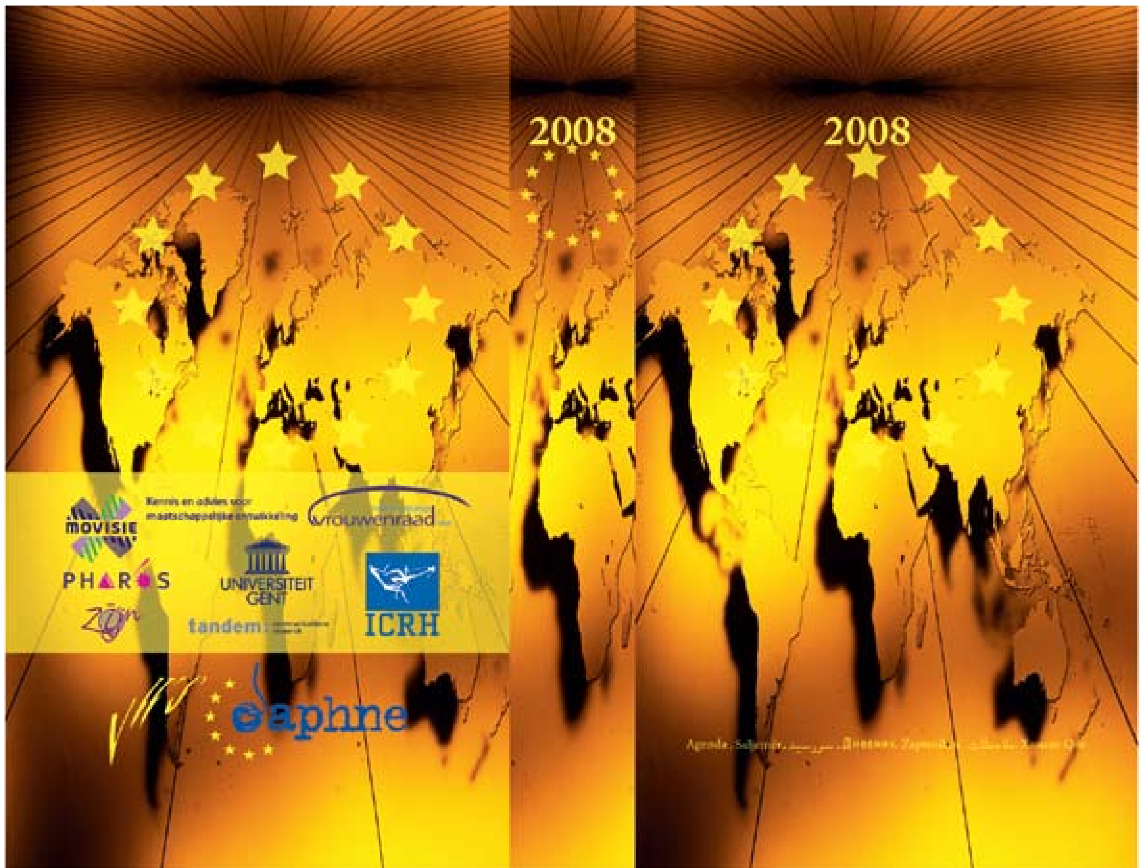
Removable postcards

At the back are network cards for social networking.

Network cards

The cover was made by Baharak, who did a really great job. We have the honour to give her the first agenda, and she will explain us why she chose to make this cover.

Baharak Pourmirzajan: I worked on this project as a community researcher and graphic designer. I will explain why we chose this cover for diary.



In the background of the cover is a map of the world. This means that our project works with people from all over the world. The EU stars mean that we work in EU countries. The lines symbolise people migrating and coming together from all over the world. The lines converge just above the agenda. This symbolises that the agenda can help people reach a place where they can live without fear and without violence. Thank you.

Hilde Bakker: Just to say a bit about what we are asking of you now. We want you to disseminate the agenda as broadly as possible amongst our target group, especially the ones who are still to arrive this year. Individuals can use it on their own, but it can also be used by intermediaries. It helps professionals broach these difficult subjects with the target group, and it also provide references for seeking further help and advice. It can be used in groups, for instance on

resilience training courses and induction courses. We recommend that you read it first and then use it in discussions.

Please bear in mind that this tool has only had a short development time, and it does need some improvements. Your input would be really useful for when it comes to revising it. We have made 26,000 copies of the agenda, which is 13,000 for Belgium and 13,000 for the Netherlands.

We will distribute the agenda through reception centres, partner organisation and so on. The agenda is also downloadable from the ICRH website and in Belgium hard copies can be ordered at Sensoa. It is a European project, funded through Daphne, and part of the understanding is that is should be accessible to other EU countries and throughout the world.I hope you can encourage the target group to use the agenda. At the coffee break, everyone will get a personal copy. Finally, thank you to everyone for making this possible.

Presentation of Workshop Recommendations for Sustainable Change
Ruth Wilson, Director, tandem

Introduction Hilde Bakker, MOVISIE: First, Ruth Wilson – one of our project partners, from Tandem Communications and Research in the UK. Ruth has been very active since the beginning of the project, on steering group. She and Vivienne Brown will be writing a report of the conference which will be available on the website. Ruth has been putting together a presentation from workshops.

Ruth Wilson:
I'm on the steering group, but haven't been involved in the hard work of the other partners and the community researchers, in carrying out the day to day research and preparing the prevention tool. I am very proud to be part of the group. The Refugee Arrivals Project was going to be a more active partner in the project, but they had to close – this is indicative of the state of refugee sector in UK.

I am going to give you a summary of the main recommendations emerging from yesterday's workshop. I have been looking at this with Ines. We have tried to catch common themes and aspirations across workshop, and we have also drawn on Ines's knowledge of the research and its findings. We haven't been able to include all the detail given in each workshop – there are some very good recommendations that won't be included in this summary. However, we will also publish the full list of recommendations, as part of the final report.

The partners in the project, and I hope all of you, will look at carrying these issues forward to policy makers. ICRH is co-ordinating the development of a new network, and this could be a very useful mechanism.

1. Policy recommendations

- Human rights obligations of EU & MS governments towards asylum seekers and undocumented migrants must be upheld:
  - Right to work legally
  - Right to study: higher education too
  - Right to receive health care: more than emergencies
- Implement ICPD Cairo & Beijing+ Action Plans for sexual & reproductive health

ICRH

1. Policy recommendations

Embed participation of refugees/asylum seekers in:

- Development of policy at all levels
- Development & delivery of services
  - Empowerment needed

Make participation a criterium of:

- Funding
- Good practice

ICRH

2. Structural recommendations

Raise awareness among:

- Host community & Refugees/AS/UM
- All ages
- Men/women: perpetrators & victims

Through: Different Media & Locations

On a range of topics:

- Sexual Health, Rights & SGBV
- Countries of origins, migration
- Rights & procedures

In appropriate languages

ICRH

2. Structural recommendations

Networks +
Collaborative research +
Sharing of knowledge & good practice:

- Multisectoral
- Multidisciplinary
- From grassroots to senior policy level

ICRH

3. Service recommendations

Service provision:

- Diversity
- Culture awareness
- Partnership working
- Community involvement
- Flexibility
- Respect
- Multi-lingual
- Targeted approaches to the hard to reach
- Support & training for staff & volunteers

ICRH

3. Service recommendations

Role of reception centres:

- Dialogue about role/existence of centres
- Safe places for women/men/children
- Involvement of residents in policy making
- Support & training professionals
- Information & meaningfull activities for residents
- Sexual & reproductive health
- Sexual & Gender-based Violence

ICRH

3. Service recommendations

Prevention & Care:

- Developed gender-focused prevention: male & female!
- Develop effective treatment options for perpetrators
- Safe places regardless of immigration status
- Adequate resources/funding
- Cooperation between different services as police, health & social workers, policy makers, ngos, cbos, ...

ICRH

Recommendations

- Extensive list in final report
- Powerpoint on www.icrh.org (March)
- Lobbying at all levels
- HERAnetwork: European network for promotion of Sexual & Reproductive Health of Refugees, Asylum Seekers & Undocumented Migrants in Europe & Beyond

ICRH

Panel with European and National Policy Makers
Chair: Gie Goris, Chief Editor Mo Magazine
Panel:

- Anne Van Lancker, Member of European Parliament, Belgium
- Prof. Dr. Marleen Temmerman, Senator, Belgium
- Paola Pace, International Migration Law and Legal Affairs, IOM
- Blanche Tax, European Affairs Officer, UNHCR

Chair: The first question is for Prof Temmerman – what motivated you and your team to start this research?

Marleen Temmerman: It goes back to start of ICRH – in 1994 with a small group of people, following the Beijing recommendations; we decided to start a research group. We are mostly from a medical background with experience of working in different developing countries. Health is more than just a problem of medical staff, it needs a multi-disciplinary approach, for instance legal, social, and so on. A participatory approach that is not just about professionals, but the need to work together with target groups. We had to knock on doors and find funding. Why sexually violence? Well, for 30 years I've been working as gynaecologist, and you see violence against women everywhere – Kenya, here, other countries. But people don't talk about it. So we decided, let's focus on most vulnerable people (refugees, asylum seekers), and we find it happens here in Europe too. We got funding from Daphne, and that was the start of the project.

Chair: I have questions now for the other panellists:
What did you think when you received results of research – did it surprise you, shock you, or reconfirm what you knew?

Blanche Tax: UNHCR is working worldwide, but most relevant to this case, we are also working in Europe trying to protect refugees and asylum seekers. I don't think as such the results were new to us, but the numbers were quite shocking. We know from our work that refugees and asylum seekers are vulnerable to this type of violence. But to see here data based on real interviews – the numbers are shocking, and we are trying to think how can we explain that. We know that things go underreported. In this project, people volunteer to participate, they are reasonably highly educated, the kind of people that do have the courage to speak out. So that is distressing because the figures among other groups who are not empowered - the figures for them may be even higher.

Paola Pace: I also wasn't necessarily shocked, but more work has to be done at European level. One thing that got my attention was that when asylum seekers, undocumented migrants etc want information on sexual and gender based violence, they will seek information from health personnel. But at IOM we know there are inequalities with regard to access to health services and health states. So if people want information from a health professional, how can they approach them? Not just irregular migrants but also regular migrants have this problem.

Anne Van Lancker: I was shocked but not surprised. Recently, on the UNIFEM website, there is a campaign going on: it shows that one in three women has experience of gender based violence. I recommend you all sign up to this campaign.

So I am not surprised by the figures, but the stories are shocking, it's a grave and cruel experience. The stories are refutable, but they show you have different levels of gender-based violence. When you see they lead to death, suicide – you can see it is very cruel. In research you see it is so cruel because of the vulnerability of refugees. With women and children in refugee camps, we know that the situation is very harsh. It's also a very fragile situation for refugees and undocumented migrants here in Europe. It has not only to do with trafficking - which is on EU agenda – it has to be pushed further. But also there is violence in reception centres. This is unbelievable. We have been trying to get a minimum law for reception of asylum seekers. General guidance is there, but when you see that violence is happening in these reception centres, then a lot more has to be done.

Chair: I have a question to Prof Temmerman – you initiated the research, got the numbers, you see it happening, you meet women and minors in increasingly bad situations. But if you read in findings that more than 50% of those interviewed have come across sexual violence – it's very high!

Marleen Temmerman: I didn't expect it to be so high, particularly in the reception centres. This indicates that the gap between law and practice is still huge. It might be an underestimate or overestimate – some interviewees tell their own story, others tell other people‘s stories – we did everything possible so as not to have duplicated stories. It is a self-selecting group of those who wanted to tell their stories, so the findings could be an underestimate. This report is important as it shakes the community, policy makers at national and international level.

Chair: Which brings us to a quite striking point: policy makers, ministers from Belgian, Dutch, Flemish government were invited. None of them accepted or thought it necessary to be here. Does that reflect on their agendas, or the importance they place on this issue?

Blanche Tax: I don't think it is helpful to take their actions as lack of interest. I am sure if this research is presented, they will take an interest, it is their responsibility. Take the research to the policy makers, sit with them, see what should be done. But not everything can be fixed at policy level. Much needs to be improved at the level of policy implementation. Policy makers have a role, but that also happens at local level, with services, individual workers. I am sure if they had known that they would miss so many interesting discussions here they would be sorry.

Paola Pace: I cannot add much to that. Maybe this report can be shared in other forums, eg IOM, where many EU states are represented, there will be opportunity. The failure to attend doesn't mean people are not interested.

Marleen Temmerman: They have a lot of competing issues on their agendas. I am sorry, but when the report is out, we will ask a question in the parliament, and then the report goes out. That can raise awareness. Eg with FGM recently, we achieved this.

Anne Van Lancker: Look at the room. I welcome the fact that gentlemen took the time to come here. It is a majority of women in the audience. I am chairing a cross party working group in the European parliament that looks at sexual and reproductive rights, the Cairo and Bejing Agenda, but not everyone in parliament is sensitive to this issue. You can raise that. Franco Fettini, he was not so aware, now he is an advocate on domestic violence and trafficking. So now it is not only Benita (for example) who speaks up on FGM, it is also Franco Fettini. I think gender violence is a big big issue, so if you can give it profile, they will move. It needs not just dedicated senators such as Marleen, it needs the media.

Chair: Do we need new regulations, policies or implementation, and what is hampering implementation of laws and policies?

Blanche Tax: At EU level, there is an attempt to come to a more common asylum system. In that way, laws containing minimum standards, for instance with regard to the reception of asylum seekers in EU countries. This is in line with Human Rights standards, but can be improved.

For instance, access to work – the EU is vague and says that member states should determine a certain period for asylum seekers to not have permission to work before entering labour market. This is problematic. In reception centre, minimum standards have been enforced for number of years, and states have freedom to adopt higher standards. This had been an issue.

Asylum procedures directive – peoples' access to legal aid – it's only obligatory to offer legal aid at the appeal stage. Before that, it is not an European obligation to offer the legal aid. It would be interesting to look at violence – when in the course of the process does it happen? This year, the EC will put forward amendments to this policy, so now is right time to lobby for raising of standards across Europe.

There may also be an issue with implementing, which I have not particularly addressed, and there needs to be lobbying on all levels – international, national, local.

Chair: IOM did an overview of what is there with regard to instruments in Europe. Could you give us an idea of what is reasonable, what needs improvement?

Paola Pace: Yes, migration is not just asylum seekers and refugees but also migrants. It is not in itself a risk to health, but the conditions surrounding migration can impact on health, including on sexual and reproductive health, and this includes violence. So IOM has produced a short publication on EU community law in the Council of Europe instruments – the right to health as a human right, for all human beings, not just EU nationals. I was very touched by one of the

sentences on the posters here, one Kurdish undocumented migrant said 'We can't do anything, we are not human beings'. That touched me strongly. So please download the document, it is free. It looks at what can be done, what are the gaps. There are inequalities in health status, in reception centres. But even when people are accepted, we still find inequalities. There are administrative, linguistic, structural, political and many other obstacles.

There are tables I would like to draw your attention to. For instance, trafficking, this is very serious - labour exploitation for trafficking, and this includes many men trafficked for labour exploitation.

One thing with regard to irregular migrants in Europe, the response and access to health services is very difficult for these people. Sometimes we have instruments at European and international level, but then at national level they do not recognise these rights, or only to emergency care. I was recently in Bratislava, in a meeting of a council of 42 Member States. The emergency care message was made again. Yet we know that there is a right to health care for every human being, and the Committee on this explains what this means, for states to ratify, not limit, not deny equal access to prevention, cure and palliative services for asylum seekers, irregular migrants and others. So we must remind them of the vulnerability of undocumented migrants, asylum seekers, refugees, and regular migrants as well, for generations.

Chair: Do you have the feeling that EU legislation or rules are taking into account this vulnerability, or is EU the level that should push limits further, and make governments act?

Anne Van Lancker: Yes – Europe is the only continent that gives rights to not only residents, but even to undocumented visitors. This is great. The problem is that legislation needs to be strengthened – such as the right of access to work, which is left to nation states, or the right to access schooling etc.

We still have a lot to do. Many member states use minimum standards as maximum standards. From 2010, we are only going to have common standards – we must be vigilant to make sure that where nations are providing above those standards, they don't lower their standards to the minimum.

Sometimes we make good laws, but we find they are rarely implemented. It is not easy to ensure proper implementations – eg not all countries even have reception centres. Refugees, documented or undocumented migrants, tend to disappear into societies – this makes it difficult to ensure that they can access their rights and services. It involves a whole community – national, regional and local governments. A recent study on the conditions of refugees and undocumented migrants, their access to legal, educational, healthcare systems – found that nothing really guarantees this.

Chair: There is a long way to go. But implementation is a key issue. Marleen, you head this research centre, but you are also active in Belgian politics. How are we doing in Belgium?

Marleen Temmerman: I don't know where Belgium is in ranking of EU countries. I think we are doing quite well. If you compare Belgium with other countries I know, we can learn from others, such as Scandanavian countries. Speaking from the health care provider side. We need greater awareness of the population, including among health care providers, going by what I see daily in my own hospital. For instance, there was a junior gynaecologist, on an emergency at night, she handled in on the phone - another doctor said it was a bladder infection, 'she can come at 8am'. True, but this was a young prostitute, who had no home address, no doctor. So even in our own staff, there is a need for more education. Why was that woman coming at 1am? It could be an appeal for help, someone who can't come at another time. It's a never ending story. We have to raise awareness, make it part of training, on sexual and gender based violence. It is not covered in nurse training or at university. You don't get that just through a nice article for a newspaper, or a conference. I think that it should be mandatory, as in our recommendations.

Chair: How does this relate, your push for better policy and laws with public opinion? How do you assess the impact of public opinion and what to do about it?

Anne Van Lancker: Public opinion is scared of migration. But once people are here, people want those migrants to have the same rights. They are keen to get standards high. When some people aren't granted same rights, they feel it makes people feel unsafe.

Questions from floor:

1. What could be done with regard to monitoring? We shouldn't focus too much on political standards, but on professional standards. In Holland, for instance, the association of doctors spoke out in favour of giving migrants the same quality of care as EU citizens – this kind of thing is very important.

2. I am concerned about people with children in centres. EU laws say don't lock up children, but nothing done about it. Experience shows it is best to get them out of the centres and then people get better support. Open centres are just as bad as closed centres. When politicians visit centres, they are hidden from reality – people get extra food, and no chance to talk.

3. The right to access to health doesn't mean anything if right to safety is not respected. It is very important that people know what rights they have, and what are the plans on EU level, if any.

4. In the UK, asylum seekers and undocumented minors have the right to healthcare, but the government is thinking of reducing this to emergency care only. Campaigns have started against these proposals. What is the EU standard, and is there anything that we can do to prevent lowering standards?

Blanche Tax: About the right to information and knowing rights – this is included in EU legislation for asylum seekers, but not for undocumented migrants. Member states have to inform people of their rights within 15 days of arrival. In practice, nations have different ways of doing this – for instance a leaflet, translated into certain languages, or translated advice sessions. The implementation is different, and the monitoring is lacking. More needs to be done and improved.

Professional standards are incredibly important – legal aid people, social workers - people need to focus on their own professional standards, and also communicate more and come up with responses, including across disciplines/professions. They should sit together, learn about each other's work, and find ways of collaborating.

Paola Pace: Yes, what can a serious society do about monitoring. For instance for women, their rights to sexual and reproductive health. Through CEDAW you have a committee, so what the research centre and others can do is when the committee, when a rapporteur visits the country, an NGO can present its own report on the situation in that country, on the gaps, That can help with the implementation and application of rights

Also I like what is said about health workers. They can influence the situation. In Italy, where I am from, the law was amended because health workers refused not to provide health care, and legislation was changed and much improved. Information about violence, and help after: there is much the health professional can do.

About detention centres: that should be the last resource. There are other options. And that is the role of member states. We must work with the governments, not set up parallel structures.

Marleen Temmerman: It is good and timely to see that a number of EU countries are working on bringing healthcare to up the appropriate standards. With regard to detention centres, in Belgium there is a lot to be done. There was a recent visit by politicians, but they didn't hear the stories or see the people that they should have seen.

Anne Van Lancker: If you have the laws, how do you implement them? The CEDAW procedure is like naming and shaming. While reviewing processes, countries are asked to write reports about how they are implementing laws – and this is a chance to focus on best practice. Detention centres and children – this is becoming a real issue in Belgium, and it is important to keep lobbying. When countries choose to use detention centres, you always need to provide guarantees, information and rights.

I must end by touching on the EU providing information on rights. The EU has done just about everything that it can do because country circumstances are different. The definition of 'emergency care' is different across Europe – for instance, pregnancy is sometimes included, sometimes not. People don't know how to get healthcare rights. You can only combat and campaign through profiling the countries that have good practice, and trying to get other countries to adopt this good practice.

Chair: That is a mobilising note to end with. We need to look at issues from the point of view of best practice to mobilise and move the issue forward.

Conclusion
Prof Dr Temmerman

This is the last but one part of the seminar. Before the dance and lunch, I would like to call up all the community researchers to come up to the front. We would like to give them a certificate and also some flowers, to thank them for all they have done. And our thanks go also to those not here with us today.

This is just a beginning. There are so many questions, more than answers. So we have to attract more funding, to draw more attention to this group. Thanks to all our partners, it has been a pleasure to work with you all. And I have to thank a very special person: Ines. Her motivation, her dreams, she has made so much happen and she has worked very hard. She had a lot of support from all of you, and of others at ICRH.

Finally I would like to invite you to watch the dance performance which is a part of the exhibition Migration in Jewels in Migration which you had the chance to visit throughout the seminar.

Dance performance & Exhibition Migration in Jewels in Migration
"Migration in Jewels in Migration" is a 'transboundary' exhibition that presents different aspects of migration as a historical and current fact. A selected group of both established and young talented Belgian jewelry designers go beyond the disciplinary boundaries in an inspiring interaction with dance and multimedia. Furthermore the exhibition is also 'transboundary' geographically speaking: both Flemish and Walloon designers present their work in a unique collaboration. The result is a heterogeneous sampling of the most recent developments in contemporary jewelry art in Belgium.

The issue 'migration' is being analyzed by the participating artists and inspires them to create new work. The following aspects are being considered: interaction and meeting of different cultures, migration as a limited and at the same time large 'movement in space' but also the inherent link between migration and jewelry. Viewed from the perspective of 'micro-history' we observe that personal jewels are often taken with/worn by 'emigrants' during their journey.

Jewels can be a means of payment but carry also an 'emotional significance/remembrance'. This fits in the current trend in international jewelry art in which attention is being paid to the (emotional) relation between the jewelry and its owner. (*Evelien Bracke)*

Participating jewelry artists:
Geertje Bruyninckx, Klaudia Croene, Michel Delpérée, Laurent Diot, Silke Fleischer, Bernard François, Michel Mousset, Katja Noelmans, Nathalie Perneel, Cathalijne Postma, Gwennaël Thérasse, Aline Vandeplas, Michel Vandenplas, Tine Vindevogel, Claude Wesel

Dance Performance: Rob Fordeyn

The exhibition is an initiative of Gallery Villa De Bondt (Ghent) and Gallery Néon (Brussels).
Curators : Wim Vandekerckhove & Miek De Brouwer (Villa De Bondt, Ghent), Bernard François (Gallery Néon, Brussel)
Photography: Wim Vandekerckhove (www.villadebondt.be)
Concept & multimedia installation: Harry De Neve

"I don't think refugees choose to become victims of violence. They are thrown into it by society itself, inhuman treatment, bad policy and a lack of guidance."

Kurdish refugee

"Hidden Violence is a Silent Rape" Seminar

"One day in Athens I heard the boy of about 16 in the tent right in front of mine scream: "I'm dying, don't do that any more, I'm in pain". I could hear everything. The traffickers had forced the boy into sex and hit him many times. The boy had called his brother in law for money, but it took some time to get the money transferred from one country to another. The money arrived half an hour late. I couldn't accept that any longer. I went outside and yelled: "What you are doing is the same what Saddam did!" They kept on committing weird sexual acts with him and said to other boys: "if you don't want to have sex with us, we'll kill you or we'll leave you behind half way". Due to all this sex the boy had appendicitis and hemorrhoids too, he had to be operated. Once arrived in the reception centre in the Netherlands the boy was very tired and psychologically ill. He drank a lot, ate little and became a skeleton. He wanted to commit suicide."

Female Kurdish Asylum seeker, living in the Netherlands

CHAPTER 4: SEMINAR RECOMMENDATIONS: A CALL FOR ACTION

“I want to scream out loud and say: enough! Let our children have a good life, we’ve seen enough misery!”
Kurdish Asylum Seeker

“Refugee children are the next generation who should participate in this society. But because of bad policy a whole generation gets lost. I think that when a country opens its doors for refugees, it should enable them to build a life and have a future in that country.”
Iranian Refugee

4.1 INTRODUCTION

At the EU Seminar “Hidden Violence is a Silent Rape: Prevention of Gender-based Violence against Refugees in Europe”, on February 14th & 15th 2008 at “Het Pand” in Ghent, Belgium, 8 workshops were held.

All workshops started from a human rights- and gender-perspective aiming at prevention. Every workshop was introduced by two key note speakers presenting a good practice in Europe.

The first four workshops addressed good practices in support and care for victims and offenders of sexual and gender-based violence practice:

1. Law, Rights & Police
2. Sexual exploitation
3. Health Care after Sexual and Gender-based Violence
4. Male Abuse(d)

The second four workshops addressed good practices in prevention of sexual and gender-based violence:

5. Empowerment in Prevention
6. Community Participation in Prevention & Care
7. Intercultural Help-Lines in Prevention & Care
8. Awareness Raising in Prevention

After the presentation of good practices, a discussion was held and recommendations were formulated for the topic of the workshop. The recommendations covered policy, structural and service recommendations. A summary of these recommendations was presented as a Call for Action to the 150 Seminar participants and to a panel of European and national policy makers at the last day of the Seminar.

Here we present the Call for Action as formulated at the Seminar.

4.2 SUMMARY RECOMMENDATIONS (as presented on February 15th)

Policy recommendations:

- Human rights obligations of EU & MS governments towards asylum seekers and undocumented migrants must be upheld:
  - Right to work legally
  - Right to study: higher education too
  - Right to receive health care: more than emergencies
- There's a need for a common EU policy on migration, asylum and violence prevention
- Implement ICPD Cairo & Beijing + Action Plans for sexual & reproductive health and sexual and gender-based violence (SGBV) prevention
- Embed participation of refugees/asylum seekers in:
  - Development of policy at all levels
  - Development & delivery of services
- Empowerment needed
- Make participation a criterion of:
  - Funding
  - Good practice

Structural recommendations:

- Raise awareness among:
  - Host community & Refugees/AS/UM
  - All ages
  - Men/women: perpetrators & victims
- Through: Different Media & Locations
- On a range of topics:
  - Sexual Health, Rights & SGBV
  - Countries of origins, migration
  - Rights & procedures
- In appropriate languages
- Networks + Collaborative research + Sharing of knowledge & good practice:
  - Multisectoral
  - Multidisciplinary
  - From grassroots to senior policy level

Service recommendations:

- Service provision:
  - Diversity & cultural awareness
  - Partnership working
  - Community involvement
  - Flexibility
  - Respect
  - Multi-lingual
  - Targeted approaches to the hard to reach
  - Support & training for staff & volunteers

- Role of reception centres:
  - Dialogue about role/existence of centres
  - Safe places for women/men/children
  - Involvement of residents in policy making
  - Support & training professionals
  - Information & meaningfull activities for residents
  - Sexual & reproductive health
  - Sexual & Gender-based Violence

- Prevention & Care:
  - Developed gender-focused prevention: male & female!
  - Develop effective treatment options for perpetrators
  - Safe places regardless of immigration status
  - Adequate resources/funding
  - Cooperation between different services as police, health & social workers, policy makers, ngos, cbos, ...

Recommendations:

- Extensive list in final report
- Overview on www.icrh.org (from March 2008 onwards)
- Lobbying at all levels
- EN-HERA!: European network for promotion of Sexual & Reproductive Health of Refugees, Asylum Seekers & Undocumented Migrants in Europe & Beyond : see www.icrh.org

4.3 RECOMMENDATIONS ON LAW, RIGHTS & POLICE

Workshop 1, Chair: Aintzane de Aguirre, UNHCR, Belgium
Speakers : Katrine Camilleri, Jesuit Refugee Service, Malta
Tanja Windbüchler, Intervention Centre against Domestic Violence, Austria

Increased gender sensitivity when designing law, policy and practice

Policy Recommendations:

- Need for a common and coherent European migration and SGBV policy with respect for the highest possible standards
- Instruments at different levels should recognize rights and overcome barriers to enjoy rights
- Implement Austrian model in other countries provided that conditions are fulfilled (e.g. barring order, cf. presentation Tanja Windbüchler)
- Honor crimes should be considered as a reason to obtain refugee status
- Ensuring that all are able to live in dignity

Structural Recommendations:

- Provision of effective means of redress
- Training of law enforcement officials and all involved in reception of migrants
- Training of case workers in asylum procedure to change perception / mentality towards asylum seekers
- Collaboration and independence between police and social services
- More outreach services / help-lines for migrants to raise awareness in a language migrants understand
- More proactively inform migrants in their own language, provide information on rights and legal issues, health care, social assistance, how police functions in host country in order to increase feeling of safety (e.g. through integration courses)
- Training in centers and schools on relations, how to live together, exchange of experience

Service Recommendations:

- Guaranteeing basic needs of migrants to prevent SGBV
- Shorten stay in reception centers and asylum procedure (6 months to max. 1 year)
- Access to social services even if undocumented
- Regular permit for victims regardless of willingness to cooperate
- More intervention programs for offenders
- Shelters for victims of violence:
  - There should be sufficient capacity
  - Access should be guaranteed for migrant women
  - Free of charge (for children) or possible if you don't have money with you
  - If needed, it should be possible to find shelter in another country

4.4 RECOMMENDATIONS ON SEXUAL EXPLOITATION

Workshop 2, Chair: Patricia Kennedy, University College of Dublin, Ireland
Speakers: Pieter Lauwaert, Payoke, Belgium
Dovile Rukaite, Women's Issues Information Centre, Lithuania

Policy recommendations:
- Relax border controls – reduce power of traffickers
- Rights based approach to bodily integrity
- Legislation to protect
- Protection as a priority rather than establishing status
- Anti-poverty policies to reduce the perceived need to migrate

Structural recommendations:
- Information at all levels
  - Officials, service providers, victims, others
  - Common definitions and interpretations
- Training & education for target populations & for service providers
  - To prevent
  - To identify
  - To inform
  - To respond
- Information campaigns on home country
- Public campaigns using different media & Tv shows

Service recommendations:
- Networking at EU level, as this seminar
- Good co-operation with local police
- Referral system, where professional help is available

4.5 RECOMMENDATIONS ON HEALTH CARE AFTER SEXUAL& GENDER-BASED VIOLENCE

Workshop 3, Chair: Dr. Peter Decat, ICRH-University of Ghent, Belgium
Speakers: Dr. Angela Burnett, Medical Foundation for Care of Victims of Torture, UK
Dr. Kristien Roelens, University Hospital Ghent, Belgium

Policy recommendations:

- For victims: Minimum means to survive and a minimum time for a fair process
- Implementation of gender guidelines
- Enhance participation of refugees in the development of protocols to deal with SGBV and policy making about SGBV
- Guarantees for undocumented migrants that reporting SGBV is not linked with deportation procedure
- Late disclosure of sexual violence should be considered seriously
- Recognize and ensure financial support for community asylum groups

Structural recommendations:

- Inform people who are entering the country about their rights in case of SGBV
- For social and health professionals: training on interviewing which can enable people to disclose
- Training in psychological items for health and social workers
- Training on domestic and SGBV for healthcare workers, social workers, workers in detention centers
- Safer accomodation in centers
- People feel safer in small centers
- Need for cultural mediators for reporting and seeking health care in case of SGBV
- Involve cultural communities to create and train key persons

Service recommendations:

- Multidisciplinary approach
- Healthcare workers should actively ask their patients for experiences with violence because women won't tell spontaneously about it
- They should initiate networks of community and healthcare workers to inform and work together in the field of GBV
- In psychotherapy one should focus not exclusively on the trauma but as well on the strength of the person. 'See the person beyond the trauma'

4.6 RECOMMENDATIONS ON MALE ABUSE(D)

Workshop 4, Chair: An-Sofie Van Parys, University Hospital Ghent, Belgium
Speakers: Ben Serkei, MOVISIE, the Netherlands
Dr. Guy T'Sjoen, University Hospital Ghent, Belgium

Policy recommendations:

- Next to psycho-social help, medication for chemical castration can be very effective for men with paraphilia:
  - Legislation on this treatment should be improved
  - The decision should be taken by forensic psychiatrist
  - This treatment should be refundable based on certificate signed by psychiatrist & endocrinologist after signed informed consent from the offender

Structural recommendations:

- Raise awareness on differences between man & women
  - Male codes (work, supporting family, ...)
  - Male abuse(d) is taboo ~ public opinion
- Education at all levels:
  - Children very early in school, violence is not normal
  - Training of professionals!
  - Be aware of our European/Western vision on this problem
  - Learning language to be able to find help
- Develop male-focused prevention & help: Prevention and cure of SGBV is now too 'women-centered'

Service recommendations:

- Focus on the men
  - As victim
  - As perpetrator
  - As both
- An anonymous registry for chemical castration should be created
- Better physical guidance of offenders should be guaranteed

4.7 RECOMMENDATIONS ON EMPOWERMENT IN PREVENTION

Workshop 5, Chair: Kristin Janssens, MOVISIE, the Netherlands
Speakers: Albena Koycheva, Bulgarian Gender Research Foundation, Bulgaria
Jan Breyne, OOOC De Morgenster, Belgium

Policy recommendations:

- European: To facilitate (more) research and sharing of good practice
- National:
  - Give asylum seekers the right to study and work
  - Have different centres, eg. reception, transition, integration centres OR no centres at all: let people live in the community
  - Shorter asylum procedure, but not a cost of quality/fairness of decisions
  - Integration policies should include tools that raise public awareness and understanding, look at situations in countries of origin
  - Regularisation of undocumented migrants
  - Facilitate networking between organisations to establish referral mechanisms
  - Improve situation in reception centres: e.g. overcrowding.
- Regional:
  - Provide resources to develop own support groups
  - Set up independent non profit organisations for reception of asylum seekers, with trained professionals

Structural recommendations:

- Inform refugees/asylum seekers & undocumented migrants on their rights and obligations and the legal procedures (in own language) re. different types of immigration status
- Inform them of the laws and legal procedure regarding domestic violence, sexual violence
- Network between organisations, establish and use referral mechanisms
- Train staff, management, volunteers who work with migrants
- Set up independent non profit organisations for reception of asylum seekers, with trained professionals

Service recommendations:

- Don't focus on problems, but on possibilities
- Build diversity in employment, inter-cultural working practices
- Respect refugees as human beings, do not label them
- Empower the client, let him/her participate in decision making process
- Create conditions to regain dignity, so they can make choices
- Create recreational activities and vocational skills
- Secure quality in service provision (eg. quality of translations)
- First contact is key, ensure quality at this stage

4.8 RECOMMENDATIONS ON COMMUNITY PARTICIPATION IN PREVENTION

Workshop 6, Chair: Ines Keygnaert, ICRH-University of Ghent, Belgium
Speakers: Cristina Florescu, OFRR, Romania
Antonio Salceda de Alba, Hospital Punta de Europa, Spain

Policy recommendations:
- Direct dialogue communities/policy makers all levels
- The enjoyment of basic human rights, such as:
  - To work legally
  - To go to school/university
  - Access to health care not only emergencies, insurance,...
  - Real participation in society: have a voice
- Policy makers should initiate and lead behavioral change trough media (soap operas,...) and education (in curricula)
- Put participation of communities as a criterion in funded practices and services

Structural recommendations:
- Develop educational programs on Sexual Health & SGBV trainings for all age levels, starting at a very young age
- Disseminate more information of local health systems and how to access their services
- Taboos should be fought together, and working with Community-based Organizations to do that
- Information should be disseminated through different channels

Service recommendations:
- Services should be safe spaces for their target group + confidence raised
- Self help capacity should be enhanced
- Invite parents of refugees to do social tutoring at schools
- Ethically diverse and intercultural training of staff
- Involve refugees in service delivery: create the possibility for them to become the service providers

4.9 RECOMMENDATIONS ON INTERCULTURAL HELP-LINES IN PREVENTION & CARE

Workshop 7, Chair: Marianne Cense, Rutger Nisso Group, the Netherlands
Speakers: Sibille Declercq, Kinder- & Jongerentelefoon, Belgium
Rusen Canpolat, Terrafem, Sweden

Policy recommendations:

- The issue of sexual and gender-based violence should be kept in the political arena and politicians should take it up
- SGBV can not be seen as a medical nor as an individual problem solely

Structural recommendations:

- Educate everybody on human rights
- Give asylum seekers information on their sexual and reproductive rights immediately when they enter the country
- Staff of reception centres and other professionals should be trained to recognise SGBV, and to treat victims in a proper, culturally sensitive way.
- Train staff at services to work with flexibility, listening, and mutual agreement

Service recommendations:

- Outreach support and psychological counselling should be available; culture sensitive, gender specific, well trained to work with victims of violence.
- Supervision should be part of the policy
- Language is very important. Talking about experiences of violence in a strange language is a big barrier. Therefore therapist centres/social workers should include staff that come from different countries and speak different languages.
- Interpreters can be a solution but they are barriers as well, because:
  - its another person in the room and this is about shameful experiences
  - if they are part of the same community, people may fear talking or have a lack of confidence
  - For interpreters the stories of violence can be hard too: they should have support for this too
- Living conditions and safety of people living in asylum centres should be improved
- Use the potential and capacities of asylum seekers and refugees to be a bridge between asylum seekers/refugees in need and professionals. And for instance to run self help groups.

4.10 RECOMMENDATIONS ON AWARENESS RAISING IN PREVENTION

Workshop 8, Chair: Bieke Machiels, Fedasil, Belgium
Speakers: Ildikó Szász, Menedék, Hungary
Ingrid Stals, Police Antwerp, Belgium

Policy recommendations
- Improve registration of offenders
- Improve legislative protection measures
- Funding to various communities to create their own solutions and support systems

Structural recommendations
- Media campaign & social events
- More awareness training for practitioners
- More intercultural training for service providers
- Access to employment for victims even if they don’t have the status yet
- Integrate awareness raising in police action plans and guidelines
- SGBV prevention should be part of the school curriculum
- Improve access to sheers, regardless of legal status
- Separate housing for asylum seeker women and children

Practice recommendations
- Integrated approach – interpreter + NGO + police + justice department + doctors…
- Awareness raising practice with doctors to improve screening and treatment of victims
- Exchange of good practices
- Work with offenders
- Improve access to information
- Improve interpretation services
- Involve communities
- Get victims out of isolation
- Volunteering jobs at reception centres

"I was taken to the detention centre where refugees who will be deported were held. After staying there for more than a month with anguish and suffering I tried with other refugees to escape by jumping from the detention walls. Many of the refugees escaped but I was left back because I fell from the wall and my left leg was broken. Police and security officers came while I was lying on the ground. They kicked my broken leg and handcuffed me at my backside. I was put in a stretch and was carried away. The officers dangled my broken leg from the stretch and intentionally rubbed it against small trees all along the way to the entrance of the camp. I was taken to a hospital (…)On the third week I was taken back to the detention centre. I was not fully recovered and the lower part of the broken leg was senseless. I lived in constant fear and anguish. Sometimes I was not given the doctor prescribed medicine that I needed for recovery. I was living in a constant pain for days(...) After a while eight security officers and a driver came and they carried me into a car which took me to the airport. While they were dragging me out of the car they saw a civilian car. Immediately, they threw me back to the car and pressed me to the floor. Then they carried me into the plane and tied me to a seat. When other passengers arrived I tried to shout as aloud as I could manage in protest against the deportation. A man sitting not far from us said that I should have been injected with drugs so that I would be cool and calm. I lost my mind when I heard that. I do not know what I have done consequently. When I gained my consciousness I saw the passengers leaving the plane. I was then taken down the stairs of the plane by two security officers who severely hit my bandaged leg with the airplane stairs to punish me for their failure. They threw me in a car and one of them came after me and punched me several times with his bare hands. I was then taken to a prison in an isolation cell (…) On the fourth day, I asked the guard if I could get any body who could speak English. The commandant of the prison came to me at the same day and took me to another room where pictures of naked women were hanging on the walls. I was ordered to look at the pictures and they snapped several photos of mine in this way"

Somali Refugee, living in the Netherlands

APPENDIX 1: PARTIPANTS LIST SEMINAR HIDDEN VIOLENCE IS A SILENT RAPE, 14th & 15th of February 2008, Het Pand, Ghent, Belgium

Nr				
1	Abu Amar	Ossama	MOVISIE	o.abuamar@movisie.nl
2	Adyns	Julie	Amnesty International Vlaanderen	JulieA@aivl.be
3	Aghamaleki	Arash	Designer postcard contest	arashaghamaleki@yahoo.com
4	Akram	Hanifa	Community Researcher	hanifaakram@hotmail.com
5	Alekozai	Jailani	Community Researcher	Aleko1960@hotmail.com
6	Audate	Valentine	Commissariaat-generaal voor de Vluchtelingen en Staatslozen	valentine.audate@ibz.fgov.be
7	Bahrami	Ramin	Community Researcher	shams_ashegh@yahoo.com
8	Bakker	Hilde	MOVISIE	hilde.bakker@movisie.nl
9	Benini	Nadia	Interpreter (English-Dutch)	nadiabenini@hotmail.com
10	Bicocchi	Luca	PICUM	luca.bicocchi@picum.org
11	Bosmans	Marleen	ICRH Ugent	marleen.bosmans@ugent.be
12	Bozikovic	Ivana	ICRH Ugent	ivana.bozikovic@ugent.be
13	Breyne	Jan	OOOC De Morgenster	breyne.lamaire@telenet.be
14	Brown	Vivienne	Tandem Communication	viviennebrown1@yahoo.co.uk
15	Burnett	Angela	Medical Foundation for the Care of Victims of Torture, U.K.	a.c.burnett@qmul.ac.uk
16	Cabus	Ria	Werkgroep Vluchtelingen Gent	ria.cabus@fulladsl.be
17	Camilleri	Katrine	Jesuit Refugee Service Malta	katrine@jrsmalta.org
18	Cense	Marianne	Rutgers Nisso Group	m.cense@rng.nl;
19	Claes	Lea	London School of Hygiene and Tropical Medicine	leaclaes@yahoo.co.uk
20	Claeys	Patricia	ICRH Ugent	patricia.claeys@ugent.be
21	Cortis	Rachelle	Ministry for Justice and Home Affairs, MJHA	rachelle.cortis@gov.mt
22	de Aguirre	Aintzane	UNHCR, Juridische Dienst	aguirre@unhcr.org
23	de Bie	Eveline	Sensoa	eveline.debie@sensoa.be
24	de Boever	Nele	Kinder- en Jongerentelefoon	tantenelleke@gmail.com
25	De Brouwer	Miek	Villa de Bondt	info@villadebondt
26	De Kesel	Greet	Dienst Minderheden Provinciebestuur Oost-Vlaanderen	greet.de.kesel@oost-vlaanderen.be

27	De Koker	Petra	ICRH Ugent	petra.dekoker@ugent.be
28	De Prins	Francine	vzw ZIJN	vorming.zijn@amazone.be
29	De Smet	Sofie	Vertrouwenscentrum Kindermishandeling Oost-Vlaanderen	info.vkgent.be
30	de Visser	Marieke	Dokters van de Wereld	m.p.devisser@gmail.com
31	Deblonde	Jessika	ICRH Ugent	jessika.deblonde@ugent.be
32	Decat	Peter	ICRH Ugent	peter.decat@ugent.be
33	Declercq	Sibille	Kinder- en Jongerentelefoon	sibille@kjt.org
34	Dedoncker	Koen	vzw ZIJN	vorming.zijn@amazone.be
35	Dekker	Anne-Floor	Vluchtelingen Organisaties Nederland	a.dekker@vluchtelingenorganisaties.nl
36	Demyttenaere	Thomas	Sensoa	thomas.demyttenaere@sensoa.be
37	Denys	Danielle	Klein Kasteeltje	
38	Devillé	Walter	NIVEL	w.deville@nivel.nl
39	Devos	Liesbeth	Caritas-Dienst Opvang	l.devos@caritasint.be
40	Driesen	Lieve	Koerdisch Instituut vzw	lievedriesen@skynet.be
41	El Mahi	Nadia	ICRH Ugent	nadia.elmahi@ugent.be
42	Florescu	Cristina	OFRR, Refugee Women's Organisation	cristina_ofrr@yahoo.fr
43	Franck	Pascale	Welzijn en Gezondheid, Coördinatie Geweld en Slachtofferbeleid	pascale.franck@welzijn.provant.be
44	Franck	Thierry	Sensoa	erika.frans@sensoa.be
45	Gerada	Joe	Foundation for Social Welfare Services	joseph.a.gerada@gov.mt
46	Gevaert	Toon	Interpreter (English-Dutch)	toon.gevaert@gmail.be
47	Ghazi	Hossein	Community Researcher	Ali64@live.nl
48	Gillespi	Aoife	IOM Dublin	agillespie@iomdublin.org
49	Gillet	Vinciane	Fedasil	vinciane.gillet@fedasil.be
50	Goris	Gie	MO* Magazine	gie.goris@mo.be
51	Gregoir	Griet	Commissariaat-generaal voor de Vluchtelingen en Staatlozen	griet.gregoir@ibz.fgov.be
52	Hagos	Asther	Refugee Action	AstherH@refugee-action.org.uk
53	Haji Faris	Havan	Community Researcher	havan82@hotmail.com
54	Heijs	Mariska	COA-opvang van asielzoekers	
55	Honinckx	Mia	Fedasil	mia.honinckx@fedasil.be
56	Hoornaert	Kries	CAW Artevelde	preventie@artevelde.be
57	Iminov	Takhir	Community Researcher	takhir_iminov@yahoo.com
58	Ismail	Stella	Community Researcher	stellahuguf@hotmail.com
59	Isomova	Irina	UNHCR Georgia	isomova@unhcr.org
60	Jambazishvili Yucer	Sophie	UNHCR Georgia	yucer@unchr.org
61	Janssens	Kristin	MOVISIE	k.janssens@movisie.nl
62	Jap	Anneke	Stichting Shakti	stshakti@xs4all.nl
63	Jorrisen	Sigrun	NVR	sigrun.jorissen@viva-svv.be
64	Kennedy	Patricia	College of Dublin	patricia.kennedy@ucd.ie

65	Kesteloot	Anne	Gewelcoörd. Prov. Oost-Vlaanderen	anne.kesteloot@oost-vlaanderen.be
66	Ketevan	Loria	Mtskheta Training Center	emc@access.sanet.ge
67	Keygnaert	Ines	ICRH Ugent	ines.keygnaert@ugent.be
68	Khalaf	Esra'a	Community Researcher	mohamed_esra2003@yahoo.com
69	Khalil	Lamia	Community Researcher	Lamia-kh@hotmail.com
70	Kohlmann	Irene	PICUM	
71	Koycheva	Albena	Bulgarian Gender Research Foundation	a.koycheva@yahoo.com
72	Kurdyukova	Larisa	Community Researcher	viktoriatje1@hotmail.com
73	Kwanten	Stijn	Fedasil	stijn.kwanten@fedasil.be
74	Lauwaert	Pieter	Payoke	pieter.lauwaert@payoke.be
75	Luyckx	Hilde	ICRH Ugent	hilde.luyckx@ugent.be
76	Machiels	Bieke	Fedasil	bieke.machiels@fedasil.be
77	Mahtab	Safaipour	Community Researcher	mski25@hotmail.com
78	Marsh	Vicky	Women Asylum Seekers Together WAST	wastmanchester@yahoo.co.uk
79	Metz	Rob	COA-opvang van asielzoekers	rmetz@coa.minjus.nl
80	Michielsen	Kristien	ICRH Ugent	kristien.michielsen@ugent.be
81	Mohammadkhani	Sousan	Community Researcher	smohammadkhani@yahoo.com
82	Morante Mendez	Almudena	European Commission- Daphne Fund	almudena.morante@ec.europa.eu
83	Oris	Henri	Co-community Researcher	viktoriatje1@hotmail.com
84	Ory	Riet	Studiedienst KAV	riet.ory@kav.be
85	Ozturk	Sultan	UNHCR Ankara, Turkey	ozturks@unhcr.org
86	Pace	Paola	IOM, International Migration Law and Legal Affairs	p.pace@iom.int
87	Parwin	Shahbazy	Community Researcher	parvin26@hotmail.com
88	Pehkonen	Pirjo	Naistenlinja, National Women's Line	pirjo.pehkonen@naistenlinja.com
89	Petrova-Benedict	Roumyana	IOM Mission with Regional Function Brussels	rpetrovabenedict@iom.int
90	Poppe	Maggi	Nederlandstalige Vrouwenraad	nvr.mpoppe@amazone.be
91	Pourmirzajan	Baharak	Community Researcher	shams_ashegh@yahoo.com
92	Quartier	Griet	ICRH Ugent	greta.quartier@ugent.be
93	Quindiagan	Marina	Princess Urduja Foundation for Filipino Woman	m_quindiagan@hotmail.com
94	Rahaee	Masoud	Designer postcard contest	m_rahaee@hotmail.com
95	Rahimian	Sima	Designer postcard contest	sima.rahimian@gmail.com
96	Ramkhelawan	Roselien	Foundation Woman for Sustainable Peace and Security	r.ramkhelawan@chello.nl
97	Rayée	Barbara	Sociale Dienst UZGent	barbara.rayee@uzgent.be
98	Rodrigo	José	European Commission- Daphne Fund	jose.rodrigo@ec.europa.eu
99	Roelens	Kristien	University Hospital Ghent	kristien.roelens@ugent.be
100	Rommel	Steven	Samenlevingsopbouw	steven.rommel@samenlevingsopbouw.be
101	Ronkes	Carla	Werkgroep Vluchtelingen Gent	carla.ronkes@clearwire.be

102	Rozumek	Martin	OPU Organisation for aid to refugees	martin.rozumek@opu.cz
103	Rubens	Laure	vzw ZIJN	laure.zijn@amazone.be
104	Ruck	William	Fedasil	
105	Rukaite	Dovile	Women's Issues Information Centre	dovile@lygus.lt
106	Rushby	Moyra	Medact	moyrarushby@medact.org
107	Ryan	Marie-Terese	Jesuit Refugee Service-Malta	marieterese.ryan@gmail.com
108	Salceda da Alba	Antonio	Hospital Punta de Europa	antonio.salceda.sspa@juntadeandalucia.es
109	Saleh	Chiman	Community Researcher	Chimansaleh36@hotmail.com
110	Scheir	Jeroen	Fedasil	jeroen.scheir@fedasil.be
111	Schillemans	An	Vertrouwenscentrum Kindermishandeling Oost-Vlaanderen	infovkgent.be
112	Serkei	Ben	MOVISIE	b.serkei@movisie.nl
113	Shulga	Natalia	Community Researcher	nataliashulga@hotmail.com
114	Somers	Liliane	Rode Kruis- Vlaanderen - Opvang asielzoekers	liliane.somers@rodekruis.be
115	Stals	Ingrid	Politie Antwerpen- Intrafamiliaal Geweld	ingrid.stals@politie.antwerpen.be
116	Standaert	Sarah	IPPF European Network	sarah.standaert@gmail.com
117	Szász	Ildikó	Menedék - Hungarian Association for Migration	ildiko.szasz@gmail.com
118	Tawfiq Marwan	Maryam	Designer postcard contest	mohamed_esra2003@yahoo.com
119	Tax	Blanche	UNHCR, European Affairs Officer	tax@unhcr.org
120	Temmerman	Marleen	ICRH Ugent	Marleen.Temmerman@UGent.be
121	Ten Hove	Leonie	COA-opvang van azielzoekers	lhove@coa.minjus.nl
122	T'sjoen	Guy	University Hospital Ghent	guy.tsjoen@ugent.be
123	Van Abbeny	Kim	Fedasil	kim.vanabbeny@fedasil.be
124	Van Bemmel	Liesbeth	Vrouwenopvang-Federatie opvang	l.vanBemmel@opvang.nl
125	Van Berkum	Monica	Pharos	m.vanberkum@pharos.nl
126	Van den Ameele	Seline	Student Medicine, University Ghent	seline.vandenameele@ugent.be
127	Van den Muijsenbergh	Maria E.T.C.	Radboud University Nijmegen Medical Centre	m.vnadenmuijsenbergh@hag.umcn.nl
128	Van Gool	Rita	Nederlandstalige Vrouwenraad	nvr.rvangool@amazone.be
129	Van Lancker	Anne	European Parliament	anne.vanlancker@europarl.europa.eu
130	Van Malderen	Anneleen	Sociale Dienst UZGent	anneleen.vanmalderen@uzgent.be
131	Van Parys	An-Sofie	University Hospital Ghent	an-sofie.vanparys@uzgent.be
132	Van Petegem	Marijke	Nederlandstalige Vrouwenraad	nvr.mvanpetegem@amazone.be
133	Van Willigen	Loes	Consultant Health and Human Rights	lvanwil@xs4all.nl
134	Van Zele	Leen	Dienst Gezondheid Stad Gent	leen.vanzele@gent.be
135	Van Zuilekom	Yolanda	Ministerie WWI	yolanda.vanzuilekom@minvrom.nl
136	Vandekerckhove	Wim	Villa de Bondt	info@villadebondt
137	Vandendriessche	Katia	Dienst gezondheid Stad Gent	katia.vandendriessche@gent.be

138	Vanderhaegen	Jacqueline	Protestants Sociaal Centrum, Vluchtelingendienst	vanderhaegenpsc@hotmail.com
139	Van Geertruyen	Godelieve	Dienst Minderheden Provinciebestuur Oost-Vlaanderen	godelieve.van.geertruyen@oost-vlaanderen.be
140	Vanheule	Ann	VERAPA	ann.vanheule@gent.be
141	Vanopdenbosch	Lily	VIVA SVV vzw	lily.vanopdenbosch@viva-svv.be
142	Verhey-Shangoli	Elaheh	Stichting Shakti	stshakti@xs4all.nl
143	Verulashvili	Iatamze	Women's Center	grc@access.sanet.ge
144	Vettenburg	Nicole	University Ghent	nicole.vettenburg@ugent.be
145	Wafa	Moezzi	Designer postcard contest	w.moezzi@gmail.com
146	Wassie	Najla	Pharos	n.wassie@pharos.nl
147	Wilson	Ruth	Tandem Communication	Ruth.wilson@tandem-uk.com
148	Windbüchler	Tanja	Intervention Centre against Domestic Violence Vienna	tanja.windbuechler@interventionsstelle-wien.at
149	Zaagsma	Miriam	Rutgers Nisso Group	m.zaagsma@rng.nl

APPENDIX 2: CAFÉ CONTACT PARTICIPANTS

Daphne Seminar: Hidden Violence is a Silent Rape
Café Contact
Exchange of Good Practices & Tools
Thursday 14th February 2008
Location: 'Kapitelzaal', ground floor, Het Pand
17:00 – 18:30

All participants of the Seminar have the opportunity to present their Tools and examples of Good practice and exchange ideas during our Café Contact in "Het Pand".

Participating Organizations

Nederlandstalige Vrouwenraad, Belgium
MOVISIE, The Netherlands
Pharos, The Netherlands
Tandem Communication, United Kingdom
WAST, Women Asylum Seekers Together, United Kingdom
UNHCR, Georgia
PICUM, Platform for International Cooperation on Undocumented Migrants, Belgium
IOM, International Organization for Migration
Refugee Action, United Kingdom
Intervention Centre against Domestic Violence Vienna, Austria
International Centre for Reproductive Health, Ghent University, Belgium

APPENDIX 3: STAKEHOLDERS LIST BELGIUM- NETHERLANDS-UK

LIST OF STAKEHOLDERS PER THEME

GENERAL
Belgium

Ziekenwagen/Ambulance Tel. 100 – 112 (GSM)
Politie Tel. 101 www.polfed-fedpol.be Voor een overzicht van de politiezones in uw buurt: www.infozone.be
Ongeval of agressie Tel 112 www.112sos.be
Tele-onthaal Tel. 106 www.tele-onthaal.be
Kinderen- en Jongerentelefoon (KJT) Tel. 102 brievenbus@kjt.org www.kjt.org
Jongeren informatie www.jongereninformatie.be

Medische zorg
Ziekenwagen/Ambulance Tel. 100 – 112 (GSM)
Wachtdienst huisartsen Tel. 09/236.50.00
Medimmigrant Gaucheretstraat 164 1030 Brussel Tel. 02/274.14.33 info@medimmigrant.be
Artsen zonder grenzen Artesiëstraat 46 1000 Brussel Tel. 02/513.25.79
Dokters van de wereld info@doktersvandewereld.org www.doktersvandewereld.org

Medische en praktische hulp
Fedasil Kartuizerstraat 21 1000 Brussel Tel. 02/213.44.11 info@fedasil.be www.fedasil.be

Netherlands

Ziekenwagen/Ambulance Tel. 112
Politie Tel. 0900/8844 www.politie.nl
Ongeval of agressie Tel 112 www.112sos.nl
Kindertelefoon Tel. 0800/0432 of 0900/0132 (van 14u tot 20u) www.kindertelefoon.nl
SOS Telefonische Hulpdienst Tel. 0900/0767 www.sostelefonischehulpdienst.nl

Medische zorg
Ziekenwagen/Ambulance/Spoed Tel. 112 www.sos112.nl
Huisartsen www.uwdokter.nl www.huisartsen.nl www.independer.nl/huisartsen
Gemeentelijke Gezondheidsdienst (GGD)
Op de site van alle GGD'en, http://www. ggd.nl, kunt u het adres van een GGD in uw regio vinden door links onderaan op contact of adressen te klikken.
Medische opvang voor Asielzoekers (MOA)
Op de site van GGD'en zijn alle adressen van de MOA in heel Nederland te vinden. Ga naar http://www.ggd.nl en klik op 'adressen'. U kunt hier het adressen bestand downloaden.

Dokters van de Wereld Rijswijkstraat 141-A 1062 ES Amsterdam Telefoon 020-4652866 info@doktersvandewereld.org www.doktersvandewereld.org

Info over medische en praktische hulp
Stichting Lampion Postbus 13318 2507 LH Utrecht Tel. 030/234.98.55 info@lapion.info www.lampion.info

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THEME 1: RIGHTS
Belgium

Juridische hulp/Onderwijs/Werk/ Sociale Huisvesting
- **Vluchtelingenwerk Vlaanderen** Gaucheretstraat 164 1030 Brussel Tel. 02/274.00.20 info@vluchtelingenwerk.be www.vluchtelingenwerk.be
- **Vlaams Minderhedencentrum** Vooruitgangsstraat 323/1 1030 Brussel Tel. 02/205.00.50 info@vmc.be

Integratiecentra Antwerpen
Antwerps Minderhedencentrum De Acht
Van Daelstraat 35 2140 Borgerhout Tel. 03/270.33.33 info@deacht.be www.de8.be
Prisma, één in diversiteit
Brusselsepoortstraat 8 2800 Mechelen Tel. 015/28.18.30 info@prismavzw.be www.prismavzw.be
Brabant
Provinciaal Integratiecentrum (PRIC) Vlaams-Brabant
Provincieplein 1 3000 Leuven Tel. 016/26.73.05 pric@vl-brabant.be www.vlaamsbrabant.be/levenenwonen/minderheden/ minderhedenCONTENT. jsp?page=5661
Regionaal Integratiecentrum Foyer
Werkhuizenstraat 25 1080 Brussel Tel. 02/411.74. 95 foyer@foyer.be www.foyer.be
Limburg
Provinciaal Integratiecentrum Limburg
Universiteitslaan 1 3500 Hasselt Tel. 011/23.82.20 pric@limburg.be www.limburg.be/pric
Oost-Vlaanderen
Intercultureel Netwerk Gent
Dok Noord 7 9000 Gent Tel. 09/224.17.18 info@ingent.be www.ingent.be
West-Vlaanderen
Provinciaal Integratiecentrum (PIC) West-Vlaanderen
Hoogstraat 98 bus 7 8800 Roeselare Tel. 051/69.79.89 info@pic-wvl.be www.pic-wvl.be
- **ODICe - Oost-Vlaams Diversiteitscentrum** Dok Noord 4, Gebouw 25 9000 Gent Tel. 09/267.66.40 odice@odice.be www.odice.be
- **Kinderrechten** www.kinderrechtswinkel.be

Netherlands

Juridische hulp/Onderwijs/Werk/ Sociale Huisvesting
Vluchtelingenwerk Nederland www.vluchtelingenwerknederland.nl
Het juridische loket Tel. 0900/80.20 (0.10€per minuut) www.hetjl.nl
De Stichting voor Vluchteling-Studenten (UAF)
Wilhelminapark 38 3581 NJ Utrecht Postbus 14300 3508 SK Utrecht Tel. 030/252.08.35 www.uaf.nl
Vluchtelingen Organisaties Nederland (VON)
Merelstraat 2 bis, 3514 CN Utrecht Tel. 030/271.45.05 www.vluchtelingenorganisaties.nl
De Immigratie- en Naturalisatiedienst (IND)
Afdeling Voorlichting Postbus 3211 2280 GE Rijswijk Tel. 0900/123.45.61 www.immigratiedienst.nl
Inburgering www.inburgering.net
Vereniging van Nederlandse Jeugd rechtadvocaten www.jeugrechtadvocaten.nl
Bureaus voor rechtshulp www.bureaurechtshulp.nl of www.rechtshulpnederland.nl

U.K.

Equality and Human Rights Commission www.equalityhumanrights.com
JCWI www.jcwi.org.uk
Immigration Advisory Service www.iasuk.org
Home Office Border and Immigration Agency www.bia.homeoffice.gov.uk
UK Lesbian and Gay Immigration Group 020 7620 6010 www.uklgig.org.uk

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THEME 2: SOCIAL NETWORK
Belgium

• **Samenlevingsopbouw** Vooruitgangsstraat 323/2 Tel. 02/201.05.65 Info.vlaanderen@samenlevingsop-bouw.be www.samenlevingsopbouw.be
• **Vlaams Minderhedencentrum** Vooruitgangsstraat 323/1 1030 Brussel Tel. 02/205.00.50 info@vmc.be www.vmc.be

• **Kif Kif Vzw** Algemeen secretariaat Lange Beeldekensstraat 245 2060 Antwerpen Tel. 03/667.69.33 Info@kifk if.be www.kifk if.be
• **Cultuurnet Vlaanderen** Sint-Gisleinstraat 62 B-1000 Brussel Tel. 02/551.18.70 Info@cultuurnet.be www.cultuurnet.be
• Elke **gemeente** heeft ook zijn eigen culturele en sociale activiteiten. Hiervoor kan u terecht op de website van die gemeente www.naamgemeente.be bijvoorbeeld: www.brussel.be Nederland

Netherlands

• **Stichting Mondiale Samenleving (SMS)**
SMS Landelijk Hollantlaan 6 3525 AM Utrecht Tel. 030/214.80.63 info@sms-vluchtelingen.nl www.sms-vluchtelingen.nl
• **Pharos** Herenstraat 35 Postbus 13318, 3507 LH Utrecht Tel. 030/234.98.00 info@pharos.nl www.pharos.nl
• **Maatschappelijk Werk** Het maatschappelijk werk in uw regio is meestal op te zoeken in de gemeentegids. www.naamgemeente.nl, bijvoorbeeld www.amsterdam.nl.
• Elke **gemeente** heeft ook zijn eigen culturele en sociale activiteiten. Hiervoor kan u terecht op de website van die gemeente www.naamgemeente.nl, bijvoorbeeld: www.amsterdam.nl

U.K.

London Lesbian and Gay Switchboard 020 7837 7324 www.llgs.org.uk
Multikulti www.multikulti.org.uk
Refugee Council 020 7346 6700www.refugeecouncil.org.uk
Refugee Action 020 7654 7700www.refugee-action.org.uk

THEME 3: RELATIONSHIPS
Belgium

• **Centrum Algemeen Welzijnswerk (CAW)**
Steunpunt Algemeen Welzijnswerk Diksmuidelaan 36a 2600 Berchem Tel. 03/366.15.40 info@steunpunt.be www.steunpunt.be www.caw.be
• **Jongeren Advies Centrum (JAC)** Geeft informatie, advies en hulp aan jongeren van 12 – 25 jaar www.jac.be Klik op *'waar'* voor de contactgegevens van het JAC in uw buurt

Netherlands

• **Relatieproblemen** info@relatieproblemen.nl www.relatie-problemen.nl
• **Geestelijke Gezondheidszorg (GGZ)**
De geestelijke gezondheidszorg biedt specialistische hulpverlening en consultatie aan mensen met psychische problemen. info@ggznederland.nl www.ggznederland.nl
• **Jongeren Informatie Punt (JIP)** www.jip.org

U.K.

Naz Project 020 8741 1879 www.naz.org.uk
Relate 0300 100 1234 www.relate.org.uk

THEME 4: REPRODUCTIVE AND SEXUAL HEALTH AND RISKS
Belgium

• **Sensoa** Veilig Vrijen Lijn van Sensoa Tel. 078/15.15.15
De services van Sensoa Positief voor mensen met hiv kan je contacteren via Tel. 078/15.10.00 (ma-do van 13u–16u) Kipdorpvest 48a 2000 Antwerpen Tel. 03/238.68.68 info@sensoa.be www.sensoa.be Heb je als jongere een persoonlijke vraag dan kan je die ook stellen via www.sensoa.be/jong
• **Informatie over Abortus** www.abortuscentra-vlaanderen.be
• **Holebifederatie** Info voor holebi's www.holebifederatie.be Tel 09/223.69.29

Netherlands

• **Rutgers Nisso Groep (RNG)** Kenniscentrum seksualiteit Oudenoord 176-178, 3513 EV Utrecht Tel. 030/231.34.31 klinieken www.rutgersnissogroep.nl
• **Seksualiteit** www.seksualiteit.nl
• **Centrum voor Anticonceptie, Seksualiteit en Abortus (CASA)** Tel. 088/888.4444 www.casa.nl
• **SOA Aids Nederland** Expertisecentrum voor HIV/AIDS en andere SOA www.soa.nl
• **Stichting Anticonceptie Nederland (SAN)** Het onafhankelijke aanspreekpunt Info voor holebi's voor al uw vragen rond anticonceptie www.anticonceptie-online.nl
• **Fiom** Hulp bij ongewenste zwangerschap Stichting Ambulante Fiom www.fiom.nl
• **Stichting Samenwerkende Abortusklinieken Nederland (StiSAN)**
De Nederlandse Koepel van Abortusklinieken Info@stisan.nl www.stisan.nl

U.K.

Fpa 0845 122 8690 www.fpa.org.uk
African AIDS Helpline 0800 0967 500 www.blackhealthagency.org.uk
NHS Direct 0845 46 47 www.nhsdirect.nhs.uk
Sexual Health Line 0800 567 123 www.condomessentialwear.co.uk
Terrence Higgins Trust 0845 122 1200 www.tht.org.uk

THEME 5: LEGAL AID AFTER VIOLENCE
Belgium

• **Advocaten** Voor een overzicht van de advocaten in uw buurt: www.advocaat.be
• **Vertrouwenscentrum Kindermishandeling (VK) Nederland** www.kindermishandeling.org
• **Kinderrechten** www.kinderrechtswinkel.be
• **Centrum Algemeen Welzijnswerk (CAW)** www.caw.be

• **Justitiehuizen** Om de adressen van de justitiehuizen te bekomen:
http://www.just.fgov.be/nl_htm/ organisation/html_org_justitiehuizen/ mj.htm

Netherlands

• **Slachtofferhulp Nederland** Biedt praktische en juridische adviezen en emotionele steun
Tel: 0900-0101(werkdagen 9.00 -17.00 uur)
www.slachtoff erhulp.nl
www.ikzitindeshit.nl voor mensen jonger dan 18 jaar.
• **Advies- en Meldpunt Kindermishandeling (AMK)**
Tel. 0900/123.123.0 www.amk-nederland.nl
• **Advies en Steunpunt Huiselijk Geweld**
Tel. 0900/126.26.26 (5 cent per minuut) www.huiselijkgeweld.nl
• **Bureaus voor rechtshulp** www.bureaurechtshulp.nl of www.rechtshulpnederland.nl
• **Het Juridisch Loket** Tel. 0900/8020 (€ 0,10 per minuut) www.hetjl.nl

U.K.

• **Community Legal Service Direct** 0845 3454345 www.clsdirect.org.uk

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THEME 6: INTIMATE PARTNER VIOLENCE
Belgium

• **Centrum Algemeen Welzijnswerk (CAW)**
www.caw.be In Vlaanderen zijn er volgende opvangpunten voor partnergeweld en erkende diensten voor slachtofferhulp:

Provincie Antwerpen
Caw De Kempen
Sint Jansstraat 17, 2200 Herentals Tel 014/ 23.02.42 slachtoff erhulp@cawdekempen.be
Caw De Mare
Lodewijk De Raetstraat 13, 2020 Antwerpen Tel 03/ 247.88.30 slachtoff erhulp@cawdemare.be
Caw Het Welzijnshuis
Guido Gezellestraat 54, 2830 Willebroek Tel 03/886.28.10 slachtoff erhulp.mechelen@ skynet.be
Provincie Brabant
Caw Archipel - Groot eiland
Groot Eiland 84, 1000 Brussel Tel 02/ 514.40.25 grooteiland.slh@archipel.be
Caw Delta
Roelandsveldstraat 22, 1700 Dilbeek Tel 02/568.01.00 secretariaat.dilbeek@cawdelta.be
Caw Regio Leuven
Redingenstraat 6, 3000 Leuven Tel 016/21 01 03 slachtoff erhulp@cawleuven.be

Provincie Limburg
Caw Sonar
Plantenstraat 127, 3500 Hasselt Tel 011/ 23 23 40 slachtoff erhulp.hasselt@ cawsonar.be
Provincie Oost-Vlaanderen
Caw 't Dak-teledienst vzw
OLV-Kerkplein 30, 9200 Dendermonde Tel 052/ 25.99.55
slachtoff erhulp@dak-teledienst.be www.dak-teledienst.be
Caw Visserij
Visserij 153a, 9000 Gent Tel 09/225.42.29
slachtoff erhulp@cawvisserij.be www.cawvisserij.be
Caw Zuid Oost-Vlaanderen
Oswald Ponettestraat 87, 9600 Ronse Tel 055/ 20.83.32 kompas@cawzuidoostvlaanderen.be
www.zuidoostvlaanderen.be

Provincie West-Vlaanderen
Caw De Papaver
P. Benoitstraat 58a, 8630 Veurne Tel 058/28.00.28 slachtoff erhulp@caw-de-papaver.be
Caw De Viersprong
Garenmarkt 3, 8000 Brugge Tel 050/ 47.10.47 caw.slachtoff erhulp@ deviersprong.be
Caw Stimulans
Groeningestraat 28, 8500 Kortrijk Tel 056/ 21.06.10 info@stimulans-groeningestraat.be

Netherlands

• **Advies en Steunpunt Huiselijk Geweld**
Tel. 0900/126.26.26 (5 cent per minuut) www.huiselijkgeweld.nl www.shginfo.nl Op de site www.huiselijkgeweld.nl staan de contactgegevens van de Advies en steunpunten. Klik op *'Organisaties'* en vervolgens op *'Advies en* steunpunten' voor een overzicht van deze organisaties per regio.

U.K.

Asylum Aid 0207 354 9264 www.asylumaid.org.uk
Imkaan 020 7434 9945 www.imkaan.org.uk
Refuge 0808 2000 247 www.refuge.org.uk
Southall Black Sisters 020 8571 9595 www.southallblacksisters.org.uk
Women's Aid 0808 2000 247 www.womensaid.org.uk

THEME 7: SEXUAL HARASSMENT
Belgium

• **Action Innocence** Streeft naar een veilig internet voor jongeren en kinderen Terkamerenlaan 62 1000 brussel Tel. 02/626.20.06 belgie@actioninnocence.org www.actioninnocence.org

Netherlands

• **Platform Seksuele Intimidatie** Postbus 9022, 3506 GA Utrecht Oudenoord 176-178, 3513 EV Utrecht Tel. 030/231.34.31 www.platformseksueleintimidatie.nl
• **MOVISIE** Programma Huiselijk en Seksueel Geweld Postbus 19129, 3501 DC Utrecht Winthontlaan 4-6, 3526 KV Utrecht Tel. 030/789.20.00 info@movisie.nl www.movisie.nl

U.K.

• **Victim Support** 020 7735 9166 www.victimsupport.org.uk
• **Refugee Women's Association** 020 7923 2412 www.refugeewomen.org.uk

THEME 8: SEXUAL VIOLENCE
Belgium and Netherlands

• **Interapy** Biedt on-line hulp voor jongeren na seksueel geweld. info@interapy.nl www.interapy.nl
Belgium
• **Vertrouwenscentrum Kindermishandeling (VK)** www.kindermishandeling.org
• **Childfocus** Tel. 110
• **Sensoa** Kipdorpvest 48a 2000 Antwerpen Tel. 03/238.68.68 info@sensoa.be www.sensoa.be

Netherlands

• **Advies en Steunpunt Huiselijk Geweld**
Tel. 0900/126.26.26 (5 cent per minuut) www.huiselijkgeweld.nl www.shginfo.nl
• **Seksueel Geweld** info@seksueelgeweld.nl www.seksueelgeweld.nl
• **Kindermishandeling** www.kindermishandeling.nl
• **Advies- en Meldpunt Kindermishandeling (AMK)**
Tel. 0900/123.123.0 www.amk-nederland.nl
• **Vereniging tegen seksuele kindermishandeling binnen het gezin, familie en andere vertrouwensrelaties (VSK)**
Postbus 641, 3500 AP Utrecht Tel. 030/789.22.50 vsk@movisie.nl www.v-s-k.nl
• **Jongeren Informatie Punt (JIP)** www.jip.org
• **Geestelijke Gezondheidszorg (GGZ)** info@ggznederland.nl www.ggznederland.nl

U.K.

Rape and Sexual Abuse Support Centre 0845 122 1331 www.rasac.org.uk
Women Against Rape 020 7482 2496 www.womenaginstrape.net
FORWARD 020 8960 4000 www.forwarduk.org
Survivors UK 0845 122 1201 www.survivorsuk.org

THEME 9: SEXUAL EXPLOITATION
Belgium

• **Payoke** Slachtoff erhulp bij mensenhandel Leguit 4, 2000 Antwerpen Tel. 03/201.16.90 admin@payoke.be www.payoke.be
• **Pagase** Slachtofferhulp bij mensenhandel Tel. 02/511.64.64
• **Asmodee** Residentiële opvang van vrouwelijk slachtoffers van mensenhandel Professor van den Wildenberglaan 2, 2100 Deurne Tel. 03/270.31.90 asmodee@cawdeterp.be

Netherlands

• **Coördinatiecentrum mensenhandel (Comensha)**
Federatie Opvang J. van Oldenbarneveltlaan 34-36, 3818 HB Amersfoort Tel. 033/461 50.29 Helpdesk 033/448.11.86 federatie@opvang.nl www.opvang.nl www.mensenhandel.nl
• **Asja** Opvangvoorziening voor jonge meisjes die slachtoff er zijn geworden van gedwongen prostitutie via “loverboys” Tel. 0900/567.5678 www.asja.nl
• **Vereniging van Nederlandse Jeugdrechtadvocaten** www.jeugdrechtadvocaten.nl

U.K.

• **Southall Black Sisters** 020 8571 9595 www.southallblacksisters.org.uk
• **SW5** 020 7370 0406 www.sw5.info
• **UK Human Trafficking Centre** 0114 252 3891 www.ukhtc.org

THEME 10: HELP FOR OFFENDERS
Belgium

Provincie Antwerpen
• **Time Out** P/A Moorkensplein 14 2140 Borgerhout Tel. (woe-do-vrij) 0472/26.14.49 0497/44.55.33 0479/82.01.06
• **CAW De Kempen – De Veder** Nederrij 20, 2200 Herentals Tel. 014/42.02.44
deveder@cawdekempen.be

• **Leerproject voor daders van seksueel geweld** Diksmuidelaan 50, 2600 Berchem
Tel. 0473/68.65.06 jennifer.schutters@skynet.be

Provincie Brabant

• **Praxis** Brussel Hamerstraat 19, 1000 Brussel Tel. 02/217.98.70 praxis@swing.be
www.asblpraxis.be

• **CAW Archipel – Groot Eiland – I.T.E.R.** Artesiëstraat 5, 1000 Brussel Tel. 02/512.62.43
iter@scarlet.be
www.iter-daderhulp.be

Provincie Limburg

• **CAW 't Verschil – Hulpverlening Seksueel Delinquente**
Lombaardstraat 20, 3500 Hasselt Tel. 011/21.20.20 hsq@cawteverschil.be
www.cawtverschil.be

Provincie Oost-Vlaanderen

• **CAW – Gent - Artevelde** Pekelharing 2, 9000 Gent Tel. 09/233.12.89 hd@artevelde.be

Provincie West-Vlaanderen

• **CAW Stimulans – Hulpverlening Seksueel Delinquenten**
Groeningestraat 28, 8500 Kortrijk Tel. 056/21.06.10 mcambier@stimulans-groeningestraat.be
www.cawstimulans.be

• **Exit – preventie van seksueel grensoverschrijdend gedraag door jongeren**
Vlamingdam 36, 8000 Brugge Tel. 0479/56.04.18 exit@steunpunt.be

Netherlands

• **Advies en Steunpunt Huiselijk Geweld** Tel. 0900/126.26.26 (5 cent per minuut) www.huiselijkgeweld.nl www.shginfo.nl

U.K.

Social services department of the local authority/council

THEME 11: VICTIM AID FOR SURVIVORS

Belgium

• **Vertrouwenscentrum Kindermishandeling (VK)** www.kindermishandeling.org
• **Childfocus** Tel. 110
• **Centrum Algemeen Welzijnswerk (CAW)** www.caw.be
Adressen zie thema 6 partnergeweld*
• **Zelfmoordpreventie** Tel. 02/649.95.55
• **Antigifcentrum** Tel. 070/245.245
• **De Druglijn** Tel. 078/15.10.20

Netherlands

• **Advies en Steunpunt Huiselijk Geweld**
Tel. 0900/126.26.26 (5 cent per minuut) www.huiselijkgeweld.nl www.shginfo.nl
• **Kindermishandeling** www.kindermishandeling.nl
• **Jongeren Informatie Punt (JIP)** www.jip.org
• **Vrouwenopvang** De Vrouwenopvang biedt hulp en onderdak aan bedreigde en mishandelde vrouwen en hun kinderen. In sommige plaatsen heet dit een "Blijf van mijn lijf-huis". De centra zijn gevestigd door heel Nederland. Vrouwenopvang Rotterdam heeft een opvanghuis voor Islamitische vrouwen en meisjes: locatie 'Duygu Tel. 010/476.90.44
• **Opvang Mannelijke slachtoffers huiselijk geweld**
Tel. 061/541.82.04 info@stichting-humanity.nl www.stichting-humanity.nl
• **Anonieme en telefonische hulp Allochtone Vrouwentelefoon**
Allochtone Vrouwentelefoon Rijnmond
Bereikbaar:
Maandag tot en met vrijdag van 10.00 - 14.00 uur
Maandagavond van 20.00 - 22.00 uur Tel. 010/ 436.71.71
Allochtone Vrouwentelefoon Den Haag
Bereikbaar:
Maandags van 18.00 – 22.00 uur Vrijdags van 11.00 – 15.00 uur Tel. 070/362.26.29

Allochtone Vrouwentelefoon Oost Nederland
Bereikbaar:
Maandag tot en met vrijdag van 10.00 - 14.00 uur
Maandag tot woensdagavond van 19.00 - 22.00 uur
Tel. 0800/024.00.27 (gratis) of 074 – 255.25.50 www.thdon.nl/avt
• **Stichting Centrum '45** Stichting Centrum '45 is het landelijk centrum voor getroff enen door vervolging, oorlog en georganiseerd geweld. Speciaal voor getraumatiseerde vluchtelingen en asielzoekers. Voor verwerken van opgedane trauma's en leren omgaan met de pijn die door moeilijke herinneringen wordt veroorzaakt. Tel. 071/364.20.70 mail.devonk@centrum45.nl Telefonisch spreekuur: maandag t/m donderdag 10.00-12.30 uur.
• **Stichting LOS** Overzicht van organisaties die op-vang bieden aan mensen zonder verblijfsvergunning Tel. 030/299.02.22 www.stichtinglos.nl
• **Fanga Musow** Opvangproject voor vrouwen en kinderen zonder verblijfsvergunning
Tel. 030/271.54.83 www.fangamusow.nl

U.K.

• **Africans Unite Against Child Abuse** 020 7704 2261 www.afruca.org
• **Victim Support** 020 7735 9166 www.victimsupport.org.uk

THEME 12: HONOUR RELATED VIOLENCE
Belgium

- **Centrum Algemeen Welzijnswerk (CAW)** Steunpunt Algemeen Welzijnswerk Diksmuidelaan 36a 2600 Berchem Tel. 03/366.15.40 info@steunpunt.be www.steunpunt.be www.caw.be

Netherlands

- **MOVISIE** www.eerwraak.info
- **Fier Fryslân** Opvang voor minderjarige slachtoffers van eergerelateerd geweld Mr. P.J. Troelstraweg 149, 8919 AA Leeuwaarden Tel. 058/215.70.84
info@fi erfryslan.nl www.fi erfryslan.nl
- **De Bocht** Opvang voor minderjarige slachtoffers van eergerelateerd geweld. Tilburgseweg 184 Postbus 133, 5050 AC Goirle Tel. 013/543.30.73 debocht@debocht.nl www.debocht.nl
- **De Veilige Haven** Biedt hulp aan jongeren van een andere etnische achtergrond met homoseksuele of lesbische gevoelens. Inloop Dinsdag en donderdag van 17u tot 20u Schorer Sarphatistraat 35, Amsterdam Tel. 020/573.94.01 info@veilige-haven.nl www.veilige-haven.nl

U.K.

- **Kurdish Women Action Against Honour Killing** www.kwahk
- **Southall Black Sisters** 020 8571 9595 www.southallblacksisters.org.uk

INTERPRETING SERVICES
Belgium

- **Fosofet of Cofetis** Sociaal Vertalen en Tolken Vooruitgangsstraat 323/9, 1030 Brussel
Tel. 02/204.09.69 info@fosovet.be www.fosovet.be www.cofetis.be
- **Centrale Ondersteuningscel voor Sociaal Tolken en Vertalen**
www.sociaaltolkenenvertalen.be

Netherlands

- **Tolk- en Vertaalcentrum Nederland (TVCN)**
Hulpverleners kunnen gratis gebruik maken van de diensten van deze landelijk werkende dienst. Tel: 088 25552 22 info@tvcn.nl www.tvcn.nl

PARTNERS
Belgium

• **International Centre for Reproductive Health (ICRH)**
Universiteit gent De Pintelaan 185 P3 9000 Gent Tel. 09/332.35.64 icrh@ugent.be www.icrh.org
• **Nederlandstalige Vrouwenraad** Middaglijnstraat 10 1210 Brussel Tel. 02/229.38.19 info@vrouwenraad.be www.vrouwenraad.be
• **Beweging tegen Geweld – Vzw ZIJN** Middaglijnstraat 10 1210 Brussel Tel. 02/229.38.70 zijn@amazone.be www.vzwzijn.be

Netherlands

• **MOVISIE** Postbus 19129, 3501 DC Utrecht Winthontlaan 4-6, 3526 KV Utrecht Tel. 030/789.20.00 info@movisie.nl www.movisie.nl
• **Pharos** Herenstraat 35 Postbus 13318, 3507 LH Utrecht Tel. 030/234.98.00 info@pharos.nl www.pharos.nl

UK

• **Tandem** 21 Kingswood Avenue Leeds LS8 2DB Tel. 0113/266.91.23 ruth.wilson@tandem-uk.com www.tandem-uk.com

APPENDIX 4: ARTICLE IN WHO MAGAZINE ENTRE NOUS

Keygnaert I. & Temmerman M. (2007): Between Theory & Practice: Gender-based Violence against Refugees, Asylum Seekers and Undocumented Migrants in Europe.Entre Nous WHO Magazine No.66, pp 12-13.

Between theory and practice:

GENDER-BASED VIOLENCE AGAINST REFUGEES, ASYLUM MIGRANTS IN EUROPE

Gender-based violence (GBV) theoretically seen

Cairo,1994, International Conference on Population and Development, the objectives are clear; 179 governments acknowledge that all couples and individuals have the right to attain the highest standards of sexual and reproductive health (SRH) and make decisions concerning their sexual health free of discrimination, coercion and violence. These governments endorse that countries should take full preventive, protective and rehabilitative measures to eliminate all forms of exploitation, abuse and violence against women and adolescents, paying special attention to protecting the rights, safety and needs of those in potentially exploitable situations. Documented and undocumented migrant women, refugee women and refugee children are specified as such.

European Union (EU) Member States ratify this action plan. One year later, during the Fourth World Conference on Women in Beijing, the definition of GBV is expanded. It now comprises any act of physical, sexual and psychological violence in the family, community, or perpetrated or condoned by the State that results, or is likely to result in, physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life or in situations of armed conflict (1). Specific groups of women are recognized to be particularly vulnerable to GBV; the elderly and the displaced; indigenous, refugee and migrants communities; women living in impoverished rural or remote areas, or in detention.

EU Member States endorse this action plan, as well as, many other international agreements that recognize gender as a determinant of health and GBV as a major public health issue, a violation of human rights, and as a crime against humanity. As goals are set to end GBV, the EU intensifies its efforts to evolve into a coherent political territory. Along with this development, new European asylum and neighbourhood policies are formulated (2). The impact of these policies on the protection and health of asylum seekers, refugees and undocumented migrants within the EU territory and on the borders remains to be seen.

GBV in practice

GBV can be of physical, psychological, socio-economic, socio-cultural or sexual nature. In addition to important negative effects on the well-being and the participation in society of the survivor, GBV may have significant consequences on the survivors' sexual, reproductive, physical and psychological health. Increasing empirical evidence suggests that health and health related behaviour is determined by the interplay of a complex set of contextual stressors, health promoters and genetic endowment (3). Stressors include social, cultural, economic and physical environmental factors, such as poverty, discrimination, inadequate housing, socially disintegrated communities, material deprivation, income inequality, oppression and unemployment, lack of social support and lack of education.

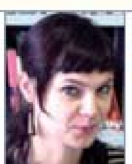
These are all ill-health factors which immigrants, asylum seekers, refugees and undocumented migrants in Europe face on a daily basis. These are also factors whose counterparts are recognized as basic economic, social, cultural, civil and political human rights. Realization of these rights is challenging when the possibility to do so is completely intertwined with the legal status one does or does not have. Refugees have obtained an official residence permit. This assures access to health care services and entitles them to realize most rights notwithstanding the financial, cultural, physical and psychological barriers they might encounter when trying to do so. Asylum seekers are still in the insecure process of achieving such a status, or having it denied. This has significant implications for their access to health care and for the fulfilment of the above-mentioned rights. Recent research indicated that European coherence on this matter is lacking. The access of asylum seekers to SRH care, for example, differs across EU Member States. In some countries, an asylum seeking woman is only entitled to emergency care, in others, exceptions will be permitted when she is pregnant, and in still other countries, full access is provided (4). Restricted access for asylum seekers applies to decent housing, employment and societal participation as well. Being an undocumented migrant multiplies the risk of being exposed to ill-health.

The International Centre for Reproductive Health (ICRH) at the University of Ghent is currently conducting a community-based participatory research project to prevent GBV against minorities in Europe. With EC Daphne funding, this research project is steered by Belgian (ICRH, Zijn, NVR), Dutch (Movisie, Pharos) and British (TandemCom) research bodies and organizations active in the field of GBV, women's rights or health of refugees. It is conducted in partnership with a community advisory board. Thirteen female and eight male refugees, or asylum seekers, with origins from Afganistan, the Islamic Republic of Iran, Iraq, Somalia, the former USSR or Roma or Kurdish communities were trained as community researchers. They have already conducted 250 in-depth interviews with their peers in Belgium and the Netherlands. They are now collaborating on analysis of the results and the development of prevention tools and strategies.

Research results will be presented at a European Seminar in Ghent, February 14-15, 2008. Preliminary results indicate several important determinants in prevention and protection of their health. The respondents' general profile is one of highly-educated women and men in their reproductive age, who have little or no close relatives accompanying them, and who are struggling with the enforced set-back in their possibility to participate actively in society. They generally relate sexual health firstly to overall physical and mental well-being, secondly to a respectful approach to sexual relationships and sexuality, thirdly to a safe and satisfying sexual life and finally to family planning

SEEKERS AND UNDOCUMENTED

Marleen Temmerman


Ines Keygnaert

and fertility. They are convinced that one is responsible for one's own sexual health. Regarding GBV, the preliminary results are very clear. An overwhelming majority of the respondents revealed they were familiar with several types of GBV: physical assault, abuse, confinement, structural discrimination, sexual harassment, rape, sexual exploitation, honour killing and forced marriages.

Most cases are not reported, due to lack of knowledge of their rights and the legal system, and fear of negative consequences for their asylum procedure or integration in society. Perpetrators are aware of this mechanism and take advantage of it.

Prevention

From a socio-ecological perspective on prevention of GBV, health status and health behaviour are viewed as affecting and being affected by multiple levels of influence, including individual, interpersonal, organizational, community and public policy. The central premise of this model is that none of its levels should function in isolation from the others. Thus, effective prevention programmes can best be achieved by stimulating synergy among the several levels that comprise the model (5).

When respondents were questioned about perceived risk and preventive factors in GBV, their answers and suggestions covered individual, interpersonal, organizational, community and public levels equally. Asylum procedure and legal status related to the phases in asylum procedure, were shown to be the crosscutting factors across all levels, as well as, a lever for positive change. These results confirm the premise that "although biological sex combined with gender contributes to differential health exposures for women and men, social determinants play a crucial role in determining their vulnerability at individual, community, programme and policy levels"(6).

Conclusion

In Europe, young female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several types of GBV. Given that all human rights are considered interdependent and indivisible, and that international agreements on the eradication of GBV are ratified, governments should be prompted to realize that they are still accountable for progressively correcting conditions that may impede the realization of the right to health and other related rights. These structural changes on public policy level should accompany real comprehensive and participatory approaches to multi-disciplinary and multi-stakeholder interventions, creating an empowering synergy between the individual, interpersonal, organizational, community and public policy level. Given that in Europe, the right to health and a life without violence is primarily an intangible theory for many refugees, asylum seekers and undocumented migrants, while GBV is a common practice, research and action are a case of emergency.

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Ines Keygnaert
PhD Fellow Socio-medical Sciences at University of Ghent, SGBV Researcher, International Centre for Reproductive Health (ICRH), WHO Collaborating Centre, Ghent, Belgium
ines.keygnaert@ugent.be

Marleen Temmerman
MD, MPH, OB/GYN,
PhD, Professor of Gynaecology, University of Ghent,
Director, International Centre for Reproductive Health (ICRH), WHO Collaborating Centre, Ghent, Belgium
marleen.temmerman@ugent.be