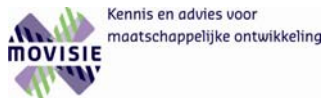




CONCISE REPORT: HIDDEN VIOLENCE IS A SILENT RAPE

RESULTS OF THE RESEARCH PROJECT:
“PREVENTION OF SEXUAL & GENDER-BASED
VIOLENCE AGAINST REFUGEES IN EUROPE: A
PARTICIPATORY APPROACH”

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Nothing in this report may be copied without reference to the authors and report:

Keygnaert, I. & Temmerman, M. 2008: Concise report: Hidden Violence is A Silent Rape. Research Results of the Research Project: Prevention of Sexual and Gender-based Violence against Refugees in Europe: A Participatory Approach. ICRH, Ugent, Ghent.

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1. SUMMARY

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 this Community-based Participatory Research Project that has been conducted in Belgium, the Netherlands and the UK. The aim of the project was twofold: Firstly to develop a prevention tool which can be used by refugees and asylum seekers themselves and secondly to raise awareness on this topic through participatory research. With EC Daphne funding, this project is steered by Belgian (Coordinator: ICRH-University Ghent, Partners: Zijn, Nederlandstalige Vrouwenraad), Dutch (MOVISIE, Pharos) and British (TandemCom) research bodies and organisations active in the field of gender-based violence, women rights and health of refugees. It has been conducted in close partnership with 23 community researchers and a large Community Advisory Board.

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. In these in-depth interviews we addressed the topics of sexual health and victimization and prevention of sexual and gender-based violence against them in Europe. 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.

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 corresponds 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%).

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.

Together with the Community Researchers, the Community Advisory Board and respondents we developed a prevention tool for 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. The participatory approach in this project, the research results and the prevention tool are presented and a Call for action is made 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.

*"I want to scream out loud and say: enough!
Let our children have a good life, we've seen enough misery.
We've got the right to live and our children are the most important to us!"
Kurdish Asylum Seeker*





2. INTRODUCTION

The following data are results from the European research project “Prevention of sexual and gender-based violence against refugees in Europe: a participatory approach”. Funded by the EC Daphne Program, the project is steered by Belgian (Coordinator: International Centre for Reproductive Health-University Ghent, Partners: Nederlandstalige Vrouwenraad and ZIJNvzw), Dutch (MOVISIE, Pharos) and British (TandemCom) research bodies and organizations active in the field of gender-based violence, women rights or health of refugees. Applying the “Community Based Participatory Research” method, the project is conducted in close partnership with a large “Community Advisory Board”, consisting of representatives of the communities, policy makers, intermediary organizations and researchers. Moreover, thirteen female and eight male refugees or asylum seekers from Iranian, Iraqi, Afghan, former USSR, Somali, Roma or Kurdish origin are trained as “Community Researchers”.

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 means we have 132 in-depth interviews 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. We first used Framework Analysis Technique to sift, sort and code the answers. Then we used SPSS to analyze the data. The socio-ecological model on health was applied. Results were discussed and interpreted with Community Researchers, respondents and the Community Advisory Board.

The project started April 4th of 2006 and still runs until April 3rd of 2008. The main goals are threefold: first to develop a prevention tool which can 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 men and to equally involve men. The Community Researchers and the Community Advisory Board collaborated in each phase of the project: from the set-up of the project, over the analysis of the results as well as in the development of the prevention tool (ISBN: 978907812168) and the European Seminar “Hidden Violence is a Silent Rape: Prevention of Gender-based Violence against Refugees in Europe”, February 14th-15th in Het Pand, Ghent.

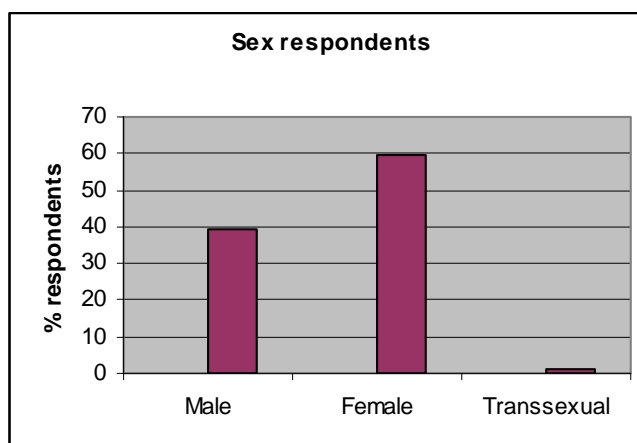




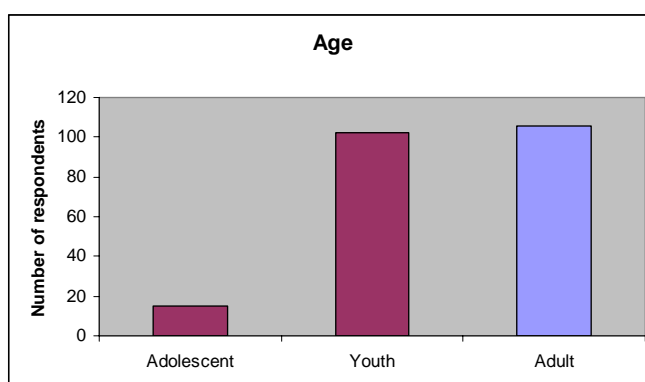
3. SOCIO-DEMOGRAPHIC PROFILE OF RESPONDENTS

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):

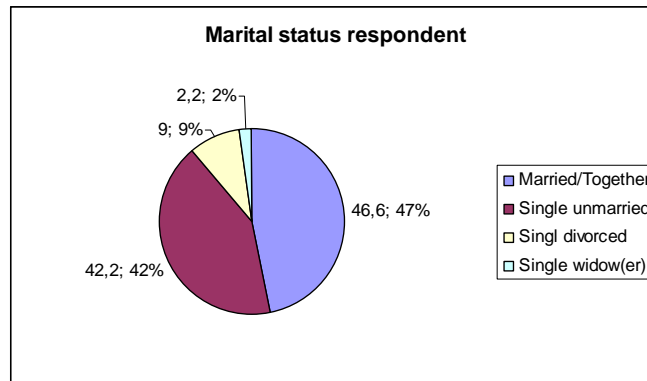


- **Sex:** 133 respondents (59,6%) were women of which 80 were living in Belgium and 53 in the Netherlands. 88 respondents (39,5%) were men of which 50 were living in Belgium and 38 in the Netherlands. 2 respondents were transsexuals (0,9%) and they both lived in Belgium.
- **Age:** 106 respondents were 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%).

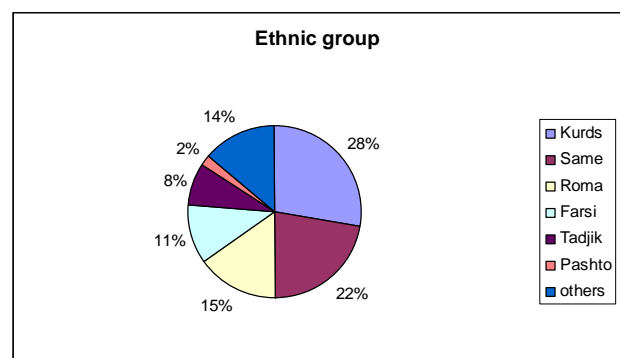
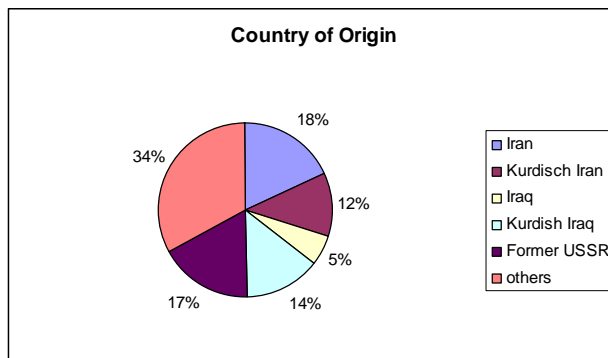




- **Marital status:** 46,6% was married or living together with her/his partner. 54,4% was single: unmarried (42,2%), divorced (9%) or a widow(er) (2,2%). This is about the same for female and male respondents. From the respondents in the Netherlands there were slightly more people living with her/his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



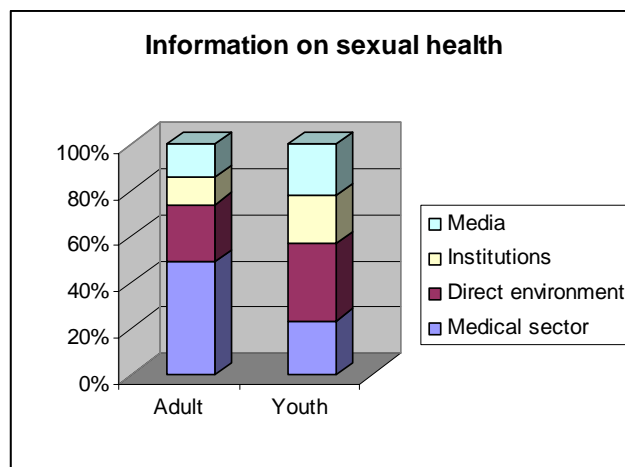
- **Highest attained level of education:** 40,8% of the respondents have higher education (higher: non-university 20,6% and higher: university 20,2%). This is 48,1% of the female respondents and 30,2% of the male respondents. 44,4% (40,6% of the female and 48,9% of the male) respondents have secondary 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%-NI: 61,5%; read Dutch fluently B: 34,1%-NI: 60,4%; write Dutch fluently B: 25%-NI: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%-NI: 6,6%), was responsible for the household (B:17,4% - NI: 9,9%), and could not work due to legal status or health (B: 21,2%- NI:17,6%). 29,7% of the respondents in the Netherlands had a paid job compared to only 17,4% of the respondents in Belgium.



4. SEXUAL HEALTH

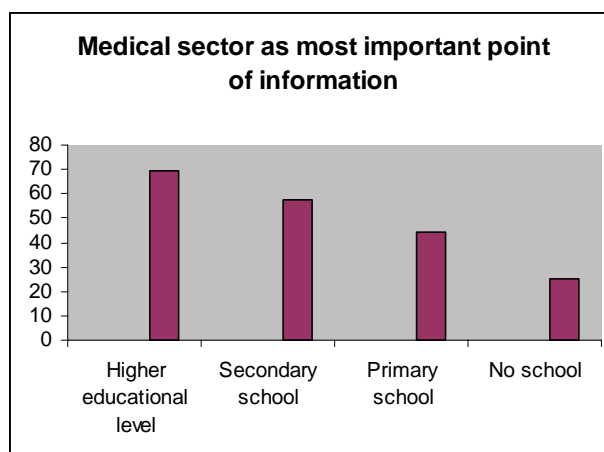
4.1. Information on sexual health in home country: frame of reference

-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 it 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% - NI: 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%-NI: 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%-NI: 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.

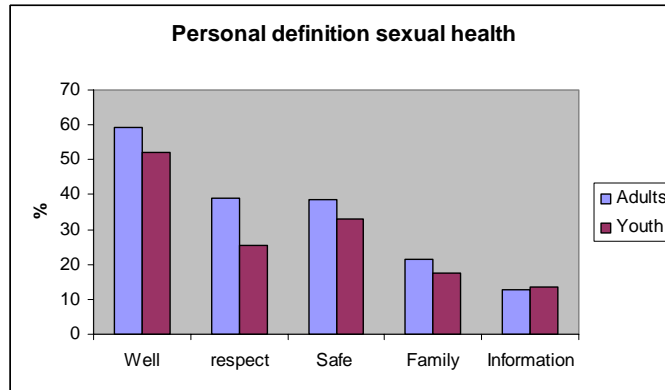
4.2 Personal definition of sexual health

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

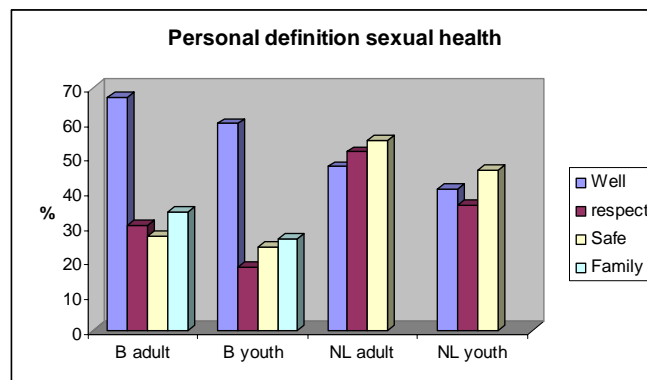
General: Respondents gave nearly the same order of interpretations of sexual health for adults and for youth. 59,2% related sexual health of adults to general well-being, 39% to a respectful approach of sexual relationships and sexuality, 38,6% to a safe and satisfying sex life, 21,5% to family planning 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%).

4.3 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.



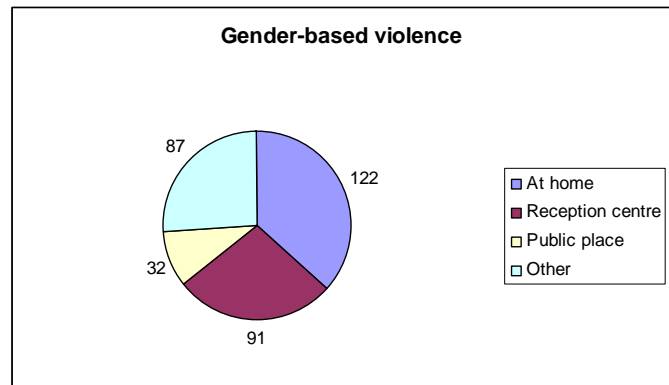
5 SEXUAL AND GENDER-BASED VIOLENCE VICTIMIZATION

*“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 of a very close peer of them (also being a refugee, asylum seeker or undocumented migrant) that she/he became 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 being victimized. If they did know a peer, the identification of the victim and the perpetrator were made.

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



5.1 Description sexual and gender-based violence cases

“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

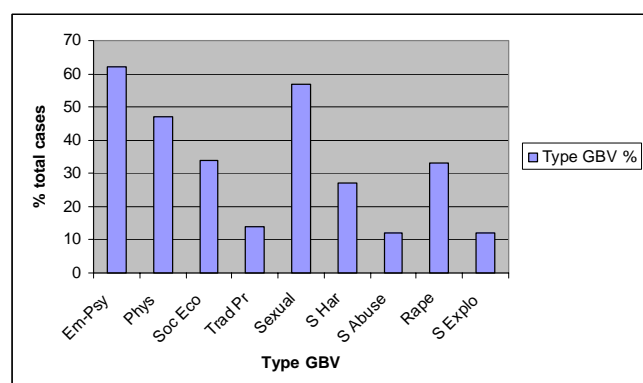
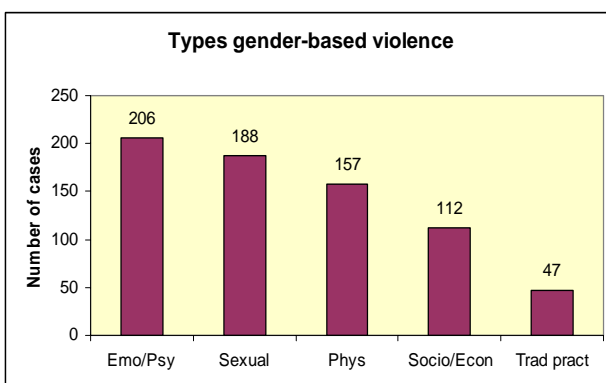
5.1.1 Identity of the victims

87 respondents or 39% of the respondents were personally victimized, this corresponds 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.

5.1.2 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).





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

- **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.
- **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%).

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

- **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%).

"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 loud 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

- **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

“I had to watch him masturbating. This made me nervous, which he found very funny”
Russian Refugee

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).



"If I wanted an ice-cream, I had to lick the head of his soldier first"
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).

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

"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*

*"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).

"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



*"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*

- **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).

5.1.3 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.

"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 haemorrhoids 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

*"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.

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

- **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.

*"Sexual health is dead in my body"
Kurdish Asylum Seeker*

- **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.

5.1.4 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.

5.2 Definition of sexual violence

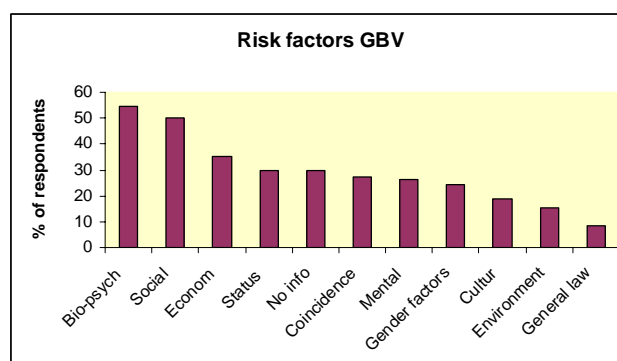
37,7% of the respondents defined sexual violence as an unwanted sexual act or sexual act without consent. They described this mostly as “a violation of someone’s rights”, “using power or violence to get something done by people” or “passing personal limits of other people”.

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 or 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”

5.3 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%).



6 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 him/herself to prevent victimization of sexual and gender-based violence, what can other persons can 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.

6.1. 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).

6.2 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 were 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%).

<i>Type of Preventive Action</i>	<i>% of Respondents</i>
<i>Information</i>	54,7
Sensitization	15,6
Education	13,9
Training	12,3
<i>Legislation</i>	34,5
Protection	19,5
Law	19,5
Safety	14,3
<i>Status</i>	
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.



6.3. 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.

7 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*

