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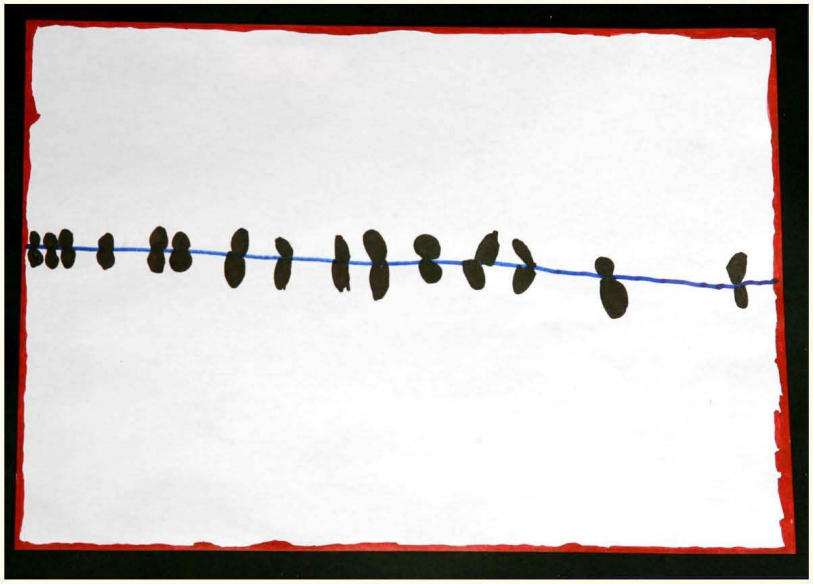
Sexual Violence and Sexual Health in Refugees, Asylum Seekers and Undocumented Migrants in Europe and the European Neighbourhood: Determinants and Desirable Prevention



Ines Keygnaert

Doctoral Thesis submitted to the Faculty of Medicine and Health Sciences, Ghent University

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SEXUAL VIOLENCE AND SEXUAL HEALTH IN REFUGEES, ASYLUM SEEKERS AND UNDOCUMENTED MIGRANTS IN EUROPE AND THE EUROPEAN NEIGHBOURHOOD: DETERMINANTS AND DESIRABLE PREVENTION

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DEDICATION

To Pepe Tielt (RIP, 1997), my grandfather, a WWI refugee, who urged me to discover the world,

To Daddy (RIP, 2008), who assured me that there was world outside my mothers' garden,

To Moetje, my mom, who taught me that gardens and houses should be open to anyone,

And above all, to Aaryan & Rayman, my dearest sons, to whom I'd like to apologize for not having a garden, but to whom I deeply wish that they'll feel at home wherever they are and might go.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CAB	Community Advisory Board
CBPR	Community Based Participatory Research
CEAS	Common European Asylum System
CESCR	United Nations Committee on Economic, Social and Cultural Rights
CRs	Community Researchers
CIS	Critical Interpretive Synthesis method
EASO	European Asylum Support Office
EC	European Commission
ECOWAS	Economic Community of West African States
ENP	European Neighbourhood Policy
EP	European Parliament
EU	European Union
EU MS	European Union Member States
EUROMED	Euro-Mediterranean Partnership
FGM	Female Genital Mutilation
FRA	European Agency for Fundamental Rights
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICRH	International Centre for Reproductive Health
International Bill of Human Rights = UDHR, ICESCR and ICCPR	
IOM	International Organisation for Migration
IPV	Intimate Partner Violence
KAP	Knowledge, Attitude & Practice study/survey
LGBT	Lesbian, Gay, Bisexual and Transgender
MSW	Migrant Sex Workers
NGO	Non-Governmental Organisation
PTSD	Post Traumatic Stress Disorder
SES	Socio-Economic Status
SGBV	Sexual and Gender-Based Violence
SH	Sexual Health
SRH(R)	Sexual and Reproductive Health & Rights
STI	Sexually Transmitted Infection
SV	Sexual Violence
UCD	University College of Dublin
UDHR	Universal Declaration of Human Rights
UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Population Fund
VAW	Violence Against Women
WHO	World Health Organisation

"Because of all her traumatic experiences she couldn't sleep with her husband. She relived everything. In the end she committed suicide."

Afghan Asylum Seeker

ICRH

"Hidden Violence is a Silent Rape" Seminar

UNIVERSITEIT GENT

SUMMARY

Introduction

Sexual violence is a public health issue of global magnitude. In addition to important adverse effects on the victim's well-being and participation in society; sexual violence may induce long lasting ill sexual, reproductive, physical and mental health, primarily affecting the victim yet also potentially harmful to the victim's peers, offspring and community.

Migrants are considered at risk of sexual victimization worldwide, with refugees, asylum seekers and undocumented migrants identified as the most vulnerable migrants. Whether these migrant groups are also at risk of sexual violence and sexual ill-health in Europe and the European Neighbourhood has not yet been considered. This can however be hypothesised as literature shows that people with similar socio-economic positions, those who are living in shelters and institutions as well as people who have directly or indirectly experienced violence at an earlier stage of life; are at enhanced risk of sexual violence. Furthermore, some non-governmental organisations draw attention to situations that support this hypothesis. Especially violent incidents with sub-Saharan migrants were reported in Morocco and at its borders with whom Europe has the closest collaboration to regulate irregular migration from Africa to Europe in the frame of the European Neighbourhood Policy.

Sexual violence is also a violation of the human right to dignity; of the right to life, liberty, autonomy and security; the right to equality and non-discrimination; the right to live a life free from torture, inhuman or degrading treatment or punishment; the right to privacy and physical and mental integrity; the right to the highest attainable standard of health including sexual and reproductive health and to live a sexual life without violence and coercion. Human rights are universal, and thus of appliance to all, regardless of the legal status one holds. Although the European Union refers to health as a human right in many internal and external communications, policies and agreements, defending its universality; this doctoral thesis hypothesises that there might be a discrepancy between the proclaimed rights-based approach and actual obstacles hampering migrants' attainment of good sexual health and protection from sexual victimization in Europe and the European Neighbourhood.

Objectives and Methods

The general objective of this study is to contribute to a better understanding of factors determining the health of refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood by exploring prevention of sexual violence and promotion of sexual health. To this end, specific objectives were set forward. First, we aimed to explore the nature and magnitude of sexual violence that refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood experience. Second, we wanted to study their definition of sexual health. Third, we aspired to identify subjective as well as objective sexual violence and sexual health determinants

at the personal, interpersonal, organisational and societal level. Fourth, we aimed to assess the impact of legal and policy frameworks on sexual violence and sexual health in the context of migration. Fifth, we intended to conduct this research in a highly participatory way, contributing to social and policy change with different sexual violence prevention and sexual health promotion tools. And finally sixth, we sat forward to formulate research, practice and policy recommendations.

To this end, we applied a conceptual framework that combines a human rights and public health approach, with the socio-ecological model on health and the concept of Desirable Prevention. Starting from this conceptual framework, we adopted a triangulation form of qualitative, applied and formative research approach, being Community-Based Participatory Research (CBPR). Three CBPR projects on sexual violence and sexual health were set up in 8 European countries (Belgium, the Netherlands, Ireland, Hungary, Portugal, Spain, Greece and Malta) and in 1 European Neighbourhood country, being Morocco, which the European Union considers the pre-eminent transit country for irregular migration from Africa to Europe with whom the EU can make contracts in the frame of the European Neighbourhood Policy. First, we conducted 377 in-depth interviews with refugees, asylum seekers and undocumented migrants in Europe and Morocco. Subsequently, by the means of a KAP survey with open-ended questions on their direct or indirect violence experiences; we examined 600 professionals' and residents' Knowledge, Attitude and Practices towards sexual violence prevention and sexual health promotion in the European asylum and reception sector. Finally, KAP interviews were held with 24 health care professionals in the Moroccan health care sector , inquiring on their Knowledge Attitude and Practices towards sexual violence prevention in sub-Saharan migrants.

We applied the Framework Analysis Technique and Nvivo8 to analyse the qualitative data and used SPSS to analyse the quantitative and check the extensiveness of the qualitative data. For the KAP-study in the European asylum and reception sector, we analysed the quantitative parts through the use of R. We conducted logistic regression analysis using generalized linear models and mixed models to evaluate the relationship between types of violence and specific characteristics of the victims and perpetrators. As for the legal and policy frameworks, we conducted a Critical Interpretative Synthesis, reviewing 187 grey literature documents and 80 academic references.

Results

Our results demonstrate that both in Europe as in the European Neighbourhood, our research population is at risk of sexual violence. Regarding the nature and magnitude of the reported violence cases, there are three characteristics that stand out. First, compared to the host populations, sexual violence is very frequently reported, and often co-occurs with physical, emotional and/or socio-economic violence in a single case. Second, sexual violence in our research population is often characterised by gang or multiple rape. Third, professionals constitute an important part of the perpetrators.

We identified several subjective and objective determinants at the four socio-ecological levels, which we discuss in detail. Yet, we consider the transversal determinants of gender and legal status as the most decisive ones for Desirable Prevention of sexual violence and for sexual health promotion. As for gender, our results demonstrate that victimisation and perpetration in the given contexts of our research population seems more gender-balanced than what is generally expected in the general population. Yet, research as well as legal and policy frameworks currently apply a dichotomist and stigmatising paradigm in which, a priori, women are considered as sole victims and men as sole perpetrators. We argue that this is problematic, since it ignores a number of victims and perpetrators which are in need of effective interventions and whom are now left unaddressed. Furthermore, it creates a bias in research by not providing the possibility of identifying real dynamics in violence. Another, and to us the most important determinant, lays in the legal status of refugees, asylum seekers and undocumented migrants being different of that of citizens, which structurally hampers them at all socio-ecological levels to participate in society and to be active agents in their life. Our results clearly demonstrate that being a refugee, asylum seeker or undocumented migrant in Europe and the European Neighbourhood is a risk factor for sexual ill-health and sexual violence and confirms that migration and legal status in this matter can be considered health determinants as such, influencing other determinants at all socio-ecological levels.

Finally, our results clearly show the absence of an overall rights-based approach in policies regulating migrants' health and protection from violence in Europe and the European Neighbourhood. There is a clear discrepancy between the increasing acknowledgment of specific migrants' needs and the simultaneous enforcement of policies restricting their right to health and controlling immigration flows. Although all 27 European Member States ratified the International Bill of Human Rights, which as such obliges them to comply and respect among others the right to dignity and health, the European Union has also a Charter on Human Rights that acknowledges national conditioning of the right to health. Our results show that several Member States do not uphold those requirements when it comes to sexual health of migrants. We thus argue that this conditioning, influenced by migration policies, creates a flawed rights-based approach as well as obstacles for migrants to attain good sexual health in the EU, and be protected from sexual violence, which from a public health perspective is a risk to ill-health beyond migrant groups.

Conclusions and Recommendations for Future Research, Policy and Practices

The data of our several studies highlight the vulnerability of refugees, asylum seekers and undocumented migrants to sexual violence and sexual ill-health in Europe and the European Neighbourhood. We identified several determinants at the four socio-ecological levels but identified gender and restricted legal status as the most decisive determinants for sexual health promotion and for Desirable Prevention of sexual violence.

For the sake of all people living in the EU and the European Neighbourhood today and in the future, it is thus paramount that future sexual health promotion and sexual violence prevention actions apply the dimensions of Desirable Prevention. This implies that they should address the root causes by assuring that human rights are enforced and upheld without exception. Consequently, it is essential that the odds that legal status and migration can still be considered as a specific health determinant are reduced and that in future policies, research and practices a gender-sensitive paradigm is applied. The development of a true rights-based approach to health for all, thus requires rethinking the current European paradigm on violence as solely directed towards women as well as on migration into one that considers migration as an opportunity rather than a threat to public health and societies which should be tackled through an ever stronger securitization. Future policy-making should address such discourses and develop broader understandings of the interaction between health, welfare, citizenship and migration. It is hereby vital that European responsibility in inducing problems and vulnerability are not neglected.

Furthermore, these health promotion and violence prevention actions should be "offensive" in the sense that they stem from a positive view on sexual health and sexuality, and that opportunities are not curtailed as specious argument for preventing them to be put at risk of sexual violence, yet promoting their health beyond the level of absence of disease or infirmity. Furthermore, the prevention should be radical, integral and democratic. Given research demonstrating life course vulnerability, intergenerational transmission and violence debut often starting at young age, it is key to stop the momentum from going and target young migrants as a specific age group of multiple vulnerability that need specific attention at all levels of prevention – from general policy to primary, secondary, tertiary prevention and care- and at all stages of problem development. All age groups have a role to play in this and should thus be addressed in a wide range of prevention actions addressing person-oriented as well context-oriented changes at all levels concurrently. Participation of migrants in all phases of these actions is a prerequisite.

Finally, we like to argue that it is not only up to European Member States and the Moroccan state to alter legal and policy frameworks on asylum and migration; and to the European asylum and reception sector to apply Desirable Prevention and response policies in order to uphold human rights and to protect refugees, asylum seekers and undocumented migrants from sexual violence and sexual ill-health. We do think that it is a matter of public health in which all health workers have a co-responsibility in promoting good health and prevention of violence in all people regardless of the status one has or not. Bearing our conceptual framework in mind, it is also a matter of general public concern in which everyone in Europe and the European Neighbourhood, being a citizen or not, has a certain role to play.

This also includes researchers, to whom we suggest an array of topics that are currently unaddressed. The most important ones can be summarized as follows. First, future sexual health and violence research should apply a gender-sensitive paradigm and reveal true dynamics in specific communities and settings in order to define the most effective interventions. Second, EU-wide datasets should be enhanced by the adoption of common indicators on legal status, sexual health and sexual violence and durable data collection. Third, the topics should encompass all aspects of sexual health and all types of sexual violence. Fourth, as migration routes tend to differ from time to time, it is advisable that the situation in other neighbouring countries comprised within European Neighbourhood Policies and Action Plans are thoroughly researched. Fifth, the long-term evaluation of Desirable Prevention measures and their impact on the health and well-being of refugees, asylum seekers and undocumented migrants compared to other people living in Europe and the European Neighbourhood would help to clarify the relationship between the different determinants. Finally, we encourage the use of CBPR as a valuable approach in researching sensitive topics as sexual violence and sexual health in refugees, asylum seekers and undocumented migrants. Yet, we do emphasize that some challenges are to be taken into account.

SAMENVATTING

Inleiding

Seksueel geweld is een volksgezondheidprobleem op wereldschaal. Naast belangrijke negatieve effecten op het welzijn en de mogelijkheid van slachtoffers om te participeren aan de maatschappij, kan seksueel geweld ook langdurige seksuele, reproductieve, fysieke en mentale gezondheidsproblemen veroorzaken. Deze zijn niet alleen van invloed op het slachtoffer, ze kunnen ook schadelijk zijn voor hun omgeving, hun kinderen en hun gemeenschap.

Migranten worden wereldwijd als kwetsbaar voor seksueel geweld aanzien. Hierbij worden vluchtelingen, asielzoekers en mensen zonder wettig verblijf als het meest kwetsbaar beschouwd. Of die migrantengroepen ook kwetsbaar zijn voor seksueel geweld en een slechte seksuele gezondheid in Europa en het Europees Nabuurschap, was tot op vandaag nog niet onderzocht. Dit kunnen we echter wel veronderstellen. Onderzoek heeft namelijk aangetoond dat mensen met een vergelijkbare socio-economische status, zij die in opvangtehuizen en instellingen verblijven, alsook die mensen die vroeger direct of indirect geweld hebben ervaren, meer kwetsbaar zijn voor seksueel geweld dan anderen. Verschillende niet-gouvernementele organisaties benadrukken situaties die deze stelling ondersteunen. Zo meldden zij bijzonder gewelddadige incidenten met sub-Saharaanse migranten in Marokko en aan haar landgrenzen. Marokko is het land waarmee de Europese Unie binnen het kader van het Europees Nabuurschap de nauwste samenwerkingsverbanden onderhoudt om clandestiene migratie van Afrika naar Europa aan banden te leggen.

Seksueel geweld is ook een schending van de mensenrechten. Iedereen heeft het recht op een menswaardig leven, recht op een leven in vrijheid, autonomie en veiligheid, recht op gelijkwaardigheid en een leven vrij van discriminatie, marteling, onmenselijke of vernederende behandeling of straf, het recht op privacy en mentale en fysieke integriteit, het recht op de hoogst mogelijke standaard van gezondheid, inclusief seksuele en reproductieve gezondheid en een seksualiteitsbeleving vrij van dwang of geweld. Mensenrechten zijn universeel en zijn dus van toepassing op iedereen, onafhankelijk van de legale status die je hebt. Hoewel de Europese Unie in vele interne en externe boodschappen, beleidsdocumenten en overeenkomsten naar mensenrechten refereert en hierbij de universaliteit ervan onderstreept, gaan wij er in deze doctoraatsthesis van uit dat er een discrepantie zou kunnen zijn tussen dat vooropgestelde mensenrechtenperspectief en werkelijke drempels die migranten in Europa en het Europees Nabuurschap verhinderen om tot een goede seksuele gezondheid te komen en gevrijwaard te blijven van seksueel geweld.

Doelstellingen en Methodes

De algemene doelstelling van deze studie is om bij te dragen tot een betere kennis van factoren die de gezondheid van vluchtelingen, asielzoekers en mensen zonder wettig

verblijf in Europa en het Europees Nabuurschap beïnvloeden door middel van onderzoek naar seksuele gezondheidspromotie en preventie van seksueel geweld. Om dit te bereiken, hebben we 6 specifieke doelstellingen vooropgesteld. Ten eerste wilden we de aard en de omvang van het seksueel geweld onderzoeken waarmee vluchtelingen, asielzoekers en mensen zonder wettig verblijf in Europa en het Europees Nabuurschap te maken krijgen. Ten tweede, wilden we hun definiëring van seksuele gezondheid bestuderen. Ten derde stelden we als doel om zowel subjectieve als objectieve determinanten van seksuele gezondheid en seksueel geweld op individueel, interpersoonlijk, organisationeel en maatschappelijk vlak in kaart te brengen. Ten vierde wilden we de impact van juridische en beleidskaders op seksueel geweld en seksuele gezondheid in de context van migratie nagaan. Ten vijfde, hadden we de intentie om dit onderzoek op een hoogst participatieve manier te voeren en zo ook bij te dragen aan sociale en politieke verandering door de ontwikkeling van instrumenten voor seksuele gezondheidspromotie en voor preventie van seksueel geweld. Ten slotte stelden we ook voorop om onderzoeks-, praktijk- en beleidsadviezen te formuleren.

Om dit te kunnen realiseren, pasten we een conceptueel raamwerk toe dat een mensenrechten- en volksgezondheidsperspectief combineert met het sociaalecologisch model in gezondheid en het concept van Wenselijke Preventie. Met dit conceptueel raamwerk als basis, pasten we een getrianguleerde vorm van kwalitatief, toegepast en formatief onderzoek toe die "Community Based Participatory Research" (CBPR) heet en ongeveer vertaald kan worden als "participatief onderzoek dat je in en mét je onderzoeksdoelgroep en hun gemeenschap uitvoert". We zetten drie CBPR projecten rond seksueel geweld en seksuele gezondheid op in 8 Europese landen (België, Nederland, Ierland, Hongarije, Portugal, Spanje, Griekenland en Malta) en in 1 land in het Europees Nabuurschap, namelijk Marokko. De Europese Unie beschouwt Marokko als het transitland bij uitstek voor clandestiene migratie van Afrika naar Europa waarmee de Europese Unie toch afspraken kan maken en overeenkomsten kan sluiten binnen het kader van het Europees Nabuurschapsbeleid.

We hebben eerst 377 diepte-interviews met vluchtelingen, asielzoekers en mensen zonder wettig verblijf in Europa en Marokko afgenomen. Vervolgens hebben we via een Kennis, Attitude en Praktijkstudie (KAP-studie) met open vragen over directe en indirecte ervaring met geweld, 600 bewoners en professionals in de Europese asiel- en opvangsector bevraagd. Tenslotte zijn ook 24 gezondheidswerkers van de Marokkaanse gezondheidssector geïnterviewd omtrent hun Kennis, Attitude en Praktijk rond preventie van seksueel geweld tegen sub-Saharaanse migranten in Marokko.

Voor de analyse van de kwalitatieve data pasten we de Raamwerk Analyse Techniek toe en maakten ook gebruik van het programma Nvivo8. We gebruikten SPSS om de omvang van de kwalitatieve data na te gaan en om de kwantitatieve gegevens te analyseren. Voor de kwantitatieve gegevens van de KAP-studie in de Europese asiel- en opvangsector,

gebruikten we het statistische programma R. Hierbij voerden we een logistische regressie analyse uit en om de relaties tussen verschillende types van geweld en specifieke kenmerken van slachtoffers en plegers te ontdekken, maakten we ook gebruik van algemeen lineaire en gemengde modellen. Voor de impactevaluatie van juridische en beleidsraamwerken, voerden we een "Kritische Interpretatieve Synthese" uit en onderzochten hierbij 187 grijze en 80 wetenschappelijke bronnen.

Resultaten

Onze onderzoeksresultaten tonen aan dat onze onderzoekspopulatie zowel in Europa als in het Europees Nabuurschap kwetsbaar is voor seksueel geweld. Er zijn drie kenmerken die op het vlak van aard en omvang van de gerapporteerde geweldsgevallen in het oog springen. In vergelijking met de autochtone bevolking, wordt deze groep mensen erg veel met seksueel geweld geconfronteerd en vaak gaat dit seksueel geweld binnen één casus gepaard met fysiek, emotioneel-psychisch en/of socio-economisch geweld. Seksueel geweld wordt in deze groep mensen ook gekenmerkt door meervoudige en groepsverkrachtingen. Tenslotte, vormen professionals die beroepshalve een dienst aan deze migranten zouden moeten verlenen, een belangrijke groep van de plegers.

We identificeerden verschillende subjectieve en objectieve determinanten op de vier sociaalecologische niveaus die we in detail bespreken. We beschouwen echter de twee transversale determinanten gender en legale status als meest doorslaggevend voor Wenselijke Preventie van seksueel geweld en voor seksuele gezondheidspromotie.

Onze resultaten tonen aan dat er in tegenstelling tot wat er doorgaans in de autochtone bevolking wordt aangenomen, er binnen de context van onze onderzoeksdoelgroep meer genderevenwicht is te vinden in zowel het plegen als het ondergaan van seksueel geweld. Nochtans vertrekken zowel onderzoeksprotocollen als juridische en beleidskaders vandaag nog steeds van een dichotoom en stigmatiserend paradigma, waarbij vrouwen a priori als slachtoffers worden gezien en mannen a priori als plegers. Wij stellen dat dit problematisch is, gezien het een aantal slachtoffers en plegers ontzegt van noodzakelijke en effectieve interventies. Bovendien creëert het een vooringenomenheid in onderzoek die niet toelaat om werkelijke geweldsdynamieken bloot te leggen.

Een ander, en voor ons de meest bepalende determinant, is de legale status die van vluchtelingen, asielzoekers en mensen zonder wettig verblijf verschilt van burgers, en die hen bijgevolg op alle sociaalecologische niveaus verhindert om aan de maatschappij deel te nemen en actieve actoren in hun eigen leven te zijn. Onze resultaten tonen duidelijk aan dat het feit om in Europa of in het Europees Nabuurschap een vluchteling, asielzoeker of persoon zonder wettig verblijf te zijn, je kwetsbaar maakt voor een slechte seksuele gezondheid en voor seksueel geweld. Het bevestigt hiermee dat migratie en legale status beschouwd kan worden als specifieke gezondheidsdeterminanten die andere determinanten op alle sociaalecologische niveaus beïnvloeden.

Tenslotte geven onze resultaten weer hoe het mensenrechtenperspectief aan de huidige beleidsraamwerken rond de gezondheid van migranten en hun bescherming op geweld in Europa en het Europees Nabuurschap ontbreekt. Er is een duidelijke discrepantie tussen de stijgende erkenning van specifieke migrantennoden en gelijktijdige verscherping van wetgeving die het recht op gezondheid beperkt en migratiestromen controleert. Hoewel alle 27 Europese lidstaten het Internationaal Verdrag van de Mensenrechten ondertekenden, en dit hen dus verplicht om onder meer het recht op menswaardigheid en gezondheid te respecteren en te verzekeren, houdt de Europese Unie er ook een Europees Charter voor de Mensenrechten op na. Dit Charter laat de individuele lidstaten toe om het recht op gezondheid aan voorwaarden te onderwerpen. Onze onderzoeksresultaten tonen aan dat die onderwerping aan voorwaarden onder invloed van migratiebeleid tot een afgezwakt en bijgeschaafd mensenrechtenperspectief leidt die voor migranten drempels creëert in hun poging om tot een goede seksuele gezondheid te komen en om gevrijwaard te blijven van seksueel geweld. Vanuit een volksgezondheidsperspectief leidt dit tot slechte gezondheid van de volledige gemeenschap, ook buiten de aanwezige migrantengroepen.

Conclusies en Aanbevelingen voor Onderzoek, Beleid en Praktijk

Onze onderzoeksresultaten benadrukken de kwetsbaarheid van vluchtelingen, asielzoekers en mensen zonder wettig verblijf voor seksueel geweld en een slechte seksuele gezondheid in Europa en het Europees Nabuurschap. We identificeerden verschillende determinanten op de vier sociaalecologische niveaus maar benadrukten het belang van gender en legale status als meest doorslaggevende determinanten voor seksuele gezondheidspromotie en Wenselijke Preventie van seksueel geweld.

Voor de gezondheid van alle mensen die vandaag en in de toekomst in Europa en het Europees Nabuurschap leven, is het van primordiaal belang dat toekomstige initiatieven in seksuele gezondheidspromotie en seksueel geweldspreventie de dimensies van Wenselijke Preventie toepassen. Dit betekent dat ze de grondoorzaken moeten aanpakken door er voor te zorgen dat de mensenrechten zonder uitzondering of voorwaarden toegepast en verzekerd worden. Hierbij is het essentieel dat de kansen dat legale status en migratie als een specifieke gezondheidsdeterminanten kunnen gelden, gereduceerd worden en dat in toekomstig beleid, onderzoek en praktijk een gendersensitief paradigma wordt gehanteerd. De ontwikkeling van een werkelijk mensenrechtenperspectief op gezondheid voor iedereen, veronderstelt dus ook het herdenken van het huidige Europese paradigma dat er per definitie van uitgaat dat vrouwen de enige slachtoffers zijn en mannen de enige plegers. Vervolgens is het ook noodzakelijke dat het huidige Europese paradigma rond migratie bijgesteld wordt waarbij migratie niet langer aanzien wordt als een bedreiging voor de volksgezondheid en de maatschappij die een steeds sterkere beveiligingsaanpak vereist, maar eerder beschouwd wordt als een opportuniteit. Toekomstige beleidsvorming zou dit discours moeten aanpakken en een beter begrip van de interactie tussen gezondheid, welzijn, burgerschap en migratie scheppen. Het is hierbij uiterst belangrijk dat de Europese verantwoordelijkheid in het creëren van problemen en kwetsbaarheid niet over het hoofd wordt gezien.

Deze initiatieven in seksuele gezondheidspromotie en in preventie van seksueel geweld zouden ook "offensief" moeten zijn in die zin dat zij vanuit een positieve kijk op seksuele gezondheid en seksualiteit vertrekken en dat de handelingsruimte van mensen niet wordt begrensd vanuit de loutere drogreden om hen minder aan het risico op geweld bloot te stellen. Hun gezondheid moet ook ruimer bevorderd worden dan enkel het voorkomen of herstellen van ziekte en beperking. Daarnaast zou de preventie ook radicaal, integraal en democratisch moeten zijn. Gezien onderzoek een levensloopkwetsbaarheid alsook intergenerationele transmissie van gevolgen van geweld aantoont, en gezien het eerste geweldsdelict vaak op jonge leeftijd wordt gepleegd, is het van uitermate belang dat dit momentum een halt wordt toegeroepen. Dit betekent dat het noodzakelijk is om jonge migranten als een specifieke doelgroep met meervoudige kwetsbaarheid te beschouwen wat specifieke aandacht op alle preventieniveaus en in alle stadia van probleemontwikkeling veronderstelt. Alle leeftijdsgroepen hebben hierin een rol te spelen en zouden dus door een brede waaier aan persoonsgerichte en contextgerichte preventie-acties aangesproken moeten worden. Participatie van migranten in alle fases van deze acties is een absoluut voorwaarde voor kwaliteit en welslagen.

Tenslotte willen we benadrukken dat om mensenrechten te verzekeren en vluchtelingen, asielzoekers en mensen zonder wettig verblijf van slechte seksuele gezondheid en seksueel geweld te vrijwaren, het niet alleen aan de Europese lidstaten en de Marokkaanse staat is om de juridische en beleidsraamwerken rond asiel en migratie aan te passen. Het is ook niet alleen aan de Europese asiel- en opvangsector om binnen hun organisaties Wenselijke Preventie acties op te zetten. Wij gaan er van uit dat het een volksgezondheids-probleem is waarbij alle gezondheidswerkers een medeverantwoordelijkheid hebben om de gezondheid van alle mensen te bevorderen en hen van geweld te beschermen, ongeacht de legale status die ze al dan niet hebben. Ons conceptueel raamwerk in acht nemend, betekent dit ook dat wij er van uitgaan dat dit een algemeen maatschappelijk probleem is waarbij iedereen in Europa en het Europees Nabuurschap een bepaalde rol te vervullen heeft, los van het feit of je een burger bent of niet.

Dit houdt dus ook in dat onderzoekers zich meer op deze thema's gaan toeleggen. Wij stellen een waaier voorstellen voorop waarvan we de belangrijkste hier samenvatten. Eerst en vooral zou toekomstig onderzoek van een gendersensitief paradigma moeten vertrekken waardoor werkelijke geweldsdynamieken binnen bepaalde gemeenschappen en contexten bloot gelegd kunnen worden en bijgevolg effectieve interventies kunnen opgezet worden. Ten tweede zou Europese dataverzameling verbeterd kunnen worden door gemeenschappelijke indicatoren in legale status, seksuele gezondheid en seksueel geweld te hanteren en systematisch deze indicatoren op te nemen. Ten derde is het noodzakelijk dat het onderzoekspectrum alle deelaspecten van seksuele gezondheid en alle vormen van seksueel geweld omvat. Ten vierde veranderen migratieroutes van tijd tot tijd en is het wenselijk dat de situatie in andere nabuurlanden onder het Europees Nabuurschap onderzocht wordt. Ten vijfde zou het nuttig zijn om de impact van Wenselijke

Preventie-initiatieven op de gezondheid en het welzijn van vluchtelingen, asielzoekers en mensen zonder wettig verblijf in vergelijking met andere groepen in Europa en het Europees Nabuurschap op lange termijn te evalueren. Dit zou ook toelaten om de relatie tussen de verschillende determinanten scherp te stellen. Tenslotte stimuleren wij de toepassing van de CBPR methode als aanpak in onderzoek naar gevoelige onderwerpen als seksueel geweld en seksuele gezondheid in vluchtelingen, asielzoekers en mensen zonder wettig verblijf maar benadrukken hierbij dat verschillende uitdagingen hierbij goed overwogen moeten worden.

"Some people consider sexual abuse to be a normal thing. It grows in their heart from childhood onwards."

Somali refugee

"Hidden Violence is a Silent Rape" Seminar

1. INTRODUCTION

1.1 Background

At the International Conference on Population and Development of September 1994 in Cairo, clear objectives were set forward as to achieve equality and equity between women and men, and to ensure that all women as well as men, would be able to exercise their human rights and participate fully in all areas of life. A total of 179 governments acknowledged 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 endorsed 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 migrants and refugees were specified as such[1].

European Union Member States endorsed this action plan, 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, as well as a violation of human rights (of the right to dignity; the right to life, liberty, autonomy and security; the right to equality and non-discrimination; the right to live a life free from torture, inhuman or degrading treatment or punishment; the right to privacy; the right to physical and mental integrity; the right to the highest attainable standard of health; the right to attain the highest standsexual and reproductive health and of the right to have a sexual life without violence and coercion) and in some cases as a crime against humanity.

At the same time as goals were set to end gender-based violence, the European Union started to intensify its efforts to evolve into a coherent political territory. Along with this development, new European asylum and neighbourhood policies were formulated[2]. 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 it borders remains to this day an issue of great concern.

In order to situate the topic of my doctoral research, we first give a brief overview of migration in Europe and the European Neighbourhood and describe what is known on migrant health. Subsequently, we summarize the state of the art literature on sexual health and its determinants. Finally, we explain the current definitions of sexual violence and present the current findings on sexual violence determinants and prevention.

1.2 Migrants and Migration

1.2.1 Defining Migrants

So far, there is no such thing as a consensual definition of "migrants"[3], which makes international comparison of data on these heterogeneous groups and the interpretation of legal, policy and academic documents a hazardous endeavour[4,5]. A frequently used terminology in migration policies is based on legal residence statuses, distinguishing regular (documented) from irregular (undocumented) migrants.

The term "regular migrants" refers to people whose entry and residence are authorized by State authorities. It regards persons with a temporary residence authorization, as asylum seekers, foreign students and temporary migrant workers; but also people with long-term resident or citizenship status as permanent immigrants, official family reunification migrants and refugees are considered regular migrants.

The most widely used legal definition of a **refugee** is contained in the 1951 'Geneva Convention Relating to the Status of Refugees', which states that: "a refugee is a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him—or herself of the protection of that country, or to return there, for fear of persecution"[6]. People who fulfil this definition are entitled to the rights and bound by the duties contained in the 1951 Convention on the status of refugees. Other definitions can be found in international treaties such as the 'Convention Governing the Specific Aspects of Refugee Problems in Africa'; the 'Cartagena Declaration on Refugees' and the 'Colloquium on the International Protection of Refugees in Central America, Mexico and Panama'.

An **asylum seeker** is someone who is seeking international protection. In countries with individualized refugee status determination procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee was initially an asylum-seeker[6].

Irregular/undocumented migrants are then persons who enter a host country without a legal authorization or overstay authorized entry as tourists, foreign students, temporary contract workers or rejected asylum seekers.

1.2.2 Migration in Europe

Migration movements in the European Union (EU) recently increased in size and complexity and regular migrants constitute an essential part of the European population. 32.967.000 people, or mere 10% of the EU population in 2012 was born outside their country of residence, two thirds of them descending from a non-European Member State[7,8]. "Third-country" or "extra-European" nationals accounted in 2011 for 6.6% of the European population against 4.4% in 2001[8].

According to UNHCR, the 27 European Member States received 2.6 asylum seekers per 1000 inhabitants between 2008 and 2012 with 296.700 new asylum claims in 2012, reaffirming a recent upward trend[9]. Refugee status was granted to 14% of those applicants[10]. While Afghanistan remained the number one country of origin in 2012, the most significant increase of applicants was from Syria. However, descendants from the six Western Balkan countries, the Russian Federation, Pakistan, Somalia, Iran, Georgia and the Democratic Republic of Congo constituted the most numerous groups of asylum seekers in the EU in 2012[11].

Accounting for irregular migration in the EU is extremely difficult, however the Frontex quarterly report of July-September 2012 stated that more migrants were denied entry in the EU than in any other quarter since the peak of 2009[12], where estimates were made of 1.9 million to 3.8 million irregular migrants in the EU[13].

Figure 1.2.2: Current migration routes to Europe. SOURCE: http://www.imap-migration.org/index.php?id=4

The migration routes as well as the preferred entry points to the EU alter from time to time. In the latest years Turkey has become one of the most important transit countries for third-country nationals seeking to enter the EU via the Greek-Turkish border and via the Eastern Mediterranean sea route as well as the Western Balkans. Migrants taking these entry points predominantly originate from Iraq, Iran, Afghanistan, Pakistan, Bangladesh and, to a lesser extent, from Algeria and Sub-Saharan Africa[11]. The three other main transit countries to the EU are Russia to the East and Libya and Morocco to the South. For decades Morocco has been considered the main southern gateway to the EU for migrants from, or passing through, Africa[14]. In the latest years however, Libya has beaten that first position with crossings to Malta and Italy.

With every enlargement of the European Union, the political, geographical, economic and social situation of the EU changed, creating new external borders and challenging the EU's migration and asylum policies. At the one hand, this urged the EU at the end of last century to intensify its efforts to come to more coherent, and thus more common, asylum and migration policies[2]. This led to the creation a European Asylum System Office (EASO) in 2010 and a Common European Asylum System (CEAS) which was completed in 2012. At the other hand, it also resulted in the reinforcement of the EU's external borders, building "a ring fence" with its neighbouring countries, through preferential partnerships[15] as well as to the creation of Frontex, "the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union", in 2004.

1.2.3 Migration and the European Neighbourhood Policy

The relationship between Europe and its border countries to the East and South are administered through the European Neighbourhood Policy (ENP). The ENP was launched in 2004 with the ambition of "avoiding the emergence of new dividing lines between the enlarged EU and [its] neighbours and instead strengthening the prosperity, stability and security of all"[16]. The EU revised the ENP in 2011, establishing instruments to provide more support to partner countries building democracy and to support inclusive economic development. Hence, the new ENP's main features are: political association and economic integration, the mobility of people, more EU financial assistance, a stronger partnership with civil society and better cooperation on specific sector policies[17]. The current adagio is that "Through its European Neighbourhood Policy, the EU works with its southern and eastern neighbours to achieve the closest possible political association and the greatest possible degree of economic integration"[18].

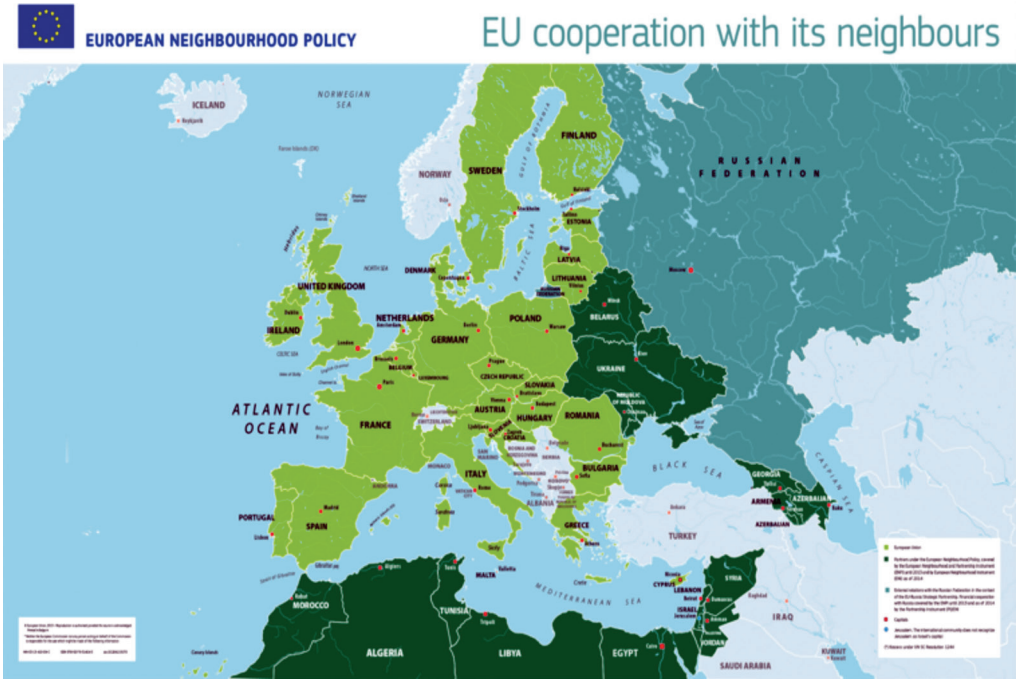

Figure 1.2.3: Map of the European Neighbourhood Countries. SOURCE: www.enpi-info.eu

The 16 European Neighbourhood countries are: Algeria, Armenia, Azerbaijan, Belarus, Egypt, Georgia, Israel, Jordan, Lebanon, Libya, Moldova, Morocco, Palestinian Authority, Syria, Tunisia and Ukraine. The European Union perceives the ENP countries as ' a ring of friends', which reflects how the EU understands peace and stability[19]. The EU provides them aid, access to the European market and cooperation, and expects from the ENP partner countries that they enhance on their economic and political performance in return[19], while building on "commitments to common values, including democracy, the rule of law, good governance and respect for human rights, and to the principles of market economy, free trade, sustainable development, poverty reduction and social cohesion"[18].

These mutual commitments and engagements are laid down in bilateral ENP action plans. All countries but four have specific action plans: Algeria is currently negotiating an ENP action plan; while Belarus, Libya and Syria, remain outside most of the ENP structures[18]. The ENP is complemented by regional and multilateral partnerships as the 'Eastern Partnership', the 'Euro-Mediterranean Partnership (EUROMED)' and the 'Black Sea Synergy'.

Migration, mobility and security are of essential concern within the ENP. Consequently, in order to promote effective management of migration flows, to combat and prevent illegal migration and to collaborate on visa facilitation, several ENP countries are urged to respect the 1951 Geneva Convention and its 1967 Protocol[19]. With Moldova, Georgia and Armenia, Mobility Partnerships have already been set up and Mobility Partnership negotiations are currently being held with Azerbaijan, Tunisia and Morocco[17].

1.2.4 Morocco as a Preferential Partner in the European Neighbourhood Policy

For decades, the European Union has had preferential partnerships with Morocco. As Morocco is considered the southern "Migration Hub" to the EU[14], the EU consequently considers it one of the leading partners in the ENP. Yet, the topic of migration has regularly sparked tensions between the two partners. In 2000, the EU initiated negotiations aiming at reaching an agreement on the readmission by third countries of their own nationals and all other persons having transited through their territories to reach Europe[20]. In 2005, the EU was also encouraging the implementation of 'transit centres' in third countries, where asylum candidates could pursue the procedure before entering the European territory; a project that was fiercely condemned by Morocco[20].

The ENP Strategy Paper drafted for the 2007-2013 period stated that "the issue of illegal migration is one of the principal sources of concern" for cooperation between Morocco and the EU[21]. Between 2007 and 2010, Morocco received a total of €654 million within the ENP framework[16], with at least €130 million in the first two years specifically dedicated to migration[22] through various instruments and notably development aid[23].

Both EU and Moroccan migration policies are based on the rationale that Sub-Saharan migrants enter and cross Morocco in the hope of crossing the borders of the Spanish enclaves of Ceuta and Melilla within Morocco or of reaching Europe by boat, hidden in vehicles, by false visas or by other means[14]. As a consequence, Morocco along with other countries was labelled in the mid-1990s as a 'transit country'.

However, research has shown that "the image that all sub-Saharan migrants present in North Africa are 'on their way' is highly misleading"[24] and that an increasing number of them settles in Morocco whether by primary choice or by default[25]. It has been noted that their journey is rarely planned from one fixed starting to another fixed end point and as failures along their journey might limit future options and drain resources[26,27]. A numerous group among them are thus rather 'stranded migrants' than 'transit migrants' enhancing their vulnerability and protection needs[26].

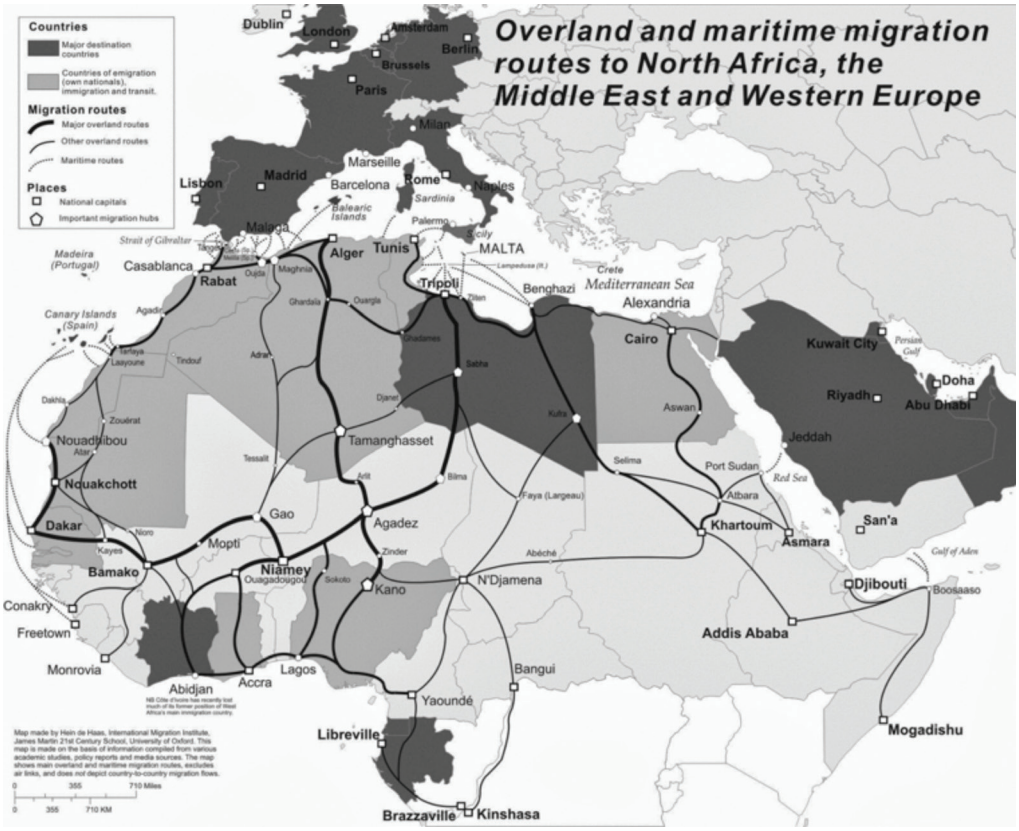

Figure 1.2.4: Migration routes to Morocco and beyond. SOURCE: HeinDeHaas.blogspot.com

The concept of 'transit migration' is however used by both the EU, which hence justifies its predominant role in the definition of migration policy in its neighbourhood[28]; and by Morocco, for which it provides a leverage for negotiations with the EU and for reinforcing its military presence in Western Sahara[25]. As a result, border controls have become increasingly militarized[29], making migrants' living conditions more precarious without succeeding at reducing migration flows[23].

In addition, although Morocco has signed the Geneva Convention in 1956, UNHCR documents are not fully acknowledged by Moroccan security forces[30] and a 2010 assessment of UNHCR action in Morocco states that "only limited progress has been made in terms of equipping the Moroccan state to assume responsibility for the country's refugees and asylum seekers"[31]. Finally, in September 2013, the Moroccan government announced to create an asylum seeker status and judicial guarantees for the rights of the undocumented migrants[32].

In 2008, Morocco estimated that around 60.000 foreigners were officially residing on its territory, predominantly from European (47%) and Algerian (19%) origin[33,34]. Undocumented migrants are mostly from sub-Saharan descent. Official estimates of sub-

Saharan undocumented migration in Morocco varied between 10.000 in 2005[33], 15.000 in 2007[34], and 20.000 in 2013[35] for a total population of nearly 33 million. The sub-Saharan migrants present in Morocco originate of about 40 different countries with the most numerous being from Nigerian, Malian, Senegalese and Congolese origin[36]. Estimates of their dispersion in Morocco in 2008, indicated that about 3000 sub-Saharan migrants were living in Rabat, 2000 in Casablanca, 600 in Oujda and Laayoune and 300 in Tangier[36]. According to UNHCR, Morocco hosted 744 refugees and had 2178 pending asylum cases in 2012[9]. IOM Morocco put forward that immigrants accounted for 0.2% of the Moroccan population at the end of 2013, 47.7% of which were women[35].

According to Frontex[37], there were 6,400 illegal crossings of the Gibraltar street from Morocco to Spain in 2012, with a top 3 of nationalities being either Algerian (2,020), "unspecified" (1,410) and 500 Moroccans. Furthermore, 170 people left from Morocco and illegally entered the Canary Islands, with 100 of them being Moroccans, 40 Gambians, 20 Senegalese and 10 from other origin.

1.3 Migrant Health

Although migrants thus constitute an important proportion of the population in Europe and to a lesser, but growing, extent in Morocco, relatively little is known about migrant health, migrants' perceptions of health determinants and migrants' utilisation of health care services. This gap in knowledge can be largely explained by a variety of technical and political reasons. First, throughout Europe, there is a great variability in the main denominators of citizenship, residency and immigration status in available databases [5,38,39]. In addition, in some countries ethnicity registration in clinical records is perceived as discriminatory and thus not done[40-42]. Second, health research protocols rarely pay attention to inclusion criteria or procedures which might by their nature inhibit participation of migrants[43]. Finally, research often favours homogenous groups hampering differentiation in migrant residence status although legally it is a decisive determinant in actual entitlements to health care in many European countries[44-46].

Migrants in Europe also constitute heterogeneous groups with respect to health practices[47-49]. Although the role of migration in the spread of diseases has long been of interest in public health, migrants are not necessarily disadvantaged in all areas of health. Upon arrival, migrants' general health status might –at first- be comparatively better than the host population ("the healthy migrant effect")[50]. Yet, depending on the policies and practices of the host countries, migrants may experience discrimination and a drop in their socio-economic position.

One's socio-economic position is determined by income, wealth, education, occupation, (subjective) social status and housing[51]. Evidence indicates a monotonic but non-linear gradual relationship between socio-economic position and health. Education and absolute income are perceived as enhancing a person's efficiency as a producer of health and as

protective factors, with education as a preventive factor for the onset and income for the progression of ill-health[52-54]. This drop in socio-economic position not only enhances their vulnerability, defined by the UN as "a state of high exposure to certain risks and uncertainties, in combination with reduced ability to protect or defend oneself against those risks and uncertainties and cope with their negative consequences"[55] but it also induces ill-health[56].

Research findings indicate that exposure to health risks in their home countries, strains in the migration process, *yet al*so daily stressors related to their migrant status, poor socioeconomic conditions, loss of social status, and change of roles when settling in a new country may result in a negative stress response and risk behaviour which makes migrants a particularly vulnerable group in society having special health needs[57-65]. Specifically for unaccompanied minors[66-68], trafficked migrants[60] and asylum seekers –especially those who were subjected to violence and torture before their flight[59,61,69,70], worse health has largely been demonstrated.

The economic and political situation of the host country is also an important determinant. The most recent World Migration Report of 2013[71] demonstrated that people migrating from high-income countries to other high-income countries believed they were generally better off than when they would have stayed at home and even evaluated their health and well-being as better than the natives. However, people originating from low or middle-income countries who migrated to high-income countries rated their lives better than if they would not have migrated but worse than the natives of the host countries. Finally, migrants who moved to other low or middle-income countries stated that their lives, well-being and health was not only worse than the natives, but also worse than in their country of origin[71]. This might be explained by the fact that, compared to the native-born populations in Europe and the European Neighbourhood, migrants are most often disadvantaged in relation to socioeconomic conditions[47,48] as healthy and safe housing, employment possibilities, economic hardship, access to health-care, participation in civil society and legal protection.These socio-economic factors connect closely with human rights[72,73].

Yet, the opportunity to realise these rights in Europe and the European Neighbourhood is intrinsically linked to the legal residence status one has or has not received upon migration; exposing refugees, asylum seekers and undocumented migrants largely to the potential downside of these socio-economic health determinants at a structural level. Legal status influences the extent to which one has and perceives access to health and social services, and to protection before the law. National laws and policies cause a considerable variation in entitlement to sexual and reproductive health services as well as the scope and quality of those services[46].

Legal restrictions on entitlement to care are particularly a problem for asylum seekers and undocumented migrants and in many European countries only emergency services are available[46,74-76]. In some countries asylum seekers are offered access to general or specially tailored services[46,77] but formal barriers for this group may include special requirements for referral to specialist care. As for undocumented migrants, current regulations and legislations in EU Member States do not guarantee full access to health care and tend to become more restrictive[74]. Hence the consideration of migration and legal status as a specific health determinant[56,78].

1.4 Sexual Health

Sexual health and sexuality are both health concepts that are still prone to definition modelling worldwide. We will first motivate the choice of definition used in this doctoral research. Then we will expand upon the current knowledge on sexual health determinants and migrant sexual health.

1.4.1 Sexual Health and Sexuality Defined

Since the recognition of sexual and reproductive health (SRH) as a human right at the International Conference on Population and Development of 1994 in Cairo, more need was felt to come to a global consensus on what sexual health entails. Starting from this rights-based and public health approach, the World Health Organisation has put some definitions forward. They posit that "Sexual health is defined as a state of physical, emotional, mental and social well-being in relation to sexuality; and is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive, respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled"[79].

In the same line, the WHO defines sexuality as: "A central aspect of human being throughout life which encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours and practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors."[80]

From a socio-ecological perspective on health, these factors can be classified at four interlinked levels: the individual, the interpersonal, the community and organisational level and finally the societal and public policy level. For migrant sexual health I identify the following key determinants.

1.4.2 Sexual Health Determinants at Individual Level

Already in the sixth week after conception, the sexual differentiation of the genitals starts, followed by sexual differentiation of the brain in the second half of pregnancy, determining one's sex, gender identity and sexual orientation[81,82]. Throughout the ages and across the globe, considering gender in sexuality and sexual health has been a topic of many heated debates. Some research has focused on differences between genders. This literature indicated that sexual stimuli trigger a wider range of both positive and negative meanings in women than in men[83]. Furthermore, whereas men's sexual identity, motivation and subjective arousal tend to be strongly controlled by stimulus-based factors; for women it appears to be more influenced by cognition-based factors as emotions, the broader quality of a relationship, dyadic conflict, personalized external events and social context factors.[84-89].Yet, other research indicates that gender differences are rather small and posit that exaggerating those differences may lead to a number of sexual and social problems [90].

Stress, sadness, anxiety, low self-esteem, unrewarded desire associated with unavailability, an individual's lack of competence, autonomy and interpersonal adjustment, dysfunctional cognitive processing and coping strategies and medication are all found to contribute to the development of sexual difficulties in both genders whereas positive feelings, trust, intimacy and good communication are found to improve sexuality[89,91,92,93,94].

Incorporated cultural norms, beliefs and attitudes towards sexual health and sexuality have equally been identified as decisive determinants. Beliefs on sexual normalcy, on definite criteria for pleasurable sex, on risks to sexual dysfunction; but also gender norms on sexual performance and ethical concerns about the function of sexuality, help-seeking and treatment are known to create and perpetuate sexual difficulties[90,92,95-100]. However, cultural norms, beliefs and attitudes also bolster one's self-esteem and self-efficacy and provide a coherent structure for interpreting life events; elements that are generally considered as health protection and promotion factors[100]. Hence comes in the discussion on the role of "health locus of control" which indicates where a person lays responsibility for one's health[102].

People with an internal locus of control believe that their health status is the result of their own behaviour and they acknowledge their own potential in preventing and controlling health problems by correct implementation of health promoting interventions and compliance to these interventions. Additionally, they believe that one can harm one's health by not having a healthy lifestyle and does not implement or comply with these interventions[103-105].

People with an external health locus of control believe that the most decisive influence on their health status and behaviour predominantly lays within the potential agency of powerful others as God, spiritual leaders, doctors and other health workers (formal help) and family or friends (informal help) or that their health is determined by luck or chance[105].

It has been found that people with a higher internal health locus of control have a more healthy lifestyle in general[106] as well as in pregnancy[107]; they demonstrate higher adequate use of contraceptive methods[108], are more compliant to treatment[109], have a higher sexual health service and treatment utilization[110] and they are less susceptible to ill-health[111] than people with a higher external health locus of control. The model posits that the constellation of influencing factors is rather stable but can be (re)shaped by individual learning experiences through age, education, cultural, spiritual or ethical convictions, major (traumatic) events and chronic diseases[104,112].

Finally, literature on sexual health suggests that marginally housed and homeless people might face social, political and practical challenges to understand and express their sexuality[113]; and take on roles that are inconsistent with their sexuality to protect themselves, using alternative orientations or hiding their gender/sexuality all together [114].

1.4.3 Sexual Health Determinants at Interpersonal Level

One's health status and health behaviour is thus not shaped independently of others. Irrespective of age, it has been found that one of the most decisive factors at the interpersonal level is social capital. The basic idea of social capital is that individuals invest, access and use resources embedded in social networks to gain a certain return of which health is one example[115]. Above all, social networks provide structure for social influence and social support. Social support can be classified as emotional (provision of empathy, trust, love), instrumental (tangible aid and services), informational (advice, suggestions, information) and appraisal (feedback useful for self-evaluation and affirmation)[116]. Social support provides self-esteem, identity, coping, trust, shared purpose and perceptions of control[117-119].

Secondly, social networks have significant impact on exposure to detailed health information and shaping of health-related norms[115,120]; on health risk perceptions and the adoption of health preventive behaviours[121,122]. Watkins & Warriner (2003) demonstrated that for sexual and reproductive health issues people tend to discuss information with persons who are considered similar or who are expected to have certain knowledge or competence. Kohler *et al*. (2007) added that social interactions on sexual and reproductive health in times of learning under uncertainty are equally determined by the costs and benefits of social learning, the various social constraints imposed on interaction due to availability or scarceness of social network partners, the social acceptability to communicate about risk and prevention strategies and the expected reduction of uncertainty about risk and prevention strategies.

Research that differentiated on age posited that adolescent and young adult sexual (health seeking) behaviour is not that stable yet and is largely influenced by peers in their network[123,124] Adolescents and young adults now frequently build their social network and subsequently also exchange information through social media as social network sites.

Moreno *et al* (2012) found that display of sexual references on young students' Facebook profiles was positively associated with the reporting intention to initiate sexual intercourse which may influence the attitudes, intentions and potential behaviours of adolescents who view them[125]. Research of Bleakley *et al* (2011) confirms that exposure to sexual media content increases adolescent sexual behaviour by enhancing their perceptions of social pressure. Yet, they stress that adolescent sexual behaviour and intention to have sexual intercourse are primarily determined by positive attitudes toward having sex, secondarily by perceived normative pressure and to a lesser extent by self-efficacy[95]. In addition, the influence of parents as powerful others are not to be neglected [126]. Although some research indicates that teenagers look to their parents as roles models and first source of sex information[127] others report that their actual role as source of sex information proves to be more peripheral[123,128].

1.4.4 Sexual Health Determinants at Organisational and Community Level

Research suggests that exposure to sexual content on media as television, music, movies and other media is associated with perceptions, beliefs and attitudes about sex as well as sexual behaviours[129-131]. Nevertheless, the extent of this relationship seems to vary across age, racial and ethnic groups[95,123,128]. Other channels for provision of sexual health information and shaping of sexual behaviour are institutional bodies as educational and religious institutions but also reception centres, rehabilitative centres and others.

Educational institutions can contribute to less sexual risk-taking, increased contraceptive use and lower pregnancy rates depending on the sexual education programs they provide and the attachment of their students[132,133]. Yet, their impact has not been proven to be the most decisive[123,134]. As for sexual health, religious bodies have been associated with lower sexual health service and treatment utilization[110], with higher reluctance to Human Papilloma Virus vaccination[135] and with higher importance of motherhood and more ethical concerns about infertility treatments through attendance[98].

1.4.5 Sexual Health Determinants at Societal & Public Policy Level

Many authors argue that where no biological sex differences can account for different health outcomes, gender inequity in health can be explained by the interplay between gender and structural economic and social processes. These processes are for example discriminatory values, norms and practices; differential exposures and vulnerabilities to risk behaviour, disease, disability and injuries; gender imbalanced health, economic, educational and political systems and biases in health research[1,136-138].

Another important form of inequity lies in the fulfilment of the right to health and health care. The right to health, including sexual health; is embedded within a wide range of international instruments and tools in the area of human rights, women's and children's rights. A set of instruments, spread across different branches, in particular refugee and international humanitarian law, addresses the right to health for specific groups of

people involved in migration. This international framework has been enriched with legal instruments and policy tools from the Council of Europe, WHO Europe and the EU.

It is commonly accepted that conditions surrounding the migration process and settling into the reception country may increase vulnerability to ill health and that health care systems may not be responsive enough to the specific needs of these migrant groups. It has been considered vital to migrants' integration and essential for good public health and wellbeing for all[43] that migrants' health is protected and that their access to quality care is guaranteed.

Since the 1946 Constitution of the World Health Organisation (WHO) and the 1948 Universal Declaration of Human Rights (UDHR) the enjoyment of the highest attainable standard of health is put forward as a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition[139]. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966[140]. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued "General Comment 14", an authoritative explanation of the Article 12.1 on the right to health of the ICESCR. It states in paragraph 12 (b) that governments have legal obligations to ensure that "health facilities, goods and services are accessible to all, especially the most vulnerable of marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds"[141], defined as "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status" §18,141.

In addition, the CESCR specified that States have an obligation to respect the right to health "by refraining from denying or limiting equal access (…) for all persons, including (…) asylum seekers and illegal immigrants, to preventive, curative and rehabilitative health services"[140]. All 27 EU MS ratified the "International Bill of Human Rights" (=UDHR, ICESCR and ICCPR) obliging them to comply. The EU prides itself as a promoter of human rights stating "[the EU sees] human rights as universal and indivisible. It actively promotes and defends them both within its borders and when engaging in relations with non-EU countries"[142]. It consequently adopted its Charter of Fundamental Rights in 2000. Yet, the Charter allows national conditioning for the right to health. Finally, within the European Neighbourhood Action Plans, respecting human rights is formulated as a core condition[17].

The European Union thus refers to health as a human right in many internal and external communications, policies and agreements, defending its universality. In parallel, specific health needs of migrants originating from outside the EU have been acknowledged. Yet, there seems to be a discrepancy between the proclaimed rights-based approach to health and actual obstacles to migrants' attainment of good SRH.

While the EU intensifies its efforts to evolve into a coherent political territory with the Common European Asylum System and European Neighbourhood policies, the right to the highest standard of health and access to health care for our research population still differs between Member States and is often left to the arbitrary decisions of individual health care and other service providers[143,144]. Substantive literature demonstrates that the absence of access to effective care for people with restricted legal status has a direct negative impact on health and can be viewed as a violation of human rights[72,73].

Access to health care is also of great importance for the wellbeing of migrants and successful integration in a new society. Despite the fact that migrants may have a higher need for care, they may also encounter more barriers in the process of getting care compared to the native-born populations[145]. Access to the healthcare system may be hampered due to both formal and informal barriers[146,147]. Formal barriers are related to the organization of the healthcare system, whereas informal barriers include unofficial obstacles that affect access and use of the healthcare system[146]. Utilization of the health care system by migrants may differ from the overall population in general, but particularly the most vulnerable populations such as refugees, asylum seekers and undocumented migrants may experience many formal and informal barriers in access.

Formal barriers include institutional and personal discrimination and racism based on ethnicity or religion has been shown to negatively affect access to care[148, 149]. Furthermore, health care providers often lack skills in culturally competent communication; they are often unaware of migrants' entitlements to SRH services and support available and they lack knowledge in screening, prevention or treatment of sexual violence and FGM[43].In addition, a lack of any formal introduction to the host country on arrival may affect access to care, particularly, for migrants who have recently arrived[148].

1.4.6 Migrant Sexual Health in Europe and the European Neighbourhood

Migrant sexual health does not span a vast amount of academic literature. The literature that is available mostly focuses on sexual and reproductive health risks. Within the body of research on migration and sexual risk, studies have posited that separation from native communities and social isolation contributes to risky sexual behaviour, including sex work and extramarital sexual relationships[150]. However, recent research stresses that the daily struggle and the existence of structural cultural values and beliefs are more decisive factors[151].

Compared to the general European population, extra-European migrant women are less often screened for cervical and breast cancer[152], have less access to family planning and contraception[153] and a lower uptake of gynaecological healthcare[154], are more at risk of unintended pregnancies, pay fewer and later antenatal care visits[155,156], have poorer pregnancy outcomes (notably more induced abortions and complications except for lower birth weight for which current findings differ from migrant group, generation and EU host

country)[153,155,157,158] and have higher infant and maternal mortality rates[153,156]. Both migrant women and men are more at risk of sexually transmitted infections (STIs), including HIV and hepatitis B[4,157,159-161] and of sexual violence[44]. Migrants also access general and SRH services far less than European citizens[162]. Female migrant sex workers are more at risk of acute STIs compared to non-migrant colleagues in high-income countries [163].

The EU Agency for Fundamental Rights consequently stresses that migrants' sexual and reproductive health vulnerability and specific needs should be considered in a public health perspective within EU societies[164]. Yet, so far those topics remain largely ignored.

1.5 Sexual Violence

Sexual violence is a term that has different connotations depending on the context in which it is used or the population in which it is being studied. We will first describe and motivate the choice for definitions applied in this doctoral research. Subsequently, we will present an overview of the current knowledge on consequences and prevalence of sexual violence. Finally, we'll describe the state of the art on determinants and prevention of sexual violence.

1.5.1 Defining Sexual Violence

Sexual violence refers to "use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed, an attempted or completed sex act involving a person who is unable to understand the nature or the condition of the act, to decline participation or to communicate unwillingness to engage in the sexual act (e.g. because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure)"[165] it is "made by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."[166]. Sexual violence includes "sexual harassment, sexual abuse, attempted or completed rape or forced sodomy. Within (forced) migration, sexual exploitation, forced prostitution and sexual violence as a weapon of war or torture are considered as extra types of sexual violence"[167].

However, in the context of international violence research in refugees, the term sexual violence as such is rarely used. Generally, it is the term "Sexual and Gender-Based Violence" (SGBV) or just "Gender-Based Violence" (GBV) which is used as is done by UNFPA, WHO, UNHCR and others global health players.

The Beijing Declaration of 1995 stated that gender-based violence is directed against a person on the basis of her/his gender or sex and "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" (Beijing Declaration, 1995). It was stipulated that although boys and men can be victimised too, it

are the women and girls who are the main group of victims and men the perpetrators[167,168]. Based on Articles 1 and 2 of the UN General Assembly Declaration on the Elimination of Violence against Women (1993) and Recommendation 19, paragraph 6 of the 11th Session of the CEDAW Committee), UNHCR expanded the definition of sexual and gender-based violence in its guidelines to SGBV prevention and response in 2003. It states: "SGBV shall be understood to encompass, but not be limited to the following:

> a. Physical, sexual and psychological violence occurring **in the family**, including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation.
>
> b. Physical, sexual and psychological violence occurring **within the general community**, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution.
>
> c. Physical, sexual and psychological violence **perpetrated or condoned by the State and institutions**, wherever it occurs"[167].

In these guidelines UNHCR stipulated very clearly that SGBV comprises 5 types of violence, being: physical, emotional-psychological, sexual, harmful traditional practices and socio-economic violence.

For the purpose of the studies in this doctoral research, I defined and summarized these five types as follows:

Physical violence

- Hitting, pulling, kicking
- Strangulation, tying up, pushing out of window/down the stairs, dragging
- Threatening with a weapon (such as a knife, gun, blunt object etc.)
- Mutilation with a weapon, shooting, burning, torturing
- Trying to kill and killing
- Trafficking for organs or body parts and physical slavery

Emotional-psychological violence

- Verbal violence: cursing, swearing, calling names, blaming, accusing unfairly, etc.
- Humiliation: teasing, showing no respect, racist or discriminatory comments, etc.
- Threatening: making you feel scared, entering your private space, destroying objects, etc.
- Confinement: deprivation of freedom (not letting you leave the house, not letting you speak your mother tongue, not allowing you to have contact with others, locking you up, etc.)
- Relational violence: not letting you see your children, infidelity, marrying someone else, destroying family relationships, etc.

Sexual violence

Depending on the level of physical contact as well as the purpose of the violence six distinct forms can be defined:

1. ***Sexual harassment (no physical contact)* –** Any unwelcome, usually repeated and unreciprocated sexual advance, unsolicited sexual attention, demand for sexual access or favours, sexual innuendo or other verbal or physical conduct of a sexual nature. For example: unwanted sexual advances or invitations, sexual intimidation, being forced to watch pornography, others masturbating or having sex or being forced to undress in a sexual context.
2. ***Sexual abuse (physical contact but no penetration)* –** Actual or threatened physical intrusion of a sexual nature, by force or under unequal or coercive conditions. It includes touching, pinching and kissing.
3. ***Attempt to rape:*** there was an attempt to penetrate with object or body part but it was not completed.
4. ***Rape (penetration with object or body part)* –** The invasion of any part of the body with a sexual organ, or of the anal or genital opening of the victim with any object or any other body part by force, threat of force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent (International Criminal Court). It regards:
   - single rape (oral, vaginal, anal, other orifice)
   - multiple rape (multiple orifices, multiple times)
   - gang rape (by more than one person at the same time or one after the other)
   - forced abortion
   - forced sexual relations with partner/spouse
5. ***Sexual exploitation (penetration with object or body part)* –** Any abuse of a position of vulnerability, differential power or trust for sexual purposes; this includes profiting momentarily, socially or politically from the sexual exploitation of another. It includes:
   - forced prostitution (forced by someone else)
   - sex in exchange for food, clothing, money, papers etc. (even if one decided to do this, yet because (s)he did not have any other option)
   - abuse of power by professional service provider
   - gang rape (by more than one person at the same time or one after another)
   - forced marriage
6. **Sexual violence as a weapon of war/torture** – Any act or threat of a sexual nature by which severe mental or physical pain or suffering is caused to obtain information, confession or punishment from the victim or third person, intimidate her or a third person or to destroy, in whole or in part, a national, ethnic, racial or religious group. It is a crime against humanity and includes:
   - rape
   - sexual slavery
   - forced abortion
   - forced sterilization

- forced pregnancy
- forced childbearing
- forced child rearing

Harmful cultural practices generally refer to the following 6 subtypes:

- o Forced or arranged marriage: arranged marriage against the wishes of at least one of the partners
- o Child marriage: arranged marriage under the age of legal consent
- o Genital mutilation: cutting of genital organs for non-medical reasons, usually done at a young age
- o Honour-related violence: maiming or murdering of a person as a punishment for acts that are believed to bring shame on the family or the community
- o Infanticide: abortion or killing of babies because their gender is considered of less value in a given society (mostly girls)
- o Neglect of children because their gender is considered of less value in a given society

Socio-economic violence

Socio-economic violence denies person assistance, opportunities, services and integration because of their gender, their sexual orientation, their colour, their religion, their legal status etc. This violence impedes a person's enjoyment of their civil, social, economic, cultural and/or political rights. It includes:

- o Discrimination and/or denial of opportunities, services
- o Refusal of assistance/services (e.g. drugs, health care, social assistance, education, remunerated employment etc.)
- o Social exclusion (denied access to a group, a community)
- o Refusal of legal assistance/legal protection

This description of SGBV became the standard interpretation in international research on violence in refugees[167,169] and comprises forms of violence which are generally not considered in other umbrella terms as intimate partner violence or violence against women. However, very soon and due to feminist lobby groups fighting to get violence high(er) on the political agenda, in public and political debates; the term SGBV was used interchangeably with violence against women (VAW), which, by definition, ignores the potential victimisation of boys and men.

This tendency got reflected in research frameworks and publications[170-174] as well as in national and international action plans, resolutions and conventions to specifically combat violence against women[175-184].

As this study aims to get a better view of determinants in sexual violence that is related to migration, we preferred to use the UNHCR definitions of sexual violence and their classification of SGBV types, minding carefully not to make contextual presumptions on perpetrators and victims which could bias our results.

1.5.2 Consequences of Sexual Violence

In addition to important adverse effects on the victim's well-being and participation in society; sexual violence may induce long lasting sexual, reproductive, physical and mental ill-health[60,185-190], primarily affecting the victim y*et al*so potentially harmful to the victim's peers, offspring and community[191-195].

Physical, sexual and reproductive consequences may be: bruises and abrasions, lacerations, injuries, bone fractures STI/HIV/AIDS, urinary tract infections, chronic genital and extra-genital pain[185,186,196,197]. Genital injuries as lacerations of the vagina, the perineum, the anus and the rectum, penal/anal/scrotal erythema are mostly linked to physically very aggressive rapes[198] as well as amputations, disabilities, unwanted pregnancy, forced abortion, infertility and death. However, no commonly accepted typology of injuries exists which hampers the role in research on forensic examinations and a multidisciplinary approach in both healthcare and criminal justice settings[198].

One of the most frequently experienced psychological consequences of sexual victimisation is post-traumatic stress disorder (PTSD) displaying a variable degree of persistent re-experiencing, avoidance/numbing and hyperarousal symptoms which are generally found to decline over time[199-201]. Yet, severe sexual victimisation and multiple aggressors have been associated with chronic PTSD, especially at the level of emotional numbing and dissociation[202-205]. Moreover, PTSD in victims of sexual violence often co-occurs with mild, moderate and severe depression, anxiety, hopelessness and hostility[201,204-206].

Other potential psychological and behavioural consequences of sexual victimisation include: shock, denial, self-imposed isolation, low self-esteem, affective and anxiety disorders, sleeping disturbances, nourishing disorders, substance abuse, social phobia, suicidal ideas or suicide, aggression, gender role confusion and sexual dysfunction[185,207-211]. Victims of sexual violence also often face socio-economic consequences as they more frequently drop out of school, cannot proceed working, are stigmatized, neglected and/or expulsed from their communities[60,69,187,212,213].

Childhood sexual abuse can have long lasting effects on brain development, psychological functioning, mental health, health risk behaviours, life expectancy and social functioning of both male and female survivors[214-217]. Sexual intrusive behaviour after child sexual abuse is demonstrated more in children who suffer intellectual disabilities, who suffer from lower family resources as low socio-economic status (SES), single-parent families as well as lower stability through migration and/or being removed from home and put in residence[218].

1.5.3 General Prevalence of Sexual Violence

Being rooted in the broader socio-cultural, political and economic fabric of society, sexual violence frequently occurs in diverse populations and settings transcending cultural,

ethnic, or economic boundaries[219,220]. Yet, little research has been done on sexual violence in isolation from other forms of violence within intimate partner violence and the majority focuses on sexual victimization of women[188,221,222]. WHO confirms this in their recent publication (2013) in which they estimate a global prevalence rate ranging between 6 and 59% of women having experienced rape from their partners during lifetime[223]. As for the European WHO Region it is stated that 25.4% of women and girls experience physical and or sexual violence by their (ex)partner and 5.2% is sexually victimised by non-partners[221].

For Morocco, a national hotline report of 2009 showed that 12,3 % of the reported cases regarded women being raped by non-partners and 1.4% by partners. Sexual harassment accounted for 8.2% and incest for 9,6% of the reported cases to national hotlines[224]. A national report of the same year gave lifetime sexual victimization rates for Moroccan women of 22,6% and an annual rate of 8.7% of sexual victimization in the last 12 months[225].

Even less is known about sexual violence prevalence in men[226]. The prevalence of adult male sexual victimisations estimated at around 5–10% of all sexual assaults per year[226] and adult lifetime victimisation of about 1-7% in Europe[222,227,228]. Several researchers attribute this lack of knowledge to prevailing myths, stereotypes, and unfounded beliefs about male sexuality, (e.g. about male victims being responsible for their assaults, that male sexual assault victims are less traumatized by the experience than their female counterparts, and that ejaculation is an indicator of a positive erotic experience) which induce underreporting of sexual assaults by male victims; stigma, denial, a lack of appropriate services for male victims; and, less legal redress for male sexual assault victims[229-232].

According to the socio-ecological framework, violence results from the interaction of factors at the four levels, by consequence research and prevention should seek to address all levels[233].

1.5.4 Sexual Violence Determinants at Individual Level

Considered to be vulnerable to sexual violence are, above all women and girls – especially the impoverished and those living in shelters or in detention[1,234]; but also adolescents girls and boys of low socio-economic status[185,209]. In addition, female and male displaced, trafficked, asylum seeking, undocumented and refugee communities are also considered as highly vulnerable[60,213,235-238]. People with restricted income might also be conveyed to transactional sex in order to survive[239] and are prone to sexual victimization[44,227,240]. Furthermore, people with a heightened risk perception, with PTSD, with a risky lifestyle and those who were personally victimized or witnessed sexual violence during childhood are often prone to subsequent (re)victimization[207,208,241-250].

Yet, people who were personally victimized or witnessed SV during childhood are also prone to perpetration of sexual violence at a later stage of their life themselves[193,194,251-253]. Child sexual abuse has also been found to be a pre-cursor for serious social and mental

health problems and to maladaptive parental practices which can feed the intergenerational transmission of violence[253]. Child sexual abuse of parents and grandparents puts also children and grandchildren to greater risk of sexual victimisation[254]. Moreover, recent research suggests that adversity in childhood can directly influence the brain development, impacting its' anatomy and neurophysiology, a process which is partly genetically mediated[255]. In general, traumatic childhood events are considered a risk factor for sexual violence perpetration[256].

In addition, high levels of sexual aggressive behaviour have been linked to psychopathic traits in adults[257-259] and other personality disorders as anti-social and externalising behaviour[260-266]. Recent research provides evidence for an additional genetic basis of aggression and anti-social behaviour[267] as well as psychopathy[268]. Yet which genes are exactly involved and how they interact with environment is not sufficiently evidenced yet[255]. This heritable nature of anti-social behaviour, delinquency and psychopathy and their association with violence and rape perpetration, urged Minh *et al* (2013) to posit that transmission of risks across generations are accumulative and might be considered "a chain of risk"[253]. While Jewkes *et al* (2012) came to conclude that part of the causal pathway in rape perpetration is thus genetic[255].

Contrary to what is often posited in public debate, there is no scientific evidence that testosterone levels influence sexual violent behaviour or aggression in boys and men[269,270], however in girls there may be some association with aggression[271] and social dominance[272]. Yet, it has been found that sexual violence perpetrators score higher than nonperpetrators on measures of positive attitudes about casual and impersonal sex, engaging in delinquency, and heavy drinking during violent incident[263,268,273,274]. Alcohol is however a situational leverage in sexual coercion and not a causal factor[274-276].

In addition, sexually aggressive men have been found to have more negative attitudes toward women, a more traditional attitude to gender roles and sexual relationships, higher frequency of misperception of women's sexual intent, stronger sexual dominance desires, and more acceptance of rape myths than men who do not perpetrate sexual violence[262,263,268,273,274,277,278]. This does not mean that these attitudes are solely acted out against women, as a study in South-Africa about perpetration against both sexes found that 10% of men who had raped a girl or a woman also raped a boy or a man [278].

1.5.5 Sexual Violence Determinants at Interpersonal Level

Although perpetrators of sexual violence are commonly known to the female victim [185,189,221], research has shown that boys as well as people with multiple spaces of vulnerability[279] as asylum seekers, refugees, undocumented, trafficked, homeless or impoverished people; are equally victimized by people they just met, strangers, persons in authority and those assigned to their protection[60,197,228,232,235,236,238,280,281]. Although not absolutely consensual, research also suggests a stronger 'gang rape' feature in male sexual victimisation compared to females[226,282].

There is very strong evidence that sexual offenders had disorganised or insecure attachment with their primary caregivers during childhood[262,283-289,289-291]. Moreover, having insecure attachment bonds with caregivers and partners in adulthood is also a risk factor for sexual victimisation and perpetration[283,285,289,292-300].

As demonstrated in the sexual health part of this introduction, social capital is a crucial aspect in transfer of knowledge on risks and prevention strategies. In addition, people in truncated networks, such as newcomers, people in poverty, unemployed people and women with controlling partners; are at risk of not having a confidant, nor of receiving appropriate instrumental and social support[301,302]. Migration frequently results in truncated networks and lower possibility of social support. Though migrants may remain in contact with their relatives and friends in their home country, the process of moving to a new country alters relations and existing social structures in which they are embedded [303]. Studies among migrants have found that they frequently experience separation from social relations, social isolation and loneliness[304-306]. In addition, migrants may be further marginalized in that language barriers can hinder access to social support found in formal relations such as health professionals[305,307,308]. Furthermore, the lack of participation as a citizen, the attitude of trusting, belonging to and bonding with other group members (sense of community) and the emotional connection to the specific people who share ones surroundings (place attachment) can hamper community resilience to disasters, such as sexual violence[119]. Furthermore, a high degree of social isolation and low quality of relationships with male confidants may lead to inappropriate sexual behaviour in males[309].

In boys, masculine ideology moderated the relationship between free testosterone and dominance, while in girls the relationship between free testosterone and dominance was moderated by same-sex peer group affiliation[310]. Strong evidence demonstrates that boys who are in personality susceptible to peer pressure engage more frequently in delinquency and gangs and become subsequently more likely to be sexually violent especially when exaggerated performance of heterosexuality have to be demonstrated [255,276,311-313].

1.5.6 Sexual Violence Determinants at Organisational and Community Level

Vulnerability to sexual violence is enhanced when living in shelters, rehabilitative facilities or detention[253,281,314-317]. In addition, schools are a place of risk to child sexual abuse[223].
Yet, when setting up our research, there was no such thing as codes of conduct or standard operating procedure in prevention or response in the European asylum reception sector. Although UNHCR issued guidelines for prevention and response of SGBV to refugees, internally displaced populations and returnees[167], in the European asylum reception sector only the European Council Directive of 2003/9/EC[318] laying down minimum standards for the reception of asylum seekers is applied. Although these standards should suffice to ensure asylum seekers a dignified standard of living, the 2003 Directive that was in force during the doctoral research, made only reference to having specific attention for assault. It did not mention any guideline on prevention of sexual violence.

1.5.7 Sexual Violence Determinants at Societal and Public Policy Level

Sexual violence started to be considered a violation of human rights in the 1990s with international fora primarily linking sexual violence to violence against women. In 1993, the 2nd World Conference on Human Rights identified violations against women's rights as fully-fledged violations of human rights[319], and the UN adopted a Declaration on the Elimination of Violence against Women[320].The 1994 International Conference on Population and Development (ICPD) in Cairo was a turning point in the recognition of sexual and reproductive rights, including the right to be free from sexual violence and coercion. This set the fight against violence against women as a core objective and acknowledged the specific vulnerabilities of migrants[321]. This was quickly followed by the UN High Commissioner for Refugees (UNHCR) first guidelines targeting sexual violence in refugees at both prevention and response levels[322].

When sexual violence against migrants is targeted at European policy level, the focus remains on victimization originating in the countries of origin (trafficking) or on specific cultural practices as female genital mutilation (FGM). The 1993 UN Declaration on Eliminating Violence against Women explicitly insists on those particular issues[320]. The Council of Europe followed this path by issuing a Recommendation on trafficking and sexual exploitation in 2000[323], before adopting a Convention in this field five years later[324]. This is also visible at European level. The STOP programs[325] and a Framework Decision adopted by the Council[326], both targeting trafficking; led to the development of an EU-wide plan promoting cooperation among member states, involving among others FRONTEX (the EU border management agency) and addressing the gender-sensitivity of prevention and response strategies[327]. The need for developing such strategy was acknowledged by the European Parliament[181]. In parallel, the European Union has paid particular attention to FGM, with a first Resolution of the European Parliament being adopted in 2001[328] and reiterated in 2009[329].

Only very few documents move beyond those perspectives by addressing sexual violence in migrants within the European territory. Also in the minimum standards for the reception of asylum seekers, it only considers provisions for asylum seekers who were victims of "torture, rape and other serious forms of sexual violence" before their flight[330].

Finally, given the policies towards undocumented migrants, it has been reported that undocumented migrants' fear of being deported also influences their access to care upon victimisation[331] and refrain them from reporting victimisation all together[332].

1.6 Prevention of Sexual Violence

There is global consensus that the spectrum of sexual violence prevention is broad and multifaceted, and requires a holistic public health approach integrating the skills and approaches from many disciplines and areas of expertise at all socio-ecological

levels[166,213,333-335]. Consequently, several global health players issue and regularly update guidelines on prevention of sexual violence. WHO dedicates a specific section of its website to general violence prevention and provides guidelines addressing sexual violence against women at global level[336]. UNHCR provides guidelines and checklists for sexual and gender-based violence prevention and response actions in conflict and humanitarian settings[213,337]. UNFPA has recommendations on policy changes regarding sexual and gender-based violence in order to meet the Millennium Development Goals[168].

While all these guidelines comprise mostly of secondary and tertiary prevention recommendations, all stress the importance of primary prevention. They agree on considering the following root causes of sexual violence: gender inequality with norms on dominant manhood, rape myths, social norms supporting violence; poverty and social inequality; traditional harmful practices, substance abuse and finally child maltreatment and abuse[333,336].

Yet, little evidence exist on which sexual violence prevention programmes are truly effective[338]. This can be partly explained by the lack of clear operational definitions in research, making it difficult to compare results and to build evidence[4,334]. Another factor that contributes to this lack of evidence is the ignorance of sexual violence in policy-making. Research has demonstrated that very few policies worldwide include sexual violence prevention as an area for action and of those that do, most are not evidenced based, and lack strategies and implementation plans for prevention[339]. Moreover, most prevention policies comprise secondary prevention actions and thus rather formulate responses than preventing sexual violence all together. Loots *et al* (2012) argue that this might be due to the fact that governments might see an easier way to measure effect of response policies[339] whereas primary prevention might be perceived of as a unachievable given many financial and other barriers[336]. In order to correct this, it has been suggested that policies should include prevention of sexual violence and ensure that sexual violence prevention and response activities are closely monitored and evaluated, rigorously documenting all outcomes[338,339].

Nevertheless, the studies that have evaluated effectiveness of prevention programmes demonstrate the following. Child maltreatment and abuse as a risk factor for later sexual perpetration and/or victimization has most effectively been addressed through parent training, home visits and parent-child programs enhancing secure attachment and developing safe, stable and nurturing relationships between children and their caregivers[338,340-349].

In 2011, the South-African Sexual Violence Research Initiative published a systematic review investigating 65 studies on reported effectiveness of interventions targeting adolescent boys' and young men's individual and group attitudes and behaviour towards sexual violence. They found substantial evidence of effectiveness of interventions

improving boys' and young men's attitudes towards rape and rigid gender stereotypes that condone or allow sexual violence occurrence. Yet these interventions rarely led to long-term changes in violent behaviour[350]. Only one school-based, multi-component and mixed-sex intervention was found to demonstrate a significant impact on behaviour[351].

That school-based programs are effective in changing attitudes towards sexual violence but not necessarily lead to behaviour change in adolescents and young adults was also posited in the WHO review on violence prevention evidence of 2010[338]. Similar results were found in social marketing campaigns challenging norms supportive of sexual violence in adolescents and young adults, urging the authors to emphasize that this evidence is promising and to encourage further action and research in the matter[338].

Within health care settings, it has been shown that interventions to identify victims break the violence cycle and that specialist measures for victims of sexual violence, as for example "Sexual Assault Nurse Examiner (SANE)" programmes, help to improve victim care and support, also facilitating rape prosecution cases[338].

In the same line, psychosocial interventions such as Trauma-Focused Cognitive Behavioural Therapy and Eye Movement Desensitisation and Reprocessing have been found to prevent chronic PTSD induced by sexual victimization in all age groups, which might lower the risk to revictimisation[352-355]. Yet single-session psychological debriefings upon sexual violence are found to rather increase the risk of PTSD[356] and depression[357] and are therefore advised against. Protection orders and special courts are found to support victims in legal procedures and to reduce revictimisation[338].

As for recidivism in sexual offenders, it has been demonstrated that psychosocial interventions can reduce recidivism in child molesters, paraphilic and affective perpetrators[257,265,266,358-360] yet not in psychopaths[360-363]. Within forensic settings, a broad range of assessment scales are being applied in order to identify and act upon recidivism risk factors in all types of sexual offenders[264,265,364-369].

1.7 Conclusion

Migrants in Europe and the European Neighbourhood constitute heterogeneous groups with respect to ethnic features, religion, culture and health practices[370-372]. Upon arrival, their general health status might be comparatively better than the host populations [50]. Yet, depending on the policies and practices of the host country; migrants may be discriminated against, face harsh socio-economic conditions and subsequently experience a set-back in their socio-economic position. This set-back not only enhances migrants' general vulnerability, it also induces ill-health[56].

A large body of evidence serves to identify sexual health determinants at individual, interpersonal, organisational and societal level. When applying this blueprint to refugees, asylum seekers and undocumented migrants, multiple spaces of vulnerability[373] arise,

suggesting their risk of sexual ill-health in Europe and the European Neighbourhood. Moreover, these health risks might be increased through sexual victimisation as a vast array of academic and grey literature demonstrates that migrants are at enhanced risk of sexual violence worldwide. For sexual violence is known to generate important adverse effects on the victim's well-being and participation in society; and to induce long lasting ill sexual, reproductive, physical and mental health consequences[187-190,236,374], primarily affecting the victim *yet al*so potentially harmful to the victim's peers, offspring and community[191-194].

Prevention of sexual violence is thus key to protect and improve health of people at risk. However, little evidence exist on effective sexual violence prevention interventions[338]. Irrespective of this, until today, prevention of sexual violence in migrants as such has not been an issue of great concern to many in Europe or the European Neighbourhood.

As for sexual health promotion, it has been demonstrated that individual behaviour change is central to improving sexual health, but that efforts are also needed to address the broader determinants of sexual health. The evidence from behavioural interventions is that no general approach to sexual health promotion can be copied from one context to another and that interventions should consists of multiple components addressing determinants at different levels[375]. Although the comprehensive formulation of WHO definition of sexual health avoids framing sexual health exclusively in terms of prevention of adverse sexual health outcomes and widens the remit to include enhancement of the quality of sexual experience and relationships, this definition has not yet been sufficiently incorporated into public health practices[376]. Regarding migrants, the scope in sexual health promotion, if any, is still limited to prevention of ill-sexual health.

It is noteworthy that many of the identified sexual health and sexual violence determinants connect closely with human rights[377,378]. Since all 27 European Union Member States ratified the "International Bill of Human Rights", they are obliged to respect the right to dignity; to life, liberty, autonomy and security; the right to equality and non-discrimination; the right to live a life free from torture, inhuman or degrading treatment or punishment; the right to privacy; the right to physical and mental integrity; the right to the highest attainable standard of health; including the right to attain the highest standard of sexual health without coercion or violence "for all persons, including (…) asylum seekers and illegal immigrants" [379].

The EU prides itself as a promoter of human rights[142] and consequently adopted a European Charter of Fundamental Rights in 2000. Yet, the Charter allows national conditioning for the right to health, resulting in vast incoherence between Member States[380,381]. The same goes for the European Neighbourhood. Although the EU is urging them to respect human rights in the bilateral European Neighbourhood Action Plans, several European Neighbourhood countries, including Morocco, have not yet ratified the Human Rights Bill.

This leads us to hypothesize that within the European Union and the European Neighbourhood; there might be a discrepancy between a proclaimed rights-based approach and actual obstacles to migrants' attainment of good sexual health and living a life free from sexual victimisation. In conclusion, given the evidence on sexual health and sexual violence determinants, it is to be assumed that refugees, asylum seekers and undocumented migrants are at risk of sexual violence and sexual ill-health in Europe and the European Neighbourhood and that their well-being is still a non-issue in current prevention and response actions.

"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

2. OBJECTIVES

2.1 General Objective

As migrants are considered at risk of sexual violence and of sexual ill-health at global level, and refugees, asylum seekers and undocumented migrants are migrants with multiple "spaces of vulnerability"[373]; the general objective of this study is to contribute to a better understanding of factors determining the health of refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood by exploring prevention of sexual violence and promotion of sexual health.

2.2 Specific Objectives

2.2.1 To Explore the Nature and Magnitude of Sexual Violence that Refugees, Asylum Seekers and Undocumented Migrants Experience in Europe and European Neighbourhood

Research has demonstrated that migrants are at risk of sexual violence at global level, with refugees, asylum seekers and undocumented migrants as being the most vulnerable ones[1,213,382]. However, most research on sexual violence in migrants focuses on victimization and perpetration in the countries of origin, in conflict or during migration[383,384].

Whether these migrant groups are also at risk of sexual violence within Europe and the European Neighbourhood has not yet been considered. This can however be hypothesised as literature shows that people with similar socio-economic positions, those who are living in shelters and institutions as well as people who have directly or indirectly experienced violence at an earlier stage of life; are at enhanced risk of sexual violence. Furthermore, some non-governmental organisations draw attention to situations that support this hypothesis. Especially violent incidents with sub-Saharan migrants were reported in Morocco and at its borders with whom Europe had the closest collaboration to regulate irregular migration to Europe in the frame of the European Neighbourhood Policy[385-388]. Hence, the first objective of our study.

Research question: What are the nature and the magnitude of sexual violence that refugees, asylum seekers and undocumented migrants experience since their arrival in Europe and/or in Morocco and at its borders?

2.2.2 To Examine How the Study Population Defines Sexual Violence and which Risk and Protective Factors they Perceive as Determinants

Sexual violence is a public health issue of global magnitude and a violation of human rights. Several determinants are described in academic and grey literature as well as ways as to go about them. In international guidelines on sexual violence prevention and response in conflict and humanitarian settings, it is posited that target populations should participate in the definition, implementation and evaluation of the actions[213].

The principle of participation is also stipulated in leading health promotion guidelines. According to the Ottawa Charter on Health Promotion of 1986, people should be "enabled to control of those things which determine their health"[389]. In 1997, in the Jakarta Declaration on Health Promotion, it was specified that "participation is essential to sustain efforts" and that in order to be effective "people have to be at the centre of health promotion action and decision-making processes"[389].

Yet, at the level of Europe and European Neighbourhood, migrants are largely ignored when it comes to being included as study population in sexual violence research as well as in being considered as active agents in shaping sexual violence prevention and response actions. As it is also their human right to decide and control those things which determine their health, and as it enhances the desirability of future prevention actions, this PhD aims to provide insight in how our study population defines and perceives sexual violence and its determinants.

Research questions:

a. How do refugees, asylum seekers and undocumented migrants define sexual violence?
b. Which factors do they perceive as protective or putting one at risk of sexual victimisation and perpetration?

2.2.3 To Identify how the Study Population Defines Sexual Health and which Risk and Protective Factors they Perceive as Determinants

Many determinants in sexual health and sexuality are well described and although migrants constitute an important proportion of the European and European Neighbourhood population, little is known about migrant sexual health. The few studies that were conducted mainly focus on migrants' higher risk to sexual health problems or on barriers in their access to sexual health programmes and services. They thus ignore the broad WHO definition on sexual health.

Beyond that, migrants without, or with a temporary or conditioned residence permit, as respectively undocumented migrants, asylum seekers and refugees; are rarely included in general sexual health studies, because of (perceived) legal, social, cultural and language barriers. Moreover, in current sexual health promotion actions, migrants' perspectives are largely ignored.

The available information is thus rather blurred and current prevention and health promotion actions are neither needs-responsive nor adapted to communication channels that migrants are accustomed to use in search of sexual health information.

In order to prevent further sexual ill-health in refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood and to improve their sexual health

beyond the level of absence of disease and infirmity; this PhD aims to provide more insight in how their sexual health can be promoted in a more desirable, ethically sound and culturally competent way.

Research questions:

a. How do refugees, asylum seekers and undocumented migrants define sexual health and sexual maturity?
b. What are the sexual health information sources they are accustomed to address and which pathways do they use?
c. Which risk and protective factors do they perceive as sexual health determinants?

2.2.4 To Study how the Current European and European Neighbourhood Legal and Policy Frameworks Affect the Sexual Health Status of our Study Population as Well as their Risk to Sexual Violence

Academic and grey literature has demonstrated that the health and health needs of extra-European migrants may differ greatly from those of the general European population[4,55,162,390-393]. Upon arrival, migrants' general health status might be comparatively better ("the healthy migrant effect")[50] yet depending on the policies and practices of the host country regarding migrants, they may experience discrimination as well as a setback in their socio-economic status. This does not only increase their vulnerability, it also induces ill-health[56,394].

Migrants' sexual and reproductive health needs are considered "particularly pressing"[55] and the European Agency for Fundamental Rights stresses that migrants' sexual and reproductive health vulnerability and specific needs should be considered in a public health perspective within European societies[164]. Attaining the highest standard of sexual health and having a sexual life without coercion and violence are human rights[141, 321].

Although the European Union refers to health as a human right in many internal and external communications, policies and agreements, defending its universality; this doctoral thesis hypothesises that there might be a discrepancy between the proclaimed rights-based approach and actual obstacles hampering migrants' attainment of good sexual health in Europe and the European Neighbourhood.

Research questions:

a. Are the current European and European Neighbourhood legal and policy frameworks on migrants' sexual health consistent with a rights-based approach?
b. Do these frameworks create obstacles for migrants to attain good sexual health and if so, how?
c. To what extent do these legal and policy frameworks address sexual violence in migrants on both prevention and response levels?

d. Based on this analysis, which sexual health policy, practices and research recommendations are to be formulated in order to prevent sexual violence and promote sexual health in a desirable manner?

2.2.5 To Conduct this Research in a Participatory Way and Subsequently Provide Instruments and Recommendations for Sexual Health Promotion and for Prevention of Sexual Violence in the Study Population

The referrals to participation as core elements in the Charters of Health Promotion [389] urged us to opt for a conceptual framework that fully accords with these statements and challenged us to apply a participatory research approach that enabled our study population to genuinely frame their own health, health needs and health promotion actions.

Community-Based Participatory Research (CBPR) is the participatory research approach we applied in all studies within this doctoral thesis. CBPR has a defined set of 10 core principles that should be thoroughly reflected in all phases of each research project. Moreover, CBPR implies that a research project should not only provide research outcomes but also contribute to social and policy change[395]. Hence, we aimed to apply CBPR as thoroughly as possible. Consequently, in addition to research, the projects needed to equally generate practical tools and policy and practice recommendations. Meanwhile, we wanted to reflect on the supposed added value and the challenges that arise when applying CBPR in this particular study population and on the sensitive topics of sexual violence and sexual health.

Research questions:

a. What is the added value of applying Community Based Participatory Research in sexual violence and sexual health research in refugees, asylum seekers and undocumented migrants?
b. What are the challenges that arise with the application of Community Based Participatory Research on sensitive issues in the study population?

2.2.6 To Formulate Recommendations for Sexual Health Promotion and Desirable Prevention of Sexual Violence in Refugees, Asylum Seekers and Undocumented Migrants in Europe & the European Neighbourhood

Desirable Prevention is a concept developed by Vettenburg et al (2003) that seeks to improve the health and well-being of all through the concurrent application of the five dimensions of integrality, participation, inclusiveness, addressing root causes and maximising agency[396,397]. This concept thus goes beyond the traditional concept of primary, secondary and tertiary prevention. In this thesis, we aimed to interpret determinants that were identified in the different studies of this doctoral research in the light of this concept.

Subsequently, we wanted to formulate recommendations for promotion of sexual health as defined by WHO and for Desirable Prevention of sexual ill-health and of sexual violence in refugees, asylum seekers and undocumented migrants in the EU and the European Neighbourhood.

Research questions:

a. Which determinants may be considered decisive for sexual health promotion and for Desirable Prevention of sexual violence in our study population?
b. Which research, policy and practice recommendations can be formulated for future implementation of sexual health promotion and Desirable Prevention of sexual violence in refugees, asylum seekers and undocumented migrants in the EU and the European Neighbourhood?

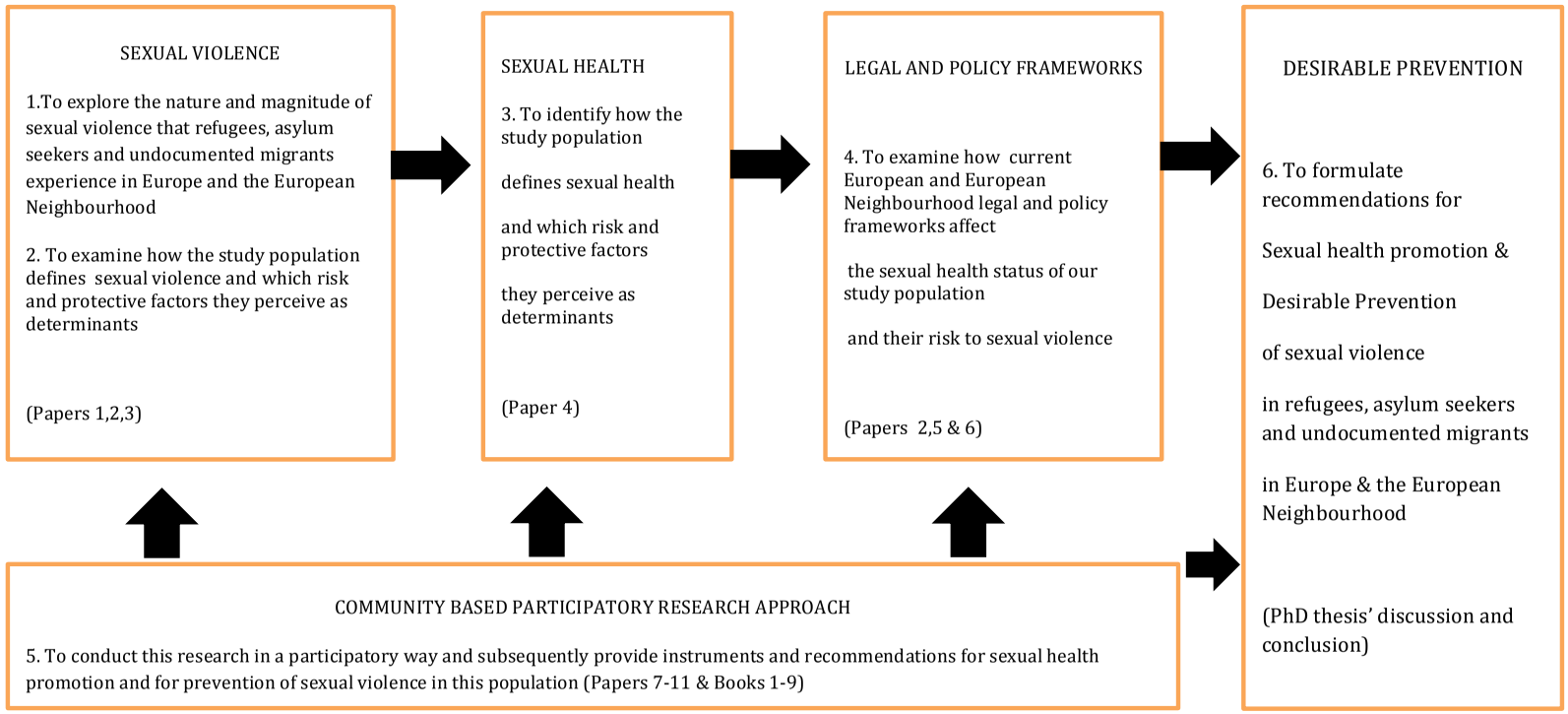

Figure 2.2 : Flow objectives and papers PhD

"I called the police
but they said:
nothing happened,
the moment something
has happened,
we will come."

Kurdish Asylum Seeker

"Hidden Violence is a Silent Rape" Seminar

3. METHODOLOGY

3.1 Conceptual Framework

Our epistemology stems from an interpretive, feminist, communitarian and dialogical research perspective[398,399]. The interpretive and feminist research perspective implies that we are convinced that the objectivity of a research process is never completely separable from a researcher's subjectivity of sensitive research topics (here sexual health, sexuality and violence), research populations (here migrants with different legal statuses) and research settings (the different research countries with their respective cultures, norms, values and regulations) and that gendered power relations in society influence both the subjectivity of the study population and the researcher. It is thus necessary to acknowledge and value these subjectivities within a research process. This is done through the choice of research methods for both collecting as well as interpreting data while considering the ethics of researching sensitive topics[400]. Furthermore, reciprocity with and empowerment of the research population as well as accounting the meaning of experiences in ways that make sense to the research population are key aspects of this perspective[400].

In the dominant feminist theory at the turn of the 20th to 21st century, it was put forward that qualitative research methods combined with critical reflection on data obtained through it were no longer sufficient to meet this objective and that henceforth, priority should be given to participatory research approaches including qualitative methods[398,399]. The communitarian and dialogical research perspective implies that our research process should allow for a close collaboration with the research communities and should also empower them to frame their own health needs and potential prevention and promotion initiatives. Interpretation of data and formulations of conclusions then should result from a dialogical process between the research communities and the researcher(s) in which divergent subjectivities and opinions are discussed and valued[398-400].

These epistemological choices frame the conceptual framework of our study combining a rights-based and public health approach with the socio-ecological model on health and the concept of Desirable Prevention[396,397]. The rights-based approach considers health as a human right and assesses policies, programmes and legislation accordingly[152,401], expecting them to promote health and guarantee access to health care for all, independently of any status. This approach is rooted in the overarching principle of universality[402].

Yet, obtaining good health is a complex and dynamic social issue involving multiple determinants[403-405]. The socio-ecological model[406] views health as a result of an individual -with her/his personal biological, psychological and behavioural characteristics- being in interaction with the environments in which the individual lives, including the family, social networks, organisations, communities and societies[407,408]. This paradigm thus identifies determinants at four interlinked levels: the individual (micro), the interpersonal (meso), the organisational and community (exo) and the societal and public policy level. This

nested structure of environments helps to identify multiple influences and allows for a better understanding of health complexity as it provides a map of complex causation factors as well as a rich context for multiple interventions and multi-levelled strategic policy-making[406,408]. According to the socio-ecological framework, violence results from the interaction of factors at the four levels, by consequence research and prevention should seek to address all levels[233,409]. The public health approach to violence prevention builds on the interaction of all levels and has been defined by Krug and colleagues as: "a science-driven, population-based, interdisciplinary, intersectoral approach based on the ecological model which emphasizes primary prevention"[166].

To the socio-ecological framework and the human-rights and public health approach, we added the concept of Desirable Prevention[396,397]. Whereas general prevention can be conceived of as initiatives which anticipate problems in a targeted and systematic way; Desirable Prevention can be defined as 'initiatives which anticipate problems ever earlier in a targeted and systematic way, are maximally "offensive", apply an integral approach, work in a participatory manner and have a democratic character, while aiming at the enhancement or protection of the target group's health and wellbeing'[396,397].

The Desirable Prevention concept harmonizes with the above mentioned models and approaches. First it considers a human being as an individual as such as well as a person in interaction with the society in which (s)he lives. Second, it considers human being as agents, as active "citizens" and hereby acknowledges children as full citizens and all human beings as equal. Subsequently, emancipation is a core concepts in the model[396,397].

Desirable Prevention comprises five dimensions which require a concurrent application in any prevention project or initiative:

1. ***Radicality***: it is desirable to stop a problem or risk situation as early as possible in its development. It is important to understand the different stages in the problem development and be aware of the root causes. A radical initiative should thus target the root causes of a problem as much as possible. Desirable Prevention should consist of different interventions targeting population groups in which the problem has not occurred yet as well groups who already deals with the problems and its consequences itself. In every action it is vital to share gained knowledge with other organisations and policy makers who are active in preventing the problem at an earlier stage of problem development.

2. ***Of-fensivity:*** it is desirable to offer people alternatives, to maximize their agency and choice range, and to stimulate them in opting voluntarily for those alternatives. This stands in contrast to defensive actions in which people's agency is restricted, the choice range is reduced and people are obliged or prohibited to participate.

3. ***Integrality:*** it is desirable to have a balance of prevention actions that target internal change in individuals (person-oriented) as well as structural changes in people's networks, in services, organisations and institutions and in legal and policy frameworks (context-oriented).

4. ***Participation:*** Given the emancipatory nature of Desirable Prevention, it is essential that people have the possibility to voice their opinions, share ideas and have them valued and to shape the society in which they live. The participation mode can vary from population and from phase of an intervention. It is however essential that the target population is involved right from the start and that they can participate in point pinning the problem. All beneficiaries and stakeholders should be granted the opportunity to participate in all phases of a prevention project or action, and it is desirable that their participation is as directly as possible.

5. ***Democratic character:*** given the human rights approach that lays at the basis of the model, this dimension stipulates that prevention should protect everybody equally from the problem at hand. This does not imply that an intervention action should not target a specific population with a certain higher risk of the problem, yet, within this population it is paramount that everybody is addressed. This can be through a wide array of actions and not necessarily the same ones.

3.2 Research Approach: Community Based Participatory Research

3.2.1 Community Based Participatory Research as Mixed Method Research Approach

Starting from this conceptual framework, we adopted a triangulation form of qualitative, applied and formative research approach, being Community-Based Participatory Research (CBPR). CBPR in public health focuses on social, structural and physical environmental inequalities[410]. It 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 and aims to improve the health and well-being of community members by integrating knowledge in action, including personal, social and policy change[410].

CBPR creates bridges between scientists and communities, through the use of shared knowledge and valuable experiences. CBPR emphasizes co-learning about issues of concern and, within those, the issues that can be studied with CBPR methods and 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. Finally CBPR establishes a mutual trust that enhances both the quantity and the quality of data collected. The ultimate benefit to emerge from such

collaborations 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[411].

The core element of CBPR is participation. Participation is both a fundamental and pragmatic choice that citizens, authorities and societies make. The fundamental choice is justified on the basis of a vision on democracy, society, active citizenship and the acknowledgement of human rights[411-413]. Citizens have the right to participate actively in the decision making and policy on the structure and organization of their community and society[412,413]. Viswanathan M. *et al* (2004) concluded that community members have a right to participate in research because they:

- are uniquely qualified and capable to investigate their lived experiences
- should have the opportunity as co-learners, to generate relevant knowledge and create critical awareness of collective self-reliance that are of immediate and direct benefit
- are entitled to own the means of knowledge production and to hold the status and roles of the researcher in relation to the participants

Participation is a planned and directed social process that facilitates open dialogue on divergent views, accommodates conflict, and agrees on structures for collaborative decision making. It is also a means for empowerment, as it engages the research group in actively examining the reasons for and consequences from either formal or informal activities of investigation through discussion, and co-learning[411]. Yet there are different degrees to which one can participate but all should have the opportunity to influence the decision making and determine the degree and nature of their participation at different stages of the research project at hand[403,411-413].

This degrees or modes of participation have been presented in ladders and spectrums[403,411,412,414], but all boil down to the following categories:

- Informational: research populations are informed about goals or outcomes of research
- Contractual: researchers contract for services or resources from research populations who agree to take part in research, inquiry or experiment
- Consultative: research populations are asked for their opinion on a defined set of questions in a manner that is decided by the researchers before the intervention is designed, it is up to the researchers to interpret them as they think best
- Collaborative: researchers and research population work together on a study that is designed, initiated and managed by researchers
- Collegiate: researchers and research population work together as colleagues, each with different skills to offer for mutual learning, to develop a system for independent research among local people.
- Auto-regulative: the research population conducts its proper research without the collaboration of external researchers

Beyond this core element of participation, CBPR is characterized by 9 principles[395]:

1. CBPR defines a community as a unit of identity. Units of identity refer to entities in which people have membership. They are socially created dimensions with a sense of identity, emotional connection to other members, common symbol systems, values and norms and shared interest on cultural, social, political, health and economic issues that may link together individuals who may or may not share a particular geographic association[395,415]. The recognition of the community as a unit of identity rather than as an aggregate of individuals living in a geographic area has important implications for the establishment of coalitions and partnerships addressing concerns such as violence[416,417]. To ensure locally relevant, culturally competent approaches for addressing violence in ethnic minority communities, initial grounding of the issue (and control of the process) needs to occur in smallest unit of community identity as units of identity are also "units of solution", providing members with support, self-help, and shared values[416].

2. CBPR builds on strengths and resources within the community, both at individual skills level as well as in available networks, organisations and other resources and assets[418] .

3. CBPR facilitates collaborative, equitable partnership in all phases of the research, involving an empowering and power-sharing process that attends to social inequalities. Hiring and training staff from the local community are hereby essential[419]. Key challenges in the process of partnership building are to remain grounded in the issues and concerns raised from within the local community of identity, a lack of trust of the outsiders intentions based on historical experiences with "hit and run" projects and a perceived lack of equal power and respect in program and research development. Trust building is a process that takes place over time, and, once established, trust cannot be taken for granted; researchers must continually prove their trustworthiness[416]. In order to be successful, it is paramount to devote considerable time and attention to the group's process facilitating trust and relationship building[420,421].

4. CBPR fosters co-learning and capacity building among all partners through reciprocal exchange of skills, knowledge, expertise, capacities and perspectives that each of the partners has and which are all valued via systematically planned encounters during each stage of research. In this they meet face-to-face to define their relationship, enter into dialogue on the requirements for equalization of power in the processes and products of research and set alongside each other, their respective legitimate knowledge and expertise for examining and addressing a particular issue[411]. The quality of a reciprocal co-learner relationship can be determined by their reflexive, dialectical, critical and face validity[422].

5. CBPR integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners. CBPR aims to contribute to science, yet when no intervention aspect is included, the research project should have the commitment to translate the findings into policy and practice recommendations that will benefit the community[415,420]. On the other hand, recent research showed that existing scale items can be re-organized to create measures of community-defined outcomes that are psychometrically reliable and scientifically valid[423,424] and that effectiveness of the interventions are statistically measured[425]. It is nevertheless necessary that researchers involved in CBPR are well-trained in how the principles can be translated into practice[395,426].

6. CBPR focuses on the local relevance of public health problems and ecologic perspectives that recognize and attend to the multiple determinants of health[406,410,418]. This implies that the research team should be cognizant and respectful of community needs and priorities during the study's implementation. Feedback loops create forums for meaningful discussion between researchers and communities on significant community issues, which can also help overcome distrust[411]. Furthermore, the research agenda and questions in community-based health research should be open to negotiation, creativity and constant reinvention[427].

7. CBPR involves a system development using a cyclical and iterative process. The ultimate goal of a collaborative research approach is to change social structures, dealing with institutional control and conflict. The acts of creating knowledge and using it to communicate a community's perspective to policymakers are fundamentally about the right to speak. Although these steps may not guarantee shifting power to communities to decide on policy, a community's capacity to interact directly with policymakers is a necessary step toward understanding and changing oppressive situations[411]. This has been identified as a challenge as the dynamics and extreme differences of policies, indirect costs, staff time and limited resources become may be very complex and time-consuming to deal with[428].

8. CBPR disseminates results to all partners and involves them in the dissemination process beyond the partnership[395,419].

9. CBPR involves a long-term process and commitment to sustainability. It hereby is vital to emphasize early in the process that eventual continuation from the research side is dependent on securing funding yet that the researchers are equally interested and committed to issues of capacity building and sustainability beyond the project[427,429].

3.2.2 Application to the Conducted Research Projects

This conceptual framework and the CBPR as overarching research approach have been applied to the three action research studies, which are:

1. "Hidden Violence" that was conducted with refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands, regardless of where they were living;
2. "Sexual Violence Morocco", conducted with sub-Saharan migrants in and around Morocco;
3. "Senperforto", which was conducted with refugees, asylum seekers, undocumented migrants residing, and with asylum reception professionals working in official reception facilities in Belgium, the Netherlands, Hungary, Ireland, Portugal, Spain, Greece and Malta.

Each of the three studies had a process course of five main phases:

1. ***Set-up:*** the development of the Community Advisory Board (CAB), the study design and the recruitment and training of community researchers (CRs).

2. ***Fieldwork:*** the sampling of the participants meeting the inclusion criteria in the most relevant areas or settings of the countries of research and consequently, the conduct of the in-depth interviews or the KAP survey by Community Researchers.

3. ***Analysis:*** ad verbatim transcription of the in-depth interviews and the insertion of the KAP-questionnaires in a database before being analysed and subsequently interpreted, nuanced and validated by the CRs and CAB at first.

4. ***Translation into practice:*** at a public seminar, preliminary results were commonly presented to a broader group of stakeholders, including respondents where possible. In these seminars we discussed the relevance of the preliminary results and conducted workshops in which we formulated policy, practice and research recommendations and set the outlines of new common research projects. In the two European projects we also developed sexual health promotion and SGBV prevention and response tools specifically for the research population and settings.

5. ***Dissemination and advocacy:*** results were reported to donors, general and academic public; the health promotion and violence prevention tools were disseminated to the research population including respondents, professionals, civil society, CRs, CAB and policy makers in the relevant fields; the policy, practice and research recommendations were promoted and disseminated to policy makers, and academics, advocated for and resulted in the writing of new project proposals.

As one project led to the following, this resulted in a great deal of similarities we will describe below. There are however also differences in sampling procedure and type of research since the locations, populations, research questions and expected outcome differed. We will subsequently consider the methodological specificities of each study.

3.2.2.1 Set-Up

At each of the 9 research sites (Belgium, the Netherlands, Ireland, Hungary, Portugal, Spain, Malta, Greece and Morocco) we started by mobilizing a large group of stakeholders. This regarded most importantly our primary beneficiaries being refugee and asylum-seeking communities, undocumented migrants and unaccompanied minors. We however also addressed the secondary and tertiary beneficiaries being the legal guardians of unaccompanied minors, asylum and reception sector services, intermediary organisations, civil society, researchers, policymakers at local, regional, national and international level and global health and protection players in migration as UNHCR, IOM and others. We invited them to participate in a Community Advisory Board (CAB) which would meet at regular intervals of the project and had decisive input on each key moment.

As the Hidden Violence study was our first project in Belgium and the Netherlands, which ran from April 2006 until March 2008, we invested 4 months in networking and in the development of this Community Advisory Board. The fundaments of the networking and the Community Advisory Boards of the Hidden Violence study permitted us to build three other projects on, which we commonly developed from proposal writing onwards until implementation and evaluation.

Upon request of the Community Researchers and CAB in Flanders, we firstly developed a small photo voice project with migrants, Flemish women and students in social welfare on their experiences with SGBV and perceived barriers in health and social care, called "Verborgen Zorgen". This resulted in a photo book (Book 3)[430], a traveling exhibition, a world café to formulate recommendations and a research report (Book 4)[431].

In addition, we sat up a European project to develop a European Network for Sexual and Reproductive Health Promotion of Refugees, Asylum Seekers and Undocumented migrants in Europe and beyond, called EN-HERA!. We developed a Frame of Reference for the Identification of Good Practices in Sexual Health Promotion Practices and Policies (Book 5)[159], set up a network and with this network we developed a research agenda and wrote a report on the process and outcome (Book 6)[432]. The latter two projects and their outcome are referred to in the recommendations section but otherwise not dealt with in this PhD thesis.

Finally, when the results of the Hidden Violence study were presented to different audiences, a lot of feedback was given. For example in the Belgian Federal Parliament a parliamentarian question was raised on the prevention and response practices to SGBV in the Belgian asylum centres. Furthermore, on a conference for asylum reception staff, several professionals argued that they also experienced violence from the residents directed to them and that no prevention or response measures existed. In addition, many professionals complained to lack the capacity, means and tools to discuss sexual health issues in a culturally competent way while many of their migrant patients have poor sexual health.

This resulted in the writing of a third project, the Senperforto KAP study, which we conducted in Belgium, the Netherlands, Ireland, Hungary, Portugal, Spain, Malta and Greece from August 2008 until December 2010. In this project we thus enlarged our prime research population of refugees, asylum seekers and undocumented migrants with professionals in European asylum and reception settings.

At the same time while the Hidden Violence study was running in Belgium and the Netherlands and our European network expanded, we also started inquiring whether it would be possible to set up a similar project in Morocco and to find allies in the proposal development. The Morocco project started in December 2007 and ran until May 2009.

In addition to aligning the project to the needs of all parties involved, a major task of the Community Advisory Boards in the set-up phase of each project was to help identify potential community researchers. These researchers had to meet the inclusion criteria of the study participants. They were invited to a personal interview with key researchers and representatives of the CAB upon which they were screened on their communication skills, potential research skills, empathic attitude, social engagement and leadership capacities. We assured to have a gender-balance that matched with the research population.

A total of about 115 persons completed 30 hours of training as Community Researchers. In the Senperforto study this also included some unaccompanied minors of 16 or older and who had permission of their legal guardians. Topics addressed in their training included migration, human rights, sexual and reproductive health, SGBV, gender, psychosocial education, the study conceptual framework and conducting interviews in an empathic and ethically sound way. At the end of the third study, thus after having conducted the training for 11 times, we considered this training program as sufficiently tested and validated to publish it as a manual for sexual health promotion and prevention of SGBV in the European reception and asylum sector[433]. This manual is freely available in English on DVD with hand-outs in 8 languages.

In every study setting about two Community Researchers dropped out after the training or during the project course because of time constraints, change of location, job opportunities or for two Nigerian sex workers in Morocco: safety issues related to pressure from their communities. Community Researchers collaborated collegiately in every further phase of the project, building rapport, capacity and mutual ownership. They firstly contributed to the shaping of the research questions, the wordings of the questions, the pilot-testing of the questionnaires, its finalisation, translation and back-translation. We did this aiming to enhance the beneficial outcomes of the participatory research approach; secondly to maximise the match between 'inner speech' and the language used[434]; and, thirdly to optimise validity and reliability[435]. They also advised on sampling strategies and ways to value the participation of respondents both at the fieldwork phase as later on in the project. Every decision in these matters was built through consensus and mutually agreed upon before being executed.

3.2.2.2 Fieldwork

The sampling strategy differed in each of the three studies. In the Hidden Violence, Community Researchers were asked to conduct 10 to 12 interviews with respondents meeting the above-mentioned inclusion criteria and of the same gender as the Community Researcher. Respondents meeting the inclusion criteria were chain-sampled through services and organisations that were members of the Community Advisory Board; Red Cross asylum reception in East Flanders, and through Community Researchers' networks. Yet in the debriefing sessions, it was mentioned that some male respondents, who were found to be victims, preferred to be interviewed by female CRs. For the interviews which followed respondents were given the choice.

In the Morocco study Community Researchers were asked to conduct 12 to 15 interviews in the cities we commonly identified as prime research locations or in its surroundings with respondents meeting the inclusion criteria following the Respondent Driven Sampling rules. As Respondent Driven Sampling is specifically designed to research hidden networks of at risk populations in precarious situations[436-440], it served as a perfect sampling strategy for the aim of our research. How the waves would be constructed and what kind of primary and secondary incentives would be given to respondents and how the community researchers would be remunerated was suggested by the participatory partnership and finally jointly decided upon with the CRs during the CR training. When starting up the fieldwork phase, riots broke out in one of the research sites urging a lot of migrants to flee. As the security of our CRs could not be guaranteed, we replaced this research site by the city to which most of the migrants had fled. The issue of matching the gender of the CR with the one of the respondent was discussed at the training of the CR and it was commonly decided that they would offer the choice to potential respondents to be interviewed by a CR of the opposite sex. It was not reported that a respondent asked for a change of CR.

In the Senperforto KAP-study, respondents were randomly sampled over all types of reception facilities and services in 6 of the 8 countries. Yet, due to political constraints, we were obliged to adopt convenience sampling in two countries. After having obtained permission of the sampled facilities, we applied the inclusion criteria and then randomly sampled the respondents on the list of residents and professionals. Given the budget constraints of the project, we initially set forward that every CR would conduct about 10-15 interviews in order to reach about 90 interviews per research country. As for the gender issue, it was commonly decided that professionals and female resident CRs could interview both men and women and that male resident CRs interviewed men.

The Hidden Violence and the Morocco in-depth interviews used the same questionnaire and interview guide, yet adapted to the specific cultural contexts. It comprised four parts. The first part addressed socio-demographic data with closed questions. The second part regarded sexual health. In this part we inquired on where respondents used to turn to

obtain sexual health information in their country of origin. We then asked them how they define sexual health, investigated their criteria of (sexual) maturity and finally inquired on their sexual health locus of control. The third part addressed violence experiences and the fourth prevention of violence (all open questions). In these parts we assessed whether the respondents and/or close peers to them had experienced victimisation since having initiated their migration towards Europe and if they had, we probed for a detailed description of the victimisation acts, the context in which it happened and the consequences. Subsequently, we examined their perception of risk and prevention factors and suggestions for action and inquired on their willingness to participate in the eventual implementation of those actions.

In the Senperforto KAP study we conducted semi-structured interviews, the Community Researchers firstly inquired on respondents' Knowledge of and experience with SGBV at the reception facility. For every case we checked for both victim and perpetrator what the gender, legal status, age, operation modus and relationship to each other and to the respondents were. Respondents had two opportunities to disclose personal involvement: at first at the end of the case description with a direct question; and once more after closure of the interview where they could indicate on an icon sheet with a smiling or sad face whether they were the victim or not and hand this over to the community researcher in a sealed envelope which was only opened by the principal researcher when analysis of the interview was done. Secondly we explored the respondents' Attitudes towards SGBV and its prevention and thirdly we investigated the current practices in SGBV prevention as well as the response actions they experienced while staying or working at the asylum reception facility.

3.2.2.3 Ethics

All study protocols applied the WHO[441] & UNHCR[442] ethical and safety guidelines in researching violence, and received ethical approval from the Ghent University Hospital Ethical Committee. Given the CBPR method, we also discussed with CRs and with CAB how we could meet best the ethical principles of beneficence, autonomy, justice and non-maleficence in each of the research projects[443]. The procedures that were carried out eventually were the result of a shared decision[444-446].

Once identified, respondents were informed about the project's objectives, interview goals, potential risks and measures taken to protect them from those risks, and modes of participation. Respondents could withdraw from the study at any point during the interview but still participate in later phases of the project. The respondents or his/her nominee signed an informed consent before the interview, and consent was regularly renegotiated during the interview and at later phases of project participation.

Upon completion of the interview, we checked if respondents were ok and needed further referral. If they did, this was arranged. Respondents also received a package with sexual

health and violence information in their mother tongue, referral addresses, condoms and some samples for daily hygiene provided by a pharmacy. In the Morocco study they also got a primary and secondary incentive as the Respondent Driven Sampling method requires.

All community researchers were closely coached by the research team and frequent personal as well as group debriefing sessions were held both during the fieldwork phase as later on in the project. When they felt they had to refer respondents and were not able to do that based on the information they had, this was taken over by the research team.

Several communication strategies were simultaneously adopted in order to facilitate knowledge sharing and shared decision-making with Community Researchers and the Community Advisory Boards. This ranged from regular phone calls, mails, personal and group intervision meetings with the CRs, regular CAB meetings and round tables to detailed newsletters being issued every few months and public participatory seminars at the end of each project.

3.2.2.4 Analysis

Interviews were only considered valid when the informed consent was signed and when the taped interview matched the notes that were taken by the CR on the interview guides. The in-depth interviews were transcribed ad verbatim in the language they were conducted and translated to Dutch, French or English. Excluded from analysis were double interviews, double SGBV cases, and cases that were not personal nor from a close peer.

For the qualitative part of the studies, we used Framework Analysis Technique to sort, code and compare the answers. Thus we first applied an emic approach to code the data into analytical categories conceived as meaningful to the communities using the respondents' definitions and wordings. We later applied our conceptual framework to interpret the content and context of the findings. For the Hidden Violence study with did this the old-fashioned style with colour marks and papers, eventually putting the data in a database. For the Morocco study, we used Nvivo 8. The quantitative socio-demographic data were analysed using SPSS and the extensiveness –the volume of and the diversity within the qualitative data[447]- was also checked through SPSS.

The quantitative parts in the Senperforto KAP were analysed through the use of R. We conducted logistic regression analysis using generalized linear models and mixed models to evaluate the relationship between types of violence and specific characteristics of the victims and perpetrators. First, we built a generalized linear model assuming there was no cluster effect. Second, we used the same generalized linear model but accounting for possible clustering at country level. Finally, we performed an analysis with mixed models. Models were estimated using the following functions and packages in R 3.0.1 and R Studio 0.97.551: 'glm' ('stats' package); 'surveyglm' ('survey' package); and 'glmer' ('lme4' packages). Model selection was performed using Akaike's Information Criterion (AIC), where the model with the lowest AIC value was considered the best model.

In each of the studies, preliminary results were discussed and interpreted with the Community Researchers and the Community Advisory Boards before final analysis and presentation and dissemination to stakeholders beyond the project.

3.2.2.5 Translation Into Practice

In all three studies, the main researchers, the Community Researchers and CAB-members presented these preliminary results to a broader group of stakeholders and invited experts from Europe and beyond at widely attended seminars. In these seminars we discussed the relevance of the preliminary results and conducted workshops in which we formulated policy, practice and research recommendations and set the outlines of new common research projects.

In the two European projects we also commonly developed sexual health promotion and SGBV prevention and response tools specifically for the research population and settings. In the Hidden Violence study this regarded the "Prevention Agenda"(Book 2)[448]. The objectives, the content, the wording and the design were co-produced and pilot-tested with the CRs and the CAB. A refugee with graphic design background in her country of origin developed the cover and was granted the permission of the printing agency to assist in the lay-out of the tool at their office. We also developed an awareness raising campaign in which participation was sought of other refugees and asylum seekers who were not yet part of the project, through a design contest for theme cards. These theme cards were integrated in the Prevention Agenda, but together with a set of posters with quotes, made available on line and used at seminars and conferences and other public spaces. The participatory process and results are described in detail in Book 1[449].

In the Senperforto study this was the "Senperforto Frame of Reference for Prevention of and response to SGBV in the European asylum and reception sector" (Book 9)[450]. The Senperforto Frame of Reference consists of SGBV Prevention Standard Operating Procedures, a Code of Conduct, a Sensitization Kit and the Make it Work! Training Manual:

1. The Senperforto **Standard Operating Procedures (SOPs)** are a set of practical tools assisting reception centres in developing comprehensive procedures for prevention of SGBV within the centre, for assisting victims and for referring perpetrators.

2. The Senperforto **Code of Conduct** is a practical guide for the reception centre, its staff members and residents. It defines the outlines and the content of their commitment in attitudes and behaviour to preventing, combating and responding to every form of SGBV.

3. The Senperforto **Sensitization Kit** is a culturally competent awareness-raising and sensitization tool fit for any public, but addressing asylum seekers and asylum professionals specifically. The Sensitization Kit consists of foldable flyers containing

information, sensitization materials and referral addresses on 12 different themes, ranging from how to enhance your social network and having good relationships to sexual and reproductive health risks and different types of SGBV.

4. The Senperforto **Make it Work! Training Manual** is a practical hands-on manual with an engaging and non-judgmental approach to sensitive issues such as sexual and reproductive health and SGBV. The Make it Work! Training Manual develops a better understanding of the factors that influence SGBV, increases communication skills on sexual health and SGBV, and stimulates group cohesion within the working group of professionals and residents that are engaged in the prevention of SGBV in their reception centre. It is available on the CD-ROM of the Senperforto Frame of Reference, yet also available in hard copy (Book 8)[433].

Also this frame of reference was a result of a participatory process in the different project countries, yet the participation mode differed from country to country. The same refugee as for the Hidden Violence project, now advancing in graphic design studies in Belgium, independently developed a Senperforto logo and conducted the full design of the Frame of Reference before being put on DVD.

3.2.2.6 Dissemination and Advocacy

The health promotion and violence prevention tools addressing the research population were disseminated along the networks of the Community Researchers and the Community Advisory Board, eventually reaching respondents and other people from the study population; but also to policy makers, relevant professionals, organisations, civil society, academics and beyond.

All policy and practice recommendations formulated at the seminars were carefully communicated in each of the reports, taken along in the development of new proposals and advocated for in the national and international policy and practice field until today.

The Senperforto Frame of Reference was primarily designed for European asylum or reception centres that wish to develop and implement a comprehensive SGBV prevention and response policy. However, with slight contextual adaptations, it can also be used in any other institutional setting where vulnerable people are cared for and prevention of SGBV is at stake. It was made freely available in many languages and is widely promoted and disseminated throughout Europe and beyond on DVD. UNHCR Europe endorses and promotes it as a good practice.

Regarding academic articles resulting from the studies, only one Community Researcher felt up to meeting co-author requirements of the journal, and subsequently also collaborated in writing and finalizing the article. Others preferred to participate in the tools and campaign but to be acknowledged in the academic articles.

Finally, both the project in Europe as the one in Morocco resulted in writing of new project proposals, aiming to implement the policy, practice and research recommendations that were formulated in the projects. We are still awaiting formal responses but the partnerships are decided to persevere until funding has been found.

3.3 Literature Review: Critical Interpretive Synthesis-Method

In addition to the action research we also conducted a literature review. While the action research studies predominantly focused on the personal, interpersonal and organisational level determinants in SGBV prevention and SRH promotion, the literature review aimed to critically examine the macro level of legal and policy frameworks. By doing so, we aimed to examine if and how these frameworks condition the sexual health of migrants as well as the prevention of and response to sexual violence in our research populations. In addition, we wanted to explore whether the current frameworks are consistent with a rights-based approach. The findings of this research would help us to complement our policy and practice recommendations in SRH promotion and SGBV prevention and response.

To address these objectives, we were confronted with both grey (including legal) and academic literature. Given the diversity of this data pool, we opted to conduct our review with the Critical Interpretive Synthesis (CIS) method[451]. The CIS-method is specifically created and frequently used to study inequalities within health care systems[452-454]. It is designed to handle a large and heterogeneous set of references, which allows for the development of concepts and theories along the review process[455-457], for a synthesis of "a diverse and complex body of evidence"[453] and for a focus on "a more flexible, iterative, dynamic, critical and reflexive approach to synthesis"[452]. The CIS-method thus harmonizes well with both the objectives as the conceptual framework and research approach we applied in the action research studies of this thesis.

3.4 Presentation of Publications

This PhD thesis is based on a set of papers that have been published or are under review in leading public health international peer-reviewed journals. I present the primary manuscripts of these papers in the Results chapter of this thesis and refer to the secondary papers and books when presenting the participatory research process results.

Publications:

Paper 1: Keygnaert I, Vettenburg N, Temmerman M (2012) Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Culture, Health & Sexuality, Vol. 14, issue 5, May 2012, pp 505-520. Type A1, Q1 public health, IF: 1.495.

Paper 2: Keygnaert I, Dialmy A, Manço A, Keygnaert J, Vettenburg N, Roelens K, Temmerman M (2014): Sexual violence and sub-Saharan migrants in Morocco: a participatory assessment using respondent driven sampling. BMC Globalization & Health 2014, 10:32. Type A1, Q1 public health, IF: 1.485.

Paper 3: Keygnaert I, Dias SF, Degomme O, Devillé W, Kennedy P, Kovats A, De Meyer S, Vettenburg N, Roelens K, Temmerman M (2014) Sexual and gender-based violence in the European asylum and reception sector: a perpetuum mobile? European Journal of Public Health, 2014, doi: 10.1093/eurpub/cku066. Type A1, Q1 public health, IF: 2.516.

Paper 4: Keygnaert I, Vettenburg N, Temmerman M, Roelens K (2014) Sexual health is dead in my body: Participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. BMC Public Health 2014, 14:416 Type A1, Q1 public health, IF: 2.076.

Paper 5: Keygnaert I., Guieu A, Ooms G, Vettenburg N, Roelens K, Temmerman M (2014) Sexual and reproductive health of migrants: does the EU care? Health Policy, Vol. 114, pp. 215-225. Type A1, Q1 public health, IF: 1.550.

Paper 6: Keygnaert I, Guieu A, Vettenburg N, Roelens K, Temmerman M (2014) What the eye doesn't see: A critical interpretative synthesis of European policies addressing sexual violence in migrants. Submitted manuscript.

Paper 7: Van den Ameele S, **Keygnaert I,** Rachidi A, Roelens K, Temmerman M (2013) The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research 2013, 13:77. Type A1, Q1 public health, IF: 1.773.

Paper 8: Keygnaert I, Deblonde J, Leye E (2011) Sexual health of migrants in Europe: Some pathways to improvement – Entre Nous n 72, WHO Regional Office for Europe, pp. 20-21. Type A2.

Paper 9: Keygnaert I, El Mahi N, Van Egmond K, Temmerman M (2011) Verborgen Zorgen: Beeldessay- Tijdschrift voor Genderstudies n3, pp. 40-41. Type A2

Paper 10: Leye E., Roelens K., **Keygnaert I.**, Claeys P & Temmerman M. (2008) Research in an ivory tower? How Research on Sexual and Gender-Based Violence can make a difference. Entre Nous n° 67, WHO Regional Office for Europe, pp. 22-23 Type A2

Paper 11: Keygnaert I. & Temmerman M. (2007) Between theory and practice: Gender-based Violence against Refugees, Asylum Seekers and Undocumented Migrants in Europe. Entre Nous n°66, WHO Regional Office for Europe, pp. 12-13.Type A2

Books, Manuals and Reports Meeting the Requirements of "Community Based Participatory Research" Methodology:

Book 1: Keygnaert I., Wilson R., Dedoncker K., Bakker H., Van Petegem M., Wassie N. & Temmerman M. (2008) Hidden Violence is a Silent Rape: Prevention of Sexual and Gender-Based Violence against Refugees & Asylum Seekers in Europe: A Participatory Approach Report. Academia Press, Ghent, Belgium. ISBN 978-90-382-1327-9. Type B1

Book 2: Keygnaert I. & Temmerman M. (2008) Preventie-agenda 2008. Lannoo Uitgeverij, Tielt, Belgium. ISBN: 978-9078128-168. Type B1

Book 3: Keygnaert I., El Mahi N., Pourmirzajan B., van Egmond K.& Temmerman M.(2009) Verborgen Zorgen Fotoboek. Academia Press, Ghent, Belgium. ISBN 978-90-382-1438-2 Type B1

Book 4: Keygnaert I., van Egmond K., El Mahi N. & Temmerman M. (2009) Verborgen Zorgen Wetenschappelijk Rapport. ICRH-UGent, May 2009. Type V

Book 5: EN-HERA! (2009) Framework for the identification of good practices in Sexual & Reproductive Health for Refugees, Asylum seekers and Undocumented Migrants. Editor: **Keygnaert I.** Academia Press, Ghent, Belgium. ISBN 978-90-75955-69-9. Type B1

Book 6: Keygnaert I., van Egmond K & Temmerman M. (2009) EN-HERA! Report 1. Academia Press, Ghent, Belgium. ISBN978-90-38214-09-2. Type B1

Book 7 : Keygnaert I., van den Ameele S., Keygnaert J., Manço A. & Temmerman M. (2009) La Route de la Souffrance : la Violence Sexuelle parmi et contre les Trans-Migrants au Maroc – Un Partenariat Participatif pour La Prévention: Rapport de recherche. ICRH-UGent, July 2009. Type V

Book 8: Frans E. & **Keygnaert I**. (2009) Make it Work! Training Manual for Prevention of SGBV in the European Reception & Asylum Sector. 150 pp, Academia Press, Ghent. ISBN 978 90 382 1575 4. Type B1

Book 9: Keygnaert I., Vangenechten J., Devillé W., Frans E. & Temmerman M. (2010) Senper¬forto Frame of Reference for Prevention of SGBV in the European Reception and Asylum Sector. Magelaan cvba, Ghent. ISBN 978-9078128-205. Type B1

“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

4. RESULTS

4.1 Outline

The general objective of this study is to contribute to a better understanding of factors determining the health of refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood by exploring prevention of sexual violence and promotion of sexual health. In order to meet this general objective, specific objectives were sat forward. These specific objectives are addressed in the different papers.

We here divide them in 4 sections. First we address sexual violence and explore the nature and magnitude of the violence that the study population experienced as well as subjective and objective determinants (Papers 1-2-3). Second, we consider their sexual health (Paper 4). Third, we assess the impact of legal and policy frameworks on sexual violence and sexual health in the context of migration (Papers 2, 5 &6). Fourth, this research was conducted in a highly participatory way, contributing to social and policy change with different sexual violence prevention and sexual health promotion tools. (Papers 7-11 and Books 1-9) The eventual interpretation of these results through the lense of Desirable Prevention is reflected on in the Discussion Section of this thesis

4.2 Sexual Violence Against Refugees, Asylum Seekers And Undocumented Migrants in Europe and The European Neighbourhood: Nature, Magnitude and Determinants

Research has demonstrated that refugees, asylum seekers and undocumented migrants are vulnerable to sexual violence in their country of origin, in conflict or during migration. Yet, whether these migrant groups are also at risk of sexual violence within Europe and the European Neighbourhood was not yet considered. This could however be hypothesised as literature shows that people in similar socio-economic positions and housing facilities as well as people who either directly or indirectly experienced violence before, are at enhanced risk of sexual violence. Furthermore, some NGO's were mentioning situations that were in support of this hypothesis. Especially violent incidents with sub Saharan migrants were reported in Morocco and at its borders with whom Europe had the closest collaboration to regulate irregular migration to Europe in the frame of the European Neighbourhood Policy.

As people have the right to shape decisions on their health and life, and are the best placed to offer insight in community's unique circumstances we opted for an objective as well as subjective investigation of sexual violence risk and prevention factors.

The following 3 papers thus meet objective 1, which aimed to explore the nature and magnitude of sexual violence that refugees, asylum seekers and undocumented migrants experience in Europe and the European Neighbourhood as well as objective 2, which

inquires on their perceived risk and protective factors and their definition of sexual violence.

In total we interviewed 1001 refugees, asylum seekers, undocumented migrants and asylum-related professionals in 8 European countries (Belgium, the Netherlands, Ireland, Hungary, Portugal, Spain, Greece and Malta) and in 1 European Neighbourhood country, being Morocco, which the European Union considers the pre-eminent transit country for irregular migration from Africa to Europe with whom the EU can make contracts.

Paper 1: Keygnaert I., Vettenburg N, Temmerman M (2012) Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Culture, Health & Sexuality, Vol. 14, issue 5, May 2012, pp. 505-520. Type A1, Q1 public health, IF:1.495.

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Paper 3: Keygnaert I., Dias SF, Degomme O, Devillé W, Kennedy P, Kovats A, De Meyer S, Vettenburg N, Roelens K, Temmerman M (2014) Sexual and gender-based violence in the European asylum and reception sector: a perpetuum mobile? European Journal of Public Health, 2014, doi: 10.1093/eurpub/cku066. Type A1, Q1 public health, IF: 2.516.

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Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands

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Although women, young people and refugees are vulnerable to sexual and gender-based violence (SGBV) worldwide, little evidence exists concerning SGBV against refugees in Europe. Using community-based participatory research, 223 in-depth interviews were conducted with refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Responses were analysed using framework analysis. The majority of the respondents were either personally victimised or knew of a close peer being victimised since their arrival in the European Union. A total of 332 experiences of SGBV were reported, mostly afflicted on them by (ex-)partners or asylum professionals. More than half of the reported violent experiences comprised sexual violence, including rape and sexual exploitation. Results suggest that refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands are extremely vulnerable to violence and, specifically, to sexual violence. Future SGBV preventive measures should consist of rights-based, desirable and participatory interventions, focusing on several socio-ecological levels concurrently.

Keywords: sexual violence; refugees; Europe; risk factors; prevention

Introduction

Sexual and gender-based violence (SGBV) is a major public health issue worldwide, a violation of human rights and in some cases a crime against humanity. It comprises sexual violence, emotional-psychological violence, physical violence, harmful cultural practices and socio-economic violence (Basile and Saltzman 2002; UNHCR 2003). In addition to important negative effects on the victim's well-being and participation in society, SGBV may have significant consequences on sexual, reproductive, physical and psychological health (Hynes and Lopes 2000; Norredam et al. 2005; Tavara 2006).

Considered to be vulnerable to SGBV are: firstly, women – especially the impoverished and those living in shelters, in remote areas or in detention (Wenzel et al. 2004), secondly, adolescents girls and boys, particularly if they live alone or with only one parent and are of low socio-economic status (Holmes and Slap 1998; Tavara 2006) and, thirdly, displaced and refugee communities (Hynes and Lopes 2000; UNHCR 2003; Ward and Vann 2002). People with heightened risk perception and those who were personally victimised or witnessed SGBV during childhood are prone to subsequent victimisation or perpetration of

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SGBV themselves (Borowsky, Hogan, and Ireland 1997; Brown et al. 2005). Research has demonstrated that perpetrators of SGBV are most often known to the victim (Tavara 2006). However, refugees, homeless or impoverished people and young men are often victimised by strangers, persons in authority and those assigned to their protection (Holmes and Slap 1998; Hynes and Lopes 2000; Norredam et al. 2005).

Several determinants in SGBV are thus known. Yet there remain considerable gaps in knowledge when it comes to SGBV victimisation of refugees in Europe, the impact of their victimisation on the individual and public health and effective prevention actions. The aim of this paper is twofold. First, it explores the nature of SGBV that refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands experienced after arriving in the EU. Second, it discusses which perceived risk and preventive factors may be considered decisive determinants for the prevention of SGBV in this population.

Methods

The above research findings encourage the use of an interpretive, feminist, communitarian and dialogical research perspective (Anderson and Doherty 2008; de Laine 2000). Applying a socio-ecological framework (Bronfenbrenner 1979) to the determinants of sexual health and violence, we first identified the potential SGBV determinants in our study population, shown in Table 1.

We added the concept of Desirable Prevention to this framework. Whereas general prevention can be conceived of in terms of those initiatives that anticipate risk factors in a targeted and systematic way, Desirable Prevention can be defined as 'initiatives which

Table 1. SGBV determinants, socio-ecologically clustered.

Individual determinants
Biology and genes
Gender
Behaviour
Mental health
Information, knowledge and experience
Individual socio-economic position
Internalised cultural norms
Interpersonal determinants
Gender
Multiple sexual partners
Social network and support
Information and knowledge exchange
Organisational determinants
Community resilience
Cultural practices
Community socio-economic position
Service provision
Physical environment
Organisational prevention policy
Societal determinants
Structural gender inequality
Economic problems
Residence/legal status
Law/justice
Accessibility of services
Societal SGBV prevention policy

anticipate risk factors even earlier in a targeted and systematic way, are maximally "of-fensive", have an integral approach, work in a participatory way and have a democratic nature, while aiming at the enhancement or protection of the target group's health and wellbeing' (Vettenburg et al. 2003, 20).

Starting from this conceptual framework, we adopted a qualitative and collaborative approach organised around the notion of Community-Based Participatory Research. Community-Based Participatory Research focuses on inequalities and aims to improve the health and well-being of community members by integrating knowledge in action, including social and policy change (Israel et al. 2001; Viswanathan et al. 2004).

We mobilised a large group of stakeholders: refugee and asylum-seeking communities, policymakers, intermediary organisations, civil society and researchers. We considered the first of these groups to be the project's main beneficiaries and identified a number of inclusion criteria. The first of these was to be a refugee, asylum seeker or undocumented migrant aged between 15 and 49 years old. Second, respondents had to be living in East Flanders in Belgium or the Randstad region in the Netherlands. The application of these criteria resulted in a sample that included participants from Iranian, Iraqi, Roma, Kurdish, Somali, Afghan and former Soviet Union backgrounds.

A total of 14 women and 10 men meeting the criteria completed 30 hours of training as Community Researchers. Topics addressed in their training included sexual and reproductive health, SGBV, gender, psychosocial education, the study conceptual framework and conducting in-depth interviews in an empathic and ethically sound way. Two male Community Researchers dropped out after training because of time constraints. Community Researchers collaborated in every phase of the project, building rapport, capacity and mutual ownership. Other stakeholders participated in a Community Advisory Board (CAB) that met at key moments throughout the duration of the project.

Community Researchers were asked to conduct 10–12 interviews with respondents meeting the above-mentioned inclusion criteria and of the same gender as themselves. Between January and May 2007, 250 respondents were chain-sampled through services and organisations that were members of the Community Advisory Board, the Red Cross asylum reception centres in East Flanders and through Community Researchers' (CRs') networks. Once identified, respondents were informed about the project's objectives, the interview goals, the potential risks and measures taken to protect them from those risks and modes of participation. Respondents could withdraw from the study at any point during the interview but still participate in later phases of the project. The respondent or his/her nominee signed an informed consent before the interview, and consent was renegotiated during later phases of participation.

The questionnaire comprised four parts: socio-demographic data (closed questions), sexual health, personal or close peer SGBV experiences since arriving in Europe and prevention of SGBV (all open questions). The questionnaire was developed jointly with the Community Researchers and the CAB: firstly, to enhance the beneficial outcomes of the participatory research approach, secondly, to maximise the match between 'inner speech' and the language used (Moran, Mohamed, and Lovel 2006) and, thirdly, to optimise validity and reliability (Gagnon, Tuck, and Barkun 2004). It was translated into the languages of the respondents by the Belgian Community Researchers and back translated by the Dutch Community Researchers before being pilot-tested and finalised for use in the mother tongue of both the Community Researchers and the respondents. The study protocol applied the WHO (Ellsberg and Heise 2005) and UNHCR (UNHCR 2003) ethical and safety guidelines in researching violence and received ethical approval from the Ghent University Hospital Ethical Committee.

Analysis

Interviews were only considered valid when informed consent had been given and when the taped interview matched the notes that were taken by the Community Researcher on the interview guide. Excluded from analysis were double interviews, double SGBV cases and cases that were not personal nor from a close peer. For the qualitative element of the study, we used framework analysis to sort, code and compare the answers. Thus, we first applied an emic approach to code the data into analytical categories conceived as meaningful to the communities using the respondents' definitions and wordings. We later applied the socio-ecological framework and the concept of Desirable Prevention to interpret the content and context of the findings. Finally, we used SPSS to check the volume of, and diversity within, the qualitative data (Safman and Sobal 2004). Quantitative socio-demographic data were also analysed using SPSS.

Results

Socio-demographic characteristics

In total, 223 of the 250 interviews were considered valid: 132 in Belgium and 91 in the Netherlands. The respondents were 88 men and 135 women, including two transsexuals in Belgium who asked to be included in the analysis as women.

Table 2 reveals the main socio-demographic characteristics of respondents. Their general profile was one of highly educated women and men of reproductive age who reported experiencing a major setback in their socio-economic position:

> You are not allowed to work, only to breathe. (Parvaneh, 37, Iranian asylum seeker)
>
> You cannot do anything, because you are not a human being. (Bohan, 20, Kurdish asylum seeker)

In addition, respondents described having poor social networks to rely and build on and being hampered in participating actively in society impeded their social functioning:

> I have no hope for the future. I live in a reception centre without any contact with other people. I have no money, no work and no contact with girls. (Zoran, 23, Kurdish asylum seeker)

Subsequently, many indicated suffering from the psychosocial burden of low subjective social status:

> My father is a highly educated, intelligent man and held a high position in Iran. When we received our asylum status here he wanted to work, not to live on support. For eight years now he's working as a welder. His hands cannot hold a cup of tea anymore and his eyes grow blind. His Dutch colleagues treat him as an idiot. He lost his self-esteem and now stutters. (Bahareh, 22, Iranian refugee)

Finally, several respondents perceived their asylum situation as a form of violence:

> This family had no right to work, to social support, to rent a house, to have an own account and after four years in the asylum centre they had to leave Belgium. Where are those human rights then here? Nowhere; That's violence too! (Hawar, 19, Kurdish asylum seeker)
>
> We've got the right to live. Making a difference between asylum seeking and other children is a form of violence! (Yasemin, 29, Kurdish asylum seeker)

Overview of reported cases of SGBV

A quarter of the respondents did not report violence (57/223). However, 87 respondents had been personally victimised and another 79 respondents knew at least of one close peer – either an (ex)-partner, family member, friend or acquaintance/neighbour – being

Table 2. Socio-demographic profile of respondents.

	$N = 223$	%
Gender		
Female	133	59.6
Male	88	39.5
Transsexual	2	0.9
Age (years)		
< 18	15	6.7
19–29	102	52.5
30–49	106	47.5
Country of origin		
Afghanistan	24	10.8
Former USSR	39	17.5
Iraq	43	19.3
Iran	67	30
Slovakia and Czech Republic	36	16.1
Somalia	14	6.3
Residence status		
Asylum seeker	92	41.3
Refugee	103	46.2
Undocumented	28	12.5
Relational status		
No steady partner	119	53.4
Steady partner	104	46.6
Children in care		
0	107	48.0
1	34	15.3
2/>2	82	36.8
Accompaniment		
Persons > 18 years		
0	65	29.1
1	72	32.3
2/>2	86	38.6
Persons < 18 years		
0	98	43.9
1	51	22.9
2/>2	74	33.9
Religion		
None	45	20.2
Christian	68	30.5
Muslim	96	43
Other	12	5.3
Educational level		
Higher/University	45	20.2
Higher/non-university	46	20.6
Secondary education	99	44.4
Primary education	25	11.2
Not educated	4	1.8
Daily activities		
Country of origin		
Paid at work	101	45.3
At job market	12	5.4
Student	88	39.5
Other	21	9.4
Host country		
Paid at work	50	22.4

Table 2 – *continued*

	$N = 223$	%
At job market	43	19.3
Not allowed to work	45	20.2
Student	51	22.9
Other	33	14.8

victimised since arriving in Europe. Together, they described 332 cases consisting of 389 SGBV acts. All types of violence (except killing and child marriage) were described in both personal as well as peer victimisation, with personal victimisation bearing at least one third of the proportion within each type of violence. Sexual and gender-based violence cases were noted by all Community Researchers in every origin, gender, age and status group interviewed.

Table 3 reveals that more than half of the victims were less than 30 years old and female, while perpetrators were predominantly over 30 and male. Nonetheless, one third of the victims were male and 25 perpetrators were female. Additionally, about half of the perpetrators had acted in a group. The majority of the victims were either refugees or asylum seekers, while a third of the perpetrators were Belgian or Dutch nationals. The perpetrator was usually the current or former partner of the victim. Yet, in a fifth of the cases authorities or professionals as reception centre staff, lawyers, police and security guards were identified as perpetrators.

Table 3. Characteristics of victims and perpetrators.

	Victim in cases		Perpetrator in cases	
	$n = 332$	%	$n = 332$	%
Gender				
Female	230	69.3	20	7.5
Male	95	28.6	241	74.0
Both	5	1.5	5	1.5
Missing	2	0.6	65	19.6
Approximate age				
Youth (<30)	184	55.4	43	12.9
Adult (>30)	144	43.4	219	66.0
Missing	5	1.5	70	21.1
Residence status				
Asylum seeker	134	40.4	68	20.5
Refugee	130	39.2	56	16.9
Undocumented migrant	30	9	4	1.2
Belgian/Dutch	–	–	113	34.0
Missing	38	11.4	91	27.4
Relationship victim-perpetrator	*Victim –*	*Respondent*	*Perpetrator*	*Victim*
Respondent	87	26.2	2	0.6
(Ex-)partner	4	1.2	102	30.7
Family	23	6.9	53	16.0
Friend	71	21.4	12	3.6
Acquaintance/neighbour	147	44.3	49	14.8
Service provider	–	–	77	23.2
Unknown	–	–	40	12.0
Missing	–	–	15	4.5

Table 4 shows the nature of described SGBV experiences. Most cases consisted of multiple forms of violence.

Sexual violence

The bulk of the sexual violence cases consisted of rape with multiple and gang rape appearing to be common practice. Sexual harassment (no physical contact), sexual abuse (physical contact without penetration) and sexual exploitation were also described. A fifth of all respondents stated being sexually victimised themselves, giving a detailed report of being raped by one or more persons and/or of being sexually exploited on a long-term basis. The victims in the other cases were close peers of the respondents:

> If I wanted an ice-cream, I had to lick the head of his soldier first. (Svetlana, 28, Russian refugee)
>
> This Dutch guy forced her to have sex to bring money home. He told her that if she didn't sell sex to other men, he'd kill her. (Muzhdah, 23, Afghan refugee)
>
> This was awful! That bunch of naked men with burning eyes, they started to fuck me all, it didn't stop. (Micha, 25, Russian undocumented migrant)

Table 4. Nature of SGBV cases.

Type of violence	Personal	Close peer	Total ($n = 332$)	%
Sexual violence	**47**	**141**	**188**	**56.6**
Sexual harassment	32	54	89	26.8
Sexual abuse	8	32	40	12.0
Rape	28	83	111	33.4
• Attempted rape	2	6	8	2.4
• Singular rape	2	19	21	6.3
• Multiple rape	19	45	64	19.3
• Gang rape	4	9	13	3.9
• Forced abortion	1	1	2	0.6
Sexual exploitation	9	31	40	12.0
Emotional/psychological violence	**64**	**142**	**206**	**62**
Verbal abuse	1	4	5	1.5
Humiliation	12	31	43	13.0
Threatening	10	22	32	9.6
Confinement	10	36	46	13.9
Relational	2	18	20	6.0
Asylum procedure related	24	23	47	14.2
Worsening combination	5	7	12	3.6
Physical violence	**40**	**117**	**157**	**47.3**
Singular non-life-threatening	19	54	74	22.9
Multiple non-life-threatening	8	16	24	7.2
Singular life-threatening	3	8	11	3.3
Multiple life-threatening	10	20	30	9.0
Killing	0	18	18	5.4
Socio-economic violence	**44**	**56**	**112**	**33.7**
Discrimination	12	11	23	6.9
Refusal of services	7	18	25	7.5
Refusal of legal assistance	25	39	64	19.3
Harmful cultural practices	**4**	**43**	**47**	**14.2**
Forced marriage	3	3	13	3.9
Child marriage	0	2	2	0.6
Honour-related	1	1	32	9.6

Emotional-psychological violence

Emotional-psychological violence consisted mostly of humiliation, confinement and emotional-psychological abuse related to the asylum process. Respondents in the Netherlands reported nearly twice as much emotional-psychological violence than in Belgium (68 versus 39%):

> 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. (Esrin, 26, Kurdish asylum seeker)

Physical violence

Physical violence largely took the form of non-life-threatening forms of violence such as beating, punching or kicking. Yet in 58 cases it regarded a life-threatening form such as being thrown out of a window, choking, being hit on the head, burning, maiming and killing:

> They were six and hit me so hard on my head that I fell down unconscious and lost a lot of blood. (Salar, 31, Afghan refugee)

Socio-economic violence

Socio-economic violence consisted most frequently of the denial of legal assistance or obstructive practice related to the asylum procedure, the denial of services such as health care and discrimination/racism. Respondents in the Netherlands reported more than twice as much socio-economic violence cases than those in Belgium (42 versus 19%):

> I lived in constant fear and anguish and was not given the prescribed medicine that I needed. I was living in constant pain for days. (Biixi, 42, Somali refugee)

Harmful cultural practices were mainly honour-related or involved forced marriage or child marriage:

> When her father heard that his daughter was raped, he killed her. He couldn't face us fellow citizens anymore after this terrible thing. (Shahrukh, 39, Afghan refugee)

Consequences of victimisation

Respondents indicated that frequently victims had to deal with multiple and long-lasting consequences.

Emotional-psychological consequences

Emotional-psychological consequences occurred in two-thirds of the cases. Respondents described being 'depressed', 'a psychological wreck', 'dispirited' or 'very insecure'. Victims often isolated themselves and no longer trusted anybody. Others dealt with anxiety, sleeping disorders, shame, guilt, anger, frustration and hatred. Many victims did not receive any psychological assistance although they requested this:

> Fear, nightmares we all know it. My children can't bear loud voices or noise. They are very kept to themselves. They have forgotten the meaning of the word 'joy'. (Parvaneh, 37, Iranian asylum seeker)

Socio-economic consequences

Frequently, violence resulted in a loss of social support. Victims were forcibly separated from their partner or children, were condemned by and expelled from their family or community or had to change reception centres disrupting their newly build social network. Several victims lost their job, fell behind in their education or could no longer participate actively in society:

> The other Afghans soon heard about it. … They had a fight, the police investigated the case and her little son was taken from her and put in childcare, she was sent to another asylum reception centre. (Farozeh, 42, Afghan asylum seeker)

Physical consequences

Physical consequences were described in about half of the cases. They included bruises, bleeding, exhaustion, unconsciousness, heart or gastrointestinal problems, weight loss and other physical complaints. Several victims were permanently injured. Others either died of the immediate consequence of the violence or by committing suicide shortly after:

> When I opened my eyes they had thrown me in a park in Ghent. I had to go to a doctor because my anus was as a raw chunk of meat and my penis was blue. After a while I heard I had AIDS, from whom I do not know, the only thing I know is that I'm going to die. (Micha, 25, Russian undocumented migrant, died of AIDS shortly after the interview)

Sexual and reproductive consequences

Sexual and reproductive consequences were mentioned in more than a fifth of the cases. In addition to STIs and HIV, these mostly included sexual disorders, unwanted pregnancy, miscarriage due to violence and forced abortion:

> He came back and raped me … I became pregnant and I tried to abort the 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. The doctor told me: after this torture, you cannot get children any more. That is the worst thing that could happen to me. (Olga, 23, Ukrainian refugee)

Perceived risk factors linked to victimisation

> I had no papers and no money, so I only had one option: to be his slave. (Svetlana, 28, Russian refugee)

In general, respondents identified behavioural factors as the most important risk factor. However, the lack of a social network and economic hardship were also identified as key risk factors. Categorising their answers on individual, interpersonal, organisational and societal socio-ecological levels, the following findings emerge.

Individual level

Individual determinants mostly comprised behavioural factors including drug/alcohol use, verbal and non-verbal attitudes and being alone on the streets at night. One third of the respondents identified lack of knowledge and information as a risk factor. This included 'not knowing the language and culture of the host country' and lack of 'sexual knowledge' and 'self-defence skills'. About the same number of respondents indicated that mental health problems put one at risk of SGBV. They described this as 'being down', having 'no self-confidence', 'being mentally ill' and 'not having a lot of brains'. A quarter of the respondents saw also risk related to gender. They described this as 'being weaker as a woman', 'being too free as a girl' and 'being a beautiful woman'.

Interpersonal level

Half of the respondents identified issues relating to social networks as important risk factors. Examples included 'not having somebody to turn to', 'trusting people too easily' and 'having bad examples as friends or parents'.

Societal level

More than one third of the respondents mentioned economic hardship as a risk factor, including 'having a bad financial situation', 'poverty' and 'taking risks to earn money'. Having no legal residence permit, having an unprotected status and not having full rights were identified as residence-related risk factors. A bad physical environment was described as 'sharing housing with too many people' and 'living in a deprived area':

> 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. (Arun, 31, Kurdish refugee)

Desired prevention measures

Subsequently we inquired about the respondents' perceptions and suggestions concerning prevention. The following themes emerged.

Individual level

Some respondents indicated that an individual could not do much. However, the majority were convinced that an individual had an important role to play in SGBV prevention. A quarter of respondents stated that an informed individual was less at risk; therefore, one should inform oneself. Mental health factors such as 'being self-confident', 'knowing your own limits', 'having a strong mind' and 'respecting yourself before you respect others' were also seen as preventive. At an individual level, behavioural factors such as 'avoiding risks', 'choosing suitable clothes' and 'avoiding drugs and alcohol' were seen as important.

Interpersonal level

A larger number of behavioural factors were in relation to others. These included 'avoiding relationships with strangers or bad friends', 'choosing your friends carefully' and 'being careful, also in intimate relationships'. The majority of respondents felt that others should react when violence occurs and provide social and parental control and support. Therefore, prevention measures should seek to enhance social networks. Successful strategies included 'making sure that parents and children are good friends', 'enhancing networks among the same age groups' and 'organising meetings in which people can share their experiences and feelings'. Sharing knowledge was also considered preventive and key strategies here included 'giving general information and education to others', 'sensitisation and advice from parents on risks' and 'making violence debatable'.

Organisational level

Although some respondents stressed that a victim should seek help by 'notifying the police', 'looking for help from knowledgeable people' and 'looking for legal aid', most respondents stated that others should help in accessing services. They identified the need to have services that are safe and trustworthy for refugees, asylum seekers and undocumented migrants, and that offer psychological assistance. Although few respondents pointed to cultural norms and values as protective factors, a quarter believed that prevention measures should address cultural norms and values, including informing the host society about refugee issues.

Societal level

For more than half of the respondents, prevention should seek to enhance knowledge through sensitisation, education on sexual health, risks and SGBV, and training about rights.

Others felt that the overall legislative framework should become more preventive. They suggested, for example, that the government should 'assure protection against violence for all', 'enforce laws on violence' and 'enhance general public safety'. Furthermore, the system of residence status should change to enhance the research populations' possibilities of enjoying rights and actively participating in host communities. This could be done by 'giving all migrants the right to work', by 'shortening the asylum procedure' and by 'educating asylum seekers on their rights and duties'.

The vast majority of respondents felt that the suggested preventive measures would work for both women and men. However, prevention for young people should be adapted to their own language and culture. Nearly three-quarters of respondents stressed they would like to participate in future SGBV-prevention activities, welcomed the focus of the research and thanked the research team for being genuinely interested in their lives. This is line with Sikweyiya and Jewkes's (2011) suggestion that risks in SGBV research can remain minimal when protocols are followed and that it can even generate a positive impact.

Discussion

Victimisation

This study explored the nature of SGBV that refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands experienced since arriving in the EU (see Table 4). Within the limited scope of our research population, we found a high incidence of combined forms of victimisation, which sometimes resulted in a fatal outcome. Not only the extent to which sexual violence was part of their victimisation, but also its nature (e.g. frequent gang and multiple rape) differs from what is known about SGBV among Belgian and Dutch nationals (MOVISIE 2009; Pieters et al. 2010). Furthermore, unlike what is expected in the general population (Tavara 2006), but in line with findings for refugees, people in poverty and adolescent boys (Holmes and Slap 1998; Hynes and Lopes 2000; Norredam et al. 2005), an important number of perpetrators in our study were either persons in authority – including those assigned to their protection – or were unknown to the victim. Our study also confirms the finding that impoverished women and girls and those living in remote areas and shelters may be especially vulnerable (Wenzel et al. 2004). Finally, it is interesting to note that the men and young boys in our study appear to be more prone to sexual and other kinds of violence than is globally expected in men. (Holmes and Slap 1998; Tavara 2006).

Together, the data highlight the vulnerability of refugees, asylum seekers and undocumented migrants to SGBV in Belgium and the Netherlands. Because research has demonstrated that people with a heightened risk perception and those who have been personally victimised and/or witnessed SGBV during childhood are prone to subsequent victimisation or the perpetration of SGBV themselves (Borowsky, Hogan, and Ireland 1997; Brown et al. 2005), there is an urgent need for intervention.

Prevention

With respect to prevention at the individual level, the great majority of our respondents were highly educated, which – according to the available literature – should in principle help to protect them against the onset of ill-health (Herd, Goesling, and House 2007). However, respondents also reported a decline in socio-economic position and low subjective social status, linked to their immigration status restricting them from working officially and from participating freely in civil society. Thus, even with a higher education degree and former professional experience, respondents were structurally hampered from investing in the host

society by turning their human capital potential into economic and social capital. Both low objective and subjective social status are considered important predictors of ill-health (Demakakos et al. 2008; Marmot 2001), and low income is associated with the progression of ill-health (Herd, Goesling, and House 2007). As a result, it is not unreasonable to assume that SGBV puts our research population at great risk of high morbidity.

At an interpersonal level, respondents identified social networks and social support, information exchange, awareness-raising and community resilience as important prevention factors. However, respondents reported (see Table 2 and socio-demographic profile) living alone, being members of truncated networks with restricted opportunities for societal participation and building social capital. Social networks provide social and emotional support, self-esteem, trust, identity, coping, shared purpose and perceptions of control, the absence of which is demonstrated to have negative impacts on health (Bracke, Christiaens, and Verhaeghe 2008; Cohen and Wills 1985; Norris et al. 2008).

People in truncated networks are at risk of not having a confidant nor receiving appropriate instrumental and social support (Cattell 2001; Weyers et al. 2008), an issue that is magnified in refugee context where the need to belong and the risk of social exclusion are key determinants of healthy sexual development as well as positive resettlement outcomes (McMichael and Gifford 2010). Beyond this, a high degree of social isolation and low quality of relationships with male confidants may lead to inappropriate sexual behaviour in men (Gutierrez-Lobos et al. 2001). Evidence also shows that social networks have a significant impact on exposure to health information, on shaping of health-related norms (Rose 2000; Scott and Hofmeyer 2007) and on health-risk perceptions and the adoption of health preventive behaviours (Kohler, Behrman, and Watkins 2007; Viswanath, Randolph, and Finnegan 2006). Lack of participation as a citizen, sense of community and attachment to a place can hamper community resilience to stressors, such as SGBV (Norris et al. 2008)

Organisational and societal factors, including unhealthy and unsafe housing, unemployment, poverty, restricted access to healthcare, higher education, participation in civil society and legal protection, all influence the ill-health (Deaton 2002; Robert and House 2000) that our research population faces on a daily basis. These factors connect closely with basic human rights (Beyrer et al. 2007; Gruskin, Mills, and Tarantola 2007), but the fulfilment of these rights is far from self-evident when the opportunity to enjoy them is linked to legal residence status. Refugees receive an official residence permit which, in Belgium and the Netherlands assures access to healthcare services and entitles refugees to realise most rights, notwithstanding the multiple barriers they might encounter when trying to do so. Asylum seekers, on the other hand, are in the insecure process of achieving this status or having it denied and undocumented migrants do not have a status, which implies that their access to healthcare is often left to the arbitrary decisions of individual healthcare and other service providers (Norredam, Mygind, and Krasnik 2005).

Conclusion and future research

Specific health-promotion and violence-prevention interventions are urgently needed to correct the unequal health conditions described in this paper. At an individual level, behavioural change, sensitisation to SGBV and its risk and protective factors and the enhancement of objective and subjective social status are of major importance. At the interpersonal level, it is paramount to empower our research population to build social networks that improve social capital and enhance the exchange of transferable knowledge skills through social learning, the creation of social support and community resilience. At the

organisational level, it is crucial that healthcare and other services are made accessible to everyone, regardless of residence status. At the societal level, structural changes in asylum policies to enable everyone to enjoy and fulfil their human rights are urgently required.

In all these measures, the participation of the target population is crucial. This accords with research findings suggesting that prevention of SGBV in migrants should be based on culturally competent interventions, empowerment, the enhancement of structural elements (Bhuyan and Senturia 2005) and the adoption of comprehensive prevention approaches in which community resilience is integrated (Krieger et al. 2002; Maciak et al. 1999; Mosavel et al. 2005).

Finally, further research is needed: firstly, to enquire into the protective role of education in this research population, given the impediment of residence status and, secondly, to determine whether (reverse) causation between socio-economic position and health applies and, if so, how much exposure to a setback in socio-economic position suffices to trigger ill-health. The long-term evaluation of Desirable Prevention measures and their impact on the health and well-being of this population compared to others would help to clarify the relationship between the different determinants.

Limitations

This study has several practical limitations. Respondents were sampled through criterion and chain sampling, following the networks of the CRs and CAB. Although we excluded (amongst others) cases that were not personal nor from a close peer, we respected the respondents' definition of a close peer. Furthermore, although all CRs were trained alike and the questionnaires were translated thoroughly, it cannot be guaranteed that their epistemological perspective while conducting and translating the interviews did not differ from those of the main researchers. These elements might introduce some biases in the data which we consider not to be generalised. However, we believe they are transferable to similar populations in comparable settings.

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Résumé

Bien que les femmes, les jeunes et les réfugiés soient vulnérables aux violences sexuelles et basées sur le genre (VSBG) à travers le monde, les connaissances sur les VSBG à l'encontre des réfugiés en Europe sont limitées. L'exploitation d'une recherche communautaire participative a permis de mener 233 entretiens en profondeur avec des réfugiés, des demandeurs d'asile et des immigrés sans papiers en Belgique et aux Pays-Bas. L'analyse du cadre a été la méthode employée pour analyser les réponses. La plupart des répondants avaient eux-mêmes été victimes de VSBG – ou connaissaient un proche dans une situation semblable à la leur qui en avait été victime – depuis leur arrivée dans l'Union européenne. 332 expériences de VSBG ont été rapportées, pour la plupart infligées aux répondants par leurs (ex-)partenaires ou par des professionnels de la demande d'asile. Plus de la moitié de ces expériences rapportées comprennent des actes de violence sexuelle, dont le viol et l'exploitation sexuelle. Les résultats suggèrent que les réfugiés, les demandeurs d'asile et les immigrés sans papiers en Belgique et aux Pays-Bas sont extrêmement vulnérables à la violence et,

spécifiquement, à la violence sexuelle. À l'avenir, les mesures préventives des VSBG devraient être composées d'interventions basées sur les droits humains, souhaitables et participatives qui se concentreraient sur plusieurs niveaux socio-écologiques, et cela en même temps.

Resumen

Aunque las mujeres, los jóvenes y los refugiados son vulnerables a la violencia sexual y de género en todo el mundo, existen pocos indicios sobre esta violencia contra refugiados en Europa. A través de un estudio de participación basado en la comunidad, se llevaron a cabo 223 entrevistas con refugiados, solicitantes de asilo e inmigrantes indocumentados en Bélgica y los Países Bajos. Las respuestas se analizaron mediante un análisis de marco. La mayoría de los entrevistados habían sido víctimas personalmente o conocían a alguien cercano que había sido víctima al llegar a la Unión Europea. Fueron informados 332 casos de violencia sexual y de género, la mayoría causados por (ex)compañeros o profesionales especializados en asilo. Más de la mitad de las experiencias violentas informadas eran casos de violencia sexual, incluyendo la violación y la explotación sexual. Los resultados indican que los refugiados, los solicitantes de asilo y los inmigrantes indocumentados en Bélgica y los Países Bajos son extremadamente vulnerables a la violencia, y en concreto, a la violencia sexual. Las futuras medidas de prevención contra la violencia sexual y de género deberían incluir programas participativos y deseables basados en los derechos, y que a la vez presten atención a los diferentes niveles socio-ecológicos.

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Sexual violence and sub-Saharan migrants in Morocco: a community-based participatory assessment using respondent driven sampling

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Abstract

Background: The European Union contracted Morocco to regulate migration from so-called "transit migrants" from Morocco to Europe via the European Neighbourhood Policy. Yet, international organisations signal that human, asylum and refugee rights are not upheld in Morocco and that many sub-Saharan migrants suffer from ill-health and violence. Hence, our study aimed at 1) investigating the nature of violence that sub-Saharan migrants experience around and in Morocco, 2) assessing which determinants they perceive as decisive and 3) formulating prevention recommendations.

Methods: Applying Community-Based Participatory Research, we trained twelve sub-Saharan migrants as Community Researchers to conduct in-depth interviews with peers, using Respondent Driven Sampling. We used Nvivo 8 to analyse the data. We interpreted results with Community Researchers and the Community Advisory Board and commonly formulated prevention recommendations.

Results: Among the 154 (60 F-94 M) sub-Saharan migrants interviewed, 90% reported cases of multiple victimizations, 45% of which was sexual, predominantly gang rape. Seventy-nine respondents were personally victimized, 41 were forced to witness how relatives or co-migrants were victimized and 18 others knew of peer victimisation. Severe long lasting ill-health consequences were reported while sub-Saharan victims are not granted access to the official health care system. Perpetrators were mostly Moroccan or Algerian officials and sub-Saharan gang leaders who function as unofficial yet rigorous migration professionals at migration 'hubs'. They seem to proceed in impunity. Respondents link risk factors mainly to their undocumented and unprotected status and suggest that migrant communities set-up awareness raising campaigns on risks while legal and policy changes enforcing human rights, legal protection and human treatment of migrants along with severe punishment of perpetrators are politically lobbied for.

Conclusion: Sub-Saharan migrants are at high risk of sexual victimization and subsequent ill-health in and around Morocco. Comprehensive cross-border and multi-level prevention actions are urgently called for. Given the European Neighbourhood Policy, we deem it paramount that the European Union politically cares for these migrants' lives and health, takes up its responsibility, drastically changes migration regulation into one that upholds human rights beyond survival and enforces all authorities involved to restore migrants' lives worthy to be lived again.

Keywords: Sexual violence, Rape, Prevention, Migrants, Morocco, Community Based Participatory Research (CBPR), Respondent Driven Sampling (RDS), European Neighbourhood Policy (ENP)

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Résumé

Contexte: Dans le cadre de sa politique de voisinage, l'Union Européenne tente, en partenariat avec le Maroc, de réguler la migration irrégulière de « transit ». Toutefois, les organisations humanitaires signalent que de nombreux migrants subsahariens souffrent de violence et d'une mauvaise santé. Notre étude vise à 1) étudier la nature des violences que les migrants subsahariens subissent au et dans le voisinage du Maroc, 2) en identifier les déterminants tels que perçus par les migrants, 3) formuler des recommandations de prévention.

Méthodes: En appliquant des méthodes de recherche participatives, nous avons formé douze migrants subsahariens en tant que chercheurs communautaires afin de conduire des entretiens approfondis, en utilisant la technique d'échantillonnage dirigé par les répondants. Nous avons analysés les données avec Nvivo8. Les résultats ont été interprétés avec le conseil communautaire du projet. Des recommandations de prévention ont été formulées.

Résultats: Parmi les 154 (60 F – 94H) migrants subsahariens interrogés, 90% ont signalé des cas de victimisation multiple, la moitié à caractère sexuel, principalement des viols collectifs. Au total, 89 répondants ont personnellement été victimes, 41 ont été forcés d'assister aux violences subies par leurs parents ou compagnons de voyage et 18 ont rapporté des situations vécues par des pairs. Les victimes subissent les séquelles de ces violences sur le long terme, alors qu'elles n'ont pas accès au système de santé marocain. Les auteurs des violences sont essentiellement des fonctionnaires, ou des chefs de gangs qui contrôlent les points de frontière. Ils semblent procéder en toute impunité. Les témoins lient les facteurs de risque notamment à leur situation irrégulière et à leur manque de protection.

Conclusion: Au Maroc, les migrants subsahariens sont à haut risque de victimisation sexuelle. Il est urgent de mettre en œuvre des actions transfrontalières de prévention à divers niveaux. Compte tenu de sa politique de voisinage, nous estimons que l'Union Européenne doit se soucier des menaces encourues par ces migrants. Elle doit prendre ses responsabilités et changer sa politique migratoire afin de respecter elle-même les droits fondamentaux et la dignité de ces groupes, ainsi que d'inciter l'ensemble des autorités concernées à faire de même.

Background

Migrants in Morocco

In 2008 as in 2005, Morocco estimated that around 60.000 foreigners were regularly residing on its territory, predominantly from European (47%) and Algerian (19%) origin [1,2]. In addition, official estimates of sub-Saharan irregular migration in Morocco varied between 10.000 in 2005 [1]; 15.000 in 2007 [2]; and 4.500 in 2010 [3] for a total population of nearly 32 million. The sub-Saharan migrants present in Morocco in 2008 originated of about 40 different countries with the most numerous being from Nigerian (15.7%), Malian (13.1%), Senegalese (12.9%) and Congolese (10.4%) origin [4]. The vast majority of them were male (79.7%) and relatively young (95.4% under the age of 36) [4], were employed in their countries of origin (76%) and more than half (56%) had completed secondary or higher education [5]. Estimates of their dispersion in Morocco in 2008, indicated that about 3000 sub-Saharan migrants were living in Rabat, 2000 in Casablanca, 600 in Oujda and Laayoune and 300 in Tangiers [4].

Migration to Morocco

Sub-Saharan migrants use different lengthy and predominantly over-land routes to get to Morocco [6]. On these routes, a stretched sub-Saharan migration network has arisen and a number of cities, such as Agadez (Niger), Nouadhibou (Mauritania) or Tamanrasset (Algeria), have become 'migration hubs' or 'turntables' for migrants [4,7], fragmenting their journeys [8]. A large majority eventually passes through Algeria and crosses the cities of Ghardaïa and Maghnia which face Oujda on the Algerian-Moroccan border [4]. Migrants with sufficient financial means pay to be smuggled along the migration networks [7]. The men are frequently asked to pay their fee fully upfront, while women only have to pay a small first instalment or are asked to pay later on [9]. Some, especially Nigerian women, know before departure they will pay through sex work with law enforcement agents or other key people along the route. Others are trapped into fierce sexual exploitation through debt bondage with the young ones, again frequently Nigerian, eventually destined to European sex industry [9-11]. The poorer sub-Saharan migrants who cannot afford a full-package smuggling, try to meander along the routes by the little means they have, fragmenting their journeys at the 'migration hubs' at longer interval [7,9]. Both groups make use of the technological developments in the Saharan and Sahel regions of cheap mobile phone and e-mail access, money transfer facilities [12] but also of the ambiguous social and economic relationships that are being formed with those who assist or accompany them during their journey [9]. Both at the 'hub' cities as at the Algerian-Moroccan borders there are migrants who organized themselves into 'migration professionals' assisting, managing, controlling and/or exploiting the migrants on the way. Especially at the Algerian-

Moroccan border, which was closed between 1994 and 2005 following diplomatic tensions [1], these men have a strong reputation of operating in gangs led by chairmen, robbing and attacking the migrants in impunity as official authority is lacking [9,11,12].

Migration policy

The legal framework around migration in Morocco is recent and is mostly determined by the law 02–03, which was passed in 2003 along with the creation of a dedicated department within the Home Affairs Ministry, and which entered into force in 2010. The provisions of this legal document have been widely debated by NGOs and human rights advocates. They emphasized that the law is poorly known by authorities and that it contains provisions criminalizing migrants. Although it theoretically provides a frame protecting some migrant groups, such as pregnant women or minors, and limiting refoulement to the borders, those provisions do not appear to be thoroughly implemented yet [13,14]. Moreover, the law 02–03 established significant fines for Moroccans helping undocumented migrants and providing them with transportation, a measure that has encouraged a number of transporters to systematically discriminate against Sub-Saharans to avoid being accused of smuggling migrants [13]. Finally, the provisions do not contain clear distinctions between the different migrant groups – refugees, asylum seekers and undocumented – and consequently fuel uncertainties and violations of rights in the field [1]. In addition, although Morocco has signed the Geneva Convention in 1956, UNHCR documents are not yet fully acknowledged by Moroccan security forces [15] and a 2010 assessment of UNHCR action in Morocco emphasized the limited progress the Moroccan state had made to protect refugees and asylum seekers [16].

The European neighbourhood policy

The relationship between Morocco and the European Union is administered though the European Neighbourhood Policy (ENP), which was launched in 2004 with the ambition of tightening relationships with the neighbouring countries in order to increase prosperity, security and stability [17]. The topic of migration has regularly sparked tensions between the two partners. In 2000, the EU initiated negotiations aiming at reaching an agreement on the readmission by third countries of their own nationals and all other persons having transited through their territories to reach Europe [5]. In 2005, the EU was also encouraging the implementation of 'transit centres' in third countries, where asylum candidates could pursue the procedure before entering the European territory, a project that was fiercely condemned by Morocco [5]. The ENP Strategy Paper drafted for the 2007–2013 period emphasized the principle concern of illegal migration for cooperation between Morocco and the EU [18]. Between 2007 and 2010, Morocco received a total of €654 million within the ENP framework [17], with at least €130 million in the first two years specifically dedicated to migration [19] through various instruments and notably development aid [13].

Morocco: a transit country to Europe?

Both EU and Moroccan migration policies are based on the rationale that Sub-Saharan migrants enter and cross Morocco in the hope of reaching Europe, over land to the Spanish enclaves of Ceuta and Melilla in Morocco, or by boat, hidden in vehicles, false visas or other means to the European main land. Consequently, Morocco, along with other countries, was labelled in the mid-1990s as a 'transit country' or the 'migration hub to Europe' [20]. However, research has shown that not all sub-Saharan migrants in North Africa are on their way to Europe [21]. In contrast, an increasing number of them settle in Morocco whether by primary choice or by default [22] as their journey is rarely planned from one fixed starting to another fixed end point and as failures along their journey might limit future options and drain resources [12,21]. A numerous group among them are thus rather 'stranded migrants' than 'transit migrants' enhancing their vulnerability and protection needs [12]. The concept of 'transit migration' is however used by both the EU, which hence justifies its predominant role in the definition of migration policy in its neighbourhood [23]; and by Morocco, for which it provides a leverage for negotiations with the EU and for reinforcing its military presence in Western Sahara [22]. As a result, border controls have become increasingly militarized [24], making migrants' living conditions more precarious without succeeding at reducing migration flows [13].

The role of the EU in the development of migration legislation and policy in Morocco is thus to be thoroughly questioned. Co-operation between the EU and third countries in the field of migration has become a major policy focus and "one of the strategic priorities in the external relations of the Union" [25] since the 1999 Tampere Council [23]. Research has consistently addressed this question and many critics have been raised towards this so-called externalization of EU migration policies [24]. The concept of externalization conveys the idea that the EU seeks to delegate its responsibilities in terms of border control to non Member States and uses international cooperation to restrict population movements [13]. Morocco has been widely used in the literature as a meaningful example of border control externalization. The relationship between the two partners has been rather unstable, with tensions in the early 2000s over the negotiation of a readmission agreement [23]. The diversity of agendas within the EU, the attempts of Morocco to divert attention from

undocumented Moroccan migrants [24], and a distorted understanding of Sub-Saharan migration patterns are listed among the main explanatory factors. The fact that sub-Saharan migrants travel mostly over land within Africa has largely been attributed to the tightening of European borders and the externalization of migration policies [6,12].

Sexual violence

Sexual violence refers to "use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed, an attempted or completed sex act involving a person who is unable to understand the nature or the condition of the act, to decline participation or to communicate unwillingness to engage in the sexual act (e.g. because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure)" [26]; it is "made by any person regardless of their relationship to the victim, in any setting." [27]. Based on the level of physical contact we can distinct 4 forms of sexual violence: sexual harassment (no physical contact); sexual abuse (physical contact-no penetration); attempted and completed rape or forced sodomy (physical contact with penetration in body opening) [28]. Within (forced) migration, sexual exploitation, forced prostitution and sexual violence as a weapon of war or torture are considered as extra types of sexual violence" [29]. Refugees, asylum seekers and undocumented migrants are considered to be at high risk of sexual victimization worldwide [30]. Research on sexual violence in these types of migrants in other countries demonstrated the frequent co-occurrence of sexual violence with physical, emotional and socio-economic forms of violence [31,32], which is commonly referred to as gender-based violence in refugee, conflict and humanitarian settings [29,33,34]. Sexual and gender-based violence in migrants can have severe and long-lasting negative repercussions on the victims' sexual, reproductive, physical and mental health and well-being as well as participation in society [29,31-37].

For Morocco, a national hotline report of 2009 showed that 12, 3% of the reported cases regarded women being raped by non-partners and 1.4% by partners. Sexual harassment accounted for 8.2% and incest for 9,6% of the reported cases to these hotlines [38]. A national report of the same year gave lifetime sexual victimization rates for Moroccan women of 22,6% and an annual rate of 8.7% [39]. This annual rate of 8.9% of violence cases that were reported to authorities in the last 12 months being sexual violence, has been found consistent since 2008 [40]. Migrants are not included in national surveys, yet NGO's emphasize in their reports that migrant women are sexually exploited and brutally raped both during migration, at the borders as well as in Morocco, which often results in severe health threats [3,4,41]. Furthermore, they registered cases where migrants were denied the lodging of a complaint and/or were brought back to the border [13].

Research objective

Given their global vulnerability to sexual violence [29-37], the fact that Morocco is contracted by the EU to regulate irregular migration from Morocco to Europe [17,18] and that international organisations signal that asylum and refugee rights are not upheld in Morocco [15], we assume that undocumented migrants might be at risk of serious ill-health and violence in Morocco and at its borders. Hence, our study aimed firstly at getting an idea of the nature and magnitude of violence that sub-Saharan migrants experience in Morocco and on their way to it; secondly, to assess which determinants the migrants perceive as decisive in victimization and prevention; and thirdly, which recommendations can be formulated for comprehensive prevention.

Methods

Community based participatory research

Our epistemology stems from an interpretive, feminist, communitarian and dialogical research perspective [42,43]. As this epistemology favours participatory research, we adopted the qualitative and collaborative research approach of Community-Based Participatory Research (CBPR) right from the initial idea to write a project proposal on this topic onwards. CBPR in public health focuses on social, structural, physical and environmental inequalities and aims to improve the health and well-being of community members by a) setting up structures for participation of the target communities, civil society, NGO's, global institutions and organisations, policy makers and researchers concerned by the research topic, and this in all phases of the project, and by b) integrating knowledge in action, including social and policy change [44,45]. In a first phase in 2008, a participatory partnership was created, comprising of a Scientific Advisory Board (SAB) and a Community Advisory Board (CAB). The purpose of this participatory partnership was to meet at regular interval, to decide mutually on processes and procedures, and to interpret results of steps taken before proceeding to a next phase. The SAB comprised of the Belgian and Moroccan coordinators, Belgian and Moroccan academic experts on migration, violence and sexual health; students mentored by the coordinators and experts on these matters and eventually the community researchers. The CAB consisted of key people in sub-Saharan communities present in Morocco, representatives of migrant associations, civil society, Moroccan and international organisations assisting migrants in Morocco, Moroccan organisations working on human rights, sexual health promotion and violence

prevention and policy makers. Along the project, more and more organisations joined the CAB. In order to facilitate knowledge sharing and joined decision-making, several communication strategies were simultaneously adopted. This ranged from regular phone calls, mails, SAB and CAB meetings to detailed newsletters being issued every six months and public participatory seminar at the end of the project in Morocco. After having created this participatory partnership, the conceptual framework and study design was jointly decided upon. The conceptual framework combined the socio-ecological framework [46] on (sexual) health and violence [31], with the concept of Desirable Prevention. Desirable Prevention seeks to improve the health and well-being of all through the concurrent application of five dimensions, being: integrality; participation; inclusiveness; addressing root causes and maximizing agency [47]. The study design intended to integrate the conceptual framework with a thorough application of the CBPR approach resulting in a process of four main phases:

1. Set-up phase with the development of the participatory partnership, the conceptual framework, the study design and the recruitment and training of Community Researchers (CRs).
2. Fieldwork phase with sampling of sub-Saharan migrants in Morocco in the most relevant areas in Morocco where those migrants are residing through Respondent Driven Sampling and consequently the conduct of in-depth interviews on sexual health, sexual violence and perceived determinants with those migrants by the CRs.
3. Analysis phase in which the interviews were transcribed ad verbatim before being analysed with Nvivo 8 and interpreted, nuanced and validated at a public seminar at the University of Mohammed V in Rabat in presence of SAB, CRs and CAB. Policy, practice and research recommendations were also formulated at this point.
4. Dissemination of results and promotion of the policy, practice and research recommendations.

Set-up phase

The participatory partnership identified the cities of Oujda, Rabat, Casablanca and Tangiers as main locations where sub-Saharan migrants were residing. Subsequently, CRs needed to be recruited here as well as the in-depth interviews conducted. Inclusion criteria for eventual respondents and CRs were the same, namely being a female or male sub-Saharan migrant between 15–49 years old and living in irregular situation (refugee, asylum seeker or undocumented) in Morocco. Consequently, potential CRs were sought for through the networks of the CAB and were asked upon identification whether they could indicate other potential CRs. In spring 2008, 25 sub-Saharan migrants meeting the inclusion criteria were invited to an interview with SAB members and screened on necessary communication skills, potential research skills, empathic attitude, social engagement and leadership capacities. Eight women and four men descending from DRC, Cameroun, Angola, Central Africa, Nigeria and Ivory Coast were withheld. Four of them lived in Oujda, 3 in Rabat, 3 in Tangiers and 2 in Casablanca. They completed a 30 hours training to become CRs. This training addressed migration, human rights, sexual and reproductive health, several types of violence, gender, psychosocial education, intercultural communication, the study conceptual framework and epistemology and finally guidelines and exercises on conducting in-depth interviews in an empathic and ethically sound way. Different SAB and key CAB members gave these courses. All CRs received a certificate of attendance issued by the Belgian and Moroccan Universities and research associations involved. The preliminary interview guide, consisting of guidelines to address respondents, to obtain informed consent, to initiate the interview, to build the interview, to come to the key questions, to probe for more in-depth answers and to close the interview; was thoroughly discussed, exercised and adapted through consensus building with the CRs after which they were piloted before finalisation. We did this aiming to enhance the beneficial outcomes of the participatory research approach; secondly to maximise the match between 'inner speech' and the language used [48]; and, thirdly to optimise validity and reliability [49]. The interview guide was developed in French and English as these were the languages that most sub-Saharan migrants in Morocco master. We first questioned for respondents' socio-demographic profile and their definition and perception of sexual health. Subsequently, we explored whether the respondents and/or close peers to them had experienced victimisation since having initiated their migration towards Europe and if they had, we probed for a detailed description of the victimisation acts, the context in which it happened and the consequences. Subsequently, we assessed their perception of risk and prevention factors and suggestions for action. This paper solely reflects on the latter two issues taking their socio-demographic profile into account. In parallel to this study, a Knowledge, Attitude and Practice survey on the role of the health care sector in prevention of sexual violence in sub-Saharan migrants was conducted among Moroccan health care workers, which is published elsewhere [50].

Fieldwork phase

It was set forward to conduct 50 interviews in both Oujda and Rabat and 30 in Casablanca and in Tangiers. Yet, when starting up the fieldwork phase in summer 2008, riots broke out in Oujda urging a lot of migrants to flee. As the security of our CRs could not be

guaranteed and it appeared that most of the migrants had fled to Fes, it was decided to replace Oujda by Fes as research site. CRs were asked to conduct 12 to 15 interviews in their respective cities or surroundings with respondents meeting the above-mentioned inclusion criteria following the Respondent Driven Sampling rules. As Respondent Driven Sampling is specifically designed to research hidden networks of at risk populations in precarious situations [51-55] it served as a perfect sampling strategy for the aim of our research. How the waves would be constructed and what kind of primary and secondary incentives would be given to respondents and how the community researchers would be remunerated, was suggested by the participatory partnership and finally jointly decided upon with the CRs during the CR training. In a first wave, the twelve CRs served as primary seeds and searched for 5 peer migrants. Once identified, respondents were informed about the project objectives, the interview goals, the potential risks and measures taken to protect them from those risks. The respondents signed an informed consent before the interview and could withdraw at any point during the interview. The interviews were recorded while CRs simultaneously took notes on their interview guides. Upon completion of the interview, the respondents were given 100 MAD (about 9 €) as primary incentive for their participation as well as a coupon and a package with information on referral organisations providing different kinds of assistance to migrants, sexual and reproductive health issues and condoms. They were asked to identify a potential other respondent among their peers meeting the inclusion criteria and bring the CR into contact with this person. If they managed to recruit an additional respondent, the initial respondent could exchange his/her coupon for their secondary incentive of 25 MAD with the CR. These secondary wave respondents were then interviewed, received their primary remuneration and where then asked to do the same until every CR had conducted 12 to 15 in-depth interviews. Respondents could participate only once. In the four study sites 3 to 4 waves per CR were conducted. The CRs were coached by the Belgian and Moroccan coordinators who in turn passed along the four research sites and intensively supervised the CRs. In the first coaching session by the Belgian coordinator problems regarding sampling and mastering of the interview guide were discussed and addressed, and group debriefings as well as personal counselling was done addressing emotions arisen by the content of the interviews. In the second round the Moroccan coordinator addressed technical and administrative problems. In both rounds, the CRs handed over the interview guides they had completed together with the recordings and received their remuneration as agreed upon during the training, namely 200 MAD as remuneration for the interview and 50 MAD for phone and transport costs per conducted interview. Two Nigerian CRs dropped out during the last weeks of the interview period because of security threats they had received.

Analysis and dissemination phase

Eventually, 154 valid interviews were conducted in French or English. Interviews were considered valid when we had the completed interview guide, the notes taken by the CR, the signed informed consent and the recording of interview. They were checked for potential doubles as they were to be deleted but none occurred. All interviews were transcribed ad verbatim in the language they were conducted in both Morocco and Belgium after which they were entered into Nvivo 8. A first round of grounded coding was done by both the Belgian and Moroccan coordinator for consensus on main categories and procedures. Subsequently, the Belgian team continued the complete coding of all interviews and drafted a report with preliminary results that was presented at a public seminar at the University Mohamed V in Rabat in May 2009 in presence of the CRs, the SAB and enlarged CAB. The preliminary results were discussed, interpreted and validated through different thematic working groups in which policy, practice and research recommendations were formulated and dissemination and continuation strategies were decided upon. For a thorough description of this seminar and its outcome we like to refer to the report of the project [56] as well to our publication on the role of the Moroccan health care sector in prevention of sexual violence [50].

Further scientific analysis of the interviews and dissemination in peer-reviewed journals was assigned to the SAB. All quotes stem from the ad verbatim transcriptions of the in-depth interviews, yet the names are pseudonyms. Quotes that were originally in French were literally translated to English by the authors. The study protocol applied the WHO [57] & UNHCR [29] ethical and safety guidelines in researching violence. In line with the CBPR methodology, safety issues and project procedures where strongly debated and commonly decided upon by the CRs and the CAB, resulting in an ethical approval from the research community itself. Furthermore, ethical approval was granted by the Ethical Committee of the Ghent University Hospital. Finally, as is accustomed in Morocco, we informed the Ministry of Interior of our study protocol and of the approval of the partnership and subsequently negotiated ethical approval with each of the respondents through informed consent.

Results

Socio-demographic profile

In the summer of 2008, 154 valid interviews were conducted by community researchers in the cities of Rabat (46), Casablanca (30), Tangiers (31) and Fes (47). Table 1

Table 1 Socio-demographic profile of respondents

Total	154	100%
Gender		
Female	60	38.96%
Male	94	61.04%
Age (years)		
< 18	11	7.14%
19 - 29	89	57.79%
> 30	53	34.42%
Unspecified	1	0.65%
Country of origin		
Democratic Rep. of Congo (DRC)	51	33.17%
Cameroun	25	16.23%
Congo Brazzaville	16	10.39%
Ivory Coast	15	9.74%
Mali	12	7.79%
Other sub-Saharan countries (14)	35	22.73%
Residence status in Morocco		
Asylum seeker	22	14.29%
UNHCR refugee	19	12.34%
Undocumented	107	69.48%
Other	6	3.90%
Children in care		
0	98	63.64%
1	26	16.88%
2	19	12.34%
3 to 5	10	6.49%
> 5	1	0.65%
Religion		
Christian	114	74.03%
Muslim	32	20.78%
Other	8	5.19%
Attained education		
Higher education	58	37.66%
Secondary education	67	43.51%
Primary school	20	12.99%
Did not attend school	5	3.25%
Other	4	2.60%
Daily activities		
Country of origin		
Paid employment	67	43.51%
Seeking employment	10	6.49%
Student	63	40.91%
No paid activity	14	9.09%
Morocco		
Paid employment	11	7.14%
Seeking employment	47	30.52%
Student	3	1.95%
No paid activity	92	59.74%
Unassigned	1	0.65%
Arrival in Morocco		
< 2 years	21	13.64%
2 - 5 years	102	66.23%
5 - 10 years	28	18.18%
> 10 years	3	1.95%

sums up the most relevant socio-demographic characteristics of the respondents.

The majority were young, well-educated migrants who predominantly originated from the Democratic Republic of Congo, Cameroun, Congo Brazzaville, Ivory Coast and Mali. Most of them were living in Morocco for between two and ten years, but could not tap their skills and capacities due to their undocumented and unemployed status. A vast majority of respondents had completed secondary or higher education (81.16%). In addition, more than half of the respondents spoke at least one other language than their mother tongue (57.14%). Although few respondents were able to read and write Arabic, nearly half of them spoke some Moroccan Arabic (43.27%). Yet, more than 80% indicated to speak, read and write French, the second official language of Morocco. Furthermore, a large discrepancy is found between their occupational activities in their countries of origin and in Morocco. An overwhelming 90.25% declared having no paid activity or seeking employment. Also their housing conditions revealed to be poor: the majority (64.29%) lived in a single room they had to share with more than three other migrants. Half of the women lived with children, while men rather shared space with other adults. A third of the respondents had only access to toilets and could not take showers inside their accommodation.

Experiencing violence

Among the 154 sub-Saharan migrants interviewed, 138 (89.61%) reported cases of sub-Saharan migrants being victimized by persons unknown to them either during their migration or in Morocco itself, while 16 did not report any violence experiences. Of those 138 respondents, 120 had been personally involved: 79 were physically and/or sexually victimized in person, while 41 were forced to witness how their partners, children, family members, friends or co-migrants were physically or sexually victimized in their presence. Eighteen other respondents only knew of sub-Saharan peers within their close relationship as relatives or friends who were victimized.

The 138 respondents described 230 independent cases of violence. The majority of those cases (132) took place in Morocco or at its borders. The most frequently mentioned cities were Oujda (74), Rabat (22) and Casablanca (12) while others indicated "in Morocco" (24). Outside Morocco, it were Maghnia or the Algerian-Moroccan border (24) - which refers to the route they take that necessitates a future passage through Oujda -, Algeria (17), Tamanrasset (8) and the desert between Mali and Algeria (8). In 26 other interviews, respondents described violence during their migration journey without indicating a specific place.

Analysing the 230 cases to the types of violence that occurred, we noted 548 single acts of violence which we classified in Table 2 according to types of sexual and gender-based violence as used in refugee and conflict settings [31]. This consisted of emotional (18%), physical (22%), sexual (45%) and socio-economic (14%) violence, indicating that most victims had to endure multiple forms of violence that were afflicted upon them in a combined way.

Table 2 Nature and scope of reported violence

Types of violence (*)	Total acts (n = 548)	100%
Emotional/psychological violence	**101**	**18.43%**
Confinement	36	6.57%
Threats	35	6.39%
• *of which with weapons*	*23*	*4.20%*
Verbal abuse	10	1.82%
Humiliation	2	0.36%
Combination	18	3.28%
Physical violence	**122**	**22.26%**
Singular non-life threatening	12	2.19%
Multiple non-life threatening	89	16.24%
Singular life threatening	1	0.18%
Multiple life threatening	6	1.09%
Killing	2	0.36%
Combination	12	2.19%
Sexual violence	**246**	**44.89%**
Rape	141	25.73%
• *of which gang and/or multiple rape*	*111*	*20.26%*
Sexual abuse	46	8.39%
Sexual harassment	33	6.02%
Sexual exploitation	24	4.38%
Sexual torture	2	0.36%
Socio-economic violence	**79**	**14.42%**
Stealing	73	13.32%
Refusal of first aid services	2	0.36%
Combination	4	0.73%
TOTAL	**548**	**100.00%**

(*)Classified according to the main types of sexual and gender-based violence as defined by UNHCR (2003).

Physical, emotional and socio-economic violence

The reported emotional violence regarded primarily confinement, threats – of which 23 with weapons - and racist verbal abuse.

> *"It happens sometimes when I go to the grocery store, there are Moroccans who insult you, call you 'filthy nigger', 'slave', they throw stones at you or if you are unlucky, they spit on you. And this everyday. You need a strong heart to walk the streets here in Morocco" Maryam, 25, female from Mali.*

While socio-economic violence consisted in nearly all reported cases of stealing of money, resources and mobile phones and to a lesser extent of being denied access to basic services such as food or healthcare.

> *"Money, clothes, jewels, everything you have: they take it all and then they throw you towards the desert over there." Vénédict, 30, male from Cameroun*

As for physical violence, respondents reported primarily non-life threatening episodes of multiple physical violence, consisting mostly of severe beating and slapping.

> *"It happened here in Morocco during the refoulement, a young girl and a young boy got their legs broken by the Moroccan military. They refused to enter the truck used for the refoulement, and the soldiers hit them." Célestine, 38, female from Rwanda*

Yet, in a few cases the physical violence was life-threatening engendering a fatal outcome.

> *"He arrived at the Medina [in Casablanca] and a group of Moroccans came out of the Medina to attack my brother in law. They attacked him and hit him until he was half dead. Eventually, he was taken to the hospital where they tried to reanimate him to make him regain his health, but it was too late, he already died." Elisa, 29, female from DRC*

Sexual violence

Sexual violence was the most common form of violence with 246 sexual violence acts or 45% of all reported violence occurring in 184 of the 230 cases. The types range from sexual harassment (no physical contact) over sexual abuse (physical contact but no penetration) to rape and sexual torture (with penetration).

Sexual harassment episodes consisted mostly of cases in which the victims were publicly forced to undress or threatened with rape.

"They asked the women to undress in front of the men, just for their pleasure, and to dance. They were completely naked, in front of everybody. Without shame, just like that. It was horrible" Fabrice, 30, male, Ivory Coast

Sexual abuse consisted primarily of unwanted sexual touching and clothes being torn to reveal body parts, again mostly in group. Searches were sometimes used as pretexts for unwanted touching or penetration of private parts.

"There were cases of touching when we had controls and they were searching for money. They were putting, circulating their hands everywhere randomly." Bene, 29, male from DRC

"There was already one touching my breasts. They said if my husband would not give them money, they would do whatever they liked with me" Vanessa, 21, female from Central Africa

"(…) they [a Nigerian gang at Oujda] beat us up and they were body-searching the girls, taking their clothes off and inserted fingers in their vaginas. The men who refused anal search, they were beaten to death." Sylvestre, 28, male from Chad

Rape was the most common form of sexual violence (142/248). It predominantly consisted of gang rape (81/142), with at least two to more than ten perpetrators raping at least one victim at the same time; or of multiple rapes (30/142), where one or more perpetrators raped the victim(s) successively for a longer period of time. In 77 rape cases there was one single victim while in 65 other cases the respondents emphasized that victims were raped in group as well. The impossibility to resist or escape was stressed by both the victim(s) and co-migrants who were forced to watch.

"They brought us to an olive tree field, so they could do whatever they wanted with us. They raped us. They were seven. We were six girls, so you can imagine, it was not easy, and it's life." Beyoncé, 23, female from Cameroun

"He called three men who grabbed my head, they were holding me by the hair and they had sex everywhere, vagina, anus, breasts, and they put sperm all over me." Agnès, 28, female from Rwanda

"It was the two girls that they took, and all six persons raped them, the two girls. (…) They put us on our knees with our hands on our head, but the mother of the two girls was put on her knees and with her forehead to the ground. (…) They hit the mother because she was crying for her children when she heard her children, she had, always, always, always, always you will shout, you will shout, always. When you hear how your child is weeping, you always, always, always shout. And that hurts, hurts badly." Diane, 42, female from Burkina Faso

Sexual exploitation included forced prostitution and forced transactional sex in return for promised food, shelter, security or pass-through.

"He brought me to this man who gave me water, food, and a shower. Then he told me that this man helped many migrants, but that I would need to work like the others. I asked what I would do: he told me to be a prostitute and he would take the money." Agnès, 28, female from Rwanda

"The two men took the youngster to their 'tranquilo' promising that they would help him find back the members of his community, help him to get to Rabat (…) The second night they tied him up and started to beat him everywhere until one Nigerian made him understand that as he did not have money he had to satisfy their sexual needs. The young guy refused, but with torture, he could not do anything as he was tied up." Denzel, 19, male from Cameroun

Identity of the victims and the perpetrators

Forty-five respondents (29.22%) reported to be sexually victimized themselves, 54 (35.06%) were forced to watch while their relatives, friends or co-migrants were sexually victimized in their presence and in 85 other sexual violence cases it were their peers, such as family, friends or acquaintances; who had been victimized independently of the respondent's presence.

Given that so many sexual victimizations occurred in group, it is impossible to give exact numbers of gender proportion. However, the respondents clearly indicated in 202/248 of the sexual violence incidents (81.45%) that at least one girl/woman was victimized and in 93 incidents (37.50%) that at least one boy/man was victimized. For rape specifically, it regards female victimization in 121/142 rape incidents (85.21%) and male victimization in a 53 of the 142 reported rape incidents (37.21%).

"It's like that they forced him to suck their penis in turn. While he was sucking, the other one penetrated him anally. Despite the shouting of the young guy, the men would not listen nor come to reason. One of the Nigerians used Vaseline and could rape the young guy penetrating him anally." Denzel, 19, male from Cameroun

In a majority of cases, the victim's age were not specified, although the respondents used "young", "boy", "girl" or "child" to describe non-adults in a third of the cases.

"They were six, they say black Moroccans, I cannot tell. One took out his sex, and he put the child in front here and them at the back [In front and at the back?] Yes, in the mouth. And when you see his big sex there it's like the bottoms of a baby. The blood pours down the child and they don't even have pity for that blood there, the other comes, and does it without a condom" Diane, 42, female from Burkina Faso

The origin of the perpetrators was mainly described as Moroccan (31.30%), Nigerian (26.09%), other sub-Saharan nationalities (14.78%), Algerian (10.46%) and "Arab" (5.21%). It is to be noted that when more description was given of the perpetrators, they can be identified as persons in authority the migrants were confronted with during their journey, as for example: soldiers (10.44%), police men (9.13%), guides (7.39%) and chairmen (4.4%). The military and police perpetrators were Moroccan or, when occurring at the border region, also Algerian.

"Because she had gone to enter Ceuta, and when they body-searched her, they raped her, it were 5 policemen, 5 Moroccan policemen." Christian, 37, male from DRC

"Yes I remember the day that the Moroccan soldiers raped, we were victims of rape." Sandrine, 22, female from Ivory Coast

"And then when we entered Tamanrasset the Algerian soldiers forced the mother to give her 2 girls (…) they raped them, and when they were ready they raped her son too, at his back" Fatoumata, 27, female from Mali

The chairmen/leaders and guides were sub-Saharan, predominantly Nigerian.

"It was at the time of the refoulement to Oujda, when they [Moroccan soldiers] set us free, we were looking for a way to come back to the city. On the way back we met a Nigerian chairman called Al Pacino and his gang. They stole from us again and they threatened to kill us, they beat us up and they were searching the girls, taking their clothes off (…)" Sylvestre, 28, male from Chad

"When we met the Nigerians in Oujda, they aggressed us. Just like that, for their pleasure" Fabrice, 30, male from Ivory Coast.

When it regarded chairmen/leaders, they frequently acted together with other disciples of his group having some authority, resulting invariably in gang rape. The perpetrators were then described as "gangs and their leader/chairman" (23.04%).

"Once we were resting at night, an armed group took us by surprise and they chose two women; their leader decided that only those two would be taken and then all the men - more than ten! - raped them" Elikia, 44, female from Congo Brazzaville

"At the border of Algeria with Morocco we saw Nigerians who were coming up to us saying we had to give them money. As we did not have any money the Moroccans said we will separate the girls. (…) What I have lived through with the girls who were with me, it is not possible. They abused us, thus they maltreated us, thus I don't know how I could say it (…) and thus they really hurt us. They slapped us. And raped. (…) They were many, but I found myself with four on top of me." Sarah, 24, female from DRC

Yet, also Moroccan citizens are identified as perpetrators of sexual violence.

"When we arrived in Fes, there were 2 Moroccans who passed by. We were 2 girls and 1 boy, they chased us. They just took the boy, and, thus the boy was raped in front of our eyes. They let us go after that saying that we were not allowed to tell otherwise they would kill us, they had knives." Deiondre, 23, Female from Cameroun.

"It was in the Takadoum neighbourhood of Rabat (…) and when he was profoundly asleep of the drugs his roommate had put in his food, his roommate went to the Moroccans to say: ok, mission accomplished. The Moroccans lived in the same building and (…) they physically and sexually abused him (…) every time he woke up lying naked on his bed and he felt a liquid coming out of his anus" Deshawn, 31, male from Cameroun

"She took a taxi at Rabat Agdal station, (…) the [Moroccan] driver and his friend took her to the beach and on the big stones they took her by her wrists and enforced them brutally on her, they raped her, (…) first the one, then his friend took also advantage, he did the same" Malika, 25, female from Niger

In some cases it also concerned other irregular migrants in distress, and once again the Nigerian origin was frequently stressed.

"The young guy was deported back to the border by the police. He went to Oujda and found himself there, alone without money (…) two Nigerians in need made a sexual object of this young guy" Kwambe, 28, male from Cameroun

Consequences of sexual violence

In 124 interviews, respondents reported a wide range of consequences following sexual violence episodes. They most often comprise of a combination of emotional and physical consequences, which are in some cases accompanied by sexual, reproductive and/or socio-economic effects. Some of them stem directly from the sexual victimization while others are induced by those direct results and emerge later on. Again, the powerlessness of both the victim(s) and co-migrants who were forced to watch was emphasized as remaining very disturbing and hard to cope with at the long run.

Emotional/psychological consequences

The sexual victimization triggered a wide range of affective consequences most commonly described as "shame", "restlessness", "not able to speak", "fear" and "emotional breakdown" which regularly resulted in further impairment of their relationships with their partners, families and communities.

"she was so ashamed that everyone knew she had been raped, that she locked herself up in her room all day long." Binéka, 22, female from Congo Brazzaville

"*You can see she is not at peace, it looks like she hurts, and it's hard for her to talk about it and when she does she always cries. What she regrets is that they were many but she does not remember how many. She says that she could feel nothing but pain for one month, and that it's still in her mind*." *Amandine, 17, female from DRC*

Physical consequences

Reported physical consequences of violence were predominantly temporary. Those included wounds, loss of consciousness or blood, belly pains, difficulty to walk or sicknesses. However, in 10 cases the consequences were permanent, as on-going pain and injuries such as vaginal and anal tearing, physical impairment or even fatal consequences in 6 cases.

"The day after [the 2 women were raped], our men transported them but they could not talk, then we had to leave them behind because the men could not carry them anymore. Given where they were, they certainly died. It hurts, because we walked together." Elikia, 44, female from Congo Brazzaville

"See my hand? I miss two fingers." Wamba, 34, male from DRC

Sexual and reproductive consequences

In 51 cases, precisions were brought as to sexual and reproductive consequences of violence. Reproductive consequences included unwanted pregnancies following rapes. Abdominal pains, STIs and HIV/AIDS infections were mentioned as sexual consequences of the victimization.

"Some of them became pregnant, others had STIs, we all know these cases" Adjoussou, 40, male from Ivory Coast

Socio-economic consequences

Socio-economic consequences were cited in 22 cases. They covered mainly testimonies of social exclusion and a lack of support structures for victims in Morocco. Some victims decided to go back to their country of origin if they could or simply wished to leave Morocco because of their experiences during migration.

"My child is one year and four months now, I became a mother too young. My parents do not trust me anymore, and the Congolese community thinks I'm a whore, an easy girl. I would like to leave Morocco to forget everything that happened here." Grace, 17, female from DRC

Perceived risk and prevention factors

Risk factors

Respondents were subsequently asked which factors they perceived as potentially putting a person at risk for sexual violence, and to determine which ones they would identify as the three most important ones. All but two respondents answered those questions.

Respondents cited risk factors primarily at the societal and public policy level, stating that these affect all other socio-ecological levels. The legal status of migrants was considered a major risk factor and it is the preferred answer for both women and men and the predominant answer for young people aged fewer than 30. Answers given in that category particularly pointed at the situation of undocumented migrants.

"And when they arrest you, they will start to, euh, maltreat you, shout at you, do whatever they want with you, just because you don't have papers. (…) We don't have any papers. The papers that UNHCR gave us maybe? The authorities here don't value those UNHCR papers, they don't consider them." Vénédict, 30, male from Cameroun

Furthermore, they indicated the dangerousness of the physical environment in which migrants live, highlighting

the absence of laws and protection in specific places and notably around borders. The refoulement -the fact of being arrested and deported to Oujda or across the border- was cited by many as increasing risk of victimization.

> *"It's because of the surroundings. The fact that we came, the route we took, it's the surroundings, the place, the place where there are gangs, so in these places, you cannot flee. You can't flee from there." Fabrice, 30, male from Ivory Coast*

A low socio-economic position was also identified as risk factor. They defined this as financial hardship (113 occurrences), the lack of employment, bad accommodation and poor opportunities within the Moroccan society. In addition, poverty in both the country of origin as well as in Morocco was stressed as risk factor; the former for forcing people to migrate in dangerous conditions and the latter to maintain them in a vulnerable state.

Respondents also identified risk factors at an individual level on both the victims' and the perpetrators' sides, yet to a much lesser extent. A number of respondents stated that the behaviour of some migrants could put them at risk for sexual violence. Answers given in this direction particularly targeted clothing, looks and attitudes of victims. Risk factors for committing sexual violence included considerations on the lack of sexual activity and the will to hurt others.

Prevention factors

All but eight respondents (4 M and 4 F) indicated means by which they think sexual violence against sub-Saharan migrants in Morocco and its borders could be prevented. Questions in this heading asked them to give their views on prevention factors both within sub-Saharan communities and the Moroccan society.

A fourth of the identified prevention factors addressed the individual and interpersonal level. Respondents insisted on the need to avoid a number of situations considered as risky, such as engaging in contacts with strangers or going through dangerous places. Being documented and employed was also perceived as preventive, as was the presence of a strong social network. Finally, answers indicated that awareness and knowledge on risk and prevention could prevent further sexual violence to happen.

Most respondents identified potential prevention actions at the organizational and community level (551/1047 suggestions). Again here, they mainly focused on knowledge transfer and suggested a wide range of channels as schools, associations, religious structures, health services and media for spreading sensitization campaigns on sexual violence. Raising awareness was also perceived as creating a sort of safety net protecting migrants from (re)victimisation. Finally, they believe the migrant communities should be empowered and organised on the matter which could enable them to subsequently lobby Moroccan authorities.

> *"If each of our communities could get organized and have a leader; those leaders could then lobby the Moroccan authorities to put an end to the assaults and rapes, even if the Moroccan authorities did not ask for us to come here. The communities could create networks to sensitize people in different neighbourhoods." Koffi, 35, male from Congo Brazzaville*

Prevention factors at macro level (246/1047 suggestions) targeted a wide range of policy changes. They firstly suggested that the Moroccan borders should be better secured and facilitate migration. Secondly, respondents emphasized that the Moroccan government should consider granting documents to more migrants in order to stabilize their status within the country and to avoid situations of refoulement. Thirdly, they requested to apply laws that punish perpetrators of sexual violence as they believed this could refrain potential perpetrators from acting out. Making use of human rights to advocate for such policies was suggested by some.

> *"[Perpetrators] must be condemned and very severely. Today there is impunity" Mamadou, 26, male from Ivory Coast*

> *"What could contribute most [to prevention] is public action" Miezi, Female, 24, Congo Brazzaville*

Although the respondents suggested so many actions to take, 16% of them stated that preventing sexual violence would encounter significant obstacles. They highlighted the difficulty for migrants to identify moments at which they could be at risk for sexual violence and insisted that information presents the only realistic way of preventing sexual violence.

Discussion

Nature and scope of violence

Our respondents stressed that violence in general and sexual violence in particular has just become an unavoidable part of the journey. Our findings support this perception as they demonstrate that multiple physical, psychological, sexual and socio-economic victimizations of sub-Saharan migrants in Morocco and at its borders are a common phenomenon and that almost half of this victimization is of sexual nature. This confirms previous tentative findings regarding migrants' sexual victimization

in Morocco [1,3,41] and might be reinforced by the fact that many migrants had already been sexually victimized in their countries of origin, and that sexual violence was for some of them part of their decision to migrate [3,15]. The omnipresence of sexual violence within sub-Saharan migration leads to a 'normalization' of sexual [15] and other types of violence [9], and could be linked to what in literature on sub-Saharan migration has been identified as 'hardship as an initiation rite' [9]. The fact of placing this in a context of cultural initiation rites, in which one endures a hardship during a certain period of time in order to get to a next phase of life with an enhanced state of being, could be interpreted as a coping strategy of the sub-Saharan communities. Trying to commonly interpret an adversity and subsequently adapt to it as a community, is as such a healthy reaction in community resilience [58]. Yet, the sexual violence reported here is of such invasive and destructive nature inducing severe long lasting ill-health consequences in a context where victims are not granted access to official health care but are dependent on rare NGO-medical and social support upon sexual victimization [50], that it can hardly build a person. On the contrary, the way the sexual victimization is performed bears many similarities with sexual violence as a weapon of war, which, by definition, has the purpose of destabilizing or extinguishing a group of people, because they belong to that group of people [29]. Even though it would take us too far to conclude that the purpose is to destabilize or extinguish sub-Saharan migrants, they are targeted here because they are undocumented sub-Saharan migrants without legal protection. Our results confirm that, given the lack of official authorities at many migration 'hubs' and given their undocumented status outside the ECOWAS region, the migrants are in a very vulnerable situation risking more victimization, exploitation or deportation when they would try to report or fight against it [9]. Furthermore, as in sexual violence as a weapon of war [59-61], gang rape is the most common form of reported sexual violence, and if migrants are not victimized personally, they are often forced to witness how their relatives or co-migrants are victimized in their presence, which is equally traumatizing. The respondents emphasized how heavy the burden is to live with the fact that they could not interfere or resist just because they were so many. Furthermore, the gang rapes are often perpetrated by either Moroccan and/or Algerian officials (soldiers, police) or gangs of Nigerian chairmen and other sub-Saharan migrant leaders who are self-identified migration professionals who installed them there where official authorities are lacking or refrain from interfering, and where migrants do have to pass on their migration route to and through Morocco. This is especially the case in the border region of Algeria (Maghnia) and Morocco (Oujda) where most of the reported sexual victimization took place. Where money and other material belongings cannot be confiscated anymore as bale for passage, migrants have to pay with their bodies. It is often the young women and men of the group and sometimes even the children who are picked by the perpetrators to be sexually victimized in return for the group's passage. The young and child migrants symbolize the hope for a better future, a purpose of migration. Yet, these bodies which bear the reason to live for the migrants, are what Agamben G. (1998) called "stripped to the bare life" at different levels. First of all literally by the perpetrators, yet also figuratively by all authorities directly and indirectly involved, who treat them as if their lives are devoid of value, "unworthy of being lived" [62]. As the perpetrators bear the local authority and sovereignty, and the victims are undocumented or have UNHCR papers which still need official recognition and subsequent protection by the Moroccan state until today, and as neither the Moroccan, Algerian nor European governments interfere; it seems that the perpetrators can proceed in mere impunity.

Treatment, prevention and response

The consequences of sexual violence listed by respondents were numerous and often combined long lasting sexual, physical, mental and socio-economic consequences which are again in line with what is found in victims of sexual violence as a weapon of war [60,63-65]. This confirms the need for desirable [47], holistic and multilevel prevention [29,66] and response actions to sexual violence targeting sub-Saharan migrants in and around Morocco. Our respondents told that they relied on NGOs to seek assistance, identifying organizations such as the Red Cross or Doctors without Borders (MSF) as sole care providers for treatment of sexual violence victims. This is an unsustainable situation and ignores the migrants' right to health care. The lack of possibilities for these populations to find help within public health services is confirmed by the simultaneously conducted study on the views of healthcare practitioners on sexual violence against Sub-Saharan migrants in Morocco [50]. The interviewed health care workers highlighted the general weaknesses of the Moroccan public health system in terms of response to sexual violence, and additional difficulties met by migrants at the entry of health services. It is therefore not surprising that migrants also cite NGOs and associative networks as a prime medium for prevention of sexual violence. Although many pointed at the role Moroccan authorities should have in preventing and responding to sexual violence, they stated that this role was not carried on yet. Even when Moroccan security or police forces do not perpetrate violence, they might discourage migrants from seeking help. Among our respondents, none

indicated that the victims reported the abuse to the authorities; on the contrary, many migrants stressed that their status prevented them from disclosing sexual violence cases, as this could lead to deportation. Additionally, their undocumented status in Morocco further hampers the victims in finding employment, with puts them subsequently at risk of more victimization, increasing their vulnerabilities [15]. Thus, a "life first" approach [67] in which needs are translated into rights demanding not only survival but also well-being and flourishing is urgently to be negotiated.

The role of legal and policy frameworks

Our results confirm earlier findings [13,14] that the legal and policy framework on migration in Morocco do not protect undocumented migrants from being sexually victimised and even fuel uncertainties and violations of rights in the field [1]. Moreover, we argue that the externalisation of EU migration policies [13,24] contributes to the vulnerability of these migrants. The perpetuate use of the 'transit migration' concept participates in the invisibility of violence committed against undocumented migrants in border areas (Algeria-Morocco, Morocco-EU) by allowing all those countries involved as well as the EU as such to refuse accountability for these acts and putting the responsibility to a country across another border who can do the same up till the root countries the "migrants" originate from. Consequently, the so-called 'transit countries' have very little incentive to develop a rights-based approach towards migrants and to implement dedicated structures and services. In this context, their victimisation nearly seems "collateral damage" of the ENP: protection nor response to these victimisations are taken into consideration and migrants' health is not considered a human right, let alone a public health issue. Moreover, Doctors without Borders recently reported that the NGO received 697 victims of sexual violence between 2010 and 2012, most of them reporting both multiple and gang assaults [68]. The sexual victimization thus continues in impunity, confirming that the lives of these migrants are politically not cared for, not by self-identified local authorities, not by Morocco, not by the EU and not at global level. Yet, in September 2013, the Moroccan government announced to create an asylum seeker status and judicial guarantees for the rights of the undocumented migrants entering into force by mid 2014 [69].

Participatory approach

The application of the CBPR method and its principles in all phases of the project is described in detail in the methods section of this paper. An overall evaluation of what the project had brought about in the research community was done at the participatory end seminar. For a thorough description of this seminar and its outcome we like to refer to the report of the project [56] and for all policy, practice and research recommendations made, we refer to our publication on the role of the Moroccan health care sector [50]. Yet, we like to emphasize here that the project has yielded overall positive effects and outcomes to all parties involved. First, the respondents stressed that they welcomed the topic of the research and thanked the team for being genuinely interested in their lives, which confirms earlier findings on sexual violence research [70]. Second, the CRs felt their knowledge on the topics at hand as well as their communication skills were strongly improved as a result of being a CR. It is however noteworthy that although all CRs participated in the same training, and interview guides were commonly developed and agreed upon in both French and English, we cannot guarantee that their epistemological perspective while conducting the in-depth interviews might have differed slightly from the ones of the scientific advisory board. These elements might induce some biases in the data and thus a limitation to our study. Furthermore, although at first, several were worried to become key persons in the migrant community on issues of violence and sexual health, at the end all -but the two Nigerian CRs who quit the project in the last weeks of fieldwork due to security threats they had received- felt strengthened as a person, had a better self-esteem, and for some of them this even resulted in job offers majorly affecting their legal status and socio-economic position. For others, their legal status did not change, which urged them to continue their irregular migration to Europe. Also at the side of the organisations, institutions and policy makers which were invited to the CAB, an initial reluctance linked to security reasons of working with irregular migrants, and even scepticism on feasibility; changed into a perseverant engagement of a growing group of organisations, institutions and policy makers who still try to take the issue further in Morocco and in Europe today. This already resulted in the implementation of several of the project's recommendations in changing formations, while others are still being lobbied for at national and international political instances or are submitted for project funding. For the principle researchers, it has proven that CBPR is scientifically a valuable but very time-consuming method which might challenge the established ways of conducting research yet resulting in a much more comprehensive understanding of the topic of research, which is in line with CBPR literature [44].

Conclusion

Sub-Saharan migrants are at high risk of multiple sexual victimizations in and around Morocco. If not being personally victimized, many are forced to witness how their

relatives or co-migrants are victimized by Moroccan or Algerian officials and/or by gangs of sub-Saharan chairmen who function as unofficial yet rigorous migration professionals. The ways in which this sexual violence is performed bears many similarities with sexual violence as a weapon of war. While many sub-Saharan young and child migrants pay for the passage of a group with their bodies, destroying their personal health and destabilizing the ones of those migrants who have to witness the victimization, it does not seem that their lives are politically cared for by any official authority. Comprehensive cross-border and multi-level prevention actions are thus urgently called for. Respondents link risk factors mainly to their undocumented and unprotected status and suggest that migrant communities set-up awareness raising campaigns while legal and policy changes enforcing human rights, legal protection and human treatment are lobbied for at different levels. Given the European Neighbourhood Policy, we deem it paramount that the European Union takes up its responsibility, drastically changes migration regulation into one that upholds human rights beyond the level of survival and enforces the Moroccan and all other authorities involved to restore migrants' lives worthy to be lived again.

Abbreviations

AIDS: Acquired Immunodeficiency Syndrome; CAB: Community Advisory Board; CBPR: Community Based Participatory Research; CRs: Community Researchers; EC: European Commission; ECOWAS: Economic Community of West African States; ENP: European Neighbourhood Policy; EU: European Union; HIV: Human Immunodeficiency Virus; RDS: Respondent Driven Sampling; SGBV: Sexual and Gender-Based Violence; STI: Sexually Transmitted Infections; SV: Sexual Violence; UNHCR: United Nations High Commissioner for Refugees.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

As coordinator of the project, IK was responsible for project management, research conception, design, acquisition of data, analysis and interpretation of data as well as for the manuscript from draft to publication. AD as local field coordinator & AM as expert/project partner gave substantial intellectual contribution to research conception, design, acquisition and interpretation of data while JK conducted in close collaboration with IK the complete analysis and interpretation of data from input to drafting the preliminary research reports. NV, KR and MT participated in the scientific advisory board and thus had decisive input in every phase of the research project. They all revised the draft manuscript critically and approved the final version.

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Sexual and gender-based violence in the European asylum and reception sector: a *perpetuum mobile*?

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Background: Refugees, asylum seekers and undocumented migrants are at risk of sexual and gender-based violence (SGBV) and subsequent ill-health in Europe; yet, European minimum reception standards do not address SGBV. Hence, this paper explores the nature of SGBV occurring in this sector and discusses determinants for 'Desirable Prevention'. **Methods:** Applying community-based participatory research, we conducted an SGBV knowledge, attitude and practice survey with residents and professionals in eight European countries. We conducted logistic regression using mixed models to analyse the data in R. **Results:** Of the 562 respondents, 58.3% reported cases of direct (23.3%) or peer (76.6%) victimization. Our results indicate that when men were involved, it most likely concerned sexual perpetration (adjusted odds ratio [aOR]: 4.09, confidence interval [CI]: 1.2; 13.89) and physical victimization (aOR: 2.57, CI: 1.65; 4), compared with females, who then rather perpetrated emotional violence (aOR: 1.85, CI: 1.08; 3.13) and underwent sexual victimization (aOR: 7.14, CI: 3.33; 16.67). Compared with others, asylum seekers appeared more likely to perpetrate physical (aOR 7.14, CI: 4; 12.5) and endure socio-economic violence (aOR: 10, CI: 1.37; 100), whereas professionals rather bore emotional (aOR: 2.01, CI: 0.98; 4.12) and perpetrated socio-economic violence (aOR: 25.91, CI: 13.41; 50.07). When group perpetration (aOR: 2.13, CI: 1.27; 3.58) or victimization (aOR: 1.84, CI: 1.1; 3.06) occurred, it most likely concerned socio-economic violence. **Conclusion:** Within the European asylum reception sector, residents and professionals of both sexes experience SGBV victimization and perpetration. Given the lack of prevention policies, our findings call for urgent Desirable Prevention programmes addressing determinants socio-ecologically.

Introduction

Sexual and gender-based violence (SGBV) is generally defined as 'any act as well as threats of acts of physical, sexual and psychological violence that is directed against a person on the basis of her/his gender or sex, and which occurs in the family, the community, or is perpetrated or condoned by the State and/or institutions'.[1] Yet, in the context of (forced) migration, the United Nations High Commissioner on Refugees (UNHCR) applies a definition that comprises five types of violence, namely, physical, psychological, sexual, socio-economic violence and harmful cultural practices.[2] Given our research population, we adopt this definition of SGBV and refer to the different categories in our analysis. In addition to important adverse effects on the victim's well-being and participation in society, SGBV may induce long-lasting ill sexual, reproductive, physical and mental health,[3–7] primarily affecting the victim, yet also potentially harmful to the victim's peers, offspring and community.[8–11]

SGBV is a global public health issue and a violation of human rights. The World Health Organization (WHO) recently stated that 25.4% of women and girls in the European WHO Region experience physical and or sexual violence by their (ex)partner and 5.2% are sexually victimized by non-partners.[12] For both sexes, one is considered vulnerable when being an adolescent of low socio-economic status;[3,13] when being an undocumented migrant (no legal residence status), an asylum seeker (temporary legal residence) or a refugee (legal residence);[14–16] and when living in shelters, rehabilitative facilities or detention.[19–20] People who were personally victimized or witnessed SGBV during childhood and those with a heightened risk perception due to victimization of linked people are prone to subsequent victimization or perpetration of SGBV at later stages of life.[10,11,21–23] Although perpetrators of SGBV are commonly known to the victim,[3,12,24] research has shown that boys, migrants or impoverished people are equally victimized by strangers, persons in authority and those assigned to their protection.[4,13,15,25,26]

The EU Member States received 296 700 new asylum claims in 2012, which is an increase of 7% compared with 2011;[27] refugee status was granted to 14% of them.[28] The asylum systems differ greatly from country to country, with housing facilities ranging from hangars and tents (Malta) to hotel rooms (Ireland and Belgium) and from small local reception initiatives in houses to big open accommodation or detention centres (in all research countries). A lot of European countries face difficulties in upholding the European minimum standards of reception,[29] which lacked SGBV prevention measures until the recast of June 2013.[30]

Although several determinants in SGBV are known, it is unclear how SGBV in the European asylum reception facilities is linked with current violence prevention knowledge, attitudes, practices and needs of residents and staff. Hence, this paper explores the nature of violence that residents and professionals experienced within the reception facilities in the year prior to the interview and discusses which determinants are decisive for 'Desirable Prevention' of SGBV in these settings.

Methods

The conceptual framework comprised the socio-ecological model on health and violence,[31] incorporating 'Desirable Prevention'[32] and

community-based participatory research (CBPR). CBPR in public health focuses on inequalities and aims to improve the health and well-being of community members by integrating knowledge in action, including social and policy change.[33,34] Applying this framework, we mobilized stakeholders in the eight countries of research (Belgium, Greece, Hungary, Ireland, Malta, The Netherlands, Portugal and Spain) to participate in community advisory boards (CAB). These CAB consisted of asylum seekers and refugees, asylum reception professionals, policymakers, intermediary organizations, civil society and researchers engaged in the asylum and reception sector. The CAB participated in every decisive phase of the project.

We considered the residents and professionals as the research's main beneficiaries and set out different inclusion criteria. For the residents this implied being member of the most numerous groups of asylum-seeking and unaccompanied minor communities. They had to be staying at, or just having left, an asylum reception facility in the country of research. The professionals had to work, or had just stopped working, there. All official and unofficial types of reception facilities were included and a geographical distribution over the country of research was sought. Subsequently, per country, we recruited one to three professionals and four to seven residents who demonstrated good social and communication skills. They completed a standardized 24-hour training course based on which they became 'Community Researchers' (CR) participating collegially throughout the project. Together with the CR and the CAB, we developed a knowledge, attitude and practice (KAP) survey. The questionnaire was translated and back-translated into the main languages of potential respondents, and pilot-tested with the CAB.

Fieldwork

The KAP survey was conducted between October 2009 and August 2010. We listed all actually used types of reception facilities and services per country and then randomly sampled them in six of the eight countries. Due to political constraints, we were obliged to adopt convenience sampling in The Netherlands and Spain. After having obtained the permission of the sampled facilities, we applied the inclusion criteria and then randomly sampled the respondents on their list of residents and professionals. Interviews were scheduled for a one-to-one interview with the CR at a private place in or near the centre in a language the respondent and the CR both mastered well and commonly agreed upon. Respondents were informed about the study and participation modes and guaranteed that their participation would not affect their asylum case and that analysis would be anonymous. Informed consent was obtained in writing.

The KAP questionnaire comprised three parts. First, we inquired about respondents' knowledge and experience of violence at the reception facility. If they answered positively; respondents could describe three violence cases of the year prior to the interview. For each of them, we checked the victim's and perpetrator's sex, legal status, age, operation modus and relationship to each other and to the respondents. Respondents had the opportunity to disclose personal involvement both directly and indirectly. Second, we explored the respondents' attitudes towards violence and its prevention. Third, we investigated the currently applied practices in violence prevention and response. Upon completion of the interview, the respondents were given information and referral material on health and violence in the language of the interview and a small incentive in phone credit or body care products. In Ireland no incentive was given, in line with the University College of Dublin's ethical guidelines. Respondents were invited to participate in further project phases. The study protocol applied the WHO and UNHCR ethical and safety guidelines in researching violence, complied with the local ethical requirements and received ethical approval from the Ghent University Hospital Ethical Committee [B67020096667].

Data analysis

In the eight countries, 600 individual interviews were conducted. The CR handed the interview guide, their notes, the translation of the open questionnaire and the signed informed consent to the country coordinator. (S)he checked validity and sent it on to the international project coordinator who did a second round of validity checking, based on which interviews and informed consent were separated. In all, 562 interviews were withheld, while all 38 Spanish interviews were excluded, as their validity could not be guaranteed. The quantitative data were put into an SPSS database. We applied the Framework Analysis Technique to analyse the qualitative data, a process conducted by three researchers who eventually consented on a set of categories that were then added to the SPSS database. Eventually, R was used for analysis.

We conducted logistic regression analysis using generalized linear models and mixed models to evaluate the relationship between types of violence and specific characteristics of the victims and perpetrators. First, we built generalized linear models assuming no cluster effect. Second, we used the same generalized linear models but accounting for possible clustering at country level. Finally, we performed an analysis with mixed models. All observations in the analysis regarded cases including at least one type of violence. The outcome in all models was a binary variable corresponding to the specific presence of the following types of violence in reported cases: (i) physical, (ii) emotional, (iii) sexual and (iv) socio-economic violence. The independent variables and fixed effects in the mixed models were sex, age and legal status of both the victim and the perpetrator; whether the victim was victimized in a group or alone; and whether the perpetrator acted in a group or alone. We included the country variable as a random effect in our mixed model and as cluster variable in our second generalized linear model. Models were estimated using the following functions and packages in R 3.0.1 and R Studio 0.97.551: 'glm' ('stats' package), 'surveyglm' ('survey' package) and 'glmer' ('lme4' packages). Model selection was performed using Akaike's Information Criterion (AIC), where the model with the lowest AIC value was considered the best model. In 19 of the 32 (60%) tested associations, the mixed model had lower AIC values than the generalized linear model. The results presented in the following text are based on the mixed-model results, but do not differ significantly from those obtained with generalized linear models. Adjusted odds ratios (aORs) accounting for inter-country variation are given in the regression models.

This paper focuses solely on the violent experiences that were reported in the first part of the KAP study. Duplicates of cases were deleted in the data cleaning rounds. The preliminary results were presented to all CABs and interpreted together to facilitate the development of the 'Senperforto Frame of Reference on SGBV prevention and response'.

RESULTS

Socio-demographic profile of respondents and their experience with violence

The 562 respondents comprised 375 (66.73%) residents and 187 (33.27%) professionals. Of the 562 respondents, 234 (41.64%) did not report cases they perceived as violence, while 328 (58.36%) did. The latter described 600 different cases consisting of personal victimization in 23.67% (142) and victimization of a co-resident or professional in 76.33% (458) in the asylum setting they live/work. Table 1 gives an overview of the profile of respondents reporting no, personal or peer victimization.

Table 2 demonstrates that the reported cases consisted mostly of a combination of multiple acts of different violence types that can be categorized as physical ($n = 437$), emotional ($n = 420$), sexual ($n = 62$) and socio-economic violence ($n = 117$).

Table 1 Reported victimization of respondents and peers

Socio-demographic characteristics	Reported no violence		Reported being personally victimized		Reported only violence against peer		Total	
	N (228)	%	*N (112)*	%	*N (217)*	%	*N (557)*	%
Country								
Belgium	31	13.6	35	31.3	26	12.0	92	16.5
Greece	23	10.1	14	12.5	29	13.4	66	11.8
Hungary	43	18.9	18	16.1	28	12.9	89	16.0
Ireland	26	11.4	12	10.7	55	25.3	93	16.7
Malta	25	11.0	17	15.2	47	21.7	89	16.0
The Netherlands	2	0.9	12	10.7	24	11.1	38	6.8
Portugal	78	34.2	4	3.6	8	3.7	90	16.2
Sex								
Female	94	41.2	50	44.6	95	44.0	239	43.0
Male	134	58.8	62	55.4	121	56.0	317	57.0
Missing					1		1	
Age (years)								
12–18	41	18.6	24	22.4	15	7.4	80	15.1
19–29	75	33.9	25	23.4	74	36.6	174	32.8
30–39	73	33.0	38	35.5	70	34.7	181	34.2
40–49	18	8.1	12	11.2	21	10.4	51	9.6
>50	14	6.3	8	7.5	22	10.9	44	8.3
Missing	7		5		15		27	
Legal status								
Asylum seeker	88	38.8	50	44.6	85	39.4	223	40.2
Humanitarian and subsidiary protection	54	23.8	9	8.0	24	11.1	87	15.7
Recognized refugee	32	14.1	6	5.4	8	3.7	46	8.3
Undocumented	9	4.0	4	3.6	9	4.2	22	4.0
National citizen	42	18.5	43	38.4	86	39.8	171	30.8
Other	2	0.9	0	0.0	4	1.9	6	1.1
Missing	1				1		2	
Facility type								
Detention centre	12	5.4	5	4.6	7	3.5	24	4.6
Open reception centre (incl. unaccomp minors)	142	64.3	82	75.9	146	72.7%	366	69.6
Local reception initiative	50	22.6	10	9.3	23	11.4	83	15.8
Return centre	2	0.9	4	3.7	0	0.0	6	1.1
Other (e.g. hotel, health service, . . .)	15	6.8	7	6.5	25	12.4	47	8.9
Missing	7		4			16		27

Table 2 Overview types of violence acts in reported cases

Types of violence acts	Respondent = victim	Peer = victim	Total acts ($n = 1036$)	100%
Emotional violence	87	333	420	40.54
Verbal violence	34	125	159	15.35
Humiliation	35	74	109	10.52
Threatening	16	89	105	10.13
Confinement	1	7	8	0.77
Relational violence	1	38	39	3.76
Physical violence	73	364	437	42.18
Singular non-life threatening	37	201	238	22.97
Multiple non-life threatening	12	51	63	6.08
Singular life threatening	12	81	93	8.98
Multiple life threatening	12	28	40	3.86
Killing	0	3	3	0.29
Sexual violence	13	49	62	5.98
Sexual harassment	8	23	31	2.99
Sexual abuse	2	10	12	1.16
Attempt to rape	0	1	1	0.10
Rape	0	6	6	0.58
Sexual exploitation	3	9	12	1.16
Socio-economic violence	38	79	117	11.29
Discrimination	10	31	41	3.96
Refusal of assistance	25	39	64	6.18
Social exclusion	2	7	9	0.87
Refusal of legal protection	1	2	3	0.29
Total	211	825	1036	100%

Table 3 shows that both sexes as well as both residents and professionals are at risk of victimization and perpetration within the European asylum reception sector. Yet, our results suggest that each of them is more likely to be involved in a specific type of violence and operation modus.

Gender

When males commit violence, it is more likely that they engage in sexual violence compared with females, who are more inclined to perpetrate emotional violence. When sexes perpetrate together, it more presumably involves socio-economic and less presumably physical violence than when they act alone or with someone of their own sex. In contrast to the other sex, males are most likely to endure physical victimization, whereas females more probably experience sexual victimization.

Legal status

When asylum seekers commit violence, they more likely engage in physical perpetration than national citizens (here = professionals). They are also more inclined to perpetrate emotional violence compared with undocumented migrants. In contrast to asylum seekers, when national citizens perpetrate, it more presumably involves socio-economic violence. This is echoed in the data on perpetrators rather being a professional than a resident and the victim rather being a resident than a professional (peer aOR: 33.8 [16.54; 69.07], $P < 0.001$; self-reported aOR 32.77 [9.34; 115.03], $P < 0.001$). When refugees are victimized, the chances are that they will be sexually victimized compared with asylum seekers. When

Table 3 Characteristics of perpetrators and victims per type of violence. (*P*-values: univariate analysis adjusted for country)

Characteristics of perpetrators and victims	Physical				Emotional				Sexual				Socio-economic			
	Peer = victim		Resp = victim		Peer = victim		Resp = victim		Peer = victim		Resp = victim		Peer = victim		Resp = victim	
	OR (95% CI)	*P*-value	OR (95% CI)	*P*-value	OR (95% CI)	*P*-value	OR (95% CI)	*P*-value	OR (95% CI)	*P*-value	OR (95%CI)	*P*-value	OR (95% CI)	*P*-value	OR (95%CI)	*P*-value
Sex of the perpetrator (Ref = female)																
Male	1.00 (0.57–1.74)	0.996	1 47 (0.56–3.88)	0.433	0 54 (0.32–0.93)	**0.027**	1 13 (0.39–3.32)	0.818	4 09 (1.20–13.89)	**0.024**	1 65 (0.32–8.46)	0.549	0.79 (0.4–1.55)	0.493	0.58 (0.18–1.86)	0.357
Both	0.24 (0.11–0.54)	**0.001**	0.67 (0.19–2.33)	0.526	0.62 (0.28–1.38)	0.244	1.05 (0.27–4.00)	0.949	3 09 (0.64–14.82)	0.158	0.00 (0.00–Inf)	0.995	3.34 (1.42–7.87)	**0.006**	1.63 (0.41–6.51)	0.493
Age of the perpetrator ≤ 30 (Ref ≥ 30)																
Yes	2.11 (1.03–4.33)	**0.042**	2.41 (0.83–7.03)	0.106	0.57 (0.32–1.04)	0.069	0.51 (0.13–1.99)	0.335	0.88 (0.33–2.34)	0.805	7 89 (0.88 70 92)	0.065	0.45 (0.19–1.07)	0.070	0.31 (0.09–1.12)	0.075
Group perpetration (Ref = no)																
Yes	0.84 (0.55–1.29)	0.422	1.25 (0.62–2.52)	0.538	0.71 (0.48–1.05)	0.086	0.49 (0.23–1.06)	0.07	1.57 (0.82–2.97)	0.171	0.60 (0.17–2.12)	0.425	2.13 (1.27–3.58)	**0.004**	3.1 (1.25–7.67)	**0.014**
Status of the perpetrator (Ref = asylum seeker)																
National citizen	0.14 (0.08–0.25)	**<0.001**	0.28 (0.12–0.67)	**0.004**	0.95 (0.58–1.56)	0.844	1.06 (0.43–2.62)	0.901	1.29 (0.6–2.78)	0.519	0.69 (0.17–2.75)	0.595	25.91 (13.41–50.07)	**<0.001**	27.5 (7.58–99.71)	**<0.001**
Refugee	0.71 (0.32–1.56)	0.390	2.84 (0.72–11.2)	0.135	0.75 (0.37–1.5)	0.414	0.61 (0.18–2.03)	0.416	1.31 (0.42–4.14)	0.641	0.44 (0.04–4.34)	0.483	0.32 (0.04–2.58)	0.283	0.00 (0.00–Inf)	0.996
Undocumented migrant	2.39 (0.53–10.8)	0.258	1.15 (0.30–4.41)	0.84	0.38 (0.17–0.84)	**0.017**	0.53 (0.13–2.18)	0.379	0.92 (0.20–4.26)	0.919	1.56 (0.26–9.39)	0.626	1.39 (0.29–6.62)	0.679	0.00 (0.00–Inf)	0.997
Sex of the victim (Ref = female)																
Male	2.57 (1.65–4.00)	**<0.001**	0.99 (0.47–2.11)	0.983	0.79 (0.52–1.18)	0.252	1.47 (0.64–3.39)	0.365	0.14 (0.06–0.30)	**<0.001**	0.29 (0.09–1.00)	**0.05**	0.93 (0.54–1.59)	0.778	2 (0.73–5.46)	0.177
Both	0.66 (0.34–1.29)	0.228	0.56 (0.21–1.45)	0.229	1.20 (0.59–2.44)	0.618	1.25 (0.43–3.61)	0.677	0.53 (0.19–1.45)	0.216	0.16 (0.02–1.36)	*0.094*	2.32 (1.08–4.95)	**0.030**	2.07 (0.61–7.00)	0.24
Age of the victim was ≤ 30 (Ref ≥ 30)																
Yes	1.42 (0.64–3.16)	0.389	0.73 (0.18–3.02)	0.666	0.97 (0.42–2.21)	0.935	0.94 (0.21–4.26)	0.934	1.88 (0.39–8.99)	0.429	2.13 (0.17 26 03)	0.553	0.62 (0.24–1.60)	0.327	181293702.45 (0.00–Inf)	0.998
Group victimization (Ref = no)																
Yes	0.80 (0.52–1.24)	0.319	1.37 (0.69–2.70)	0.365	1.19 (0.79–1.78)	0.397	0.96 (0.44–2.07)	0.912	1.28 (0.66.–2.47)	0.463	0.75 (0.24–2.35)	0.617	1.84 (1.10–3.06)	**0.020**	2.28 (0.94–5.53)	0.067
Status of the victim (Ref = asylum seeker)																
National citizen	0.97 (0.5–1.88)	0.924	1.51 (0.72–3.18)	0.274	2.01 (0.98–4.12)	0.055	1.68 (0.73–3.86)	0.219	0.59 (0.17–2.04)	0.406	3 04 (0.74–12.56)	0.125	0.10 (0.01–0.73)	**0.023**	0.04 (0.01–0.21)	**<0.001**
Refugee	0.69 (0.34–1.40)	0.305	0.47 (0.14–1.53)	0.21	1.02 (0.51–2.06)	0.958	1.3 (0.37–4.62)	0.683	2.58 (1.08 6.15)	**0.032**	4 72 (0.81 27 67)	0.085	0.39 (0.11–1.32)	0.130	0.52 (0.13–2.04)	0.348
Undocumented migrant	1.73 (0.71–4.20)	0.224	0.94 (0.21–4.09)	0.929	1.39 (0.7–2.76)	0.353	0.6 (0.13–2.92)	0.531	0.21 (0.03 1.68)	0.142	2.99 (0.25 35 46)	0.385	1.57 (0.71–3.50)	0.265	0.00 (0.00–Inf)	0.995

Significant P<0.05 bolded.

Table 4 Reaction to the reported violence cases

Did someone react to the violence incidents?	Yes	Co-residents	Residents and staff	Soc. worker/care worker	Security police/army	Management	Staff management/ security police
N = 1036	832 (80.31%)	116 (11.20%)	157 (15.15%)	158 (15.25%)	114 (11.00%)	131 (12.64%)	156 (15.06%)
Physical violence (*N* = 437)	363 (83.07%)	47 (10.76%)	68 (15.56%)	73 (16.70%)	54 (12.36%)	53 (12.13%)	68 (15.56%)
Emotional violence (*N* = 420)	347 (82.62%)	36 (8.57%)	74 (17.62%)	69 (16.43%)	42 (10.00%)	58 (13.81%)	68 (16.19%)
Sexual violence (*N* = 62)	48 (77.42%)	11 (17.74%)	9 (14.52%)	9 (14.52%)	4 (6.54%)	8 (12.90%)	7 (11.29%)
Socio-economic violence (*N* = 117)	7 (5.98%)	22 (18.80%)	6 (5.13%)	7 (5.98%)	14 (11.97%)	12 (10.26%)	13 (11.11%)
Reaction consisted of:	Number of reaction	Discussing arranged friends	Interrupting fight calming down	Reporting and investigation	Informing security police army	Arrest	Transfer perpetrator
Physical violence (*N* = 437)	74 (16.93%)	96 (21.97%)	105 (24.03%)	42 (9.61%)	64 (14.65%)	20 (4.58%)	23 (5.26%)
Emotional violence (*N* = 420)	73 (17.38%)	101 (24.05%)	84 (20.00%)	39 (9.29%)	69 (16.43%)	15 (3.57%)	29 (6.90%)
Sexual violence (*N* = 62)	14 (22.58%)	8 (12.90%)	11 (17.74%)	10 (16.13%)	6 (9.68%)	0 (0 00%)	9 (14.52%)
Socio-economic violence (*N* = 117)	42 (35.90%)	14 (11.97%)	3 (2.56%)	21 (17.95%)	20 (17.09%)	4 (3.42%)	12 (10.26%)

asylum seekers are victimized, it more likely concerns socio-economical violence in contrast to national citizens. When national citizens are victimized, it more plausibly concerns emotional victimization compared with asylum seekers.

Operation modus

When a group of perpetrators commit violence and when this group consists of both sexes, it more probably involves socio-economic violence compared with violence committed alone or by one single sex. When one is victimized in a group, regardless of its gender composition, it again more likely concerns socio-economic violence compared with being victimized alone.

Reported responses to the reported SGBV cases

In the majority of the violence incidents, someone reacted. Table 4 shows who reacted and what the reactions entailed per type of violence.

Discussion

Our results confirm earlier literature on vulnerability to SGBV of people with restricted residence permits as asylum seekers, refugees and undocumented migrants,[14–16] as well as people living in detention.[17–20] Yet our results also suggest that living or working in an asylum reception facility is to be considered a risk factor as such. In terms of Desirable Prevention actions, these findings imply that it is paramount to invest in integral prevention actions at the organizational level of the reception settings within the whole European asylum reception sector. While mainstreaming for sexual violence perpetration, it is however advisable to pay attention to preventing asylum seekers from physical and emotional perpetration and to preventing professionals from committing socio-economic violence. Overall, all potential staff members should be better screened on attitudes towards conflict and violence, human rights and discrimination, power indifferences and their coping skills and intercultural competence. Once employed, they need regular training and a code of conduct as part of a violence prevention and response policy that addresses the root causes and triggers of violence rather than consisting of repressive measures. Given the clear group character that socio-economic violence has in this sector, it is vital to address group dynamics in perpetration and build on community resilience when addressing victims. Given the many reports of violence committed by security staff and service providers employed by others, and the fact that residents are regularly transferred from one setting to another as a 'solution' to an incident of violence, it is crucial that these policies are imbedded in a sector-wide approach with high-level participation of both residents and professionals.

Another important finding is that victimization and perpetration in this sector seem more gender-balanced than what is generally expected in people outside this sector.[26,35,36] Our results demonstrate that both sexes here perpetrate and experience all types of violence. Moreover, whereas both sexes have a comparable tendency to physical perpetration, a dynamic of mixed-sex perpetration and victimization is to be noted in socio-economic violence. Yet, when they commit sexual and emotional violence, males are more likely to involve in sexual perpetration and emotional victimization, whereas females are more likely to perpetrate emotional violence and experience sexual victimization. This questions the prevailing paradigm in current violence research, in which men are considered a priori the perpetrators and women the victims. Recent research on autochthon intimate partner and domestic violence already pointed to gender dynamics similar to our findings;[37–39] yet, in migration research, this hypothesis has not yet been reflected. This is problematic, because it ignores a number of victims and perpetrators who are in need of effective interventions and who are now left unaddressed. This ignorance leads to ill health consequences and enhances the risk of subsequent perpetration and victimization in current and future generations.[10,11,21–23] It is thus paramount that future research on violence stems from a gender-sensitive paradigm and reveals all sex and gender dynamics. Consequently, violence prevention actions in the European asylum reception sector should thus avoid messages in which men are stereotyped as sole perpetrators and women as sole victims. Bearing our conceptual framework in mind, we however recommend that these actions are culturally competent, developed and implemented with high-level participation of all types of professionals and residents.

Finally, for all types of violence but socio-economic, only a minority of the significant findings in peer reported victimization were statistically confirmed in the personal victimization cases. This limitation may be due to the possibility of violence being witnessed in asylum centres, increasing the odds of reporting to us by a peer. However, this could also be influenced by residents who feared impact on their asylum case or stay at the facility, as many indicated before, during or after the interview. In addition, in some big facilities and/or communities with honour rules, residents discouraged others to participate, warning of potential stigma and/or community repercussions. Also, professionals indicated not daring to speak openly, although the management had consented to it. In The Netherlands, respondents were recruited and interviewed through the external health care facilities of the reception sector, and feared less disclosure to peers in the centres. This might explain why in The Netherlands, more

people disclosed personal victimization in comparison with the other countries. However, disclosing proper involvement was not necessary, and although respondents could disclose indirectly, as is recommended in detention research,[20] they were not obliged to respond. This suggests that our findings give a good indication, yet probably still underestimate the real magnitude of violence occurring in this sector. Furthermore, it also indicates that for our research population, trust is a non-evident matter that hampers them from disclosing personally. Therefore, it is important that in future comparable research, respondents are granted the opportunity to both personal and peer reporting, as considering only one of them will only result in revealing parts of the picture. Ideally, retrospective research could complement the findings. The low reporting of violence in Portugal is presumably due to the small number of reception facilities, while our research specifically inquired on violence within those facilities. Another limitation could be the epistemology of the CR, which might have deferred, despite their standard training. Given our findings, and the lack of standard violence prevention policies in this sector, we consider it paramount that professionals, residents and the European citizens proceed to action. As the Senperforto Frame of Reference is freely available in many languages and endorsed by UNHCR, we suggest that when not implemented directly, it is at least consulted as inspiration. It would be interesting to further research the impact of specific housing aspects of the asylum reception facilities on violence occurrence. Finally, understanding how social capital and definitions of violence affect violence reporting would surely build to a better understanding of violence occurrence and its Desirable Prevention.

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Keypoints

- Living and/or working in the European asylum and reception sector exposes one to violence.
- Both residents and professionals are at risk of both victimization and perpetration, yet they differ in types of violence, targeted victims and perpetration modus.
- Both females and males are at risk of both victimization and perpetration of all types of violence, yet specific characteristics in perpetration and victimization are found.
- When violence occurs in group, it most likely involves socio-economic violence committed by professionals of both genders targeting a group of residents.
- There is an urgent need for mainstreamed, gender-sensitive and culturally competent violence prevention and response actions that stem from a Desirable Prevention approach addressing determinants at the individual, interpersonal, organizational and societal level.

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4.3 Sexual Health of Refugees, Asylum Seekers and Undocumented Migrants: Definitions, Pathways and Determinants

Sexual health and sexuality are both health concepts that are still prone to definition modelling worldwide. Yet many determinants are known and although migrants constitute an important proportion of the European population, little is known about migrant sexual health. When it is done, the main focus is on their higher risk to sexual health problems or on barriers in their access to sexual health programmes and services and migrants' perspectives on potential solutions are often ignored. Furthermore, migrants with no, a temporary or conditioned residence permit as respectively undocumented migrants, asylum seekers and refugees are rarely included as legal aspects, cultural and language barriers might seem insurmountable. The available information is thus rather blurred and offers little insight in how their sexual health could be promoted in a desirable, ethically sound and culturally competent way beyond the scope of preventing sexual ill-health. From a human rights perspective, the participatory approach of this PhD, as well as from Desirable Prevention, it is vital that people frame their own health, health needs and health promotion actions.

This paper addresses objective 3: to identify how the study population defines sexual health and which risk and protective factors they perceive as sexual health determinants.

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Sexual health is dead in my body: participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands

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Abstract

Background: Although migrants constitute an important proportion of the European population, little is known about migrant sexual health. Existing research mainly focuses on migrants' sexual health risks and accessibility issues while recommendations on adequate sexual health promotion are rarely provided. Hence, this paper explores how refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands define sexual health, search for sexual health information and perceive sexual health determinants.

Methods: Applying Community-based Participatory Research as the overarching research approach, we conducted 223 in-depth interviews with refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. The Framework Analysis Technique was used to analyse qualitative data. We checked the extensiveness of the qualitative data and analysed the quantitative socio-demographic data with SPSS.

Results: Our results indicate that gender and age do not appear to be decisive determinants. However, incorporated cultural norms and education attainment are important to consider in desirable sexual health promotion in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Furthermore, our results demonstrate that these migrants have a predominant internal health locus of control. Yet, most of them feel that this personal attitude is hugely challenged by the Belgian and Dutch asylum system and migration laws which force them into a structural dependent situation inducing sexual ill-health.

Conclusion: Refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands are at risk of sexual ill-health. Incorporated cultural norms and attained education are important determinants to address in desirable sexual health promotion. Yet, as their legal status demonstrates to be the key determinant, the prime concern is to alter organizational and societal factors linked to the Belgian and Dutch asylum system. Refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands should be granted the same opportunity as Belgian and Dutch citizens have, to become equally in control of their sexual health and sexuality.

Keywords: Sexual health, Sexuality, Health determinants, Migrants, Refugees, Asylum seekers, Undocumented, Health locus of control, Community-based participatory research

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Background

Defining and framing sexual health

Sexual health and sexuality are both health concepts that are still prone to definition modelling worldwide. Since the recognition of sexual and reproductive health as a human right at the International Conference of Population and Development of 1994 in Cairo, more need was felt to come to a global consensus. Starting from this rights-based and public health approach, the World Health Organisation (WHO, 2010) defines sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality; and is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive, respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" [1]. In the same line, the WHO defines sexuality as: "A central aspect of human being throughout life which encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours and practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors" [2].

From a socio-ecological perspective on health [3], these factors can be identified at four interlinked levels being: the individual, the interpersonal, the community and organisational level and finally the societal and public policy level. As the central premise of this model is that none of its levels should function in isolation from the others, it has been advised that effective health promotion and prevention programmes should stimulate synergy among the different levels [4].

Migrant sexual health

Migration movements in Europe recently increased in size and complexity. In 2011, 6.6% (33.3 million) of the EU population were "third-country" or "extra-EU" nationals [5]. According to United Nations High Commissioner on Refugees (UNHCR) data for the industrialized world, Belgium was the sixth and the Netherlands the twelfth largest receiving country of new asylum-seekers in 2011 [6]. In both countries, asylum seekers were predominantly housed in asylum reception centres and local reception initiatives. Yet, when the amount of available facilities proved to be insufficient to accommodate all asylum seekers, they were also forced to share rooms in hotels or left to find any kind of accommodation of their own. Just as for undocumented migrants, this often resulted in homelessness or life-threatening living conditions. Refugees were entitled to regular housing, but regularly struggled with financial barriers [7].

Although migrants constitute an important proportion of the European population, relatively little is known about migrant sexual health and sexuality. This gap in knowledge can be largely explained by a variety of technical and political reasons. First, throughout Europe, there is a great variability in the main denominators of citizenship, residency and immigration status in available databases [8,9]. In addition, in some countries ethnicity registration in clinical records is perceived as discriminatory and thus not done [10-12]. Third, sexual health research protocols rarely pay attention to inclusion criteria or procedures which might by their nature inhibit participation of migrants [13]. Finally, research often favours homogenous groups hampering differentiation in migrant residence status although legally it is a decisive determinant in actual entitlements to health care in many European countries [14-16]. Within the body of research on migration and sexual risk, studies have posited that separation from native communities and social isolation contributes to risky sexual behaviour, including sex work and extramarital sexual relationships [17]. However, recent research stresses that the daily struggle and the existence of structural cultural values and beliefs are more decisive factors [18]. For the European Union (EU) it has been demonstrated that migrants suffer from higher maternal morbidity and mortality and experience poorer pregnancy outcomes [19-21]. They face higher levels of the Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STI's) and have less access to sexual and reproductive services including family planning and safe abortion services [19,22-24]. Furthermore they are more likely to become victims of sexual and other types of interpersonal violence [14,24] and harmful cultural practices including female genital mutilation (FGM) [25,26].

Problem statement

Many determinants in sexual health and sexuality are known, yet the link to migrants in Europe is rarely made. When it is done, the main focus is on their higher risk to sexual health problems or on barriers in their access to sexual health programmes and services [27]. These studies thus ignore the broad WHO definition on sexual health. Furthermore, migrants without, or with a temporary or conditioned residence permit, as respectively undocumented migrants, asylum seekers and refugees; are rarely included in general sexual health studies. This is due to (perceived) legal, social, cultural and language barriers [27,28]. The available information is thus rather blurred and current prevention and health

promotion actions are neither needs-responsive nor adapted to communication channels that migrants are accustomed to use in search for sexual health information.

Objective

The general objective of this study is to provide more insight in how the sexual health of refugees, asylum seekers and undocumented migrant in Belgium and the Netherlands can be promoted in a more desirable, ethically sound and culturally competent way. To that end, this paper aims to explore how refugees, asylum seekers and undocumented migrants define sexual health; to examine what pathways they use in search of sexual health information and to identify risk and protective factors they perceive as determinants after having fled to and applied for asylum in Belgium or the Netherlands.

Methods

This paper describes one part of a larger participatory study on sexual health and sexual violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. The results on sexual violence experience and prevention have been published elsewhere [14].

Epistemology & conceptual framework

This study is grounded in a phenomenological and dialogical research perspective and supports an interpretive, feminist communitarian epistemology [29,30]. Consequently, this study required both a conceptual framework as well as a research approach that allowed for a close collaboration with the research communities and which empowered them to frame their own health needs and potential prevention and promotion initiatives [29,30]. Our conceptual framework was based on three theoretical stances. First, we started from a human rights perspective on health adopting the WHO definition on sexual health and sexuality. Second, we integrated the socio-ecological perspective on health and violence which allows for a better understanding of health complexity through the identification of determinants at the individual, interpersonal, organisational and societal level [3]. Third; we added the concept of Desirable Prevention which can be defined as "Those initiatives that anticipate risk factors ever earlier in a targeted and systematic way, are maximally "of-fensive", have an integral approach, work in a participatory way and have a democratic nature, while aiming at the enhancement or protection of the target group's health and wellbeing" [31].

Selection of participants

Starting from this conceptual framework, we adopted Community -Based Participatory Research (CBPR) as our overarching qualitative research approach. CBPR in public health focuses on social, structural and physical environmental inequalities and aims to improve the health and well-being of community members by integrating gained knowledge in action, including social and policy change [32,33]. A large group of stakeholders were mobilized whom either joined the Community Advisory Board (CAB) or became community researchers (CRs) and collaborated collegiately through all phases of the project, building rapport, capacity and mutual ownership [32]. General inclusion criteria for CRs and potential respondents were to be within reproductive age (set by WHO as 15–49 years old) and belong to one of the main ethnic groups of refugees, asylum seekers and undocumented migrants living in the region of East-Flanders in Belgium and of the Randstad in the Netherlands. Additionally, potential CRs were invited to an interview with the project coordinators and were screened on necessary communication and potential research skills, empathic attitude, social engagement and leadership capacities. Fourteen women and ten men from Iranian, Iraqi, Roma from Slovakia and the Czech Republic, Kurdish from Iraq and Iran, Somali, Afghan and the Common Wealth of Independent States (CIS) descent completed 30 hours of CR training. This training addressed migration, human rights, sexual and reproductive health, several types of violence, gender, psychosocial education, intercultural communication, the study conceptual framework and epistemology and finally guidelines and exercises on conducting in-depth interviews in an empathic and ethically sound way. Two male CRs dropped out after training because of time constraints.

Data collection

Given the piloting nature of this study and the fact that the population was hard to reach; we opted for criterion and chain sampling [34] of the respondents. This implied that we initiated our search for potential respondents from a vast pool of primary sources, being acquaintances of the project coordinators, the CRs, the CAB services and organisations and the Red Cross asylum reception centres in East Flanders. We subsequently explored their respective networks in search for respondents meeting the inclusion criteria. Upon identification, we informed the potential respondents about the project's objectives, the interview goals, the voluntary aspect of it, potential risks and measures taken to protect them from those risks, and participation modes. Respondents could withdraw at any point during the interview but still participate in later phases of the project. The respondents – or in case of minors (15–17 years old), their parent or guardian and in case of language barriers, their nominee- signed an informed consent before the interview, and we renegotiated consent at later phases of project participation.

Between January and April 2007, CRs were asked to conduct 10 to 12 in-depth interviews with respondents

meeting the inclusion criteria and of the same gender as the CR. In order to maximise the match between 'inner speech' and the language used [35]; to optimise validity and reliability [36] and to enhance the positive outcomes of the participatory research approach; we developed, pilot-tested, translated and back-translated the interview guide jointly with the CRs and the CAB. The interview addressed four main topics: 1) their socio-demographic profile and their appreciation of that profile; 2) their definition and perception of sexual health; 3) their experience with sexual victimization since their arrival in Europe and 4) their opinions on violence prevention.

This paper covers the sexual health data. In order to come to better sexual health promotion in refugees, asylum seekers and undocumented migrants, we firstly assessed how these migrants define sexual health and sexual maturity. Secondly, we explored the sexual health information sources they are accustomed to address and the pathways they use. Thirdly, we examined the risk and protective factors they perceived as affecting one's sexual health and influencing one's sexual behaviour. For each of their answers we asked the respondents to differentiate according to (sexual) maturity (adults-youth) and gender where applicable in their opinion. The interviews were audiotaped and the CRs took notes on their interview guides. Upon completion of the interview, we checked, and if necessary, organised professional psychological, medical, social, or judicial assistance. Respondents also received a package with sexual health and violence information in their mother tongue, referral addresses, condoms and some samples for daily hygiene (e.g. shampoo, shower gel, body lotion, raiser gel, combs, baby oil, eye liner) provided by a pharmacy. In line with the CBPR methodology [32], safety issues and project procedures were strongly debated and commonly decided upon by the CRs and the CAB, resulting in an ethical approval from the research community itself. In addition, the study protocol received ethical approval from the Ghent University Hospital Ethical Committee.

Analysis

We considered interviews only valid when having signed informed consent and when the taped interview matched the notes that were taken by the CR on the interview guide. Duplicates of interviews were checked for, but none were found. All open questions were written ad verbatim and translated to Dutch or English. We used the Framework Analysis Technique to sort, code and constantly compare the qualitative data. We started by inductively grouping the coded data into analytical themes and categories conceived as meaningful and important to the involved communities while using the respondents' definitions and wordings. Subsequently, we applied our conceptual framework, which resulted in an analysis along five sexual health core components:

1. General well-being and development with factors related to personal health practice & lifestyle, physical, mental, social (socio-economic and cultural) well-being
2. Safe and satisfying sex life
3. Respectful approach to sexual relationships and sexuality
4. Family planning and fertility
5. Access to Information & Care

This qualitative analytical process was itinerated by the first author and a fellow researcher who independently from each other coded and analysed the data. They discussed and agreed on every aspect before heading to the next analytical step. In addition, at regular interval, preliminary results were discussed and interpreted with CRs and CAB members before moving to a next level of analysis. Subsequently, we used SPSS to analyse the quantitative socio-demographic data and to check the extensiveness (the volume of and the diversity within) of the qualitative data [37]. We hereby verified whether gender, age, country of origin, host country, level of education and legal status had an impact on the results. At the end of the project, an open seminar was held with 200 CRs, CAB, respondents and other stakeholders discussing the first results, interpreting them in workshops and formulating policy, research and practice recommendations that were also taken into consideration in the final analysis phase [7]. All quotes stem from the ad verbatim transcriptions of the in-depth interviews, yet the names are pseudonyms. Quotes that were originally in other languages were literally translated to Dutch or English by the CR who conducted the interview and double checked and approved by the group of CRs and project coordinators.

Results

Socio-demographic profile of the respondents

Of the 250 conducted in-depth interviews, 223 were considered valid. This regarded 132 interviews in Belgium and 91 in the Netherlands with refugees (46%), asylum seekers (41%) and undocumented migrants (13%). The respondents comprised 88 males and 135 females from Iranian (40), Iraqi (12), Slovakian and Czech Roma (36), Kurdish from Iran and Iraq (58), Somali (14), Afghan (24) and CIS (39) descent. Two transsexuals in Belgium were included as women in the analysis upon their request. The respondents were relatively young and generally highly educated women and men. Slightly more than half of them did not have a steady partner and the majority was not or only fairly accompanied by other adults or children.

Table 1 Socio-demographic profile of respondents

	N = 223	=100%
Country of origin		
Afghanistan	24	10.8%
Common Wealth of Independent States (CIS)	39	17.5%
Iraq (including Kurds)	43	19.3%
Iran (including Kurds)	67	30.0%
Slovakia & Czech Republic (Roma)	36	16.1%
Somalia	14	6.3%
Residence status		
Asylum seeker	92	41.3%
Refugee	103	46.2%
Undocumented	28	12.5%
Gender		
Female	133	59.6%
Male	88	39.5%
Transgender	2	0.9%
Age		
< 18 years	15	6.7%
19–29 years	102	52.5%
30–49 years	106	47.5%
Relational status		
No steady partner	119	53.4%
Steady partner	104	46.6%
Accompaniment		
Persons > 18 years		
0	65	29.1%
1	72	32.3%
2/>2	86	38.6%
Persons < 18 years		
0	98	43.9%
1	51	22.9%
2/>2	74	33.9%
Educational level		
Higher/University	45	20.2%
Higher/Non-university	46	20.6%
Secondary education	99	44.4%
Primary education	25	11.2%
Not educated	4	1.8%
Daily activities		
Country of origin:		
Paid at work	101	5.3%
At job market	12	5.4%
Student	88	39.5%
Other	21	9.4%
Host country:		
Paid at work	50	22.4%
At job market	43	19.3%
Not allowed to work	45	20.2%
Student	51	22.9%
Other	33	14.8%

In their appreciation of their profile, respondents indicated that having poor social networks to rely and build on and being hampered in participating actively in society was wearing them down. Furthermore, respondents complained of a socio-economic setback compared to their country of origin as is reflected in the daily activities in Table 1. The 22% who were employed in the host country, often suffered from functioning far below their capacities and being treated with disrespect. Finally, eighty per cent stated to be religiously active, mostly within Islam (43%) and Christianity (30%). For more socio-demographic data we would like to refer to the article on the sexual violence part of this study [14].

Definition of sexual health

> *"Some people think that sexual contact between people is just a biological process and they do not think about feelings and the mental side of 2 people. While, this is give and take, so with nice words and soft touching you should help each other to become ready for sex" (Aref, 35, male Afghan Refugee)*

Our respondents generally defined sexual health of adults and youth in the same terms. To them, being sexually healthy meant above all being generally well (A: 60%-Y: 52%), and subsequently also being sexually safe and satisfied (A: 39%-Y: 33%) and respectful to sexual partners (A: 39%-Y: 26%). Yet, family planning and fertility (A: 22%-Y: 18%) and being informed and medically cared for (A: 13%-Y: 14%) seemed of less importance.

General well-being (n 132) was mostly formulated as "not having a sexually transmitted disease or infection", being "both physically as well as mentally healthy and ready", or being "fully physically healthy".

A safe and satisfying sex life (n 86) was frequently described as: "being completely comfortable with having sex (no pain, tension, coercion)", "using contraception", "enjoying sex" or "having sex on a regular basis".

A respectful approach to sexuality and sexual relationships (n 87) was mainly formulated as "having sex only from the moment you are married and within the marriage", "being conscientious about risk behaviour and limits of yourself and your partner" and by "having one steady partner".

Family planning and fertility (n 48) was largely defined in terms of "being able to bare children", "being fertile" and "having healthy children".

Having access to information and care (n 28) was mostly described as "having enough information on what sexual health is" and as "knowing what the risks of having sex can be".

"When I was 17, I had a boyfriend who kissed me once. I got wounds on my lips, so I thought God had punished me and gave me lip cancer" (Dilbar, 41, female Iranian refugee)

It is noteworthy that age and gender of the respondents did not impact these results, while educational attainment and country of origin did. Although being generally well was the most important to the majority of all attained education levels, its perceived importance raised along with the level of education up to the highest value for the ones with higher university or non-university education. A respectful approach was equally important to about 30% of all attained levels. Access to information and care and a safe and satisfying sex life became more important the higher the education attainment while family planning was mostly an issue to those with intermediate levels of education. For every origin, general well-being was important to more than half of the respondents. However respondents from the CIS mentioned this much more frequently, closely followed by Iranian and Iraqi respondents. Both a respectful approach as well as a safe and satisfying sex life was predominantly indicated as an important aspect of sexual health by respondents from Somalia and the Middle East. To the Slovakian and Czech Roma respondents and those from the CIS, family planning seemed to be more of an issue. Access to information and care was not important to any of these groups and even not mentioned at all by these Roma respondents. Taking all five components into account, the data suggests that people from Iraq and Iran have the most balanced interpretation of what constitutes sexual health according to the WHO definition used here.

Criteria of sexual maturity

"A man has to be mature with his head and not only with his penis and balls" (Yelena, 21, Russian female asylum seeker)

When asked how one could make a distinction between adults and youth, the following criteria were set. For both females and males, the same top three of criteria were given: it firstly depended on their general physical, mental and social development; secondly on their age and thirdly on their respectful approach to relationships and sexuality. The gender, age and the level of education of the respondents did not impact the results, yet country of origin did have some influence.

A girl becomes a woman

The moment where a girl turns into a woman depended for the majority (59% or 131) on their general development. The phrasing was mostly related to mental health aspects as: "being mentally mature", "being able to take up responsibility" but also more physically as "when girls got their first menstruation". For all countries of origin those descriptions were spontaneously given by more than half of the respondents, yet the physical aspect of menstruation as a turning point was particularly stressed by Somali and Slovakian Roma respondents. About a fourth of the respondents (60) said that becoming a woman had to do with age, but the age they set was quite different. Eight respondents put the limit at 13/14 years; a third said 15/17 years, while for more than half of them one had to be at least 18 or older. The indication of age was provided by the majority of Somali and Afghan respondents and all the references to being 13 or 14 as maturity age were found in this group. In other origins age was indicated by less than a third. Another fourth of the respondents (57) said that turning into a woman depended on one's approach to relationships and sexuality and the utmost majority of them (80%) related this to "being married". Only a few (15) from all origins except Somalia, related becoming a woman to family planning and described this as "having the feeling of motherhood after having bared the first child", "being able to become a mother" and "being able to become pregnant". Even less (11 or 5%) related this to sexual debut.

A boy becomes a man

For about 48% (107) of respondents, a boy becomes a man when he is physically, mentally and socially well developed. Half of them defined this as "being mentally mature", a third as "being able to take up responsibility" and a fifth as "has had his first wet dream". Nearly a third of the respondents believed that male maturity was related to age, mainly defined as "being more than 18". Some 20 respondents exclusively from the Middle East and Somalia found that being between 15 and 17 was old enough. Another fourth, again predominantly originating from the Middle East, said this depended on their approach to relationships and sexuality, again primarily defined as being married (73%). From all origins but Somalia, 30

respondents mentioned sexual debut as a turning point and 20 family planning or fertility as "having a family to take care of" or "being a father".

Sources of sexual health information (SHI) in the home country

> *"When I married it was my mother-in-law who informed me on sex, I was so afraid of sex that during the first week, I slept with her" (Dilbar, 41, female Iranian refugee)*

General

Asking respondents where adults as well as youth in their home country turned to in order to find information on sexual health, 40% stated that there was not really an official place or person where you could turn to, or that it was a big taboo. However 60% of the respondents mentioned several SHI-sources which we categorized as health sector, one's direct environment, media and institutions. The respondents were convinced that adults and youth do consult the same type of SHI-sources, yet they did not follow the same pathways. Adult primarily searched for information in the health sector (60%), and to a much lesser extent in one's direct environment (30%), in media (18%) and institutions (16%). The majority (64%) was convinced that these pathways were equally consulted by adult women and men. Yet, if they indicated differences, this was mostly to nuance that men turn to men and women to women. As for youth, our respondents stated that the SHI-source that stood out for both female and male youth is their direct environment (43%). At a second level, the health sector (30%), the media (29%) and institutions (27%) are equally important sources they consult. Testing for age, educational level and origin of the respondents did not appear to influence the mentioned pathways decisively. However, the gender of the respondents revealed to be determining the pathways to obtain sexual health information.

Medical

For both female and male respondents (M: 64%- F: 58%), it was a matter of course that an adult turned to the health sector in search of SHI. However, we saw that the lower the education level of the respondents, the less the health sector was considered as the most obvious SHI-source (No school: 25%, primary education: 44%, secondary education: 58%, higher education 69%). According to half of the respondents, seeing a general practitioner was the readiest medical SHI source regardless of age or sex (Y: 56%- A: 49%). Seeing a gynaecologist and an outpatients' clinic were mentioned by a fourth of them with female and young respondents preferring a gynaecologist (F: 31%-M: 15%; Y: 26% - A: 22%) while male and adult ones preferred the outpatients' clinic (F: 20%-M: 38%; Y: 18%-A: 36%). Urologists and a general health centre were mentioned by 10%.

Direct environment/peers

In general, youth considered their direct environment as most important SHI-source (44%) while adults of both sexes considered it as subordinate to the health sector. Yet, adult women consulted their direct environment as SHI-source considerably more than their male counterparts (F: 43%-M: 19%). Finally, for Kurdish respondents as well as for respondents who did not go to school, the direct environment was not the second, but the first SHI-source (K:51%- NS: 50%). Within the answers indicating direct environment as SHI-source the most important were family (75%) and friends (67%). When family was specified, it predominantly regarded parents, brothers and sisters and only occasionally a further relative. Adult women and youth seemed to attribute more importance to friends (W: 58%-Y: 67%) than family (W: 41%-Y: 54%), while for adult men these are equally important sources (40%).

Media

Using the media as an information tool was slightly more relevant for female than for male (F: 20%-M: 14%) and for respondents in Belgium than the ones in the Netherlands (B: 21%- NL: 13%). Their age and education level does not impact this, while origin did: media as an SHI source was the most popular among Iranian and Kurdish respondents. For the respondents indicating media as a SHI source, the tools that were mentioned mostly for adults were: books (46%), internet (33%) and TV (27%), while for youth seeking SHI they considered internet (55%) as preferable source over books (42%) and TV (22%). Books were more accessed by female respondents compared to males (F: 62%-M: 17%) and by people with higher education levels. Male respondents preferred internet (F: 31%-M: 42%) and TV (F: 19%-M: 33%). Internet was about equally important to all levels of education while TV was more important to respondents with a lower education attainment level (HE: 11%-LE: 75%).

Institutions

Turning to institutions as a source of SHI was relevant for 15% of female and male respondents with levels of education of secondary school and more. According to them school/university was the readiest institutional SHI source for both adults and youth (A: 58%-Y: 83%) followed by religious institutions (A: 18%-Y: 8%). Yet, more importance was attributed to them for females than for males (school: F: 65%-M: 46%; religious: F: 20%-M15%) In general, institutions as a SHI source were

more popular for respondents in Belgium (71%) than in the Netherlands (42%).

Perceived sexual health determinants

"Good behaviour makes people beautiful, they make you feel safe" (Perwin, 37, Female Kurdish Refugee)

The factors they perceived as influencing one's sexual health can be divided into internal and external health locus of control factors.

Internal sexual health locus of control

"Refugees who are sexually frustrated and who don't have enough money to pay a prostitute should masturbate" (Zalmai, 28, male Afghan refugee)

More than half of the respondents (54%) distributed among all levels of education, thought that by assuring to have a safe sex life one could obtain good sexual health. The descriptions most given were "using a condom", "using contraception in general" and "considering the health status of the sex partner before having sex". Irrespective of one's level of education, age and origin, about half of the respondents (49%) believed that one should take responsibility of one's sexual health by doing things that contributed to a general well-being and lifestyle as "looking after personal physical care & hygiene", "eat healthy", "do sports" and "detent and stress less".

"You have to inform yourself on STI's, that's not so difficult, but not only look for health information but also on how to make love" (Lexei, 32, male Russian asylum seeker)

They were equally convinced that having access to information and care was a determinant. They phrased this as "getting informed on sex, sexual risks and sexual health" and as "seeing a medical professional on a regular basis" or "seeing a doctor at least when problems occur". Respondents from the Middle East stressed the information part more while the others rather emphasized the accessibility of care. A third of the respondents, mostly with higher education levels, said that in order to have good sexual health, one needed a respectful approach by "having one sex partner" or "knowing the sex partner before having sex". Respondents from the Middle East mentioned more relational aspects as "free choice of partner", "no forced marriage" and "good communication" than people from the CIS, Somalia and the Slovakian and Czech Roma who emphasized the importance of having "one steady" and "healthy partner".

External sexual health locus of control

The majority of the respondents (68%) said that there were additional external factors which could influence one's sexual health in a positive or negative way. Factors which could have a positive or a negative impact were situated in the sphere of informal help of powerful others and were defined as "friends", and "one's upbringing". Religion was only mentioned by three respondents. The extent to which "sexual health is publicly debatable" and "having sexual education at school" were mostly mentioned as external positive factors. Yet, "drugs/alcohol", "sexual diseases and problems", "having "stress", "bad financial situation", "separated from family", "unavailability of having sex" or "forced sex", were considered as negatively influencing one's general and sexual health and well-being.

"Because of all her traumatic experiences she could not sleep with her husband. She relived everything; in the end she committed suicide" (Shahrukh, 39, *male Afghan asylum seeker)*

Most respondents felt that given the asylum situation in which they live(d), they were made heavily dependent on formal help of powerful others. They thus could not manage work, financial or asylum issues personally, which was indicated as being very frustrating and causing "relational problems" and "negative emotions".

"Like me for example, because I'm depressed I never think of having sex, due to long stay at the centre, the problems in relations and discrimination by white Dutch people, you don't feel well" (Kimiya, 31, female Iranian refugee)

Many respondents also mentioned "the asylum procedure" as such as a negative influence on their sexual health. The education level influenced this perception and dominates small differences in age, gender and origin. The higher the education attainment, the broader interpersonal and structural factors were indicated as negatively influencing one's health. People with lower levels of education attainment were more likely to mention individual and intimate interpersonal factors as sexual risk behaviour, relational tension and violence.

Discussion

"Sexual Health is dead in my body" (Zoran, 23, male Kurdish asylum seeker)

Our results demonstrate that refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands have a fair good understanding of the different aspects

comprising sexual health. Moreover, they are also to identify a variety of determinants. Some of these determinants are important requiring consideration in future sexual health promotion research and activities. Given our conceptual framework, we discuss the determinants according to the socio-ecological level they can be classified in.

Individual level

Age does not play a decisive role in defining sexual health in our study population. Both young and adult respondents define sexual health in a rather balanced way identifying aspects of general well-being, a respectful approach of sexual relationships and sexuality, a safe and pleasurable sex life, family planning and fertility and access to information and care. Yet pathways to search for sexual health information differ. Youth indicate their direct environment as primary sexual health source while the health sector, media - preferably internet- and educational institutions share an equal important second place. In identifying determinants, respondents attribute more importance to a safe and satisfying sex life than adults and indicate determinants preferably in the individual and intimate interpersonal level.

> *"A human being is a human being, whether you're a man or a woman" (Maiah, 34, female Kurdish asylum seeker)*

Gender Although it is often assumed that gender imbalances induced by beliefs, practices and norms of the countries of origin of our respondents might have a negative effect on their sexual health, our results rather confirm earlier findings [38] that there are no groundbreaking gender differences regarding sexual health definition and determinants in our population. When defining sexual health, both male and female respondents emphasized that the most important element was to be physically and mentally well. In addition to being well, one had to feel well about sexuality both personally as within a respectful relationship where trust and mutual respect were named as essential to it, which is in line with literature [39-42]. However, a safe and satisfying sex life was for both genders an equally important aspect. Within their descriptions of what this should entail, we could not state that men indicated more stimulus-based factors and women more cognition-based factors -as emotions, the broader quality of a relationship, dyadic conflict, personalized external events and social context factors- which is posited in literature emphasizing differences between gender [39,43-47]. Respondents did not attribute major differences in sexual maturity criteria either. In addition, for both females and males, fertility, family planning and access to information and care were of less importance. As for the sources of sexual health information, the health sector was indicated as the readiest SHI source for both women and men.

The only differences we could find between genders were the explored pathways in search for SHI. Compared to their male counterparts, women and girls tend to address people in their direct environment and especially friends much more. They also prefer media –especially books- more than men who then prefer internet if they indicate media as source of sexual health information. Women also indicated institutions more, preferably educational institutions but also religious ones. Thus, future sexual health promotion activities towards migrants descending from these origins can be gender inclusive when it concerns content. Only the channels through which the messages are conveyed could be diversified to maximize the possibilities of getting the message across.

Cultural beliefs and norms that have been equally incorporated by women and men seem to influence their sexual health frame of reference decisively.

> *"In Iran they say you get blind if you masturbate, here they say it's good for your health" (Bârân, 26, female Iranian Refugee)*

When respondents described criteria for sexual maturity, all stressed the importance of a balanced mental, physical and social development as the most decisive element for both genders. Age and respectful approach were criteria for both girls and boys and were indicated by a third to a fourth of the respondents. Yet, we saw that country of origin clearly influences these findings. Somali and Afghan respondents tended to emphasize the physical development aspects and an earlier age of sexual maturity (girls 13–15, boys 15–17) more than the others. For them, issues related to sexual debut, fertility and family planning were rarely mentioned, while aspects of respectful approach were stressed. This tendency is consistent with their definition of sexual health whereby aspects of general well-being and a safe and satisfying sex life are mentioned as important aspects to all origins. However, respondents from Somalia, Iraq, Iran and Afghanistan stressed that this should happen within a steady relation (mostly marriage) where one feels respected, trusted and at ease. Yet, for CIS respondents and the Slovakian and Czech Roma ones, family planning seemed to be more of an issue in addition to a general well-being and a safe and satisfying sex life. This confirms literature stating that cultural norms, beliefs and attitudes bolster one's self-esteem and self-efficacy, provide a coherent structure for interpreting life events [48] and are more decisive in sexual behaviour of these migrants than their separation from native communities [18]. Yet, as the Belgian and Dutch asylum system enforces them in a dependent situation, their general beliefs

and norms on sexual normalcy, on pleasurable sex, on risks to sexual dysfunction, on sexual performance as well as their ethical concerns about the function of sexuality, help-seeking and treatment; might be seriously challenged. All of this is known to create and perpetuate sexual difficulties [38,49-54].

The attained education does not influence the perception of sexual maturity criteria, the importance of general well-being, a respectful approach or the personal health responsibility. Yet respondents with no or low education attainment levels tend to diversify their definition of sexual health less. Moreover, they particularly stress individual and intimate interpersonal sexual health determinants and consider family and friends as first sexual health information sources, additionally taking up on info spread by TV. Respondents with higher educational levels considered safety and satisfaction more as well as access to information and care. In addition, they mentioned more organizational and societal determinants and also preferred the health sector above all other sexual health information sources. This indicates that sexual health promotion activities could be more effective if they do not differentiate the content, but rather use other channels whereby migrants with lower education attainment seem to be more susceptible to gaining knowledge through experienced peers (informal help), while migrants with higher education attainment give more appraisal to persons who gained their knowledge and expertise through education and profession (formal help).

Health locus of control Our respondents demonstrated a predominant internal health locus of control as the majority was convinced that one is responsible for shaping and maintaining good sexual health. They were convinced this could be done by having a general healthy life style, using contraceptives, not having multiple sex partners, being informed on risks and prevention strategies and seeing a doctor when necessary. This is in line with earlier findings on internal health locus of control and sexual health [55-57]. Yet, most of them felt that this personal attitude was hugely challenged by the structural dependent situation they were living in. This situation is induced by the organization of the Belgian and Dutch asylum reception system and migration law, the impact of which we will discuss when addressing determinants at the organizational and societal level.

Interpersonal level

> *"I have no hope for the future. I live in a reception centre without any contact with other people. I have no money, no work and no contact with girls."*
> *(Zoran, 23, male Kurdish asylum seeker)*

Additionally, given the societal aspects of their restricted legal status which reduce possibilities to participate in Belgian and Dutch society [14], respondents are also structurally hampered tap their human and social capital. Literature has shown that having restricted social networks is not only bad for their mental health [58-60]; it also reduces the number and quality of channels they can address in search for sexual health prevention and promotion norms and strategies [61-63]. Our respondents, and especially the young as well as the female respondents, indicated that their direct environment, –preferably friends, parents and siblings-, were one of the first sexual health sources to consider. This confirms earlier literature stating that adolescents' sexual behaviour is strongly influenced by peers [64,65] and parents [65]. Given these pathways, it is to be advised that refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands are empowered to strengthen social networks and are facilitated to take up an active parental or peer educative role in order to enhance the exchange of transferable knowledge skills through social learning and the creation of social support.

Organizational and societal level

Although 80% of the respondents reported to be practicing religion, only very rarely religion was mentioned as a determinant and in the analysis no links could be found either.

> *"Men are very proud if they speak about sex with their friends and it is a declaration of their sex excellence; but for women it is embarrassing to talk about sex. And I don't think that the religion has an effect here."*
> *(Farrah, 34, female Iraqi asylum seeker)*

This questions the often suggested intervention to set up health promotion campaigns through religious institutions and by religious key people. In our, mostly highly educated, group of respondents it seemed that other institutional and public channels are preferable to address, as there is media, educational bodies and the health sector. Our findings confirm that in addition to traditional channels as TV, radio, books, magazines; it is wise to invest in social media as channels for culturally competent sexual health promotion activities emphasizing a positive, yet critical and balanced approach to sexual health and sexuality, especially when targeting youth [49,66]. Educational bodies as schools and universities were indicated as facilitating sources for sexual health information rather than primary sources. This has to be taken in consideration in school programmes for minors since the right to education in Belgium and the Netherlands is restricted to the age of 18 for asylum seekers and undocumented migrants. For adults, this could be

addressed through the language and societal courses that are often considered as compulsory to a potential prolonged stay in the host country. Yet, our findings confirm that these educational programs better not stem from one cognitive behavioural model solely but should take factors at all socio-ecological level into account [67]. Given the preference for the health sector as primary sexual health source in all ages and genders and especially in more educated persons, and the induced external health locus of control putting more dependence on powerful others as health practitioners [47]; it needs to be emphasized that health workers should be strongly encouraged and trained to play a leading role in culturally competent sexual health promotion activities towards this population.

Finally, although the respondents demonstrated a predominantly internal health locus of control, most of them emphasized that this personal attitude is challenged, given the structural dependent situation enforced upon them by the current organization of the Belgian and Dutch asylum reception system and migration law.

> *"During this long period refugees are under constant fear, anxiety, stress and other mental disorder. They see no future and end up into drug abuse, frustration, sleeplessness and change of behaviour" (Keynaan, 36, male Somali asylum seeker)*

They indicated that the asylum system and its procedures brought about stress, sadness and frustration, which they perceive as negatively impacting their sexual health. Moreover, the asylum system also creates barriers to being sexually active. Due to infrastructural limitations, the privacy for couples and families can physically nor emotionally be guaranteed, and both genders are either forced to live together or on the contrary separated from each other, irrespective of what residents would prefer as housing rules. Furthermore, in a lot of reception facilities there are strict rules on receiving guests. This all adds up to unavailability of intimacy and sex opportunities which are perceived as negative factors. Also in other domains of life as seeing a doctor, cooking, managing administration, participation in social activities outside the facilities, work and others; asylum seekers are taken care off and room for autonomy, own initiative or responsibility is heavily reduced. These social, political and practical challenges linked to the Belgian and Dutch asylum reception system dependency force migrants to have a more external passive health locus of control, reduced autonomy, low self-esteem, heightened stress and sexual unavailability. According to literature, these aspects are known to create sexual difficulties in both genders [39-42,68-70] and may also lead to poor lifestyle, less adequate use of contraceptive methods, lower adherence and service utilisation and higher risk behaviour and susceptibility to ill-health [55-57,71-73]. It is thus to be advised that the Belgian and Dutch asylum reception sector can dispose of organizational policies that promote sexual health rather than restricting it by enhancing the individual capacities and skills of residents thereby facilitating their proper mastering of health and inducing good sexual health at the long run.

Conclusion

Our results demonstrate that being a refugee, asylum seeker or undocumented migrant in Belgium and the Netherlands is a risk factor for sexual ill-health and confirms that migration and legal status in this matter can be considered a health determinant as such [74]. Yet, as the Belgian and Dutch governments endorsed sexual health as a human rights issue; they should be enforced to develop sexual health promotion activities that are more desirable in the sense that they reduce the odds of having migration and legal status as a sexual health determinant. This entails that actual determinants at all socio-ecological levels are concurrently addressed. First of all, refugees, asylum seekers and undocumented migrants should be considered as potential active agents in the Belgian and Dutch society who also have the right to good sexual health and sexuality beyond the level of absence of disease or infirmity. As a consequence, sexual health promotion activities should be made culturally competent, also taking their sexual health frame of reference and pathways into account. This implies that in order to maximize the potentiality of getting the message across, used channels should differ. As the constitution and origin of those populations fluctuates over time, more research is needed to inquire on refugees, asylum seekers and undocumented migrants of other descent. Last but not least, structural organizational and societal factors linked to the asylum reception system that now hamper the building of social networks and their active participation in society should be addressed in order to give refugees, asylum seekers and undocumented migrants the same opportunity as general citizens to be equally in control of their sexual health and sexuality.

Limitations

As a pilot study on sexual health in hard to reach populations, the sampling of the respondents was done through criterion and chain sampling within the networks of the coordinators, the CRs, the CAB members and some asylum reception centres. Although we initiated our search for respondents from a vast pool of primary sources, this sampling method cannot assure a representative sample. In addition, although all CRs participated in the same training, and questionnaires were translated and back-

translated, we cannot guarantee that their epistemological perspective while conducting and translating the in-depth interviews might have differed slightly from the ones of the main researchers. Both these elements might induce biases in the data which we consider not generalizable. Yet, we do believe they are transferable to similar populations in comparable settings. Furthermore, this research addressed the main groups of asylum seekers, refugees and undocumented migrants in Belgium and the Netherlands at that time. Therefore, cultural aspects linked to those origins cannot be plainly extrapolated to any other refugee, asylum seeking and undocumented community present in Belgium or the Netherlands.

Competing interests
The authors declare that they have no competing interests.

Authors' contributions
IK conducted the research from conception to final reporting of the results to the funding body and coordinated the participatory approach in all phases of the research project in collegiate collaboration with CRs and the CAB. IK also drafted this manuscript. NV, KR and MT participated in the CAB as experts and thus had decisive input in every phase of the research project. They all contributed to the draft of the manuscript and approved the final version.

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4.4 The Impact of Legal and Policy Frameworks on Sexual Violence And Sexual Health in the Context of Migration.

The health status and health needs of refugees, asylum seekers and undocumented migrants may differ greatly from those of the general European and Moroccan population. The healthy migrant effect that might have helped them to initiate and endure migration might be heavily challenged upon arrival at the entry gates of Europe. A setback in their legal and socio-economic status as well as discrimination on different levels creates vulnerability and induces ill-health. Although attaining the highest standard of sexual health is a human right and the European Union defends its universality; there seems to be a discrepancy between a proclaimed rights-based approach to health and actual obstacles to migrants' protection of violence and attainment of good sexual health in Europe and the European Neighbourhood.

The following papers address objective 4: to study how the current European and European Neighbourhood legal and policy frameworks affect the sexual health status of our study population as well as their risk to sexual violence.

Paper 2: Keygnaert I., Dialmy A, Manço A, Keygnaert J, Vettenburg N, Roelens K, Temmerman M (2014): Sexual violence and sub-Saharan migrants in Morocco: a participatory assessment using respondent driven sampling. BMC Globalization & Health 2014, 10:32. Type A1, Q1 public health, IF: 1.485.

Paper 5: Keygnaert I., Guieu A, Ooms G, Vettenburg N, Roelens K, Temmerman M (2014) Sexual and reproductive health of migrants: does the EU care? Health Policy, Vol.114, pp. 215-225. Type A1, Q1 public health, IF: 1.550.

Paper 6: Keygnaert I., Guieu A, Vettenburg N, Roelens K, Temmerman M (2014) What the eye doesn't see: A critical interpretative synthesis of European policies addressing sexual violence in migrants. Submitted manuscript.

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Sexual and reproductive health of migrants: Does the EU care?☆

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ABSTRACT

The European Union (EU) refers to health as a human right in many internal and external communications, policies and agreements, defending its universality. In parallel, specific health needs of migrants originating from outside the EU have been acknowledged. Yet, their right to health and in particular sexual and reproductive health (SRH) is currently not ensured throughout the EU. This paper reflects on the results of a comprehensive literature review on migrants' SRH in the EU applying the Critical Interpretive Synthesis review method.

We highlight the discrepancy between a proclaimed rights-based approach to health and actual obstacles to migrants' attainment of good SRH. Uncertainties on entitlements of diverse migrant groups are fuelled by unclear legal provisions, creating significant barriers to access health systems in general and SRH services in particular. Furthermore, the rare strategies addressing migrants' health fail to address sexual health and are generally limited to perinatal care and HIV screening. Thus, future European public health policy-making should not only strongly encourage its Member States to ensure equal access to health care for migrants as for EU citizens, but also promote migrants' SRH effectively through a holistic and inclusive approach in SRH policies, prevention and care.

1. Introduction

Migration policy has become a prime area of EU activity with the development of the "Common European Asylum System", five-year migration programmes, and partnerships with neighbouring countries.

However, there exists no consensual definition of "migrants" yet [1], which makes international comparison of data on these heterogeneous groups and the interpretation of legal, policy and academic documents a hazardous endeavour [2,3]. A frequently used terminology in migration policies is based on legal residence statuses, distinguishing regular (documented), whose entry and residence are authorized by State authorities; from irregular (undocumented) migrants. The former refers to people with a temporary residence authorization, as asylum seekers, foreign

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students and temporary migrant workers, but also people with long-term resident or citizenship status as permanent immigrants, official family reunification migrants and refugees. Irregular/undocumented migrants are persons who enter a host country without a legal authorization or overstay authorized entry as tourists, foreign students, temporary contract workers or rejected asylum seekers.

Regular migrants constitute an essential part of the European population. A mere 10% of the EU population in 2011 was born outside their country of residence, two thirds of them descending from a non EU Member State (MS) [4,5]. "Third-country" or "extra-EU" nationals accounted in 2011 for 6.6% (33.3 million) of the EU population against 4.4% in 2001 [5]. According to UNHCR, the 27 EU MS received between 2008 and 2012 2.6 asylum seekers per 1000 inhabitants with 296.700 new asylum claims in 2012, reaffirming the recent upward trend with an increase of 7% compared to 2011 [6]. Refugee status was granted to 14% of those applicants [7]. Accounting for irregular migration in the EU is extremely difficult, however the latest Frontex quarterly report (July–September 2012) states that more migrants were denied entry in the EU than in any other quarter since the peak of 2009 [8], where estimates were made of 1.9 million to 3.8 million irregular migrants in the EU [9].

Academic and grey literature are unanimous: the health and health needs of extra-EU migrants may differ greatly from those of the general European population [2,10–15]. Upon arrival, migrants' general health status might be comparatively better ("the healthy migrant effect") [16] yet depending on the policies and practices of the host country regarding migrants, they may experience discrimination and a drop in their socio-economic status. This does not only enhance their vulnerability, defined by the UN as "*a state of high exposure to certain risks and uncertainties, in combination with reduced ability to protect or defend oneself against those risks and uncertainties and cope with their negative consequences*" [11] but it also induces ill-health [17,18]. Their sexual and reproductive health (SRH) needs are considered "*particularly pressing*" [11]. Compared to the general EU population, extra-EU migrant women are less often screened for cervical and breast cancer [19], have less access to family planning and contraception [20] and a lower uptake of gynaecological healthcare [21], are more at risk of unintended pregnancies, pay fewer and later antenatal care visits [22,23], have poorer pregnancy outcomes (notably more induced abortions and complications except for lower birth weight for which current findings differ from migrant group, generation and EU host country) [20,22,24,25] and have higher infant and maternal mortality rates [20,23]. Both migrant women and men are more at risk of sexually transmitted infections (STIs), including HIV and hepatitis B [2,19,24,26,27] and of sexual violence [18]. Migrants also access general and SRH services far less than EU citizens [15] and health practitioners stress that "*some come only to die*" [28]. Female migrant sex workers (MSWs) are more at risk of acute STIs compared to non-migrant colleagues in high-income countries [29]. The EU Agency for Fundamental Rights (FRA) consequently stresses that migrants' SRH vulnerability and specific needs should be considered in a public health perspective within EU societies [30]. Yet, those topics remain largely ignored.

Since the 1946 Constitution of the World Health Organization (WHO) and the 1948 Universal Declaration of Human Rights (UDHR) the enjoyment of the highest attainable standard of health is put forward as a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition [31]. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966. [31]. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued "General Comment 14", an authoritative explanation of the Article 12.1 on the right to health of the ICESCR. It states in paragraph 12 (b) that governments have legal obligations to ensure that "*health facilities, goods and services are accessible to all, especially the most vulnerable of marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds*" [32], defined as "*race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status*" (§18 [32]). In addition, the CESCR specified that States have an obligation to respect the right to health "*by refraining from denying or limiting equal access (. . .) for all persons, including (. . .) asylum seekers and illegal immigrants, to preventive, curative and rehabilitative health services*" [31]. All 27 EU MS ratified the "International Bill of Human Rights" (= UDHR, ICESCR and ICCPR) obliging them to comply. The EU prides itself as a promoter of human rights stating "[the EU sees] *human rights as universal and indivisible. It actively promotes and defends them both within its borders and when engaging in relations with non-EU countries*" [33]. It consequently adopted its Charter of Fundamental Rights in 2000. Yet, the Charter allows national conditioning for the right to health.

The first comprehensive framework on sexual health (SH) was drawn at the 1994 International Conference on Population and Development (ICPD) in Cairo, which put SH forward as a human right. The ICPD final declaration stated that "*for sexual health to be attained and maintained, sexual rights of all persons must be respected, protected and fulfilled*" [34], which was re-emphasized in the General Comment no. 14 [32]. Furthermore, the ICPD Action Plan fostered specific actions to overcome migrants' vulnerability and was endorsed by the EU MS. Hence, SH was defined as "*a state of physical, emotional, mental and social well-being related to sexuality [and] not merely the absence of disease, dysfunction or infirmity*" [34]. While SH has long been considered subsumed to reproductive health, the WHO proposed in 2010 to reverse this understanding by stating that "*sexual health requires a positive, respectful approach to sexuality and sexual relationships and that sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction*" [35]. It re-asserted the need to ensure SRH through a "*positive approach*" [35] stressing good health and well-being aspects rather than the absence of diseases. This also echoes research defining

migrants' health as "*going beyond the traditional management of diseases and intrinsically linked with the broader social determinants of health and unequal distribution of such determinants as such as services*" [36]. Understanding health as a holistic state has thus lately irrigated literature on both SRH and migrants' health.

Yet, this holistic perspective in the context of migrants' SRH was little developed at an EU level. Given the specific SRH needs and vulnerability of extra-EU migrants, the objectives of our study were fourfold. We wanted to (1) explore whether the current European policy frame on extra-EU migrants' SRH is consistent with a rights-based approach, respecting the right to health for all; (2) assess if and how this frame creates obstacles for migrants in the EU to attain a good SRH; (3) examine the current migrant health field suggestions on how to overcome these obstacles. Based on this analysis, we finally aimed (4) to formulate SRH policy, practices and research recommendations in order to promote SRH in the EU holistically and in a migrant-inclusive manner.

2. Methods

2.1. Conceptual framework

The conceptual framework in which we conducted our study combines a rights-based approach with the socio-ecological model on health. The rights-based approach considers health as a human right and assesses policies, programmes and legislation accordingly [19,37], expecting them to promote health and guarantee access to health care for all independently of any status. This approach is rooted in the overarching principle of universality [38].

Obtaining good health is a complex and dynamic social issue involving multiple determinants. The socio-ecological model identifies determinants at the individual, interpersonal, organizational and societal levels, allowing a better understanding of health complexity and facilitating multi-levelled strategic policy-making [39]. As both favour a holistic vision of health, it is compatible with a rights-based approach.

We restricted the review to the 27 EU MS as of April 2013. Because intra-EU migration is submitted to different frameworks, we focused on extra-EU migrants solely, further referred to in this paper as "migrants". As we wanted to explore the impact of legal status on the right to health, we included refugees, asylum seekers, and irregular migrants. Finally, we gave special attention to migrant sex workers (MSWs) and LGBT migrants. The rationale behind those choices is our hypothesis that diverse migrant groups might face specific vulnerabilities and depend upon different legal and policy documents.

2.2. Review method

To address our four objectives, we were confronted with both grey (including legal) and academic literature. Given the diversity of this data pool, we opted to conduct our review with the Critical Interpretive Synthesis (CIS) method [40], specifically created and frequently used to study inequalities within health care systems [41–43]. Designed to handle a large and heterogeneous set of references, CIS allows for the development of concepts and theories along the review process [44–46], for a synthesis of "*a diverse and complex body of evidence*" [42] and for a focus on "*a more flexible, iterative, dynamic, critical and reflexive approach to synthesis*" [41]. This conceptual framework served to conduct our review and analyze our findings, combining CIS with a rights-based approach and a socio-ecological model.

We searched for academic references on Web of Science using 'SRH' or 'SRHR' as Mesh terms associated with 'Europe/EU' and 'migrant'. To those main ones, we added: 'regular', 'legal' 'refugees', 'asylum seekers', 'undocumented', 'irregular' and 'illegal', 'LGBT' and 'sex work/sex workers'. As European institutions and competences were reorganized following the adoption of the Lisbon Treaty in December 2007, the period chosen for academic sources was 2008–2013. Yet, the references of this literature provided us with additional relevant academic references published between 2000 and 2008. We included two non-EU studies with general recommendations on migrant-friendly health services applicable to any setting. Grey literature was sought for manually, with a European/EU perspective and a focus on policy-making as selection criteria. International (WHO and UN), Council of Europe and EU (European Parliament, Commission and Council) institutions' websites were used to find relevant legal provisions. Field recommendations on migrant health practices were searched for by assessing websites and newsletters of major NGOs and networks working in the field of health and/or migration. Given the language skills of the authors and the diversity of EU official languages, this search was however limited to those providing information in English, French, Dutch or German. We eventually included 187 advocacy and legal references (grey literature) and 80 academic articles.

2.3. Analysis

Subsequently, we analyzed this data pool through the lens of our research questions:

1. Is the current European policy frame on SRH of extra-EU migrants consistent with a rights-based approach respecting the right to health for all?
2. Does this policy frame create obstacles for migrants in the EU to attain good SRH and if so, how?
3. What does the current migrant health field suggest on how to overcome these obstacles and what unconsidered SRH issues are to be found?
4. Which policy, practice and research recommendations can we formulate on the basis of our analysis in order to promote SRH in the EU holistically and in a migrant-inclusive manner?

We used NVivo 9.0 to analyze the grey literature, initially coding the findings around 47 grounded thematic nodes and three main transversal categories, being legal status, people and gender. Subsequently, we applied our conceptual framework, structuring nodes and categories

along the four socio-ecological levels. We used the resulting blueprint to filter academic references for results and merged outcomes. This process was itinerated by the two main researchers.

3. Results

We will firstly discuss the applicable EU legal and policy SRH frameworks and their consistence with a rights-based approach. National particularities are only mentioned when they highlight a lack of coherence throughout the EU. Subsequently, we address some major obstacles in migrants' attainment of good SRH in the EU and compare them with current field suggestions on improvement of migrant health practices.

3.1. An inconsistent rights-based approach in legal and policy frameworks

The scarcity of specific European and international legal and policy provisions illustrates the relative newness of SRH and rights (SRHR) in EU health policy discussions. However, specific obstacles for migrants' SRH and measures to overcome them from a rights-based approach were already identified at the 1994 ICPD Conference and in the General comment no. 14 in 2000. Despite a formal recognition of SRH issues and an acknowledgement of a needed rights-based approach to SRH, the EU has taken few actions accordingly. Among other documents, its latest Women's and Men's Health reports barely address migrants' health needs or SRH [27,47]. This reticence hinders the inclusion of migrants into SRH policy-making and sustains legal uncertainties, fuelling discrimination and the difficulty for migrants to seek redress [21]. Moreover, the review of the few legal provisions on migrants' SRH reveals that most retain a 'reproductive' logic and have not yet broadened their scope to all the dimensions of SH. This means that existing provisions focus on women, particularly pregnant [48–50], increasing thus legal uncertainties for other non-pregnant migrants, leaving their specific needs unaddressed and their right to the highest attainable standard of SH potentially breached.

Research has shown that addressing migration as a threat to European health systems and finances also hinders the realization of migrants' SRHR by impacting both public opinion [51] as well as migrants themselves, who "*fear of being thought of as using too many resources*" [52]. Studies on the intersection between ethnicity and gender indicate that migrant women may suffer from particular discrimination within general [21] and SRH care [53]. In the case of MSWs, irregular migrant status combined with legal frameworks surrounding sex work has shown to lead to a heightened fear among MSWs, preventing them from accessing SRH services [54]. Despite the General Comment no. 14, the IOM stressing the fundamental role of access to quality care in the attainment of the highest standard of health and migrants' social inclusion [55] and a few EU statements in this direction [56,57], the overall policy focus at both European and MS levels undoubtedly remains on controlling migration flows. The collision of health and immigration policies thus acts as a "*blackmailing*" [58], deterring migrants and particularly irregular ones from entering SRH care and consequently attaining good SRH.

While the rights-based approach of health seems to gain some momentum in international and regional frameworks, EU MS face a hiatus between these requirements and their own migration policies. This clearly conflicts with a rights-based approach, as the prioritization of migration controls creates obstacles preventing migrants from realizing their right to health, particularly by restricting access to care. Allowing (ir)regular migrants to access health care is now often considered a State charity or generosity [31] while General Comment no.14 specifies that accessibility is core in the right to health [32] and thus a "*legal obligation and not a matter of charity or political choice*" [59].

3.2. Legal and policy obstacles to migrants' SRH

Legal and policy frameworks heavily determine the accessibility of SRH services for migrants and their review shows that they are consistently barring the realization of migrants' SRHR. Above all, within the examination of a rights-based approach, the question of access to healthcare in general is central since it is a "*crucial component of a person's fundamental right to health*" [21]. Despite of all 27 EU MS having ratified the "International Bill of Human Rights", and thus acknowledging migrants' right to health, migrants' access to health care is simultaneously framed by other binding documents [60,61]. The EU Charter of Fundamental Rights for example sets out in Article 35 that "*everyone has the right of access of preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices*" [61]. This leaves room to different and potentially more restrictive national or subnational provisions which might be inspired by other pressing issues and policies, as is migration.

The 'criminalization of migration' affects migrants' realization of their right to health as their access to health care can easily be restricted [62]. In several MS, legal provisions on health at (sub)national level overlook migrants or circumscribe their access to emergency care and "*core benefits*" solely [63]. Additionally, a consistent definition of what emergency care exactly entails is often lacking, provoking uncertainty around SRH among countries and over time. The UK removed for example HIV treatment from its emergency care list in 2009, hence abandoning free of charge treatment for all patients [64]. Pace stressed that MS restricting access to health care to emergency care only fail as such to meet the principle of non-discrimination set out in Article 2 of the ICESCR [62]. Restrictions often increase for irregular migrants. Research of Rechel et al. demonstrated that even emergency care was not accessible to irregular migrants in nine of the EU MS in 2010 [65]. Yet, already in 2005 the European Court of Human Rights stated that social benefits as health services are a property right, irrespective of work or other contributions, and that denying health care to irregular migrants may equally breach the right to be free from inhumane and degrading treatment (resp. Article 1 and Article 8 of the first Protocol to European Convention on Human Rights) [62]. Similarly, the European Parliament (EP) recently advocated for a better integration of all migrants within health systems [66].

Beyond emergency situations, the access to care is dependent on regional and subnational differences. While historically the Mediterranean and Benelux regions used to grant access to a wider range of services to all, current policies to counter the economic crisis alter this practice [64,65,67]. Finally, countries providing free access to SRH care rarely properly advertise it and migrants ignore such entitlements [64].

Although public health policy remains a MS national competence, since the Lisbon Treaty entered into force in 2009, positions and powers are shifting. The European Charter of Fundamental Rights became binding on MS (except opt-outs) and respect for human rights was emphasized as a founding value for the EU [62]. Subsequently, promoting "wellbeing" – as linked to health in the WHO Constitution – became a new EU objective and the EU may now introduce binding public health legislation regarding health safety concerns [62]. The EU level in health policy is thus slowly strengthening. Yet, the current combination of (sub)national, European and international frameworks consequently turns the right to (SR)health into a patchy situation with an array of obstacles barring the exercise of this right [12,37,65,68].

3.3. Additional obstacles barring migrants' access to SRH services

The current complexity and uncertainty prevents migrants from accessing SRH health care and attaining good SRH. Navigating health systems and available NGO services is arduous because of linguistic difficulties, rendering basic interaction a challenge [52,69]. Interpreters and cultural mediators are rarely used to facilitate dialogue and mutual understanding of body, health and illness [70], while the building of a "*safe space*" [53] is considered essential to effective migrant-friendly SRH care and consequently of the right to health [32]. Though a 2013 report of the EU FRA highlights the crucial role of understanding to exert one's rights to information, explanation and informed consent [21]; potential discrimination within healthcare hinders such communication. Literature shows how perceptions of race, ethnicity and gender participate in excluding migrants, particularly female, from care [53]. This is heightened, in the case of MSWs, by social and moral views on sex work [13].

Covering the (often full) costs of care constitutes an additional barrier affecting especially but not exclusively undocumented migrants [65,67], who experience for example strong (sub)national variations in perinatal care costs, being charged recently between €0 (in Spanish Catalonia and Andalusia) and €2685 (Sweden) for a delivery [65,67]. Additional indirect strains include housing and transport costs when migrants are obliged to move regularly or live in under-served areas [52].

In addition to linguistic and financial obstacles, migrants face a high administrative burden. A survey on 1218 irregular migrants in 11 EU MS showed that 74% of them deem health systems as too complex [64]. Even when legally entitled to care, migrants are often required to provide proofs of residence, insurance or resources, requirements that remain in most cases obscure to themselves and health professionals [19].

Those uncertainties are attested by medical and administrative staff reporting difficulties in determining what level of service they can provide to which migrant groups. This lack of information adds to the absence of reimbursement guarantees and leads practitioners to adopt discretionary measures. Whether (mostly) more excluding or more beneficial to individuals, this breaches equal treatment [12,71]. Uncertainties force local authorities to implement small scale mechanisms and NGOs to become care providers [64,67]. Research has questioned the sustainability of such strategies, denouncing differentiated treatment as a contradiction to a rights-based approach. Despite formal acknowledgments of NGO expertise and a "*shift*" of responsibility [67,71] from MS to NGOs, the latter still receive little public funding [72–74]. As the Greek, Spanish and Portuguese examples recently prove, public funding for health and social care is often among the first to be cut when (forced) austerity measures are issued in times of economic crisis, inducing high health risks for the most vulnerable [75]. As an effect of austerity in Greece, NGOs that initially provided free health care to undocumented migrants are now called upon by the general population while they are not able to provide on such level [76]. Finally, some NGOs are reluctant to include LGBT migrants or MSWs, isolating them even further [77]. Outsourcing SRH care could be a sign of EU States' reluctance to address migrants' SRH in a positive and holistic frame.

3.4. Migrant health field recommendations on SRH

Literature provides field recommendations addressing these gaps. They aim at strengthening a rights-based approach to SRH in the EU and inclusive SRH policies. Two aspects that have been particularly explored by previous research are culturally sensitive SRH care and strategic policy planning. We articulate here non exhaustively the main field recommendations socio-ecologically clustered. They address both European and national policy-makers and serve as tools for a more comprehensive rights-based approach.

Cultural and Gender Sensitive Health Care	
Individual and Interpersonal levels	
Involving migrants and communities	Considering migrants as "*active agents of choice*" towards SRH [13]
	Encouraging communication on family planning, sexual behaviours and gender equality [19,53]
	Collecting "*input for services planning and development*" [55] through participatory methods [78]
Overcoming language barriers	Generalizing the use of professional interpreters [79,80]
	Guaranteeing interpreting services with legal provisions [80,81]
Raising Awareness for migrants	Providing information on the right to health to migrants [63]
	Circulating information packages including SRH information, legal entitlements, financial assistance, local services [82]

Developing health literacy of migrants	Considering cultural understandings and taboos around body, sexuality and health [78] Including socio-cultural dimensions in sexual education [83]
Organizational level	
Raising awareness for health staff	Encouraging staff to propose counselling over systematic medication [52] Raising awareness of discrimination among health staff [84]
Enhancing cultural competence of staff	Integrating gender, legal, cultural, socio-economic and communication aspects in health professionals' formation [13,82] Providing specific cultural training on dealing with traumatic experiences, including sexual violence [70,78,85]
Act upon financial barriers	Assessing the impact national healthcare systems [12,21]
Improve accessibility of healthcare services	Considering diverse populations' (migrants-inclusive) needs for services (opening hours, appointments, etc.) [21] Recognizing multi-dimensional aspects of accessibility [32]
Societal level	
Strategic Policy Planning	
Collecting Data	Enhancing the use of uniform indicators on migration and include improved questions on migration in existing data collection processes [3] Conducting large statistic studies to obtain strong comparable EU data [21,86] Collecting quantitative and qualitative data and clinical evidence on migrants' health and SRH determinants [2,87]
Developing European coordination	Implementing horizontal technical cooperation on specific SRH topics [88]
Mainstreaming Health & Migration	Integrating health and migration from a rights-based approach in all policies for a "*holistic approach*" [55] Understanding migration as a phenomenon spilling beyond immigration control policy [71]
Building Policy	Targeting health inequalities through systematic interventions, from observation to implementation and evaluation [89] Improving acceptability and quality of health facilities, goods and services for all [32]
Developing Funding	Making EU financial resources for asylum and migration policies more coherent [73] Enhancing funding for migrant-friendly hospitals and practices [90]
Assessing Impact and Monitoring	Combining different methods of evaluation: audits, questionnaires, anonymous reporting, benchmarking... [82] Ensuring evaluation is continuous [13]

4. Discussion

4.1. Questioning the consistency of a rights-based approach to SRH in the EU

Our results clearly show the absence of an overall rights-based approach in policies regulating migrants' SRH in the EU, as legal status remains a major determinant in accessing care and in attaining good (SR)health in the EU. This does not mean that EU nationals do benefit from a comprehensive rights-based approach to SRH, but rather that the specific legal and policy documents framing migration do not ensure a rights-based vision of SRH for migrants. Our review underlines that even when frameworks refer to a rights-based approach, their application might vary with migrants' status. Most documents constituting those frameworks, however, do not differentiate and target all groups indifferently [2]. The study of international, European, national and subnational frameworks clearly reveals a discrepancy between the increasing acknowledgement of specific migrants' needs and the simultaneous enforcement of policies restricting their right to health. This hiatus could be analyzed as "*managing the paradox*" [91], a concept grounded in organizational theory that aims at understanding organizations conducting two apparently contradictory policies. The International Organization for Migration applied it to migrant health and concluded that EU MS adopt diverse strategies to address the paradox between guaranteeing human rights and controlling immigration flows [37]. Such strategies aim at circumventing rather than solving the paradox, resulting in a flawed rights-based approach and negative outcomes for migrants. This diversity of strategies is also an obstacle to potential EU-wide coherent policies.

The MS are the core agents in ensuring that the right to health is fully respected within their territory, as only States can endorse the International Bill of Human Rights and as the EU Charter acknowledges national conditions to this right [92,93]. As stated earlier, all 27 EU MS ratified the International Bill of Human Rights which as such obliges them to comply. Moreover, the EU does not condone national conditioning of all human rights. Does the EU then care more for one human right than for another? This double standard would not be problematic if all MS had national laws and practices that satisfy the requirements of international human rights law. Yet, our results show that several MS do not uphold those requirements when it comes to SRH of migrants. We thus argue that this conditioning, influenced by migration policies, creates a flawed rights-based approach as well as obstacles for migrants to attain good SRH in the EU, which from a public health perspective is a risk to ill-health beyond migrant groups. For the sake of all people living in the EU today and in the future, it is thus paramount that laws and policies regulating SRH&R are altered. Firstly, we agree with the FRA that the further outsourcing of responsibility to provide accessible (SR)health care from EU MS to NGOs and civil society is revised [94]. In addition, we agree with Rechel et al. that it would already be a major step forward to strengthen the legislative basis for protection of the right to (SR)health for irregular migrants and asylum seekers at the national level and to ensure implementation [65]. Yet, we mostly support the thesis that Alston and Weiler already advanced in 1999, postulating that the role of the EU and its MS in upholding human rights were to lead to an empowered EU as "*the promotion and protection of human rights is not a one-time undertaking and neither government nor bureaucracies can be counted upon to remain consistently, let alone insistently,*

vigilant" [93]. Meanwhile, positions have shifted a little. The Lisbon Treaty posits that the MS remain responsible for the "*definition of their health policies*" and the delivery of care services, while the EU policies must ensure "*a high level of human health protection*" [95]. The European Commission (EC) also recently reiterated its ambitions in health public policy by stating that "*respecting national responsibility for health systems does not mean doing nothing at European level*" [96]. SRH&R are however only hesitantly dealt with at EU level, being hardly consensual topics [97]. Answering to a question on abortion and SRHR submitted by EP Members [98], the EC stated that this primarily remained a national competence and that the EU had no vocation to take the lead [99]. We thus consider it necessary to fuel the debate and encourage further empowerment of the EU aiming at a shared responsibility of all MS and the EU to lead by example by ensuring and controlling that also the right to (SR) health is truly upheld for all in every place of its political territory.

4.2. Legal and policy frameworks on migration as obstacles to migrant health

Migration management has become a major challenge for the EU and relevant legislation is currently being revised. The EP agreed to recast the 2003 Directive on minimum standards for reception of asylum seekers, which was accepted by the Council in 2012 and now awaits formal adoption. This was accompanied by the establishment of the European Asylum Support Office in 2011. The overall objective of the Stockholm programme setting the EU migration strategy is to realize a Common European Asylum System (CEAS) and "*progressively establish an area of freedom, security and justice open to those who, forced by circumstances, legitimately seek protection in the Union*" [100]. Although EU Commissioner Malmström acknowledged the necessity to protect the rights of everyone living in the EU [101], the most recent legislation and policies focus on asylum seekers and beneficiaries of international protection solely. In parallel, the EU has developed bilateral partnerships and Actions Plans through the Neighbourhood Policy (ENP). Migration is no explicit topic there, although combating 'illegal' migration is listed among cooperation objectives in working documents. This policy orientation has been questioned in the light of the EU responsibility in negative outcomes of border controls for migrants' safety [102].

Migration and health/SRH remain separate in policy-making at national and EU levels [55]. The few strategic documents addressing both issues tend to tackle HIV/AIDS transmission, which might be interpreted as a construction of migration as a health security threat. This is particularly visible in the case of MSWs, where the emphasis on protection of host societies' health is reinforced by historical perspectives on both migration and sex work [29,103], as illustrated by the continuation of mandatory HIV testing for MSWs in some EU MS (Austria, Hungary, Latvia) [13]. On July 1st, 2013, Greece has reactivated mandatory HIV testing for high-risk groups, including undocumented migrants and sex workers, a move that was globally condemned after pictures of tested women were leaked online without their consent [104]. Coupled with current divergences among EU countries, this is an obstacle not only to the realization of migrants' rights but also to an EU standardized and coherent policy response to migration and health issues. Previous findings indicate that discrimination towards migrants in health systems hinders their right to health in general and SRH in particular [19,53,57,58]. As noted by Dean [105], the application of a rights-based approach is currently overlooked by European welfare regimes traditionally based on citizenship rather than on universality. This may be linked to the European democracies' conception of state sovereignty based on citizenship and subsequent perceptions of migration as a potential threat to this sovereignty [4].

The development of a true rights-based approach to health and SRH for all thus also requires rethinking the current European paradigm on migration, notably by recognizing the need for legal and policy bridges between health and migration policies. In the current economic context, mainstreaming health and migration and optimizing the use of resources has become a need [4]. However, this can only be done if migration is no longer considered a threat to public health and societies and if the discourse on migration flows stops revolving around an ever stronger securitization. Future policy-making should address such discourses and develop broader understandings of the interaction between health, welfare, citizenship and migration.

4.3. Obstacles in care provision to a rights-based approach of migrants' SRH

The need of consistent migrant-friendly care is increasingly acknowledged in literature and legal – although mainly non-binding – provisions [66,74]. A consensus seems to be reached on different pathways to enhance culturally sensitive care [55,79,80,90,106,107]. Engaging in such reforms would help consensus building on the right to health and reinforce migrants' integration. Simultaneously tackling frameworks and practices is consistent with research on 'Europeanization' process of integrating common standards in the different MS as "*dynamic and contingent – taking into account informal norms, discourses, socialization, learning and the role of ideas*" [108]. Further research combining those aspects would allow for a better identification of policy gaps and persistent barriers for migrants in European societies. It would also benefit European citizens through the development of patient-centred care [85,109].

4.4. Gaps in current research and recommendations for future endeavours in the field

Grey literature on migrants' (SR)health has been produced by a heterogeneous range of NGOs working on migration and/or SRHR. Because those organizations undertake mostly specific and small-scale research [110], their results are often limited to some dimensions of migrants' SRH. Relevant academic sources were scarce and often narrow. Although many acknowledged the necessity to conduct multi-dimensional thinking on migrants'

(SR)health, few effectively combined political and economic analysis with field and participatory studies on migrants' access to health. Despite a growing interest, no cost-efficiency analysis of access across European countries has been consistently conducted yet [111].

Studies on migrant health have especially engaged in conflict settings and mental health issues [19]. Research addressing migrants' SRH has rarely stepped outside the scope of maternal health and HIV/AIDS. Although SH is now understood as encompassing perinatal aspects and STIs [19], research and practices in the field have undoubtedly continued focusing on those topics. As a consequence, a significant number of SH topics are left unaddressed, such as sexual education, choice of partner, deciding to be sexually active and pursuing a satisfying sexual life. Family planning, which bridges sexual and reproductive health, is another pressing issue in migrants which requires more attention. Migrants still have poor access to family planning and effective contraception, while evidence shows that access improves reproductive health outcomes as well as general health, education and economic situation [112,113]. We deem it thus paramount to prioritize family planning in migrants, starting from a positive SH promotion perspective.

Another gap arises in defining target groups as the majority of migrants in the EU are neither pregnant nor infected with an STI. Hence, future migrants' SRH interventions should stem from a holistic and positive approach and also address SH promotion in adolescents, women without children, men, elderly, LGBT and MSWs. Finally, irregular migrants remain under-researched, particularly regarding their SRH behaviours [15].

These research gaps should be addressed with a double objective. First, future research should include a broader range of migrant populations and explore currently over-looked topics. Second, EU-wide datasets should be enhanced by common indicators, durable data collection [2,3,10] and the use of disaggregated data to explore simple and multiple discriminations [21]. Data collection is deemed essential to inform policy-making and monitor the impact of future interventions [3,110,114]. Those gaps in research might be partly explained by the lack of EU funding to support SRH research and interventions in Europe [115].

5. Conclusion

The question of migrants' access to SRH services is key to understand the position of extra-EU migrants and the extent to which a positive approach of SRH is applied throughout EU MS. The assessment of the current situation clearly unveils both blurred legal and policy frameworks and patchy practices, which are major breaches to the realization of a rights-based approach to (SR)health. Given that all MS ratified the International Bill of Human Rights and the European Charter on Fundamental Rights leaving room for conditioning the right to health, they remain responsible for enforcing this right and conducting public health policy. However, our review shows that migrants' health is far from being prioritized in (sub)national policies. Since the Universal Declaration of Human Rights was forged to ensure supranational protection of human rights and the Lisbon Treaty re-asserted their importance and EU competence, we deem it a prerequisite that the EU at least promotes the right to (SR)health for both host European societies and migrant groups more adequately and coherently and that it encourages its MS more strongly to live up to their human rights obligations. Yet, at a moment where migration policies are increasingly taken up at EU level and where the need for common policies is acknowledged, we encourage the debate to also investigate new avenues of health policy-making for a more prominent role of the EU and a stronger mutual control between the EU and MS in upholding human rights. This requires to no longer perceive migration as a threat to European societies but as a challenge and opportunity for the region's sustainability. Finally, it also requires to reconsider SRH, expand it comprehensively beyond the limited scope of reproductive health, and acknowledge it as a right for all.

Grasping the multi-dimensionality of sexual and reproductive health would thus allow for a better inclusion of diverse population groups in SRH promotion policies, an increased awareness of SRH complexity and fairer SRH care throughout the EU for all.

6. Limitations

As the language skills of the authors unfortunately do not span the rich diversity of EU national languages, we were not able to search for potentially relevant documents on national websites in other languages than English, French, Dutch or German. This is a clear limitation to our review. We however covered those national regulations when translated or covered by other grey literature provided by EU institutions and NGO documents in the above-mentioned languages. They largely confirm our findings rather than challenging them.

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What the eye does not see: A critical interpretative synthesis of EU policies addressing sexual violence in migrants.

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ABSTRACT

BACKGROUND Migrants are considered at risk of sexual violence worldwide. This literature review examines how legal and policy frameworks condition the prevention of and response to sexual violence affecting diverse migrant communities living in the European Union (EU).

METHODS We reviewed 187 grey literature documents and 80 academic references on extra-EU migrants solely in 27 EU Member States applying the Critical Interpretive Synthesis method.

RESULTS The current EU frameworks ignore frequently occurring types of sexual violence in both genders as well as risk factors within the EU, notably migrants' legal status and living conditions. Furthermore, they are poorly implemented at national level.

DISCUSSION The current paradigm in EU policy-making relegates sexual violence in migrants as a 'female' and an 'outsider' issue while EU migration and asylum policies reinforce its invisibility. In order to be desirable, future prevention and response action must stem from a rights-based approach and acknowledge the reality of sexual victimization of both female and male migrants within the EU.

Keywords

Sexual violence, violence against women, gender-based violence, migrants, refugees, European Union, policies

INTRODUCTION

Sexual violence (SV) refers to the "use of physical force to compel a person to engage in a sexual act against his or her will, whether attempted or completed, involving a person who is unable to understand the nature or the condition of the act, to decline participation or to communicate unwillingness to engage in the sexual act" [1] and conducted "by any person regardless of their relationship to the victim, in any setting including but not limited to home and work" [2]. SV includes sexual harassment, sexual abuse, attempted or completed rape or forced sodomy. Within (forced) migration, sexual exploitation, forced prostitution and SV as a weapon of war or torture are considered as extra types of SV [3]. SV can generate severe sexual, reproductive, physical and mental health consequences and socio-economic problems in both female and male victims [4-7]. Subsequently, the victimization might also be harmful to the victim's peers, offspring and community [8-10].

SV occurs in all populations around the globe [11], yet migrants are considered to be highly vulnerable [12-14]. Consequently, United Nations (UN) action plans specifically address prevention of SV in migrants [15-17]. Throughout the European Union (EU), SV remains widely under-reported with only 2 to 10% of the cases reported and with less than half of the Member States (MS) providing dedicated services or helplines to victims of rape so far [18]. Meanwhile the social stigma associated with victimization may express differently in migrant communities [13] and different comprehension of what SV entails might encourage under-reporting and self-blame [19] while at European level, both female and male migrants have been found to be at high risk of SV [20-25]. To what extent European legal and policy frameworks address prevention of and response to SV in migrants is however unclear.

Hence, this literature review examines how legal frameworks and current policies on health, violence and migration condition the prevention of and response to SV affecting diverse migrant communities living in the EU.

CONCEPTUAL FRAMEWORK

Our conceptual framework combines a public health and rights-based approach with the socio-ecological model on health and the concept of desirable prevention. A rights-based approach considers health as a universal human right and consequently assesses how far legal and policy frameworks enforce a universal access to the best standard of health attainable for all, regardless of individual status [26,27]. The socio-ecological model identifies health determinants at individual, interpersonal, organizational and societal levels, thus allowing for a better understanding of health complexity and facilitating multi-leveled policy-making [28]. Desirable Prevention seeks to improve the health and well-being of all through integrality, participation, inclusiveness, addressing root causes and maximizing agency [29].

METHODS

This review is part of a broader study on extra-European migrants' sexual and reproductive health (SRH) and SV in the EU-27. For a detailed description of our methods, we refer to our article on SRH and European legal and policy frameworks [30].

We knew our study was likely to confront us with a very diverse and ever-evolving data pool of literature addressing migration, SRH and/or SV. We therefore chose to use Critical Interpretive Synthesis (CIS) [31], a review method tailored to study inequalities within health care systems and to address a large and heterogeneous dataset [32-34]. CIS is designed to synthetize "a diverse and complex body of evidence" [33] and supports the development of concepts and theories along the review process [35-37].

Our search was conducted through scientific databases for academic references and manual search for grey literature. CIS favours prioritization over exclusion for literature search and therefore our only criteria of selection were a focus on EU contexts and policy-making. Because the EU institutions were reformed following the adoption of the Lisbon Treaty in 2007, we concentrated on the period 2008-2013, however some earlier relevant references were included ad hoc. Our broad study on SRH finally included 187 grey literature documents and 80 academic references. Respectively 37 and 12 of them focus on SV, however many references are cross-cutting as they inform the context in which frameworks on SV in migrants have been developed. We limited our scope to the 27 EU Member States as of April 2013 and focused on extra-EU migrants solely as EU citizens are subjected to different regulations. As we aimed to explore the impact of legal status on the right to health, we tackle more specifically refugees, asylum seekers, and undocumented migrants. Furthermore, as we hypothesized that diverse migrant groups might face specific vulnerabilities and depend upon different legal and policy documents; we gave special attention to migrant sex workers and lesbian, gay, bisexual and transgender (LGBT) migrants. Throughout this paper, we use 'migrants' when references explicitly include all migrant groups or did not differentiate themselves. For literature reviews, no ethical approval is required within our University.

RESULTS

Global frameworks affecting the EU

Sexual violence was long considered a "woman's issue". It was only in 1993 that the United Nations (UN) acknowledged violations of women's rights as fully-fledged violations of human rights [38]. Subsequently, the 1994 Cairo Conference on Population and Development, became a turning point in listing the right to be free from SV and coercion as a sexual and reproductive health right [39]. It also recognized migrants' vulnerability. Yet, the 1951 Convention listing

grounds for international protection [40] remained untouched and thus blind to SV until the UN issued specific guidelines for its application in 2002 [41].

In the meantime, the UN quasi-systematically tackled SV as a weapon of war and/or a form of violence experienced by women in conflict [42,43]. The terminology used in international frameworks was often confusing, jumping from 'SV' to 'violence against women' and later 'gender-based violence' [11,44,45] while rarely defining precisely what those terms cover. This not only fed uncertainty but also ignored evidence that migrant men were also vulnerable to SV [20,46-50]. The situation has partly evolved in the 2000s with some major documents such as the UN High Commissariat for Refugees (UNHCR) guidelines on SV in refugees being recast to become more inclusive of various experiences of SV [17].

European frameworks

Also at European level, a growing body of frameworks is aiming to prevent or respond to violence. Yet, those frameworks that address SV in migrants predominantly apply the same colored lenses: they focus on victimization of female migrants and on victimization that occurred in countries of origin, during (forced) migration as in trafficking, or on victimization resulting from harmful cultural practices such as female genital mutilation (FGM).

In 1997, the Hague ministerial conference issued a declaration on trafficking that resulted in EU-wide STOP programs [51]. In 2000, the Council of Europe issued a Recommendation [52] and a Convention on trafficking and sexual exploitation [53]. A Council Framework Decision [54] followed in 2002. A plan on combatting trafficking and sexual exploitation was developed by the EU institutions in 2005, addressing gender-sensitivity in prevention and response strategies and promoting cooperation among Member and with the EU border management agency FRONTEX [55,56]. FGM was tackled in both European Parliament Resolutions and European Commission Strategy for Equality between Women and Men [57-59]. The European

Commission also launched a Pilot project for Victims of Torture, which however remains a small-scale initiative with limited funding [60].

The first European Directive on minimum standards for reception of asylum seekers was issued in 2003 and stipulated that victims of torture, rape or other serious forms of SV should receive treatment [61]. The 2013 recast of this Directive goes further and now also requests member states to take "appropriate measures that prevent gender-based violence including sexual assault and harassment" within accommodation centers and to ensure "access to appropriate medical and psychological treatment or care for vulnerable groups", which now include victims of torture, rape and other serious forms of SV such as FGM [62]. Although these requirements remain limited and the implementation is still to be evaluated, this might be a starting point for more holistic prevention and response policies.

Furthermore, the European "Istanbul" Convention on preventing and combating violence against women and domestic violence [63] which was issued in 2011 and will enter into force in August 2014, specifies sexual violence, including rape and sexual harassment as specific types of violence against women. It also puts forwards that multiple perpetrators or repeated offences are to be considered as aggravating circumstances in legislation. Moreover, a full chapter (VII) is dedicated to migration and asylum, broadening opportunities regarding residence status, gender-based asylum claims and non-refoulement.

Poor and inconsistent implementation at national level

The body of international and EU provisions on prevention of and response to SV thus seems to grow and to become more adapted to the complexity of SV in general and in migrants in particular. However, national implementation follows at slow pace, and critical needs of (potential) migrant victims remain unanswered.

Only 7 MS were found to address SV with a gender perspective in National Action Plans in 2011 [64]. In 2010, only 10 of them had a rights-based approach towards victims of trafficking and only 9 clearly framed FGM in their criminal law [65], resulting in a low number of cases to reach European national courts [66]. In May 2014, only 5 EU MS, 3 candidate EU MS and 2 potential EU MS had ratified the Istanbul Convention while the process had started in 2011 and entry into force is foreseen for August 2014 [67]. Despite the apparent prioritization of this topic, EU coordination remains thus still poor in the field [68]. Only a few countries, as for example Spain [69], currently have national strategies on prevention of SV in migrants. Furthermore, although funding opportunities and joint initiatives between public health services, governmental agencies and NGOs have been encouraged at EU level [56,60,63,70], the latter are voicing strong concerns about their structural lack of funding limiting them to volunteer-based, small-scaled and short-term actions when implementing SV prevention and response strategies at national level [21,22,64,71].

Finally, specific tools designed to facilitate the protection of migrants against SV are often overlooked. NGOs working with migrants note that Country of Origin Information (COI) is often unreliable and misused when assessing asylum seekers' protection needs [72]. This COI-system has been championed by the UNHCR since 2003 as an effective way to "become informed about the refugee and host country or community culture, protection traditions, customs and gender/power relations" [17]. COI was endorsed by the EU in its Qualification Directive [73] and the European Asylum Support Office (EASO) is now in charge of regularly updating it [74]. The European Court of Human Rights recently stated that "on a purely pragmatic basis, it cannot be required that an expelling Contracting State only returns an alien to a country which is in full and effective enforcement of all rights and freedoms set out in the Convention" [75].

Invisibility of vulnerable migrant groups

Very little frameworks address particularly vulnerable migrant groups such as LGBT and migrant sex workers. It is only around 2010 that LGBT migrants have appeared in legal provisions around migration and/or SV [76,77]. Although they are particularly vulnerable to SV in both origin and host countries [78] and UNHCR increasingly includes them in violence guidelines [17,79], very few asylum seekers obtain a legal status based on their gender identity and/or sexual orientation in the EU [80]. Their migration remains poorly documented [81] and the COI is very often incomplete as to actual living conditions for LGBT individuals [78]. Additionally, LGBT migrants are often confronted with stereotypes and negative attitudes from migration agencies staff [82]. This results in an enduring invisibility of this migrant group in the EU.

Migrant sex workers remain similarly invisible. In many EU Member States, including those where sex work is legalized, they are often requested to exit the sex industry before applying for legal assistance [22,25,83]. Finally, protection mechanisms for migrant victims of SV often discard potential distress and memory issues hampering their capacity to cooperate in procedures and consequently to obtain protection [19]. This confirms that accessing a protected status for migrant SV victims is dependent upon conforming to expectations on gender or activity. Such a paradigm overlooks the complexity of SV and migrants' experiences.

Literature recommendations

It thus appears that the potential for developing effective prevention and response policies in the EU remains significantly hampered. Both grey and academic literature formulates suggestions to overcome those obstacles. As they are mostly similar to those identified in promoting migrants' SRH in the EU we described in the first part of our study [30], we hereby summarize the SV recommendations. Migrants should be empowered [63,84] and active

participation of migrants (particularly women) and communities should be increased in SV primary prevention, research and policy-making [20,63,71,85]. At care provider level, it is advised to train healthcare, migration and social staff on SV and victims' needs [60,63,86]; to monitor service provision and SV referrals [21,27,84]; to implement cultural and gender-sensitive care [87-91]; to favour interpreters for migrants' disclosure of SV [27]; and to ensure structural funding for working with SV migrant victims [68,92]. These recommendations aim at stimulating long-term structural change in behaviours and attitudes on SV in the European society at large [93].

DISCUSSION

Breaching a rights-based approach

Examining the literature shows that legal provisions fuel a double and somehow contradictory interaction between SV and migrants' status in EU MS. On the one hand, the increased recognition of SV as a breach to human rights has led to the adoption of provisions opening international protection to victims of such forms of violence. On the other hand, research has highlighted the legal obstacles migrants still face when trying to access SRH services [26,30,92,94].

Although a growing number of provisions acknowledge sexual and gender-related forms of persecution, there is still a reluctance to grant them the same attention as to more 'traditional' forms of persecution, structurally hampering SV prevention and response. For example, the EU Qualification Directive differentiates torture from SV, including rape [73]. The European Asylum System Office, established in 2011, only aims at developing a training module on gender in the course of 2014 [95] although NGOs strongly advocated to develop gender expertise within the agency [86]. Yet, here again, the Istanbul Convention [63] broadens the scope: the convention includes different types of SV and stipulates in article 60 that gender

guidelines and gender-sensitive asylum and reception procedures, including refugee status determination and application for international protection should be developed. This seems thus promising for female victims, yet male victims are not covered by this Convention. Furthermore, while the articles on gender-based asylum claims and non-refoulement for victims of violence against women are inclusive to the Convention, the article on protective measure related to the residence status of a victim (art.59) is subject to national conditioning of the Member States.

"Not in our house": Ignoring the full scope of SV

The current legal and policy frameworks on violence, migration and migrant health, apply a too narrow scope of SV. First, there is an apparent confusion of SV with violence against women. These terms are however no synonyms as the latter term encompasses a broad range of violence forms that are not sexual, and although women represent a majority of victims, men and boys are also sexually victimized [5,96][97]. Moreover, the specific vulnerabilities of both female and male migrants to sexual victimization and barriers to reporting that are described in literature [20,22,27,98] are poorly reflected in legal provisions, structurally ignoring potential migrant male victims. Moreover, the current binary vision of women-victims, men-perpetrators ignores the complexity of SV, the multiplicity of its forms, the agency of women, the existence of male victims and finally, the role of both genders in the continuation of social norms on violence as acceptable behavior [91,99,100]. This could be exemplified by potential experiences of SV in migrant male sex workers due to the interaction of stigma associated with sex work, migration and homosexuality [101]. Finally, any credible prevention policy should address both women and men as their "equal participation […] is a crucial factor for lasting development" and long-term change [84].

Second, when legal frameworks do tackle SV and the victims' needs for international protection and access to specific health and legal services, they focus on a limited set of SV forms that put the agency of perpetration merely in the countries or cultures of origin. Trafficking for sexual exploitation purposes and FGM clearly hold a pole position in this respect, and this "fail[s] to acknowledge the diverse experiences of violence that migrants may experience" [102]. By focusing on accommodation centers as does the recast Directive of minimum reception standards [62], occurrences of SV in migrants outside those centers is ignored. Finally, the assumption that European citizens and professionals might sexually victimize migrants beyond the scope of sex work is not even made and the fact that they do [20,98] is thus not yet reflected in implemented prevention policies which perpetuates migrants' risk to victimisation [103].

Furthermore, by setting a systematic and exclusive discursive link between trafficking and sex work, frameworks ignore voluntary decisions of some migrants to engage in sex work and equally inhibit victimized migrant sex workers from seeking protection and from obtaining a residence permit without stopping working in the sex industry which might be economically impossible and dangerous for their own security [83]. Despite a recent broadening in SV topics, the most recent documents have been drafted specifically for the asylum seekers/refugees populations, leaving a number of migrant groups and notably undocumented migrants unaddressed.

CONCLUSIONS

The main obstacle to a holistic and effective prevention and response policy at EU level addressing SV in migrants seems not so much to be the lack of frameworks and plans but the lack of willingness to grab the topic of SV, not only in migrants but in all population groups. This is not as such EU specificity. Literature shows clearly a "lack of worldwide commitment to

acknowledging the effect of sexual violence on health and human rights, and to taking the necessary legal, policy and programming steps to eradicate it" [104]. However, the EU is a specific case as it aims at developing a common area of justice as well as common policies on migration and asylum. Thus, making the case for the development of a strong and coherent EU policy-making addressing the multidimensional aspects of SV is highly justified and supported by evidence [84]. Not only would such rights-based approach be beneficial for migrants themselves, but also for the general EU population [91].

The current paradigm in EU policy-making enforces the idea that SV is rather an 'outsider' issue, with violence against migrants happening almost exclusively within their countries of origin or at the doors of Europe, and/or caused by cultural factors. Its own migration and asylum policies however contribute to the reinforcement of the topic invisibility. The interaction between migrants' status and living conditions and SV is complex, however it is striking that while SV victimization should open grounds for international protection, the legal and social status of migrants still often conditions and prevents their access to specialized support and care in Europe.

By not acknowledging openly experiences of violence against migrants happening on its territory or the impact of its own policies, the EU turns away from the issue. As the proverb goes: "what the eye does not see, the heart does not grieve over". We argue that by remaining ignorant of the issue, the EU is less likely to produce and enforce effective legal and policy frameworks on sexual violence prevention and response. In order to address reality in the EU, we urge that the true magnitude, nature and determinants in sexual violence in migrants are considered. As it is a prerequisite that migrants' human rights are upheld in further sexual violence prevention and response actions, we suggest that the dimensions of Desirable Prevention are applied.

NEW CONTRIBUTIONS TO THE LITERATURE

1. The current EU frameworks focus on trafficking, violence against women and FGM while ignoring other frequently occurring types of SV in both female and male migrants. Furthermore, the frameworks are poorly implemented at national level.
2. The current paradigm in EU policy-making enforces the idea that SV is rather an 'outsider' issue, with violence against migrants happening almost exclusively within their countries of origin or at the doors of Europe, and/or caused by cultural factors. Its own migration and asylum policies contribute to the reinforcement of the topic invisibility.
3. In order to address reality in the EU, we urge that the true magnitude, nature and determinants in sexual violence in migrants are considered. As it is a prerequisite that migrants' human rights are upheld in further sexual violence prevention and response actions, we suggest that the dimensions of Desirable Prevention are applied.

Limitations

The review is limited to frameworks as made publicly accessible by December 2013. In addition, as the language skills of the authors unfortunately do not span the rich diversity of EU national languages, we were not able to search for potentially relevant documents on national websites in other languages than English, French, Dutch or German. This is a clear limitation to our review. We however covered those national regulations when translated or covered by other grey literature provided by EU institutions and NGO documents in the above-mentioned languages. They largely confirm our findings rather than challenging them.

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4.5 Participatory Research Generating Tools for Social and Policy Change

According to the Ottawa Charter on Health Promotion of 1986, people should be "enabled to control of those things which determine their health"[389]. In 1997, in the Jakarta Declaration on Health Promotion, it was specified that "participation is essential to sustain efforts" and that in order to be effective "people have to be at the centre of health promotion action and decision-making processes"[389]. This urged us to opt for a conceptual framework that fully accords with these statements and challenged us to apply a participatory research approach that enabled my study population to genuinely frame their own health, health needs and health promotion actions.

Yet, applying Community-Based Participatory Research approach implies that research projects should contribute to social and policy change. This is generated through a lot of mechanisms: developing tools and formulating policy and practice recommendations are part of them. We describe the application of the Community-Based Participatory Research approach in the methodology section of this thesis, reflect on this approach in the Discussion of this thesis and briefly mention the policy and practice recommendations (Paper 7-11), tools and instruments (Books 1-9) we developed to meet this objective.
These tools meet objective 5: To conduct this research in a participatory way and subsequently provide instruments and recommendations for sexual health promotion and for prevention of sexual violence in the study population

Policy and Practice Papers:

Paper 7: Van den Ameele S, **Keygnaert I.**, Rachidi A, Roelens K, Temmerman M (2013) The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research 2013, 13:77. Type A1, Q1 public health, IF: 1.773.

Paper 8: Keygnaert I., Deblonde J, Leye E (2011) Sexual health of migrants in Europe: Some pathways to improvement – Entre Nous n 72, WHO Regional Office for Europe, pp. 20-21. Type A2.

Paper 9: Keygnaert I., El Mahi N, Van Egmond K, Temmerman M (2011) Verborgen Zorgen: Beeldessay- Tijdschrift voor Genderstudies n3, pp40-41. Type A2

Paper 10: Leye E., Roelens K., **Keygnaert I**., Claeys P & Temmerman M. (2008) Research in an ivory tower? How Research on Sexual and Gender-Based Violence can make a difference. Entre Nous n° 67, WHO Regional Office for Europe, pp. 22-23 Type A2

Paper 11: Keygnaert I. & Temmerman M. (2007) Between theory and practice: Gender-based Violence against Refugees, Asylum Seekers and Undocumented Migrants in Europe. Entre Nous n°66, WHO Regional Office for Europe, pp. 12-13.Type A2

Policy and Practice Books, Manuals and Reports:

Book 1: Keygnaert I., Wilson R., Dedoncker K., Bakker H., Van Petegem M., Wassie N. & Temmerman M. (2008) Hidden Violence is a Silent Rape: Prevention of Sexual and Gender-Based Violence against Refugees & Asylum Seekers in Europe: A Participatory Approach Report. Academia Press, Ghent, Belgium. ISBN 978-90-382-1327-9. Type B1

Book 2: Keygnaert I. & Temmerman M. (2008) Preventie-agenda 2008. Lannoo Uitgeverij, Tielt, Belgium. ISBN: 978-9078128-168. Type B1

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Book 4: Keygnaert I., van Egmond K., El Mahi N. & Temmerman M. (2009) Verborgen Zorgen Wetenschappelijk Rapport. ICRH-UGent, May 2009. Type V

Book 5: EN-HERA! (2009) Framework for the identification of good practices in Sexual & Reproductive Health for Refugees, Asylum seekers and Undocumented Migrants. Editor: **Keygnaert I**. Academia Press, Ghent, Belgium. ISBN 978-90-75955-69-9. Type B1

Book 6: Keygnaert I., van Egmond K & Temmerman M. (2009) EN-HERA! Report 1. Academia Press, Ghent, Belgium. ISBN978-90-38214-09-2. Type B1

Book 7 : Keygnaert I., van den Ameele S., Keygnaert J., Manço A. & Temmerman M. (2009) La Route de la Souffrance : la Violence Sexuelle parmi et contre les Trans-Migrants au Maroc – Un Partenariat Participatif pour La Prévention: Rapport de recherche. ICRH-UGent, July 2009. Type V

Book 8: Frans E. & **Keygnaert I.** (2009) Make it Work! Training Manual for Prevention of SGBV in the European Reception & Asylum Sector. 150 pp, Academia Press, Ghent. ISBN 978 90 382 1575 4. Type B1

Book 9: Keygnaert I., Vangenechten J., Devillé W., Frans E. & Temmerman M. (2010) Senperforto Frame of Reference for Prevention of SGBV in the European Reception and Asylum Sector. Magelaan cvba, Ghent. ISBN 978-9078128-205. Type B1

"You can't do anything, because you're not a human being."

Kurdish Undocumented Migrant

"Hidden Violence is a Silent Rape" Seminar

5. DISCUSSION

5.1 Introduction

As migrants are considered at risk of SGBV and of sexual ill-health at global level, and refugees, asylum seekers and undocumented migrants are migrants with multiple levels of vulnerability[458]; the general objective of this study was to contribute to a better understanding of factors determining the health of refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood by exploring prevention of sexual violence and promotion of sexual health. In order to do so, we assessed the nature and magnitude of sexual violence that this research population experiences and identified determinants in sexual health and violence at the personal, interpersonal, organisational and societal level in a participatory way. Subsequently, we interpreted these determinants in the light of the applied conceptual framework and developed policy and practice improvement tools and recommendations.

In the discussion section of this thesis we aim to reflect on the findings of the studies, discussing which determinants we consider decisive in sexual health promotion and in desirable prevention of sexual violence against refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood. In addition, we consider the use of Community Based Participatory Research in this research population and discuss challenges and limitations. We finally formulate conclusions as well as recommendations for future practices, policies and research.

5.2 The Nature of Sexual Violence Against Refugees, Asylum Seekers and Undocumented Migrants in Europe and the European Neighbourhood

5.2.1 The Trinity in Defining Violence

Sexual violence, sexual abuse, intimate partner violence, domestic violence, sexual and gender-based violence, violence against women, harmful cultural practices, honour-related violence, child abuse, elderly abuse and many other terms are used in the field of researching, debating and combating violence. There is however rare consensus on what is meant by those different terms. In our opinion this is due to the perspective one choses to adopt in order to frame violence.

Generally speaking there are three perspectives to look at interpersonal violence.
First, there are certain violent acts that have occurred between two or more people, which can be classified on the basis of facts: these violent acts were physical, emotional-psychological, sexual and/or socio-economic. This leads to the terminology of physical, emotional-psychological, sexual and socio-economic violence as we described in the introduction part of this thesis.

Second, there is the perspective in which the relations between the perpetrators and victims and potential motives or drivers are taken into account to define different types of violence. This regards for example the umbrella terms as intimate partner violence, domestic violence, child abuse, elderly abuse, gender-based violence and violence as a weapon of war.

Third, there is the societal perspective which interprets whether the acts that happened, within the given relations and with provided motives, are transgressive rather than acceptable behaviour in the context of a given society. This perspective decides whether these acts are a crime or not –providing judicial definitions of violence (e.g. sexual offense, sexual assault and others) that might differ from the other given above- and stipulates how the society should react to it.

Donors, politicians and civil society mostly use the relational umbrella terms without however always specifying what these terms exactly entail and on which premises they are based. This hampers research in multiple ways. First of all, it makes it very hard to compare data of prevalence of violence between studies, between different populations and across countries. This difficulty is confirmed in the recent WHO publication of global and regional estimates of violence against women as they demonstrated it was impossible to give reliable comparison data on sexual violence prevalence committed by other perpetrators than partners[221].

As for our study we aimed to address sexual violence in refugees, asylum seekers and undocumented migrants. Yet, in most studies in general populations, sexual violence is limited to sexual harassment, abuse and rape. The specific types of sexual exploitation and sexual violence as a weapon of war, as specified by UNCHR in 2003, are not included. However, in research on conflict and humanitarian contexts, they mostly are, but are then framed within the terminology and context of gender-based violence. Applying the GBV definition has the advantage that it encompasses all types of sexual violence and puts them into a context of multiple violence. As described in the introductory part of our thesis, physical, emotional-psychological and socio-economic violence are thus included.

Furthermore, GBV also addresses cultural practices which can be considered as harmful. Whether these practices are also to be considered as violence is a subject of heated debates. Yet, beyond the magnitude of conflict and research on violence in developing countries, GBV is rarely used as definition and concept including all those different violence types. It is not something Europe identifies itself with. Within the context of Europe it are rather the other umbrella terms of domestic violence, intimate partner violence, child and elderly abuse that are commonly used, researched and addressed in action plans and policies. However, the practice of using the term "Violence Against Women" interchangeably or even as a synonym for GBV at global level, has recently been echoed at European level. GBV is now frequently used as synonym for domestic violence and intimate partner violence

as well. That does not only hamper research in comparing data, this also has major effects on policy framework developments and subsequently, on public health. We will however reflect further on the gender aspect of used violence definitions when we are discussing gender as a transversal determinant.

In our study we thus adopted the categories of sexual harassment, sexual abuse, attempt to rape, rape, sexual exploitation and sexual violence as a weapon of war as defined by UNHCR [213] and examined them in the broad scope of multiple violence that refugees, asylum seekers and undocumented migrants experience in Europe and Morocco. We hereby used the GBV types of violence of physical, emotional-psychological, sexual and socio-economic violence and harmful cultural practices without however assuming a priori that one sex or gender would be the perpetrator and the other the victim.

5.2.2 The Nature of Experienced Violence

We interviewed a total of 977 refugees, asylum seekers, undocumented migrants and asylum-related professionals in our 3 studies exploring the nature and magnitude of violence they directly or indirectly experienced. Our results demonstrate that both in Europe as in the European Neighbourhood, our research population is at risk of violence. There are three characteristics that stand out in the reported violence cases. First, sexual violence is very frequently reported, and often co-occurs with physical, emotional and/or socio-economic violence in a single case. Second, sexual violence in our research population is often characterised by gang or multiple rape. Third, professionals constitute an important part of the perpetrators. We will consider these three characteristics in more detail.

The first study (Hidden Violence) explored the nature and magnitude of SGBV that refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands experienced since arriving in the EU. The majority of the 223 respondents were either personally victimised or knew of a close peer being victimised since their arrival in the European Union. A total of 332 experiences of SGBV were reported, mostly afflicted on them by (ex-) partners or asylum professionals. Within the limited scope of our research population, we found a high incidence of combined forms of victimisation which sometimes resulted in a fatal outcome. More than half of these reported cases of combined violence experiences comprised sexual violence, including individual and gang rape and sexual exploitation.
Not only the extent to which sexual violence was part of their victimisation, but also its nature (e.g. frequent gang and multiple rape) differs from what is known about SGBV among Belgian and Dutch nationals[228,459].

Furthermore, unlike what is expected in the general population[460] but in line with findings for refugees, people in poverty and adolescent boys[384,461,462], an important number of perpetrators in our study were either persons in authority - including those assigned to their protection - or were unknown to the victim. Our study also confirms the finding

that impoverished women and girls and those living in shelters may be particularly vulnerable[463]. Finally, it is interesting to note that the men and young boys in our study appear to be more prone to sexual and other kinds of violence than is globally expected in men[460,461]. Together, the data highlight the vulnerability of refugees, asylum seekers and undocumented migrants to SGBV in Belgium and the Netherlands.

The second study addressed sexual violence in sub-Saharan migrants in Morocco and at its border. This study firstly confirmed the occurrence of sexual violence within a combination of other types of violence against migrants with restricted legal status. Among the 154 (60F-94M) sub-Saharan migrants interviewed, 90% reported cases consisting of multiple acts of victimization. Of the 548 victimisation acts, 45% regarded sexual violence, predominantly gang rape. Seventy-nine respondents were personally victimized, 41 were forced to witness how relatives or co-migrants were victimized and 18 others knew of peer victimisation. Our respondents stressed that violence in general and sexual violence in particular has just become an unavoidable part of the journey. This adds up to the sexual and other victimisation a lot of them already went through in their home country and which might have been part of their decision to migrate[464,465]. The second part of this study, consisting of KAP-interviews with 24 health care workers in Morocco, demonstrated that sub-Saharan victims face huge barriers to access Moroccan public health services and are bound to assistance of non-governmental organisations[466].

The omnipresence of sexual violence within sub-Saharan migration leads to a 'normalization' of sexual violence[464], and other types of violence[467], and could be linked to what in literature on sub-Saharan migration has been identified as "hardship as an initiation rite"[467] or in other words: in order to become a real migrant, you have to be victimized and subsequently live with the consequences. The fact of placing this in a context of cultural initiation rites, in which one endures a hardship during a certain period of time in order to get to a next phase of life with an enhanced state of being, could be interpreted as a coping strategy of the sub-Saharan communities. Trying to commonly interpret an adversity and subsequently adapt to it as a community, is as such a healthy reaction in community resilience[468]. Yet, the sexual violence reported here is of such invasive and destructive nature inducing severe long lasting ill-health consequences in a context where victims are not granted access to official health care but are dependent on rare NGO-medical and social support upon sexual victimization[466], that it can hardly build a person.

On the contrary, the way the sexual victimization is performed here bears many similarities with sexual violence as a weapon of war, which, by definition, has the purpose of destabilizing or extinguishing a group of people because they belong to that group of people. Even though it would take us too far to conclude that the purpose is to destabilize or extinguish sub-Saharan migrants, they are targeted here because they are undocumented sub-Saharan migrants without legal protection. Given the lack of official authorities at many migration 'hubs' and given their undocumented status outside the ECOWAS region,

the migrants are in a very vulnerable situation risking more victimization, exploitation or deportation when they would try to report or fight against it[467].

Second, the "operation modus" of frequent multiple and gang rape as noted in the Hidden Violence study is confirmed and even magnified in the Morocco study. Gang rape is the most common form of reported sexual violence in this study, and if migrants are not victimized personally, they are often forced to witness how their relatives or co-migrants are victimized in their presence, which is equally traumatizing. The respondents emphasized how heavy the burden is to live with the fact that they could not interfere or resist just because the perpetrators were so many.

Third, the role of migration professionals in the violence perpetration is emphasized. In the reported cases, gang rapes are often perpetrated by either Moroccan and/or Algerian officials (soldiers, police) or gangs of Nigerian chairmen and other sub-Saharan migrant leaders who are self-identified migration professionals who installed them there where official authorities are lacking or refrain from interfering and where migrants do have to pass on their migration route to and through Morocco. This is especially the case in the border region of Algeria (Maghnia) and Morocco (Oujda) where most of the reported sexual victimization took place. Where money and other material belongings cannot be confiscated anymore as bale for passage, migrants have to pay with their bodies. Also for the reported sexual violence occurring away from the border sides, it often took place in a situation of exploitation in return for food, shelter, services or survival.

In our third study (Senperforto), we assessed the nature and magnitude of violence that refugees, asylum seekers and undocumented migrants as residents and their service providers, the asylum professionals, experience in asylum reception settings in Belgium, Greece, Hungary, Ireland, Malta, the Netherlands and Portugal. Of the 562 respondents, 58 % reported cases of incidents they perceived as violence. They described 600 different cases in a fourth of which they were personally victimised and in 75% a co-resident and/or professional in the asylum setting they live/work.

Again in this study, the 600 reported cases consisted mostly of a combination of multiple acts of different violence types. Within the scope of the 1056 acts, 437 can be categorized as physical, 420 as emotional, 62 as sexual and 117 as socio-economic violence. The relatively low level of sexual violence (6% of the reported acts – 10.33% of the cases) compared to the other types is surprising, especially in comparison to the other two studies where sexual violence comprised 45%- 56% of the reported violence acts. When discussing this with the Community Researchers and the Community Advisory Boards several hypotheses were formulated. First of all we could assume that the levels are lower because we now also included professionals and that they are less sexually victimised. We do however found this hypothesis rather implausible as our results show within the reported sexual violence, both residents and professionals are to be found at the perpetrator and victim

side. We then could as well wonder whether sexual violence occurs much more outside the reception settings than within its premises. However, although the Hidden Violence study did not specifically target reception settings, it still included an important number of sexual violence cases occurring within asylum reception facilities. Moreover, given the extent to which other types of violence are occurring, how much infrastructure and housing facilities were mentioned by the respondents as perceived risk factors, and the rare existences of violence prevention and response policies, we have serious doubts to conclude that sexual violence would occur much less in the current asylum reception settings than outside these settings. Further analysis of these aspects within the Senperforto data could help to understand this better. In addition, a prevalence study comparing in-site and out-site perpetration would have to be set up to examine this.

Another hypothesis we found more plausible lays in the fear that respondents had that their disclosure of sexual violence would impact their asylum case, their life, stay or work at the facility despite the guaranteed anonymity, the fact that they could disclose indirectly as is recommended in detention research and the fact that the community researchers and community advisory board co-decided on the procedure and did not expect problems. We however noted that in some big facilities and/or communities with honour rules, residents discouraged others to participate, warning for potential stigma and/or community repercussions if participating in the study when sampled. In the Netherlands respondents were recruited and interviewed through the external health care facilities of the reception sector, and feared less disclosure to peers in the centres. This might explain why in the Netherlands more people disclosed personal victimisation in comparison to the other countries. This was also the case in the Hidden Violence study, where the utmost majority of the respondents who reported sexual violence occurring in facilities did not live there anymore at the time of the interview.

It is also noteworthy that the timespan of violence occurrence inclusion differs greatly from study to study. In Senperforto we inquired on violence happening in the year prior to the interview, while in the Hidden Violence study this was since their arrival in Europe and in the Morocco study since they initiated their migration to Morocco.

This all suggests that the Senperforto findings give a good indication of the combined form of violence yet probably still underestimate the real magnitude of the sexual violence that occurs in this sector. Therefore, it is important that in future research within asylum settings, respondents are granted the opportunity to both personal and peer reporting, as considering only one of them will only result in revealing parts of the picture. Ideally retrospective research could complement the findings.

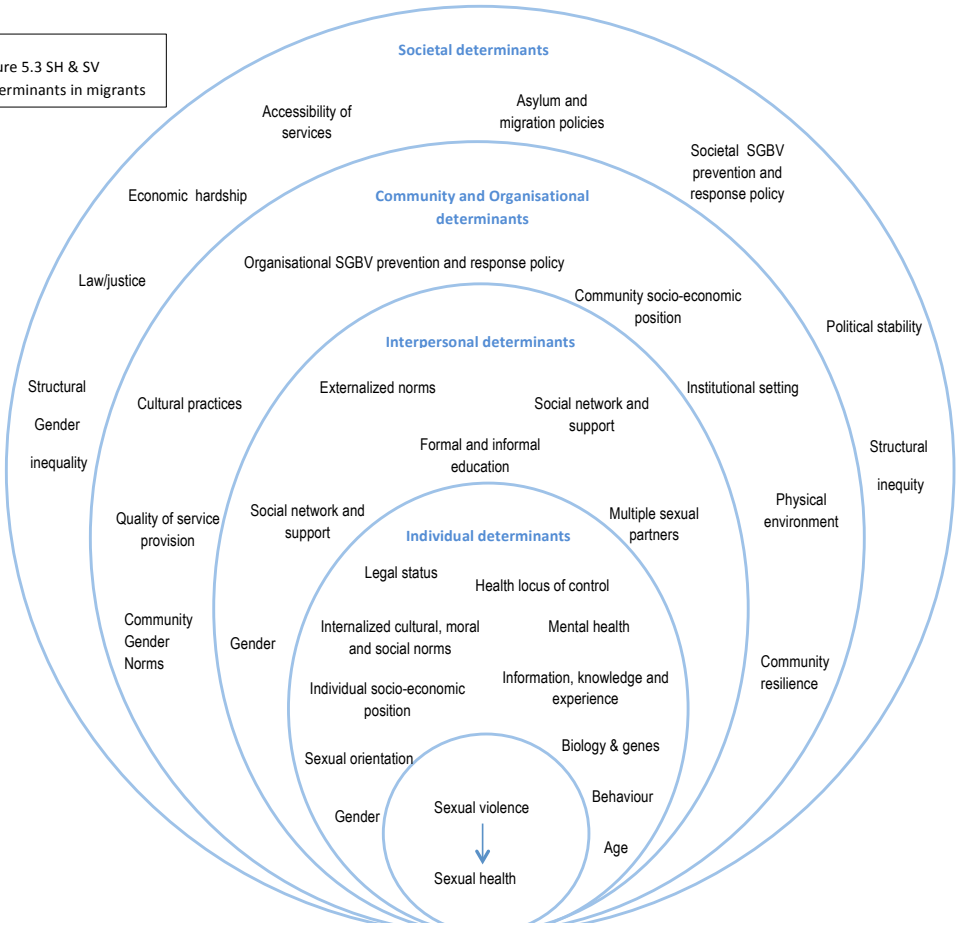
Furthermore, it also indicates that for our research population trust is a non-evident matter which hampers them from disclosing personally. In this sense the type of questioning and general objective of the study might also influence the outcome.

We applied Community Based Participatory Research in all three studies and were assured of the cultural competence and the needs responsiveness. Yet in Senperforto we conducted interviews with an extensive Knowledge Attitude and Practice Questionnaire. Whereas in the Hidden Violence and Morocco study we conducted in-depth interviews and the Community Researchers had sufficient time to build rapport and trust with the respondents and follow their pace. This and the fact that the project goals and outcome were also potentially more locally tangible for the respondents than in the big Senperforto study, might have resulted in the respondents' lesser feeling of being of important added value compared to the other two studies. At the other hand, we need to stress that the majority of the respondents, both residents and professionals, welcomed the focus of the research and thanked the research team for being genuinely interested in their lives and working atmosphere. This stimulated many to participate in later phases of the project in which the Senperforto project group developed a Frame of Reference on SGBV prevention and response for the European asylum and reception sector.

Nevertheless, although the number of reported sexual violence is not as high as in the other studies, 62 cases were reported. Furthermore, the extent to which other types of violence were reported is high and not to be neglected. Moreover, as for the profile of the perpetrator and the relation between the perpetrator and the victim; Senperforto showed that everybody in the settings - ranging from young to old, from female to male, from all types of resident to all types of professionals- is involved in victimisation and perpetration. Yet there are differences to be found in the types of violence they are involved in, targeted victims and operation modus. Just as in the other two studies, the Senperforto results demonstrate that violence perpetration and victimisation in European reception settings often occur in group. Yet again, we found statistical differences in the types of violence and people involved which we will discuss further in the next part on interpretation of determinants.

5.3 Identification of Determinants in Sexual Health and Sexual Violence Decisive for Desirable Prevention

Our results demonstrated that refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood are vulnerable to sexual and gender-based violence and to sexual ill-health. In order to change this vulnerability, we need to understand the root causes of the problem. Yet, our findings reveal that understanding risk and prevention factors in sexual violence and sexual health in our research population is a complex matter. Moreover, also refugees, asylum seekers and undocumented migrants have the right to the highest standard of health, including sexual health, which goes beyond the absence of disease or infirmity. They thus also have the right to well-being, healthy sexual relationships and sexual pleasure. Determinants thus need to take that perspective into account as well. To get a better grip on them, we identified determinants at the four socio-ecological levels.



All these determinants are relevant for prevention of sexual and gender-based violence and for the promotion of sexual health in our research population and by extension in the general population in Europe and the European Neighbourhood. We first discuss the most important determinants we found at each of the socio-ecological levels before we consider the two transversal determinants of gender and legal status in depth.

5.3.1 Individual Level

Age does not seem to play a very decisive role in defining sexual health in our study population. Both young and adult respondents define sexual health in a rather balanced way –when taking the 5 aspects of sexual health in the WHO definition into account- identifying aspects of general well-being, a respectful approach of sexual relationships and sexuality, a safe and pleasurable sex life, family planning and fertility and access to information and care. Yet pathways to search for sexual health information differ. Youth indicate their direct environment as primary sexual health source while the health sector, media - preferably internet- and educational institutions share an equal important second place. In identifying determinants, young people attribute more importance to a safe and

satisfying sex life than adults and indicate determinants preferably in the individual and intimate interpersonal level.

As for violence we note a high vulnerability in young people. In all 3 studies, it was reported that children under the age of 18 were victimised in about 7% for the Hidden violence to 30% in the Moroccan and the Senperforto study. However, young adults, defined as being 19-29, constituted about half of the victims. In the Hidden Violence they constituted 53% and in Senperforto 60% of the victims. For Morocco we have no absolute number of the age of the victims as the community researchers not always probed for it. However, 58% of the respondents were aged 19-29 and 78% of self-victimisation was reported, we could thus assume that it is quite probable that about 46% of the victims fell in this age range. This means that taking young people as a whole, we have a range from 60% to 90% of the victims. This is problematic for several reasons. First, recent research suggests that adversity in childhood can directly influence the brain development, impacting it's' anatomy and neurophysiology, a process which is partly genetically mediated[255]. Furthermore, there is vast evidence that people who were personally victimized or witnessed sexual violence during childhood and those with a heightened risk perception due to victimisation of linked people; are prone to subsequent victimization or perpetration of SGBV at a later stage of their life[469,470, 193,193,194,194,253,253,256,469,470]. Child sexual abuse has also been found to be a pre-cursor for serious social and mental health problems and to maladaptive parental practices which can feed the intergenerational transmission of violence[253,254]. We can thus conclude that victimisation is not only dangerous for the victim itself yet also potentially harmful to the victim's peers, offspring and community[191-194]. Given all those links, and subsequently putting all those people at risk, it is paramount that radical prevention actions are set up and that this momentum is stopped from going.

Respondents were convinced that the type and content of prevention actions did not need to differ for adults and young people. They however recommended that the messages and the used channels for getting the messages across should be adapted to children and youth's language and culture. We however argue that in Desirable Prevention of sexual violence against children, adolescents and young adults, it is important to take their sexual health development into account, which across these different age groups varies a lot. In this, it is crucial that the prevention actions are maximally "of-fensive" and thus stems from a positive view on sexual health development, implying that their sexual health development opportunities are not curtailed as specious arguments for preventing them to be put at risk of sexual violence. Furthermore, the prevention should be radical, integral and democratic. Given the research demonstrating life course vulnerability and the fact that intergenerational transmission and violence debut often start at young age, they are a specific age group of multiple vulnerability that need specific attention at all levels of prevention – from general policy to primary, secondary, tertiary prevention and care- and at all stages of problem development. All age groups have a role to play in this and should thus be addressed in a wide range of prevention actions targeting both internal

change in young potential perpetrators and victims, as well as more structural changes in their networks, in the reception centres where they are staying, at school and at other institutions in which they spend time. The necessity to ensure participation of young people in this goes without saying.

Attained education As for sexual health promotion, the attained education did not seem to influence the perception of sexual maturity criteria or the importance attributed to general well-being, a respectful approach and the personal health responsibility in attaining good sexual health in our studies. Yet respondents with no or low education attainment tend to diversify their definition of sexual health less and particularly stress individual and intimate interpersonal sexual health determinants. They consider family and friends as first sexual health information sources, additionally taking up on info spread by TV. Respondents with higher education attainment consider safety and satisfaction more as well as access to information and care. In addition, compared to people with lower education attainment levels, they mention more organisational and societal determinants and also prefer the health sector above all other sexual health information sources.

This indicates that sexual health promotion activities could be more effective if they do not differentiate the content, but rather use other channels whereby migrants with lower education attainment seem to be more susceptible to gaining knowledge through experienced peers (informal help), while migrants with higher education attainment give more appraisal to persons who gained their knowledge and expertise through education and profession (formal help).

Cultural beliefs and norms that have been equally incorporated by women and men seem to influence their sexual health frame of reference decisively. When respondents describe criteria for sexual maturity, all stress the importance of a balanced mental, physical and social development as the most decisive element for both genders. Also age and respectful approach are important criteria of gaining maturity for both girls and boys. Yet, our results demonstrated that country of origin influenced the findings of who attributed more importance to biological aspects of maturity as age and more behavioural aspects of maturity as respectful approach.

This confirms literature stating that cultural norms, beliefs and attitudes bolster one's self-esteem and self-efficacy, provide a coherent structure for interpreting life events[471] and are more decisive in sexual behaviour of these migrants than their separation from native communities[472].

Yet, given their dependant and vulnerable situation linked to the European or Moroccan asylum system, their beliefs and norms on sexual normalcy, pleasurable sex, on risks to sexual dysfunction; on sexual performance and ethical concerns about the function of sexuality, help-seeking and treatment; might be seriously challenged. All of these stressors

are known to create and perpetuate sexual difficulties[92,473-479]. Although few respondents pointed to cultural norms and values as protective factors for sexual violence, a quarter believed that prevention measures should address cultural norms and values including informing the host society about refugee issues.

Health locus of control: Our respondents demonstrate a predominant internal health locus of control as the majority is convinced that one is responsible for shaping and maintaining good sexual health. They were convinced this could be done by having a general healthy life style, using contraceptives, not having multiple sex partners and being informed on risks and prevention strategies and seeing a doctor when necessary. This is in line with earlier findings on internal health locus of control and sexual health[106,480,481].

Also in relation to sexual violence, the majority is convinced that a refugee, asylum seeker or undocumented migrant has an important role to play in SGBV prevention. Suggestions on how to do so ranged from informing oneself on risk factors and ways to prevent them, taking care of one's proper mental health, knowing one's limits and acting upon it, avoiding drugs and alcohol, reacting to violence when you come across it in others, bonding with others to make safety nets and setting up awareness raising campaigns in own communities and reception settings as well as to indicate representatives who can lobby with authorities.

Yet, most of them feel that this personal attitude is hugely challenged by the structural dependent situation they are living in. This is due to the current organization of the asylum reception system and migration law, the impact of which we will discuss further when addressing determinants at the organisational and societal level.

5.3.2 Interpersonal Level

At an interpersonal level, respondents identified social networks and social support, information exchange, awareness-raising and community resilience as important prevention factors. However, quite some respondents reported living alone or being members of truncated networks with restricted opportunities for societal participation and building social capital. Social networks provide social and emotional support, self-esteem, trust, identity, coping, shared purpose and perceptions of control, the absence of which is demonstrated to have negative impacts on health[482-484]. People in truncated networks are at risk of not having a confidant nor receiving appropriate instrumental and social support[485,486], an issue that is magnified in refugee context where the need to belong and the risk of social exclusion are key determinants of healthy sexual development as well as positive resettlement outcomes[487]. Beyond this, a high degree of social isolation and low quality of relationships with male confidants may lead to inappropriate sexual behaviour in men [488]. Evidence also shows that social networks have a significant impact on exposure to health information, on shaping of health-related norms[489,490], and on health risk perceptions and the adoption of health preventive behaviours[491,492]. Lack of

participation as a citizen, sense of community and attachment to a place can also hamper community resilience to stressors, such as SGBV[484].

Building on evidence of the individual level determinants: Since our respondents, and especially the young but also those with lower education attainment, indicated that their direct environment, -preferably friends, parents and siblings-, is one of the first sexual health sources to consider, and literature has confirmed that adolescents' sexual behaviour is strongly influenced by peers[493,494] and parents[66]; it is to be advised that refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood are empowered to strengthen social networks and are facilitated to take up an active parental or peer educative role in order to enhance the exchange of transferable knowledge skills on sexual health promotion and sexual violence prevention through social learning and the creation of social support.

5.3.3 Organisational Level

Although about 80% of the respondents in all our studies reported to be practicing religion, only rarely religion was mentioned as a determinant and in the analysis no links could be found either. This questions the often suggested intervention to set up health promotion and violence prevention campaigns through religious institutions and by religious key people. In our, mostly highly educated, group of respondents it seems that other institutional and public channels are preferable to address, as there is media, educational bodies and the health sector. Our findings confirm that in addition to traditional channels as TV, radio, books, magazines and such, it is wise to invest in social media as channels for culturally competent sexual health promotion activities emphasizing a positive, yet critical and balanced approach to sexual health and sexuality, especially when targeting youth[474, 495].

Educational bodies as schools and universities are rather indicated as facilitating sources for sexual health than primary sources. This has to be taken into consideration in schools for minors since the right to education in Europe is generally restricted to the age of 18 for asylum seekers and undocumented migrants. For adults, this could be addressed through the language and societal courses that are often considered as complementary to a potentially prolonged stay in the host country.

Yet, our findings confirm that these educational programs better not stem from one cognitive behavioural model solely but should take factors at all socio-ecological level into account[496].

Building on the individual and interpersonal level: Given the preference for the health sector as primary sexual health source in all ages and genders but more preferentially by the more highly educated persons, and the induced external health locus of control putting more dependence on powerful others as health practitioners[48], it needs to be emphasized

that health workers should be strongly encouraged and trained to play a leading role in culturally competent sexual health promotion activities towards this population. At the level of asylum reception settings, it would be wise to consider setting up sexual health promotion teams in which skilled health workers train community key people to become sexual health peer educators and in which the health workers are coached by the peer educators on cultural norms and values in order to enhance the professionals' cultural competence. As a team they can then address both the people who are more in favour of informal help as well as those who prefer formal help and refer to each other.

5.3.4 Societal Level

Our respondents indicated that societal prevention programs should seek to enhance knowledge through sensitisation, education on sexual health, risks and SGBV, and ways to respond to it. Others felt that the overall legislative framework should become more preventive and responsive. Both in Europe as in Morocco they suggested that the government should assure protection against violence for all, enforce laws on violence perpetration and enhance general public safety. Our respondents mentioned that very few cases of victimisation are reported to the police because of fear for repercussions on their asylum case, stay or work at the reception facilities or fear for deportation and refoulement. They thus viewed responsibility of assuring general public safety predominantly as a governmental and judicial matter, while a vast group of respondents in each of the studies of this doctoral research had also stressed in their interviews how they suffered from daily stressors as for example discrimination and racism by host society citizens. Some suggested to set up intercultural campaigns implying knowledge transfer from migrants to host society citizens. Yet, most of them linked their multiple discriminations hampering them in their access to education, health care, the job market, participation in society and other social and cultural rights to one key determinant, namely their legal status, the fact of being an asylum seeker, refugee or undocumented migrant affected by the European-Moroccan migration, asylum and Neighbourhood policies.

These policies however affect several determinants at all socio-ecological levels. We thus consider legal status as a transversal determinant in sexual health and sexual violence. Another transversal determinant is gender. As the radicality dimension of Desirable Prevention states that it are the root causes that should be known and addressed, we shall discuss them in more detail.

5.4 Gender As Transversal Determinant Decisive For Desirable Prevention

"A human being is a human being, whether you're a man or a woman"
(Maiah, 34, female Kurdish asylum seeker)

5.4.1 Individual Level

Although it is often assumed that gender imbalances induced by beliefs, practices and norms of the countries of origin of our respondents might have a negative effect on their sexual health, our results rather confirm earlier findings[473] that there are no ground-breaking gender differences regarding sexual health definition and determinants in our population. When defining sexual health, both male and female respondents emphasized that the most important element was to be physically and mentally well. In addition to being well, one has to feel well about sexuality both personally as within a respectful relationship where trust and mutual respect were named as essential to it, which is in line with literature[497-500]. However, a safe and satisfying sex life was for both genders an equally important aspect and within their descriptions of what this should entail, we could not state that men indicated more stimulus-based factors and women more cognition-based factors as emotions, the broader quality of a relationship, dyadic conflict, personalized external events and social context factors which is posited in literature emphasizing differences between gender[497,501-505]. They did not attribute major differences in sexual maturity criteria either. In addition, for both of them fertility, family planning and access to information and care were of less importance.

As for the sources of sexual health information, the health sector was indicated as the readiest sexual health information source for both women and men, yet, where possible women turn to women and men to men to get information. The only difference we could find was in other explored pathways to obtain sexual health information. Women and girls tend to prefer addressing people in their direct environment and especially friends much more than men and boys. They also prefer media –especially books- more than men, who in turn then prefer internet if they indicate media as source of sexual health information. Women also indicated institutions more, preferably educational institutions but also religious ones. Thus, future sexual health promotion activities towards migrants descending from these origins can be gender inclusive when it concerns content, only the channels through which the messages are conveyed could be diversified to maximize the possibilities of getting the message across.

As for sexual and gender-based violence, our results confirm that women constitute the most numerous group of victims. In the large majority of the cases reported in the Hidden violence and in the Morocco study, at least one girl or woman was victimised, ranging from 71% in the Hidden Violence, to 81% in the Morocco study. Yet as so many sexual victimizations occurred in group, it frequently happened that more than one girl or woman was victimised or that also boys and/or men were victimised. On the other hand,

an important group of boys and men were also victimised in single sex cases. We had male victims in 30% of the cases in the Hidden violence (of which 2% was mixed gender) and in at least 38% in the Morocco study, where exact gender distributions were not noted down. For Senperforto, 44% of the victims were female and in 56% it regarded males, yet for sexual violence the most numerous group were also female. Perpetrators were predominantly male, yet in 9% of the Hidden Violence cases and 30% of the ones in Senperforto, female perpetrators were involved. This leads us to conclude that victimisation and perpetration in the given contexts of our research population seems more gender-balanced than what is generally expected in the general population[228,506,507].

5.4.2 Interpersonal Level

This gender-balance does however not necessarily mean that women and men are involved in the same types of violence with the same type of operation modus. Our results show that both girls/women and boys/men are subjected to different types of sexual victimisation, and especially to rape. Yet for the other types, the Senperforto study revealed some noteworthy characteristics. There it was found that whereas both sexes have a comparable tendency to physical perpetration, a dynamic of mixed sex perpetration and victimisation is to be noted in socio-economic violence. Yet, when they commit sexual and emotional violence, males are more likely to involve in sexual perpetration and emotional victimisation while females are more likely to perpetrate emotional violence and experience sexual victimization.

5.4.3 Organisational Level

Building on the individual and interpersonal level and bearing the concept of Desirable Prevention in mind: The gender-dynamics in victimisation and perpetration support the thesis that violence prevention and response actions in the European asylum and reception sector should be gender-sensitive in the sense that they avoid messages in which men are stereotyped as sole perpetrators and women as sole victims. As for sexual health promotion, it is important to consider that both women and men prefer to obtain sexual health information from someone of the same gender. This implies that it wise to train peer educators of both genders, and to foresee where possible health professionals of both genders.

On the other hand, if those sexual health promoters would also have to convey sexual violence prevention or reponse messages, it is important to acknowledge that most victimised men were victimised by other men, and that they might thus be more susceptible to actions undertaken by women. We however recommend that within this gender-sensitive approach promotion, prevention and response actions are thoroughly culturally competent and developed as well as implemented with high-level participation of all types of professionals and residents.

5.4.4 Societal Level

We however argue that it is only possible to change this current paradigm of female victims and male perpetrators at the individual, interpersonal and organisational levels thoroughly, if at societal and public policy level this paradigm is also challenged and subsequently altered. Our findings demonstrate that the fact that violence against women is now internationally considered a synonym for gender-based violence, and subsequently sexual violence, is problematic for several reasons.

First, it defines or interprets gender-based violence as one-directional focusing on the gender or sex of the victim, while our data suggest that there are also at the perpetrator side some statistical gender preferences to be found. This means that if men and women perpetrate violence, that they are more likely to engage in this specific type of violence, targeting specific victims in a specific way because they are men or because they are women and not only because the victims are women or men. Recent research on intimate partner and domestic violence in the US and some European countries[508-514] and also some on sexual violence perpetration in South Africa[515] has already pointed to similar findings, even noting gender dynamics in mutual violence. Yet in migration research this hypothesis has not yet been reflected.

Second, it is dichotomist and stigmatising in the sense that only women are considered to be the victims or survivors and thus by consequence that men, when they appear in the picture, are perpetrators. This is problematic, because it ignores a number of victims and perpetrators which are in need of effective interventions and whom are now left unaddressed. Furthermore, it creates a bias in research by not providing the possibility of identifying real dynamics in violence.

Subsequently, it impacts policy framework developments which are based on research data and international action plans. We can thus conclude that this ignorance leads to ill-health consequences and enhances the risk of subsequent perpetration and victimisation in current and future generations when taking life course aspects into account[193,194,253,469,470].

Taking the four socio-ecological levels into account, it is thus paramount that future research on violence also applies the principles of Desirable Prevention and stems from a real gender-sensitive paradigm and reveals all gender dynamics in specific communities and settings in order to define the most effective interventions. In this, it should be investigated to what extent the asylum centres/system increases the risk of males to be victimised and females to perpetrate compared to what is known on male victimisation and female perpetration in the general European societies, and how much the research paradigm might induce biases in the outcome. As research needs funding, and funding is often decided upon at political level, it is vital that calls for proposals do not induce a gender bias. Finally, action plans should be adapted according to the outcome of gender-

sensitive research. As the political level is thus a leverage for changes in the other levels, lobbying for adopting a gender-sensitive paradigm at political level is thus urgently called for.

5.5 Legal Status as Transversal Determinant Decisive for Desirable Prevention

'You cannot do anything, because you are not a human being'
(Bohan, 20, Kurdish Asylum Seeker)

Another, and to us the most important root cause, lays in the legal status of refugees, asylum seekers and undocumented migrants being different of that of citizens, which structurally hampers them at all socio-ecological levels to participate in society and to be active agents in their life. Our results demonstrate that being a refugee, asylum seeker or undocumented migrant in Europe and the European Neighbourhood is a risk factor for sexual ill-health and sexual violence and confirms that migration and legal status in this matter can be considered a health determinant as such[516] influencing other determinants at all socio-ecological levels.

5.5.1 Individual Level

Attained education: The majority of our respondents were highly educated, which – according to the available literature – should in principle help to protect them against the onset of ill-health[517]. However, respondents in all studies, also reported a decline in socio-economic position and low subjective social status, linked to their legal status restricting them in a lot of countries from working officially and from participating freely in civil society. Thus, even with a higher education degree and former professional experience, our research population is structurally hampered from investing in the host society by turning their human capital potential into economic and social capital. Both low objective and subjective social status are considered important predictors of ill-health[518,519] and low income is associated with the progression of ill-health[517]. As a result, it is not unreasonable to assume that SGBV puts our research population at great risk of high morbidity in Europe and the European Neighbourhood.

Health locus of control: Although the respondents demonstrate a predominant internal health locus of control most of them emphasized that this personal attitude is challenged, given the structural dependent situation enforced upon them by the current organization of the asylum reception system and migration law. They indicate that the system and its procedures do not only bring about stress, sadness and frustration which they perceive as a negative impact on their sexual health. The current reception facilities also create barriers to being sexually active as often privacy for couples and families can physically nor emotionally be guaranteed due to infrastructural limitations, and both genders are either forced to live together or on the contrary being separated from each other, irrespective of

what residents would prefer as housing rules. Furthermore, in a lot of reception facilities there are strict rules on receiving guests. This all adds up to unavailability of intimacy and sex opportunities which are perceived as negative factors.

Also in other domains of life as seeing a doctor, cooking, managing administration, participation in social activities outside the facilities, work and others, residents are taken care off and room for autonomy, own initiative or responsibility is heavily reduced. These social, political and practical challenges linked to the European reception system create a dependency, which force them to have a more external passive health locus of control, reduced autonomy, low self-esteem, heightened stress and sexual unavailability which according to literature are linked to creating sexual difficulties in both genders[497-500,520-522]; as well as poor lifestyle, less adequate use of contraceptive methods, lower adherence and service utilisation and higher risk behaviour and susceptibility to ill-health[106,107,109,111,480,481]. It is thus to be advised that the European asylum reception sector can dispose of "offensive" organisational policies that promote sexual health rather than restricting it by enhancing the individual capacities and skills of residents facilitating their proper mastering of health, inducing a good sexual health status at the long run. The recast of the European Directive of minimum standards on reception of asylum seekers[523] of June 2013 seems to promote more possibilities in this sense, which is promising. It will however depend on how this Directive will be implemented at the national level and the ones of the settings itself.

5.5.2 Interpersonal Level

As pointed out earlier, social capital is an important determinant in violence prevention and in health promotion. Yet, their restricted legal status reduces their possibilities to participate actively in the host societies[394]. Refugees, asylum seekers and undocumented migrants are thus structurally hampered to tap their human and social capital beyond the level of the reception settings in which they live and/or the migrant communities they know. This is undesirable, since literature has shown that having restricted social networks is not only bad for one's mental health[482-484] it also reduces the number and quality of channels one can address in order to inform them on sexual violence prevention and sexual health promotion norms and strategies[490-492].

Furthermore, our results demonstrate that legal status or the fact of having only a restricted one or none is decisive in the nature of the violence that one is involved in. The Senperforto study showed that when asylum seekers commit violence, they more likely engage in physical perpetration than national citizens (here=professionals). They are also more inclined to perpetrate emotional violence compared to undocumented migrants. In contrast to asylum seekers, when national citizens perpetrate, it more presumably involves socio-economic violence. When refugees are victimized, the chances are that they will be sexually victimized compared to asylum seekers. When asylum seekers are victimized, it more likely concerns socio-economical violence in contrast to national citizens. When

national citizens are victimised, it is more plausible that it concerns emotional victimisation compared to asylum seekers.

Our study on violence in Morocco and at its borders illustrates that this can even take a more perverse form of specifically victimising the most vulnerable of the vulnerable if no legal authorities interfere. At the Algerian-Moroccan border, it is often the young women and men of the group and sometimes even the children who are picked by the perpetrators to be sexually victimized in return for the group's passage. The young and child migrants symbolize the hope for a better future, the purpose of the migrant's migration. Yet, these bodies which bear the reason to live for the migrants, are what Agamben G. (1998) called "stripped to the bare life" at different levels. First of all literally, by the perpetrators, yet also figuratively, by all authorities directly and indirectly involved, who treat them as if their lives are devoid of value, "unworthy of being lived"[524]. As the perpetrators bear the local authority and sovereignty and thus decide on the criteria and procedures to allow further passage, and the victims are undocumented or have UNHCR papers which still need official recognition and subsequent protection by the Moroccan state until today, and as neither the Moroccan, Algerian or European governments interfere; it seems that the perpetrators can proceed in mere impunity.

5.5.3 Organisational Level

Our results also confirm earlier literature on vulnerability to sexual victimisation of people living in shelters, rehabilitative centres and detention[281,315,316,463] and suggest that the setting of an asylum reception facility is to be considered a risk factor.

In terms of Desirable Prevention and response actions bearing all socio-ecological levels in mind, these findings imply that it is paramount to invest in integral violence prevention and response actions at the organisational level of the asylum reception settings within the whole European asylum reception sector. While mainstreaming for sexual violence perpetration in both residents and professionals, it is however advisable to pay specific attention to preventing asylum seekers from physical and emotional perpetration and to preventing professionals from committing socio-economic violence. In this it is important that potential staff members for all types of work are better screened on attitudes towards conflict and violence, human rights and discrimination, power indifferences and on their coping skills and intercultural competence. A code of conduct could be part of the contract while regular training on conflict and stress management and on violence prevention and response are provided as part of the violence prevention and response policy. In order to be desirable, this policy should firstly stem more from an approach that addresses the root causes and triggers of violence rather than consisting of repressive measures.

Given the clear group character that socio-economic violence has in this sector, it is vital to address group dynamics in perpetration and build on community resilience theories in actions addressing victims. Secondly, policies should be developed and implemented

with a high-level participation of both residents and professionals. Given the many reports of violence committed by security staff and service providers who do not directly report to the management of the asylum reception centre; and the fact that in many countries residents are transferred from one setting to another as a "solution" to an incident of violence, it is crucial that these policies are imbedded in a sector-wide approach.

Furthermore, centres working with or providing housing to vulnerable youth react in very diverse ways to sexuality and risk behaviour. They often develop, independently and ad hoc, some rules as part of their general policy. However, such rules often lack a vision on how to deal with sexuality and risk behaviour, which results in policies aiming solely at preventing risks[525]. The consequence of ignoring sexuality as a positive aspect of young people's lives, is that sexuality is not dealt with and is not integrated in the different policy domains such as care and education, house rules and accommodation, competence of staff and communication[526], resulting in undesirable defensive measures.

However, the social climate at the level of youth or asylum seeker facilities is an important determinant in preventing SGBV and sexual risk behaviour. It is a factor that has to be taken into account when developing and implementing programs that aim at improving the quality of life of residents in youth facilities or other centres[527]. A policy model that can be adapted to a centre's concrete situation should offer a large enough framework to cover all aspects regarding sexuality and SGBV and should offer enough space to adapt general guidelines to a specific context and target population. It should be ergonomic in the sense that with minimal training, staff members should be able to use the organisational policy model in their concrete situation[525].

We developed several instruments that meet the above-mentioned criteria and build on the interaction of all socio-ecological levels. First of all, within the EN-HERA! Network we set up, we developed a Framework for the identification of good practices in sexual health promotion in refugees, asylum seekers and undocumented migrants in Europe and beyond[159]. This framework provides strategic guidance to stakeholders and field organizations in the field of sexual and reproductive health and rights regarding the development of Sexual and Reproductive Health & Rights (SRH&R) policies as well as the deliverance of Sexual and Reproductive Health (SRH) services towards refugees, asylum seekers and undocumented migrants.

Furthermore, within the Senperforto project we developed the "Senperforto Frame of Reference for Prevention of SGBV in the European Reception and Asylum Sector[450]". This multilingual Frame of Reference comprises (a) a training manual on SGBV prevention and health promotion, (b) a multilingual SGBV sensitization kit, (c) a Code of conduct for residents as well as professionals and d) an organisational SGBV prevention and response protocol. The training manual "Make it Work!"[433] specifically addresses sexual health promotion and prevention of SGBV in a culturally competent way, and is also available as

a hard copy folder. It is ideal for the training of peer educators and it provides them with a hands-on tool for setting up as activities with refugees, asylum seekers or undocumented migrants. The sensitisation kit is ready information on sexual health promotion and sexual violence prevention and response that has been widely tested and approved by different age, gender, educational attainment level and cultural groups. The code of conduct is a blueprint for organisations enabling them to integrate their views on sexual health and sexual violence for both professionals as well as residents. Finally, the protocol provides a step-by-step guide to setting up sexual health promotion and sexual violence prevention and response teams that comprise of professionals, residents and extra-facility citizens. They train and coach eachother to enhance all necessary skills. They build intra- and extra-facility networks to which they provide sexual health promotion and violence prevention and response actions conveying messages along the readiest channels for every gender, age and educational attainment group. To a variable degree of participation mode, management and residents participate in the full decision-making and delivery processes of the promotion and prevention teams, and the team participates in the management processes. The lessons learnt are communicated to policy makers and other organisations dealing with similar problems.

While those different tools have been widely disseminated throughout Europe and beyond, and UNHCR promotes the Frame of Reference as good practice, a lot of boxes remain stocked at asylum authorities withholding asylum reception professionals of critical capacity building[528], residents from tapping their human and social capital as well as further empowerment and asylum-related organisations from better performance.

5.5.4 Societal Level

Again, the interaction with the societal and public policy level is crucial in order to have the above-mentioned synergy of necessary changes at the individual, interpersonal and organisational level. It is however noteworthy that, as a result of interaction with the other socio-ecological levels, and with the aim of changing policies and practices at reception organisations, things are moving into a positive direction at the European policy level. Until very recently, within the European Directive laying down minimal standards of reception of asylum seekers, there was only a reference made in that "Member States shall pay particular attention to the prevention of assault within a) premises used for the purpose of housing applicants during the examination of and application for asylum lodged at the border and b) accommodation centres which guarantee an adequate standard of living" (Article 14 paragraph of Directive 2003/9/EC[297]). This means that so far, other forms of violence did not have to be included in prevention, and that this did not apply to detention centres or "private houses, flats, hotels or other premises adapted for housing applicants".

Yet, due to lobbying from among others our project consortia, this has been altered in the recently recast Directive of June 2013 to "Member States shall take appropriate measures to prevent assault and gender-based violence, including sexual assault and harassment,

within the premises used for the purpose of housing applicants during the examination of an application for international protection made at the border or in transit zones and in accommodation centres which guarantee an adequate standard of living." (Article 18, paragraph 4 of Recast Directive 2013/33/EU[499])

There is still room for improvement but at least it is clearly stated that measures should be taken for physical and other types of gender-based violence, and in addition to rape, sexual harassment and sexual assault are specified as including this type of violence as well. Throughout the Directive, directions are also given to enhance housing facilities protecting vulnerable people from victimisation or re-victimisation.

We however recommend that in the evaluation of the implementation of the new Directive, Member States are evaluated on how their prevention and response initiatives encompass the recommendations we make in this thesis in all types of reception facilities and also train their asylum reception staff in gender-sensitive and culturally competent sexual health promotion and sexual and gender-based violence to become active agents in implementing these Desirable Prevention policies.

Furthermore, the "Istanbul Convention"[529] on preventing and combating violence against women and domestic violence which was issued in 2011 and will enter into force in August 2014, also applies a definition of sexual violence including rape and sexual harassment, yet within the scope of violence against women. The Convention also puts forwards that multiple perpetrators or repeated offences are to be considered as aggravating circumstances in legislation. Moreover, a full chapter (VII) is dedicated to migration and asylum, broadening opportunities regarding residence status, gender-based asylum claims and non-refoulement. It also supports the measures of the recast Directive on reception and even goes further in integrating it in more broader legal and policy frameworks that should be made gender-sensitive, preventive and responding to violence against women and domestic violence.

Certainly, as such this Convention is a tremendous step forward in creating the necessary legal and policy frameworks to prevent and respond to violence against migrant, refugee and asylum-seeking women. Yet, it is another example of how the current terminology on gender-based violence has become a synonym for violence against women installing a firm dichotomist and stigmatizing paradigm that ignores the fact that within European Member States, it are not only female migrants which are victimized, yet also an important number of male refugees, asylum seekers and undocumented migrants are victimized. They are now completely left out of the picture and consequentely, they will thus also be left out of the prevention and protection measures that are to be developed in the implementation of this Convention. In addition, the fact that Article 59 on protective measures related to the residence status of a victim is one of the few articles which are subject to national reservations for at least five years with options to renew it for periods

of the same duration, demonstrates that national migration policies will still prevail over the choice to implement human rights for all consistently in all European Member States for many years to come.

In addition to determinants in the asylum and reception procedures, it is to be emphasized that respondents identified risk and prevention factors mostly at the public policy level and made a wide range of recommendations to render this situation more inclusive. They suggested to change the asylum system granting them the opportunity to participate legally in the host society, to work and to have access to education also after the age of 18. Furthermore they emphasized that the asylum procedure had to be shortened. As for Morocco, respondents emphasized that the Moroccan government should consider granting documents to more migrants in order to stabilize their status within the country, to avoid situations of refoulement and to secure borders better facilitating migration. Some pointed out that these suggestions are just assuring that their human rights are upheld. Yet, the fulfilment of these rights is far from self-evident when the opportunity to enjoy them is linked to legal residence status. This is a matter that is framed in migration and asylum law which impacts ample domains of life and which we will discuss in greater detail.

Access to health care and human rights: Legal and policy frameworks determine the accessibility of sexual health services for migrants and our findings show that they are consistently barring the realization of migrants' sexual and reproductive health and rights. Above all, within the examination of a rights-based approach, the question of access to healthcare in general is central since it is a "crucial component of a person's fundamental right to health"[530]. Despite of all 27 European Member States having ratified the "International Bill of Human Rights", and thus acknowledging migrants' right to health, migrants' access to health care is simultaneously framed by other binding documents [531,532]. The EU Charter of Fundamental Rights for example sets out in Article 35 that "everyone has the right of access of preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices"[532]. This leaves room to different and potentially more restrictive national or subnational provisions which might be inspired by other pressing issues and policies, as is migration. The 'criminalization of migration' affects migrants' realisation of their right to health as their access to health care can easily be restricted[533]. In several European countries, legal provisions on health at (sub)national level overlook migrants or circumscribe their access to emergency care and "core benefits" solely[534].

Additionally, a consistent definition of what emergency care exactly entails is often lacking, provoking uncertainty among countries and over time. However restricting access to health care to emergency care means that this country fails to meet the principle of non-discrimination set out in Article 2 of the ICESCR[533]. In at least nine of the European Member States, undocumented migrants were not even granted access to emergency care

in 2010[535]. Beyond emergency situations, the access to care is dependent on regional and subnational differences in Europe. While historically the Mediterranean and Benelux regions used to grant access to a wider range of services to all, current policies to counter the economic crisis alter this practice making it stricter[535-537].

Migration policy: In Europe and the European Neighbourhood human rights can thus be moulded according to migration and asylum policies. This could be explained by the fact that European welfare regimes are traditionally based on citizenship rather than on universality[538]. Subsequently, European democracies' conception of state sovereignty based on citizenship might induce perceptions of migration as a potential threat to this sovereignty[7].

So far, migration and health remain separate in policy-making at national and EU levels[539]. The few strategic documents addressing sexual health and migration tend to tackle communicable diseases transmission, which might be interpreted as a construction of migration as a health security threat. Also the policies and action plan addressing violence and migration mostly refer to human trafficking, female genital mutilation, honour-related violence and intimate partner violence. They thus also perceive violence mainly as a problem within the migrant communities which Europe now has to deal with, while any proper responsibility in the matter is not really considered.

Although this is thus still a matter of the individual Member States, Europe is evolving towards more coherency and common migration and asylum policies. This was accompanied by the establishment of the European Asylum Support Office in 2011. The overall objective of the Stockholm programme setting the European migration strategy is to realize a Common European Asylum System (CEAS) and "progressively establish an area of freedom, security and justice open to those who, forced by circumstances, legitimately seek protection in the Union"[540]. In parallel, the European Union has developed bilateral partnerships and Actions Plans through the Neighbourhood Policy (ENP) which was launched in 2004 with the ambition of "avoiding the emergence of new dividing lines between the enlarged EU and [its] neighbours and instead strengthening the prosperity, stability and security of all"[541]. In 2005, the European Union was also encouraging the implementation of 'transit centres' in third countries, where asylum candidates could pursue the procedure before entering the European territory, a project that was fiercely condemned by Morocco[542]. The ENP Strategy Paper drafted for the 2007-2013 period stated that "the issue of illegal migration is one of the principal sources of concern" for cooperation between Morocco and the EU[543].

The concept of externalization conveys the idea that the EU seeks to delegate its responsibilities in terms of border control to non-Member States and uses international cooperation to restrict population movements[544]. Both European and Moroccan migration policies are based on the rationale that Sub-Saharan migrants enter and cross Morocco in

the hope of eventually reaching Europe, which would turn Morocco in a 'transit country'. However, research has shown that a numerous group of undocumented migrants in Morocco rather 'stranded migrants' than 'transit migrants' enhancing their vulnerability and protection needs[26]. The concept of 'transit migration' is however used by both the EU, which hence justifies its predominant role in the definition of migration policy in its neighbourhood[545]; and by Morocco, for which it provides a leverage for negotiations with the EU and for reinforcing its military presence in Western Sahara[546].

We argue that the use of the 'transit migration' concept participates in the invisibility of violence committed against undocumented migrants in border areas (Algeria-Morocco, Morocco-EU) by allowing all those countries involved as well as the EU as such to refuse accountability for these acts and putting the responsibility to a country across another border who can do the same up till the root countries the "migrants" originate from. Consequently, the so-called 'transit countries' have very little incentive to develop a rights-based approach towards migrants and to implement dedicated structures and services. In this context, migrants' health is not considered a human right, let alone a public health issue.

The legal framework around migration in Morocco is recent and is mostly determined by the law 02-03, passed in 2003 along with the creation of a dedicated department within the Home Affairs ministry, and entered into force in 2010. Although it theoretically provides a frame protecting some migrant groups, such as pregnant women or minors, and limiting refoulement to the borders, those provisions do not appear to be thoroughly implemented yet[544,547]. The provisions do also not contain clear distinctions between the different migrant groups – refugees, asylum seekers and undocumented – and consequently fuel uncertainties and violations of rights in the field[33]. Moreover, although Morocco has signed the Geneva Convention in 1956, UNHCR documents are not yet fully acknowledged by Moroccan security forces[464]. However, in September 2013, the Moroccan government announced to create an asylum seeker status and judicial guarantees for the rights of the undocumented migrants, entering into force from spring 2014 onwards[32].

In the meantime, the sexual victimization can continue in impunity, confirming that the lives of these migrants are politically not cared for, not by self-identified local authorities, not by Morocco, not by the EU and not at global level.

5.6 CBPR as Research Approach in Refugees, Asylum Seekers and Undocumented Migrants

The definition of Community Based Participatory Research reminds us that CBPR in public health:

a) focuses on social, structural and physical environmental inequalities[410],
b) 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 and;

c) Aims to improve the health and well-being of community members by integrating knowledge in action, including personal, social and policy change[404,411,548].

The application of CBPR certainly induced personal change in the Community Researchers. As described in the project reports[449,549], many of them testified that this happened at many levels.

First of all their knowledge on sexual health, violence, migration and conducting research was greatly expanded. In addition, by conducting the in-depth interviews on such delicate topics, their communication and social skills were enhanced. They got to better understand their own experiences and had more skills and self-esteem to address these matters from a semi-professional side. Several of them became key persons in their community. They were addressed during the project but also later on. For some of them, both in Europe as in Morocco, this experience and change of position was considered as positive and led to taking up studies or even direct job offers because of their experience as Community Researchers. However for others this became a burden. On the one hand they felt strengthened and confirmed that they are valuable to the host society. Yet on the other hand, and to a great extent in the highly educated ones, this increased their expectations that were/are not met as they kept/keep on struggling with language difficulties, with the legal and policy frameworks and the practices in our countries to see and treat them as others. This added to former frustration regarding their migration and life in the host society for several of them and led to periods of depression in some.

We definitely consider this as a huge challenge the principle of commitment to sustainability in conducting CBPR with refugees, asylum seekers, and undocumented migrants as not having a full legal status is a solid barrier in society participation which go beyond the power of the research team. During the project, there are often ways to go about these barriers. In our case for example, upon ample negotiations, several institutions were willing to make exceptions within the frame of the projects. Furthermore, in all our projects we dealt with institutional control and conflict. The acts of creating knowledge and using it to communicate a community's perspective to policymakers through direct interaction policymakers were realised both at regional, national and international level. This contributed to institutional, legal and policy changes, yet not always directly tangible for our research population. This, once the projects were ended and no further funding could be obtained, the community researchers and their communities were often confronted with the same problems as before in daily life.

Furthermore, it is currently fashionable to require participation of the research population in calls for proposals. Yet, successfulness of participatory research projects lay within the processes which as such are very time-consuming and often subsequently, albeit not necessarily, more costly. In times of crises where research on migration is as such a topic to which less funding is granted -unless it is directed towards surveillance, terrorism and

safety- time and money for long and difficult participation processes are not foreseen in calls for project proposals. This might increase to the already existing health inequalities these populations face.

In addition, applying a high-level participatory mode in research projects requires attitudes and skills from the professional researchers that are often contradictory to what they have been taught in their scientific education or have learned throughout their professional career. This is particularly the case for the principles of collaborative and equitable partnership; the co-learning and reciprocal exchange of skills, knowledge and expertise; and the principle of balance between knowledge generation and intervention in CBPR. This pitfall of false participation is something that should be evaluated in future research projects where participation was set as a criterion for funding.

A CBPR project should also contribute to social and policy change and our projects do. First of all, in the respondents. The majority of the respondents, both residents and professionals, welcomed the focus of the research and thanked the research team for being genuinely interested in their lives and working atmosphere. This stimulated many to participate in later phases of the project in which the Senperforto project group developed a Frame of Reference on SGBV prevention and response for the European asylum and reception sector. This is in line with Sikweyiya and Jewkes's[550,550] suggestion that risks in SGBV research can remain minimal when protocols are followed and even generate a positive impact. Furthermore, the Community Researchers were empowered and for many their social and economic status was altered as a result of participating in the research studies.

We identified determinants at the individual, interpersonal, organisational, community, public policy and societal level which can contribute to that social and policy change improving the health and well-being of our research population. We shared this knowledge with the research population, a wide range of stakeholders and policy makers at national and international level. We also interpreted the determinants through the concept of Desirable Prevention and formulated policy and practice recommendations at each of these levels. Several of these recommendations are already translated into practical tools, for example the EN-HERA! Frame for the identification of good practices in sexual health promotion, the "Verborgen Zorgen" travelling exhibition, and most importantly the Make it Work! Manual on sexual health promotion and SGBV prevention and the Senperforto Frame of Reference on SGBV prevention and responses. Although they were widely disseminated and they are endorsed and promoted as good practices by global health and protection players in the field of migration, structural implementation is still lacking. A recent inquiry taught that a lot of boxes remained stocked at the official instances to disseminate them which hampers asylum and reception professionals from critical capacity building[528]. This thus requires political action to have them integrated in the implementation of the minimum reception standards. Furthermore, research should be conducted to evaluate what the implementation brought about.

It is noteworthy that also at political level things have shifted. In addition to representatives of our research population, civil society, related services and others, our Community Advisory Boards always consisted of policy makers as well as global health and protection players in the field of migration and asylum. This grounding of our projects ensured that preliminary results, tool development and formulation of recommendations were taken along to political negotiation tables. As a consequence, our project consortia contributed to the altering of the Directive on minimum standards of reception. In the recast Directive of June 2013, it is now stated that "Member States shall take appropriate measures to prevent assault and gender-based violence, including sexual assault and harassment, within the premises used for the purpose of housing applicants during the examination of an application for international protection made at the border or in transit zones and in accommodation centres which guarantee an adequate standard of living." (Article 18, paragraph 4 of Recast Directive[523] 2013/33/EU). Compared to the Directive of 2003, gender-based violence is now included whereas before it was only assault, and the different types of sexual violence in addition to rape are specified. Moreover, the "Istanbul Convention" on preventing and combating violence against women and domestic violence [529] foresees measures that should provide better support to female victims when residing in Europe and protect them from being returned to a country where they could be at risk of revictimisation. Yet, as at national levels, there are tendencies to harshen up on migration and asylum policies, making it difficult to apply for asylum and stay at the reception facilities all together, we encourage the recent developments of a Common European Asylum System, provided that humane treatment is at the basis of it and participation of the target population included.

Finally, both the projects in Europe as the one in Morocco resulted in writing of new project proposals, aiming to implement the policy, practice and research recommendations that were formulated in the projects. We are still awaiting formal responses but the partnerships are decided to persevere until funding has been found. This is however not an evident stance for both community as well as professional researchers. For community researchers and other members of the study population who are motivated to collaborate, the time between formulating a problem together, writing a proposal and then finally being able to start is so lengthy that their lives, legal status and other factors contributing to their participation, might have been turned upside down several times, potentially hampering their eventual participation. Yet also at academic level –and certainly in Belgium- researchers often work at project basis, which implies that in between projects salaries might not be foreseen. In the case they have to take up on another job, it is not guaranteed that the next researcher will have the same motivation and attitude towards applying a CBPR methodology to the project at hand, nor that (s)he will connect and bond with the Community Researchers in the same way.

In conclusion, we do believe that much of the CBPR success of a project is largely due to personal commitment of the principle researchers as well as to their connection and fruitful collaboration with the Community Researchers and Community Advisory Board, which is a process of years. If principle researchers are not motivated and supported to apply such a demanding and time-consuming methodology, the project risks to become one more hit-and-run project. On the other hand, we are convinced of the added value of CBPR and would surely recommend its application. After all, at the start of the Hidden Violence project in 2006, we could not foresee that so many other projects, interventions and project proposals would follow. Any evaluation of a CBPR project thus needs to be done at several years' time interval.

"Making a difference between asylum seekers and other children is a form of violence."

Kurdish Asylum Seeker

"Hidden Violence is a Silent Rape" Seminar

6. CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH, POLICY AND PRACTICES

"I live in an unliveable situation"
(Geesi, 43, male Somali undocumented migrant)

6.1 Uphold all Human Rights Without Exception, take up Co-Responsibility and Move from Public to Planetary Health

The data of our several studies highlight the vulnerability of refugees, asylum seekers and undocumented migrants to SGBV in Europe and the European Neighbourhood because of their restricted legal status and the powerlessness and dependency that goes with that status. In some European countries refugees have the same rights as citizens but in several countries they are still bound to some restrictions. Asylum seekers have a restricted legal status and undocumented migrants have no legal status at all.

This implies that these specific groups of migrants are not treated as citizens and that they do not have the same rights as citizens. Furthermore, as our findings demonstrate, they are often not even treated as humans, not by the host society members nor by the authorities, as the application of human rights is moulded and conditioned in order not to apply to them. Finally, if they are considered humans, they are often criminalised, perceived as a potential threat to society and public health or as people whose autonomy should be reduced in order to handle them better.

Yet migration is still a human right- one has the right to leave a country as the European Commissioner on Human Rights just emphasized in an issue paper[551]- and so is the right to the highest attainable standard of health, as well as the right to live a life in dignity, autonomy, security and equality with respect for one's integrity and privacy; a life free from discrimination, inhuman or degrading treatment, violence or coercion. Human rights are considered to be universal.

Our results however clearly show the absence of an overall rights-based approach in policies regulating migrants' health and protection from violence in Europe and the European Neighbourhood. There is a clear discrepancy between the increasing acknowledgment of specific migrants' needs and the simultaneous enforcement of policies restricting their right to health and controlling immigration flows[401]. The European Member States are the core agents in ensuring that the right to health, to dignity, autonomy, security and equality; to respect for one's integrity and privacy; and to a life without discrimination, inhuman or degrading treatment, violence or coercion, is fully respected within their territory, as only States can endorse the International Bill of Human Rights and as the EU Charter acknowledges national conditions to this right[552,553].

As stated earlier, all 27 European Member States ratified the International Bill of Human Rights which as such obliges them to comply. Moreover, the EU does not condone national conditioning of all human rights. Does the EU then care more for one human right than for another? This double standard would not be problematic if all Member States had national laws and practices that satisfy the requirements of international human rights law. Yet, our results show that several do not uphold those requirements when it comes to sexual health of migrants.

We thus argue that this conditioning, influenced by migration policies, creates a flawed rights-based approach as well as obstacles for migrants to attain good sexual health in the EU, and be protected from sexual violence, which from a public health perspective is a risk to ill-health beyond migrant groups.

For the sake of all people living in the EU today and in the future, it is thus paramount that laws and policies regulating sexual health and sexual violence are altered. The development of a true rights-based approach to health and to a life in dignity without inhuman or degrading treatment, violence and coercion for all thus also requires rethinking the current European paradigm on migration, notably by recognizing the need for legal and policy bridges between health and migration policies.

In the current economic context, mainstreaming health and migration and optimizing the use of resources has become a need[7]. However, this can only be done if migration is no longer considered a threat to European public health and societies and if the discourse on migration flows stops revolving around an ever stronger securitization. Future policy-making should address such discourses and develop broader understandings of the interaction between health, welfare, citizenship and migration. It is hereby vital that responsibilities in inducing problems at all political levels, including the European one, is not neglected.

We thus encourage further empowerment of the EU aiming at a shared responsibility of all Member States and the EU to lead by example by ensuring and controlling that also the right to sexual health, to dignity and to be free from violence and coercion is truly upheld for all in every place of its political territory. Subsequently, we encourage the recent developments of a Common European Asylum System, provided that humane treatment is at the basis of it and participation of the target population included. Given the European Neighbourhood Policy, we deem it paramount that the European Union takes up its responsibility, drastically changes migration regulation into one that upholds human rights beyond the level of survival and enforces the Moroccan and all other authorities involved restoring migrants' lives worthy to be lived again.

Yet, we like to argue that it is not only up to European Member States and the Moroccan state to alter legal and policy frameworks on asylum and migration in order to uphold human rights and to protect refugees, asylum seekers and undocumented migrants from sexual violence and sexual ill-health. We do think that it is a matter of public health in which all health workers have a co-responsibility in promoting good health and prevention of violence in all people regardless of the status one has or not.

This stems from a concept described by Devisch (2010) as "oughtonomy": as soon as one becomes an ethical agent, he or she ought to do something. He posits that there can't be autonomy in the health sector without "oughtonomy"[554]. He further specifies that "Co-responsibility means that responsibility is never me or the other's, but the intermingling of the other's and me, not in the way that they are shared, but that they intrude or contaminate one another. Co-responsibility means that responsibility is divided between several instances or people and that it first of all comes down to understand the social horizon out of which responsibility as co-responsibility pops up"[555].

We support this thesis and would even suggest taking it beyond the health sector to the level of the general society. Given our conceptual framework stating that health is determined by risk and preventive factors at the personal, interpersonal, organisational and societal level and that within the concept of Desirable Prevention one is always in interaction with someone else and the environment, this means that everyone in Europe and the European Neighbourhood, being a citizen or not, "oughts" to do something and should take up co-responsibility to promote sexual health in its broadest sense and to prevent sexual violence for all.

This stance supports as such the recently published manifesto (Lancet, March 2014) to transform public into planetary health and to create a social movement for planetary health: "Planetary health is an attitude towards life and a philosophy for living. It emphasizes people, not diseases, and equity, not the creation of unjust societies. We seek to minimise differences in health according to wealth, education, gender and place. We support knowledge as one source of social transformation, and the right to realise, progressively, the highest attainable levels of health and well-being. (…) An urgent transformation is required in our values and our practices based on recognition of our interdependence and the interconnectedness of the risks we face"[556].

How sexual health promotion, prevention of sexual violence and research could contribute to this in our opinion, is the subject of our following recommendations.

6.2 Recommendations for Sexual Health Promotion

Our results demonstrate that being a refugee, asylum seeker or undocumented migrant in Belgium and the Netherlands is a risk factor for sexual ill-health and confirms that migration and legal status in this matter can be considered a health determinant as such[516].

Yet, as European Member States endorsed sexual health as a human right; they should be enforced to develop and stimulate sexual health promotion activities that are more radical in the sense that they reduce the odds of having migration and legal status as a sexual health determinant and which correct the unequal health conditions described in this thesis.

This means that above all, it is time to put sexual health on the agenda in the matter of refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood. This requires concurrent actions at all socio-ecological levels. Yet, at all the levels, it is important that the sexual health promotion actions stem from a human rights approach and a positive view on sexual health and sexuality. This is in contradiction to the current disease-oriented approaches, if any, and the perception of migrant sexual health as a public health threat. Sexual health encompasses much more than just reproductive health and all of these issues should be addressed. Yet as reproduction is part of it, and the European population is ageing, it is wise to consider migration an opportunity.

Furthermore, in order to meet the comprehensive formulation of the WHO definition of sexual health, instead of curtailing on people's agency in order to reduce sexual health risks, it is vital that actions are "of-fensive" and that people are well-informed, are offered alternatives to shape their behaviour and to enhance their quality of sexual relationships and finally, that they are granted the opportunity to participate in the decision-making on what has to be or can be done to meet a better standard of sexual health.

6.2.1 Individual Level

At an individual level, it is important that refugees, asylum seekers and undocumented migrants in Europe and Morocco are informed on what sexual health entails and what one can do to stay and improve one's sexual health in a culturally competent way. Furthermore, the enhancement of their objective and subjective social status is of major importance. If the recommendations at the interpersonal, organisational and societal level are implemented, they should affect the sexual health of our research population majorly.

6.2.2 Interpersonal Level

At the interpersonal level, it is paramount to empower our research population to build social networks that improve social capital and enhance the exchange of transferable knowledge skills beyond the scope of their proper communities and the reception facilities. Since our respondents, and especially young, those with lower education attainment as well as female respondents, indicated that their direct environment, -preferably friends, parents and siblings-, is one of the first sexual health sources to consider, and literature has confirmed that adolescents sexual behaviour is strongly influenced by peers[493,494] and parents[66]; it is to be advised that refugees, asylum seekers and undocumented migrants in Europe and the European Neighbourhood are empowered to strengthen social networks and are facilitated to take up an active parental or peer educative role in order to enhance

the exchange of transferable knowledge skills through social learning, the creation of social support and community resilience.

6.2.3 Organisational Level

At the organisational level, it is crucial that health-care and other services are made accessible to everyone, regardless of residence status. Given the preference for the health sector as primary sexual health source in all ages and genders but more for more educated persons, and the induced external health locus of control putting more dependence on powerful others as health practitioners[48], it needs to be emphasized that health workers should be strongly encouraged and trained to play a leading role in culturally competent sexual health promotion activities towards this population.

As for the reception settings, it is urgent to develop and implement sexual health promotion policies. A policy model that can be adapted to a centre's concrete situation should offer a large enough framework to cover all aspects regarding sexuality and SGBV and should offer enough space to adapt general guidelines to a specific context and target population. It should be ergonomic in the sense that with minimal training staff members should be able to use the policy model in their concrete situation[525] and that participation of residents can be assured.

In addition to policies, it would be also be wise to consider setting up sexual health promotion teams in which skilled health workers train community key people to become sexual health peer educators and in which the health workers are coached by the peer educators on cultural norms and values in order to enhance the professionals' cultural competence. As a team they can then address both the people who are more in favour of informal help as well as those who prefer formal help and refer to each other.

We developed several instruments that meet the above-mentioned criteria. First of all, within the EN-HERA! Network, we developed a Framework for the identification of good practices in sexual health promotion in refugees, asylum seekers and undocumented migrants in Europe and beyond[159]. Furthermore, within the Senperforto project we developed the "Senperforto Frame of Reference for Prevention of SGBV in the European Reception and Asylum Sector[450]". This multilingual Frame of Reference comprises a) a training manual on SGBV prevention and health promotion, b) a multilingual sexual health promotion and SGBV sensitization kit, c) a Code of conduct for residents as well as professionals and d) an organisational SGBV prevention and response protocol. The Training manual "Make it Work!"[433] specifically addresses sexual health promotion and prevention of SGBV, and is also available as a hard copy folder. It is advisable that if not directly implemented, these instruments are at least considered as inspiration.

6.2.4 Societal Level

At the societal level, structural changes in asylum policies and host society attitudes to enable everyone to enjoy and fulfil their human rights are urgently required. Furthermore,

general sexual health promotion campaigns should be made more culturally competent, taking their sexual health frame of reference and pathways into account, and be integral in order to also address refugees, asylum seekers and undocumented migrants. In addition specific awareness raising initiatives should be developed. In both of those campaigns, we do not advise to differentiate the content, but rather to use other channels whereby migrants with lower educational levels seem to be more susceptible to gaining knowledge through experienced peers (informal help), why for those with a higher attained education more appraisal is given to persons who gained their knowledge and expertise through education and profession (formal help). In addition to traditional channels as TV, radio, books, magazines and such, it is wise to invest in social media as channels for culturally competent sexual health promotion activities emphasizing a positive, yet critical and balanced approach to sexual health and sexuality, especially when targeting youth [474,495].

In addition, structural organisational and societal factors linked to the asylum reception system that now hamper the building of social networks and their active participation in society are to be addressed in order to give them the opportunity to be equally in control of the shaping and perception of their sexual health and sexuality as general citizens. As we managed through CBPR to tackle some of existing barriers in conducting research with this group, we also call upon different societal yet non-governmental stakeholders to take initiatives that may eventually challenge further existence of current barriers.

Finally, we recommend that in the evaluation of the implementation of the new Directive, Member States are evaluated on how their prevention initiatives encompass the recommendations we make in this thesis in all types of reception facilities and also train their asylum reception staff in gender-sensitive and culturally competent sexual health promotion and sexual and gender-based violence to become active agents in implementing these Desirable Prevention policies.

6.3 Recommendations for Desirable Prevention of Sexual Violence

Our research has demonstrated that refugees, asylum seekers and undocumented migrants are at high risk of multiple victimisation in which brutal forms of sexual violence are highly prominent, inducing multiple and long-lasting ill health consequences. We identified their lack of legal status as the major determinant in sexual victimisation risk and this at all socio-ecological levels. This requires urgent changes in migration and asylum policies in which human rights are truly and completely upheld without exception.

In addition it is necessary to set up Desirable sexual violence prevention actions at all socio-ecological levels that stem from this human-rights approach as well as a positive view on sexual health. Furthermore, any violence prevention and response action in which refugees, asylum seekers and undocumented migrants are directly or indirectly targeted, should be gender-sensitive in the sense that they avoid messages in which men are stereotyped as sole perpetrators and women as sole victims. Bearing our conceptual framework in mind, we however recommend that within this gender-sensitive approach prevention actions

are thoroughly culturally competent and developed as well as implemented with high-level participation of all types of professionals and residents.

6.3.1 Individual Level

We argue that in Desirable Prevention of sexual violence against children, adolescents and young adults, it is important to take their sexual health development into account. In this, it is crucial that the prevention actions are maximally "of-fensive" and thus stems from a positive view on sexual health development and that their sexual health development opportunities are not curtailed as specious argument for preventing them to be put at risk of sexual violence.

6.3.2 Interpersonal Level

The social climate at the level of youth or asylum seeker facilities is an important determinant in preventing SGBV and sexual risk behaviour. It is a factor that has to be taken into account when developing and implementing programs that aim at improving the quality of life of residents in youth facilities or other centres[527]. This accords with research findings suggesting that prevention of SGBV in migrants should be based on culturally competent interventions, empowerment, the enhancement of structural elements[557], and the adoption of comprehensive prevention approaches in which community resilience is integrated[558-560].

Furthermore, the prevention should be radical, integral and democratic. Given research demonstrating life course vulnerability, intergenerational transmission and violence debut often starting at young age, they are a specific age group of multiple vulnerability that need specific attention at all levels of prevention – from general policy to primary, secondary, tertiary prevention and care- and at all stages of problem development. All age groups have a role to play in this and should thus be addressed in a wide range of prevention actions. Services addressing patients of sexual abuse should ensure that also children's needs are adequately met[26] within broader policies addressing sexual violence; child specific services should be included[26]. The necessity to ensure participation of young people in this goes without saying.

6.3.3 Organisational Level

Organisational: It is paramount to invest in integral violence prevention and response actions at the organisational level of the asylum reception settings within the whole European asylum reception sector. While mainstreaming for sexual violence perpetration in both residents and professionals, it is however advisable to pay specific attention to preventing asylum seekers from physical and emotional perpetration and to preventing professionals from committing socio-economic violence. In this it is important that potential staff members for all types of work are better screened on attitudes towards conflict and violence, human rights and discrimination, power indifferences and on their coping skills and intercultural competence. A code of conduct could be part of the contract

while regular training on conflict and stress management and on violence prevention and response are provided as part of the violence prevention and response policy.

In order to be desirable, this policy should firstly stem more from an approach that addresses the root causes and triggers of violence –thus be radical- rather than consisting of repressive measures –and thus be of-fensive- as now is mostly the case. Given the clear group character that socio-economic violence has in this sector, it is vital to address group dynamics in perpetration and build on community resilience theories in actions addressing victims. Secondly, policies should be developed and implemented with a high-level participation of both residents and professionals. Given the many reports of violence committed by security staff and service providers who do not directly report to the management of the asylum reception centre; and the fact that in many countries residents are transferred from one setting to another as a "solution" to an incident of violence, it is crucial that these policies are imbedded in a sector-wide approach.

The"Senperforto Frame of Reference for Prevention of SGBV in the European Reception and Asylum Sector[450]" deals with a lot of these issues and is a hands-on toolkit that can be easily consulted and adapted to any European reception initiative. Once more, we emphasize the availability and the recommendation to at least consult is as inspiration.

6.3.4 Societal Level

Given the above, political action is required to have sexual violence prevention policies integrated in the implementation of the minimum reception standards. We however recommend that in the evaluation of the implementation of the new Directive and the "Istanbul Convention", Member States are evaluated on how their prevention initiatives encompass the recommendations we make in this thesis in all types of reception facilities and also train their asylum reception staff in true gender-sensitive and culturally competent sexual health promotion and sexual and gender-based violence to become active agents in implementing these Desirable Prevention policies. We encourage the recent developments of a Common European Asylum System, provided that humane treatment is at the basis of it and participation of the target population included.

However, these prevention actions should not be limited to Europe. Comprehensive cross-border and multi-level prevention actions are thus urgently called for. Given the European Neighbourhood Policy, we deem it paramount that the European Union takes up its responsibility, drastically changes migration regulation into one that upholds human rights beyond the level of survival and enforces the Moroccan and all other authorities involved restoring migrants' lives worthy to be lived again.

Finally, we would like to emphasize again that preventing violence is not solely a matter of law and policy makers. Referring to what Devisch called "oughtonomy", also health workers have a role to play. Taking this concept further, and especially given the general

hostility of host society members often resulting in interpersonal violence, everybody has a role to play. It is thus advisable that in addition to those non-governmental organisations who already advocate for the matter, also other societal movements and initiatives are fuelled and supported to prevent violence in our/their societies.

6.4 Recommendations for Future Research

Studies on refugee, asylum seeker or migrant health have especially engaged in conflict settings and mental health issues[152]. In general, as the constitution and origin of those populations fluctuates over time, more research is thus needed to inquire on refugees, asylum seekers and undocumented migrants of other descent.

First, future research should include a broader range of migrant populations and explore currently over-looked topics. Second, EU-wide datasets should be enhanced by common indicators, durable data collection[4,5,390] and the use of disaggregated data to explore simple and multiple discriminations[530]. Data collection is deemed essential to inform policy-making and monitor the impact of future interventions[5,561,562]. In this sense, I agree that sexual violence, pleasure and satisfaction should be routinely incorporated in sexual health datasets as both explanatory variables and outcomes in studies on sexual behaviour as well as in endpoints in trials of the effectiveness of sexual health intervention[376].

6.4.1 Individual Level

It is paramount that future research on violence stems from a gender-sensitive paradigm and reveals all gender dynamics in specific communities and settings in order to define the most effective interventions. In this, it should be investigated to what extent the asylum centres/system increases the risk of males to be victimised and females to perpetrate compared to what is known on male victimisation and female perpetration in the general European societies, and how much the research paradigm might induce biases in the outcome.

As research needs funding, and funding is often decided upon at political level, it is vital that calls for proposals do not induce a gender bias. Finally, action plans should be adapted according to the outcome of gender-sensitive research. Therefore lobbying for adopting a gender-sensitive paradigm at political level is thus urgently called for.

In addition, research should enquire into the protective role of education in this research population, given the impediment of residence status; and secondly, to determine whether (reverse) causation between socio-economic position and health applies, and if so, how much exposure to a setback in socio-economic position suffices to trigger ill-health.

6.4.2 Interpersonal Level

Research addressing migrants' sexual and reproductive health has rarely stepped outside the scope of maternal health and HIV/AIDS. Although sexual health is now understood

as encompassing perinatal aspects and STIs[152], research and practices in the field have undoubtedly continued focusing on those topics. As a consequence, a significant number of sexual health topics are left unaddressed, such as sexual education, choice of partner, deciding to be sexually active and pursuing a satisfying sexual life. Family planning, which bridges sexual and reproductive health, is another pressing issue in migrants which requires more attention. Migrants still have poor access to family planning and effective contraception, while evidence shows that access improves reproductive health outcomes as well as general health, education and economic situation[563,564].

Also for sexual violence, several types beyond trafficking for sexual exploitation and female genital mutilation and torture before the flight are currently under researched or only addressed in conflict and humanitarian settings. Prevalence studies on interactions between host societies and migrants are urgently called for.

6.4.3 Organisational Level

It would be interesting to further research the impact of specific housing aspects of the asylum reception facilities on violence occurrence. In any research on sexual violence within asylum settings, respondents should be granted the opportunity to both personal and peer reporting, as considering only one of them will only result in revealing parts of the picture. Ideally retrospective research could complement the findings.

6.4.4 Societal Level

Understanding how personal, organisational and societal definitions of violence affect violence reporting, would surely build to a better understanding of violence occurrence and its Desirable Prevention. In addition, as migration routes tend to differ from time to time, it is advisable that the situation in other neighbouring countries within European Neighbourhood Policies and Action Plans are thoroughly researched.

Finally, the long-term evaluation of Desirable Prevention measures and initiatives taken by a wide range of stakeholders and their impact on the health and well-being of this population compared to others would help to clarify the relationship between the different determinants.

"You need healthy people to have a healthy society"
(Surab, 28, male Afghan refugee)

“Sexual health is dead in my body.”

Kurdish Asylum Seeker

ICRH

“Hidden Violence is a Silent Rape” Seminar

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"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

ICRH

"Hidden Violence is a Silent Rape" Seminar

UNIVERSITEIT GENT

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“If I wanted an icecream, I had to lick the head of his soldier first.”

Russian refugee

“Hidden Violence is a Silent Rape” Seminar

APPENDICES

APPENDIX 1: PAPER 7

Paper 7: Van den Ameele S, **Keygnaert I.**, Rachidi A, Roelens K, Temmerman M (2013) The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research 2013, 13:77. Type A1, Q1 public health, IF: 1.773.

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RESEARCH ARTICLE Open Access

The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers

Seline van den Ameele[1*], Ines Keygnaert[1], Alima Rachidi[2], Kristien Roelens[1] and Marleen Temmerman[1]

Abstract

Background: Sub-Saharan transmigrants in Morocco are extremely vulnerable to sexual violence. From a public health perspective, the healthcare system is globally considered an important partner in the prevention of sexual violence. The aim of this study is twofold. In a first phase, we aimed to identify the current role and position of the Moroccan healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants. In a second phase, we wanted these results and available guidelines to be the topic of a participatory process with local stakeholders in order to formulate recommendations for a more desirable prevention of sexual violence against sub-Saharan transmigrants by the Moroccan healthcare sector.

Methods: Knowledge, attitudes and practices of healthcare workers in Morocco concerning sexual violence against sub-Saharan transmigrants and its prevention were firstly explored in semi-structured interviews after which they were discussed in a participatory process resulting in the formulation of recommendations.

Results: All participants (n=24) acknowledged the need for desirable prevention of sexual violence against transmigrants. Furthermore, important barriers in tertiary prevention practices, i.e. psychosocial and judicial referral and long-term follow-up, and in secondary prevention attitudes, i.e. active identification of victims were identified. Moreover, existing services for Moroccan victims of sexual violence currently do not address the sub-Saharan population. Thus, transmigrants are bound to rely on the aid of civil society.

Conclusions: This research demonstrates the low accessibility of existing Moroccan services for sub-Saharan migrants. In particular, there is an absence of prevention initiatives addressing sexual violence against the sub-Saharan transmigrant population. Although healthcare workers do wish to develop prevention initiatives, they are dealing with structural difficulties and a lack of expertise. Recommendations adapted to the context of sub-Saharan transmigrants in Morocco are suggested.

Keywords: Sub-Saharan migrants, Morocco, Sexual violence, Health services, Prevention

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Background

Transmigrants in Morocco

Yearly, an estimated 65,000 to 120,000 sub-Saharan Africans cross North Africa on their way to Europe. These sub-Saharan migrants try to survive in the Maghreb countries as a region of transit, until they have saved enough to fund further migration to Europe, hence the term 'transmigrants'. However, only one-third of these transmigrants eventually continues to Europe, as this has become increasingly difficult due to strict European immigration and Neighbourhood policies [1-3]. As a result, Northern Africa has become a region of destination rather than a region of transit. Approximately 10,000 to 15,000 sub-Saharan transmigrants are currently living in Morocco [2,4,5].

Sexual violence as a public health problem

According to the World Health Organization (WHO), the problem of sexual violence is a public health issue [6,7]. Healthcare workers are ideally placed to recognize and intervene in sexual violence since they are frequently consulted by victims for years after the violation and are often confronted with its physical and mental health consequences.. Furthermore, healthcare workers offer long-term services, have contact with a broad range of people in both early and late stages of victimization and should offer physically and emotionally safe care in a non-judgemental and supportive way [8-10].

The healthcare sector's response to sexual victimization can be situated in three phases of problem development: prevention of victimization; identification of persons in a violent situation and early intervention; and care for the victim after victimization (primary, secondary and tertiary prevention, respectively). In practice, healthcare's main role concerns secondary and tertiary prevention [11-13].

Several consistent, international guidelines exist regarding the role of the healthcare sector in tertiary prevention of sexual violence. They address immediate care for victims, long-term follow-up and psychosocial and legal referral [10,13,14]. Since these guidelines do not provide an elaborated strategy for every unique context, the actual planning and implementation of sexual violence prevention and response programs relies on collaboration and partnerships with target communities, governments and national and international non-governmental organizations (NGO's) [13].

Concerning secondary prevention, no consistent standard of care is currently globally accepted [10,15]. This can be attributed to reluctance of healthcare workers to screen their patients, to insufficient evidence on the impact of screening over the long term or to lack of effective interventions following identification [15-17]. Nevertheless, many victims of sexual violence consult healthcare workers because of masked consequences of violence (i.e. anxiety, chronic pain, irritable bowel syndrome. . .). Yet, because of shame or fear to be blamed, victims rarely raise the topic of sexual violence spontaneously. Hence, the undisclosed violence can result in a negative line of thought concerning the experience with increasing isolation, feelings of guilt, shame and worthlessness. Without any intervention, it is assumed that symptoms persist, aggravate and that the risk of revictimization increases [10,11,18].

Research on women's perceptions of being asked about sexual violence revealed that most women find it appropriate to be asked about it by healthcare workers as the latter are regarded as reliable and having knowledge on adequate care and referral possibilities. Women find it easier if the healthcare worker opens up the dialogue and empowers them to talk about their experiences. Risk of stigmatizing or offending should be reduced by ensuring a respectful attitude and explaining the reasons for asking about sexual violence [10,19,20].

Thus, secondary prevention, performed in a sensitive, non-judgmental way could be a first step to help victims of sexual violence to relieve themselves of their undisclosed experiences and to offer alternatives to feelings of shame and guilt. In this respect, knowledge and awareness of healthcare workers about these processes seems essential [10,19,20].

Sexual violence in Morocco – situation of sub-Saharan transmigrants

In the last decennia, awareness on sexual violence against women and children in Morocco has substantially raised. In 2002, growing attention resulted in the 'National Strategy for the Elimination of Violence Against Women'. This multi-sectorial strategy had been developed in a collaborative approach between government and NGO's. It encompasses a yearly awareness-raising campaign, an expanding number of psychological and legal counseling centers for victims of sexual violence and the creation of reception centers in courts and medical centers. These projects, initiated by the government, are focusing on female Moroccan victims solely and are primarily carried out by specialized NGO's [21,22].

Sub-Saharan transmigrants in Morocco face serious violations of their reproductive and sexual rights. Several reports ascribe the extreme vulnerability of the sub-Saharan transmigrants to their poor living conditions and irregular situation. They denounce the high incidence of rape of sub-Saharan transmigrants committed by gangs and soldiers in the Algerian–Moroccan border region ("no man's land"), of trafficking and of forced prostitution of sub-Saharan women [3,4,23,24]. From April 2003 to May 2005, Médecins Sans Frontières (MSF) dealt with complaints related to violence in 25% of their medical consultations with sub-Saharan transmigrants. In 65% of the cases, Moroccan or Spanish

police forces committed the violence; gangs and human traffickers were responsible for the other 35% [23]. It needs to be stressed that in transmigrants, women, as well as men and children are victimized [3,4,23,24]. At time of publication, severe violent incidents against sub-Saharan transmigrants are still being reported [25,26]. Furthermore transmigrants face several difficulties in order to access healthcare services. It ranges from fear of authorities, expulsion and stigmatization to other financial, linguistic and cultural barriers that hamper transmigrants to consult public health services [4,23].

The Moroccan healthcare system is a mixed public-private system with a compulsory insurance system guaranteeing access to public healthcare services for Moroccan citizens [27]. Current healthcare services for migrants in Morocco are essentially organized by civil society. Several NGO's offer medical care to transmigrants and propagate their safe access to free public health services [4,23,24,28].

Growing awareness among United Nations specialized agencies, NGO's and researchers on reproductive healthcare has given rise to numerous recommendations to promote sexual and reproductive health among refugees and asylum-seekers [13,29,30]. However, existing recommendations are not tailored to the context of sub-Saharan transmigrants in Morocco. Therefore, this research project on the role of the healthcare system regarding the problem of sexual violence and sub-Saharan transmigrants in Morocco was set up.

Research questions

In order to identify the current role and position of the healthcare sector in Morocco in the prevention of sexual violence against sub-Saharan transmigrants, we questioned Moroccan healthcare workers on their knowledge, attitudes and practices concerning this particular problem within the three stages of prevention. We also inquired about their perceived needs to provide desirable prevention of sexual violence against sub-Saharan transmigrants. The results were taken as a starting point for a participatory debate with local stakeholders resulting in the formulation of recommendations concerning the desirable future response of the healthcare sector in Morocco to sexual violence against sub-Saharan migrants.

Methods

Conceptual framework: a socio-ecological perspective on health and desirable prevention

The existence of a complex health problem such as sexual violence can be explained by means of the socio-ecological model. This approach assumes that violence is the consequence of a permanent dynamic interaction between determinants situated on four levels: individual, relational, community and society [31]. Preventive interventions are most effective when they are multidisciplinary in nature, when they aim simultaneously and concordantly at the four levels of the socio-ecological model and, as mentioned earlier, when they target all stages of problem development, i.e. primary, secondary and tertiary prevention [14,32-34].

To evaluate the effectiveness of prevention initiatives, the criteria of 'desirable prevention' are used. Whereas general prevention can be conceived of in terms of those initiatives which anticipate risk factors in a targeted and systematic way, 'desirable prevention' can be defined as 'those initiatives which anticipate risk factors ever earlier in a targeted and systematic way, are maximally "offensive", have an integral approach, work in a participatory way and have a democratic nature, while aiming at the enhancement or protection of the target group's health and wellbeing' [35]. The recommendations issued from this research project are embedded in this conceptual framework.

Study context: a participatory partnership

This study is part of a larger Belgian-Moroccan research project. The goals of the larger project are: to identify decisive determinants of sexual violence against transmigrants, to explore the experiences of transmigrants with sexual violence, and to formulate potential prevention activities. Applying a 'Community Based Participatory Research (CBPR)' method, this project was conducted in a close participatory partnership between Belgian and Moroccan researchers and an extensive Moroccan Community Advisory Board (CAB). The CAB consisted of transmigrants, NGO's and other key-actors working with sub-Saharan transmigrants and working on sexual health in Morocco. Aspiring sustainable change, participation is emphasized in every step of the project.

In line with this participatory framework, our results and interpretations were scrupulously verified by the CAB and other local actors and transmigrants at the seminar 'Sexual Violence and Sub-Saharan Transmigrants in Morocco' (University of Mohammed V, Rabat, May 6th 2009).

Study design

A KAP (Knowledge, Attitudes, Practices) questionnaire, identifying knowledge, attitudes and practices, guided the semi-structured interviews. The underlying theory is that information has to change knowledge and attitudes successively in order to affect healthcare workers' behaviour and practices. A KAP study aims to identify potential barriers to behaviour change on each of these three levels [36-38].

The questionnaire consisted of 44 questions, including 8 open questions. Closed questions, with answers scored by a five- or six-point Likert scale, scrutinized healthcare workers' knowledge, attitudes and practices regarding

sexual violence. The content of these questions was based on United Nations High Commissioner of Refugees (UNHCR) guidelines concerning the response of the healthcare sector to sexual violence against refugees and asylum-seekers [13], and the guidelines of the United Nations Population Fund (UNFPA) on the identification of hidden victims of sexual violence [10]. The closed design was extended by the possibility to comment on the topic of the questions. The open questions assessed potential differences in dealing with sub-Saharan or Moroccan patients, as well as specific needs of healthcare workers who are working with sub-Saharan transmigrants in Morocco. Although the format of the questionnaire allowed written participation, most participating healthcare workers preferred a personal interview, enabling them to expound their point of view on both open and closed questions. To ensure the feasibility, completeness and relevance of the questionnaire in the Moroccan context, a Moroccan professor in sociology, a Congolese and a Moroccan physician, and a Congolese refugee-nurse piloted the questionnaire. The piloting resulted in a few linguistic changes. A Belgian female medical student conducted all interviews in French. The interviewer took notes, and most interviews were recorded. The Ethics Committee of the Ghent University Hospital approved the study.

Recruitment

Given the indications of our CAB and literature review we initially opted for recruitment in Rabat, Oujda, Casablanca and Tangier as they are sheltering the largest number of residing sub-Saharan transmigrants. However, due to emergency security reasons at the time of the field research, most transmigrants tried to flee from Oujda to Fes. Subsequently, we were forced to replace Oujda by Fes. This resulted in recruiting participants in Rabat, Fes, Casablanca and Tangiers between June 20 and July 30, 2008.

A snowball sampling strategy was used. Initially, our sampling goal was to include first-line healthcare workers (general practitioners, community workers, obstetricians) in Morocco who are confronted with both the Moroccan and the sub-Saharan population. However, in the field, these inclusion criteria appeared too vigorous and unrealistic. Therefore, recruitment was refocused on key-persons and key-organizations specialized in either sexual violence in general in Morocco, or in healthcare for sub-Saharan transmigrants in Morocco. First-wave participants were healthcare workers either suggested by members of the CAB or found by online searches. Subsequently, these first-wave participants, in turn, indicated other potential participants. During recruitment we were confronted with saturation of the sample. Participants could only indicate healthcare workers who were already recruited. At the end of the period of field research, however, some new actors turned up.

Eligible healthcare workers were first contacted by email, later by telephone or by a personal meeting in the field. Each participant signed the informed consent, except one who participated through email. Anonymous participation was possible, but most responders provided their contact details.

Data analysis

Interviews were transcribed *ad verbatim*. NVivo8 was used for analysis because of the experience of the researchers. Transcripts and field notes were closely read and scrupulously coded and organized in a tree structure. This structure was systematically reviewed and refined during analysis [39]. The master's student who carried out the interviews did the coding and analysis. A researcher experienced in the field of qualitative and participatory research supervised the whole process.

To ensure reliability of our research, the criteria of Lincoln and Guba were applied. These criteria of credibility, transferability, dependability and confirmability were guaranteed by means of a) triangulation of resources (formal and informal interviews, observations, literature, media etc.); b) verification of results by participants and experts; c) a diverse profile of participants; d) participation of healthcare workers and transmigrants during the whole research project; e) diverse background of researchers; f) thorough description of results, preparation work, activities on the ground, recruitment and analysis and accurate coding; and finally g) extensive reflection on difficulties and limitations [40,41].

Results

Results of recruitment

Of the 57 targeted healthcare workers or organizations, 24 people agreed to participate and 2 contacts agreed to an informal conversation on the subject. The results of those 2 interviews were not included in the formal analysis, but provided important background information. There were 7 non-responders and 24 refusals. Reasons for refusal included "no experience with sexual violence or with sub-Saharan patients"(n:10); "holiday"(n:5); "lack of time"(n:4); "fear of damaging the relationship of trust with the transmigrant"(n:3); "bad experiences with previous research"(n:1) and "no formal permission from the ministry to engage in research"(n:1). Refusal to participate predominantly came from the public healthcare sector, mostly because of lack of experience with sexual violence or sub-Saharan patients. In Rabat, the positive response rate of the targeted NGO's active in the field of transmigrant health, mounted to 75%. Both national and international NGO's participated.

Table 1 Profile of participants (N=24)

	N		N
Sex		*Religion*	
Male	12	Muslim	11
Female	12	Christian	6
Age		Other	2
18-29	6	Unknown	5
30-49	13	*Working area*	
50-59	5	Rabat	18
Country of origin		Casablanca	4
Morocco	10	Fes	4
DRC	6	Oujda	1
Burkina-Faso	1	Tangiers	1
Togo	1	France	1
Sierra Leone	1	*Function*	
Ivory Coast	1	Medical doctor	8
Senegal	1	Community health worker	7
France	2	Relief worker reception centre	2
Argentina	1	Coordinator (MDM/UNAIDS)	2
Highest level of education		Nurse	2
Secondary	2	Midwife	1
Higher, non-university	8	Medical student in practice	1
University	14	Psychometrician	1

Profile of participants

Within the group of 24 participants, there were 12 men and 12 women from different age groups. Ten of the participants were originally from Morocco, 12 from several sub-Saharan countries, 2 from France and 1 from Argentina. Three out of four participants worked in Rabat, 4 in Casablanca and 4 in Fes. Some of the participants worked in multiple Moroccan cities. One participant, active in Médecins du Monde (MDM), was operating in both France and Rabat. Participants were predominantly medical doctors and community health workers. For more details on the profile of participants see Table 1. Most participants (n=14) were employed by NGO's. Seven other participants were employed by both NGO's and the public health sector, while 3 were exclusively employed by the public health sector (Table 2).

Knowledge on prevalence and determinants of sexual violence

Closed questions with a five-point Likert scale assessed the estimated prevalence of sexual violence in Morocco against women, children and men respectively and assessed the estimated frequency of confrontation of healthcare workers with victims of sexual violence. Results of these questions are found in Table 3.

All participants agreed on the existence of sexual victimization of women in Morocco. Likewise, there was a general agreement on the occurrence of sexual victimization of children, with only 3 participants being uncertain on this matter. Eighteen participants reported that men are sexually victimized while 4 were uncertain and 2 indicated that this phenomenon did not exist. Five participants reported frequent confrontation with victims of sexual violence. All participants acknowledged the general vulnerability of transmigrants to sexual violence. However, most of them feel unable to compare the vulnerability of Moroccan people to that of sub-Saharan transmigrants. At the same time, they emphasize the general occurrence of sexual violence within the Moroccan society.

The participating healthcare workers raised several determinants of sexual violence against sub-Saharan transmigrants in Morocco. Female sex, legal status, precarious living condition and ethnicity were mentioned most frequently. The determinants were organized in accordance with the socio-ecological model in micro-, meso-, exo- and macrolevel respectively in Figure 1.

Following quote illustrates the high incidence of sexual violence against sub-Saharan transmigrants in the region of Oujda:

> *« In the forest of Oujda, when you have the bad luck to meet them, they rape you, they take everything, your money, everything. (. . .) Men and women are raped in Oujda. In Oujda, there are a lot of killings. Over there they rape you, they kill you, they rape you, they kill you.»*
>
> - Physician and community health worker, Democratic Republic of Congo (DRC)

Table 2 Origin of patient group in relation to participants' employment (N=24)

	Origin patient group:			
	Sub-Saharan	**Moroccan/sub-Saharan**	**Moroccan**	**French/sub-Saharan**
Participant employed in:				
NGO	6	5	2	1
NGO & public health sector	0	7	0	0
Public health sector	0	1	2	0

Table 3 Estimated frequency of sexual violence in Morocco by healthcare workers and their confrontation with victims (N=24)

	Very frequently	Frequently	Sometimes	Rarely	Never	I don't know
Estimated frequency of sexual violence in Morocco in:						
women	4	14	6	0	0	0
children	2	7	10	2	0	3
men	0	3	8	7	2	4
Confrontation with victims of sexual violence	2	3	5	5	3	1

Attitudes and practices on the level of tertiary prevention

Based on the UNHCR guidelines [13], attitudes and practices concerning care for injuries, pregnancy testing, sexual transmittable infections (STI)-screening and treatment, abortion, psychosocial and legal assistance and long-term follow-up were questioned.

Attitudes concerning the practice of immediate care after victimization, i.e. care for injuries, pregnancy testing and STI-screening and treatment, largely matched the UNHCR guidelines. However on the subject of abortion, there was great reticence to make a statement. There was unanimous confirmation of the importance of psychological assistance. Most participants agreed that healthcare workers should assist in guiding patients towards a safer living environment, although they also emphasized the difficulties related to it. Likewise, these participants considered it their responsibility to provide evidence of the violence and to refer victims to legal assistance. In the interviews several objections were raised: 'legal issues are not within the scope of healthcare', 'it is not possible to document violence that took place during the route of migration', 'reporting will not help the victim', 'the police reacts only in cases of Moroccan victims', 'illegal transmigrants risk being deported', 'healthcare workers are unaware of existing legal procedures'. Finally, a small majority of participants agreed on the need for long-term follow-up regarding physical and reproductive health. Some participants were skeptical and mentioned difficulties, such as the intrinsic mobility of transmigrants and the low accessibility of certain communities. They limit the healthcare worker's responsibility of long-term follow-up to one year after victimization and outsource later follow-up to psychologists.

Practices concerning immediate care for victims of sexual violence are in line with the above mentioned attitudes. For religious and legal reasons, few healthcare workers carry out abortions. Most participants reported referring victims to psychological help. Half of them stated that they try to guide victims towards a safer living environment. The participating healthcare workers did not collect evidence of violence, which was justified by 'difficulties in Morocco', 'lack of time' or 'someone

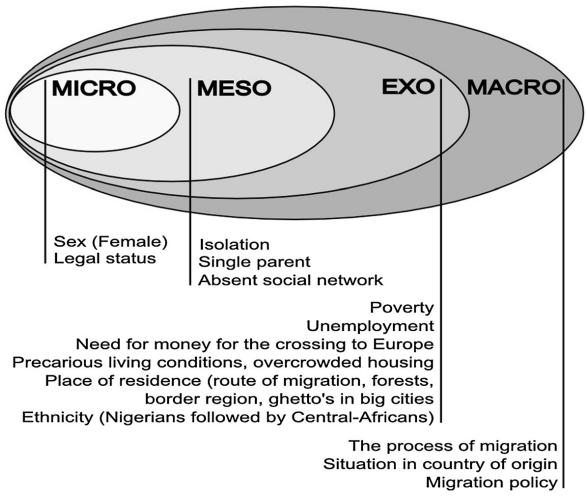

Figure 1 Determinants of sexual violence against sub-Saharan transmigrants in Morocco specified by healthcare workers.

Table 4 Attitudes of participants towards active identification of hidden victims by healthcare workers

Attitudes	Number of participants (N=24)
Pro	*12*
Healthcare workers are in a position of confidence	5
Identification is crucial	5
Healthcare workers are responsible for diagnosing accurately and treating properly	1
Medical attestation is required for legal procedures	1
Contra	*8*
Not a specific responsibility of the healthcare worker	3
Active searching for victims is not done	3
Risk of raising bad ideas in society	1
Lack of time	1
No opinion	*4*

else's responsibility'. Half of the participants reported organizing judicial referral. In practice, long-term follow-up did not take place.

Attitudes and practices on the level of secondary prevention

Attitudes on whether healthcare workers have the responsibility to actively identify victims are presented in Table 4. Half of the participants argue that the active identification of hidden victims is one of the responsibilities of healthcare workers. The other half does not report an opinion or does not believe identification belongs to their professional duty:

> "No, I don't think a healthcare worker should look for health problems. We feel more comfortable being consulted than when we provoke problems. Otherwise we will find sick persons everywhere." (Physician, DRC)

Three out of 4 participants agreed that making enquiries with the aim of identifying potential victims could be a first step to ending the violence and its consequences. Some expounded this point of view, stating that ending the violence is too ambitious; indicating that contributing to the reduction of violence is more realistic.

Regarding practices, ten participants claimed to systematically ask their patients about sexual violence when they suspect them to be victims. Nine participants avoid asking about it for various reasons. Indicated barriers are listed below. These ranged from not feeling competent or not having the right intervention possibilities, to believing that enquiring about violence is not in the patients' best interest. Others approach the issue in an indirect way and encourage victims to bring up the topic themselves. Some said that they need obvious evidence of sexual violence before mentioning it.

Barriers to questioning patients about possible sexual violence when suspecting it

- Not among the competences of healthcare workers
- No appropriate possibilities to intervene after identification of a victim
- Anxiety of offending the victim
- Identification is not part of the mandate of some healthcare workers
- Lack of time
- Reluctance of healthcare worker to open up old wounds
- Respect for the victim's choice to maintain silence

> "The victim has to take her own responsibility; when she wants help, she will confide her problem. (. . .) Unfortunately, I don't know how to deal with this issue. I don't know who to refer to." (Physician and community health worker, DRC)
> "The community health workers meet the people, they have to enter upon the subject of rape. I don't do it because it is not part of my project. Community health workers who enquire about sexual violence do not exist." (Community health worker, DRC)

Role of the public health sector versus NGO's in the prevention of sexual violence

The participants' overall attitude is that the public health sector should play a leading role in the prevention of sexual violence and this within the three stages of prevention. In practice, several participants indicated that transmigrants rely entirely on help from NGO's. There are cultural, legal and financial limitations to the current response of the public healthcare sector for both Moroccan and sub-Saharan victims of sexual violence. The limitations of the Moroccan public health sector regarding the response to sexual violence mentioned by the participating healthcare workers are listed below.

Limitations of the Moroccan public health sector regarding the response to sexual violence

General limitations
- Medical sector provides primarily physical care after violence
- Violence in women is hushed up in Moroccan society
- Insufficient staffing, structures and resources
- Insufficient awareness among healthcare workers

Specific limitations for transmigrants
- Differences in culture, language and religion
- Lack of financial means
- Anxiety of being expelled
- Reticence of medical staff towards transmigrants
- Misperception of sexual liberty in sub-Saharan culture

Needs of the healthcare sector regarding the response to sexual violence

A great need for education was reported. Participants described the need for competent and sensitized staff. They wished to gain better insight into the current possibilities of assistance (medical, psychological and legal) for both Moroccan and sub-Saharan victims of sexual violence. Almost all participants emphasized the importance of creating a specialized, multidisciplinary structure that engages in an overall approach to sexual violence and that collaborate in a more coordinated and structured way. They also stressed the importance of formal inclusion of sub-Saharan transmigrants in the 'National Strategy for the Elimination of Violence Against Women', with special attention to the current migration policy and accessibility to healthcare.

Discussion

Our results demonstrate that all participants recognize the need for desirable prevention of sexual violence against transmigrants. We identified important barriers in tertiary prevention practices, i.e. psychosocial and judicial referral and long-term follow-up, and in secondary prevention attitudes, i.e. active identification of victims. Existing services for Moroccan victims of sexual violence do not yet address the sub-Saharan population. Thus, transmigrants are bound to rely on the aid of the civil society.

Discussion of methods

Initially, our sampling aim was to include first-line healthcare workers confronted with both the Moroccan as well as the sub-Saharan population. However, in the field, these inclusion criteria appeared to be too vigorous and unrealistic, as there seem to exist two parallel circuits in which respectively sub-Saharan healthcare workers see sub-Saharan patients, and Moroccan healthcare workers see predominantly native Moroccan patients. Only a few Moroccan healthcare workers active within the public sector also work in an NGO and have experience with both populations. Therefore, recruitment was refocused on key-persons and key-organizations specialized in either sexual violence in general in Morocco, or in healthcare for sub-Saharan transmigrants in Morocco.

Despite extensive recruitment efforts in all 4 cities, only one fourth of the responding healthcare workers that were included, are operating outside of Rabat. This reflects a relatively higher density of services for sub-Saharan transmigrants in the capital.

For Moroccan patients as well as for transmigrants, the organization of the Moroccan network engaged in reproductive and sexual health lacks transparency and structure. This lack hampered the search for participants and resulted in a false early saturation of sampling. At the end of the period of field research, however, some new actors turned up. The high rate of non-responders and of refusals from the public healthcare sector, due to a reported lack of experience with sub-Saharan patients or with sexual violence in general, consequently results in an underrepresentation of the public healthcare sector. This can be seen as important information, as this might reflect lack of knowledge, taboo, anxiety and low accessibility, especially bearing in mind the high prevalence of sexual violence in Morocco [21].

The areas of field research, i.e. Rabat, Casablanca, Tanger and Fes, were contingent on the larger Belgian-Moroccan research project and they aimed to cover areas in Morocco sheltering the largest number of residing sub-Saharan transmigrants. Several participants reported a high incidence of sexual violence in Oujda and in the Algerian border region. As there is only one participant with working-experience in Oujda, this might have biased the results and underestimated the urgency of a response to sexual violence in this area.

Using a KAP-questionnaire to identify current practices forces researchers to rely on the veracity of the answers of the participants. Awareness of the importance of some practices could influence participants towards desirable answering. However, we believe that the diverse profile of participants and critical analysis of results together with transmigrants and healthcare workers, helped to diminish the impact of this possible bias when drawing conclusions on current practices.

The criteria of Lincoln and Guba were applied to ensure reliability of our research. Confirmability, dependability and credibility in particular were strengthened by participation of healthcare workers and transmigrants during the whole research project and by verification of the results by experts at a local seminar. Difficulties in recruitment and underrepresentation of the public healthcare sector might however reduce credibility of our research [40,41].

Prevalence and determinants of sexual violence

The responding healthcare workers were aware of the existence of sexual violence against women and children and of the particular vulnerability of transmigrants. Simultaneous research of Keygnaert et al. [42] confirms the high incidence of sexual violence, 89% of 154 interviewed transmigrants reported a total of 548 acts of violence in

their close environment. These acts involved sexual violence in 45% of the cases. Notwithstanding the fact that transmigrants in the research of Keygnaert et al. [42] reported male victims in 36% of the reported cases of rape, most health workers interviewed in this study are not convinced of the occurrence of male victimization.

Despite the estimated high frequency of sexual violence, the responding health workers indicated that they rarely came into contact with victims. This discrepancy makes an underestimation by healthcare workers of actual contact with victims of sexual violence very probable.

Determinants of sexual violence indicated by our participants were similar to those reported by the interviewed transmigrants in the research of Keygnaert et al. [42]. Although the vulnerability of Moroccan people is emphasized, participants were aware of an extreme vulnerability of sub-Saharan transmigrants, and this on all levels of the socio-ecological model.

Tertiary prevention

Attitudes of healthcare workers in their response to sexual violence roughly match the suggested approach of the UNHCR guidelines [13]. These attitudes are put into practice without any adaptation to the local context nor standardization. There is a lack of knowledge and there are structural difficulties in long-term follow-up, psychosocial and judicial referral, which has repercussions on current practices. Awareness of the importance of psychosocial support might bias the response of participants towards desirable behaviour when reporting their practices. The numerous obstacles that were revealed suggest a discrepancy between reported and actual practices.

The lack of transparent procedures and the presence of structural and legal difficulties account for a discrepancy between attitudes and practices within the legal aspects of the healthcare response to sexual violence.

There hardly is any long-term follow-up, as it is hindered by the attitude that the responsibility of the physician ends when physical problems are healed. Physical long term-consequences of sexual violence were not taken into account and follow-up was believed to be the domain of psychologists. The intrinsic mobility of the transmigrant population might complicate actual follow-up.

Secondary prevention

Most participants do not recognize the usefulness of active victim identification practices. Several participants indicated that systematic screening of potential victims would not help to reduce sexual violence. They motivated this point of view by stating that the highest prevalence of violence was found at the border. They deem care unnecessary for victims of violence that has already taken place during the route of migration. This illustrates a lack of knowledge concerning the utility of secondary prevention.

It is difficult to draw conclusions from the responses of the 10 participants stating that they systematically broach the topic of sexual violence when suspecting it. Questions related to the signs of violence demonstrated that the healthcare workers were mainly alerted to immediate consequences of sexual violence.

The results suggest that in current practice, unless there are obvious signs of sexual violence, the majority of healthcare workers prefers to adopt an open, but passive attitude. Most participants were motivated to identify victims of sexual violence, but their current lack of competences and of appropriate interventions makes the healthcare workers to wait for the victims' initiative.

The barriers at the levels of knowledge, attitudes and practices, which were identified in this study, are similar to those identified in research on screening for intimate partner violence by healthcare workers [11,15,16,19,37]. Bearing in mind current opinion on women's perceptions of being asked about sexual violence, a first challenge on this prevention level seems to be awareness-raising and adequate training of healthcare workers in order to help them understand the behaviour and needs of victims of sexual violence [19,20].

Role of the public healthcare sector versus NGO's

The gap between the public healthcare sector and NGO's is striking in the Moroccan healthcare system. All participants, with the exception of participants working exclusively in the public health sector, indicated that healthcare for transmigrants lies entirely in the hands of NGO's. Although transmigrants' access to the public health sector is possibly in theory, many barriers were mentioned. These findings confirm the reported low accessibility of Moroccan public healthcare for migrants in earlier research [4,23,24].

It is unclear to what extent the participants' perceptions are influenced by the fact that they are familiar with either NGO's or public services. The limited number of healthcare workers working exclusively in the public sector does not allow their opinions to be compared to those working in NGO's. Nevertheless, the opinions of participants working in both settings largely correspond to those working exclusively in NGO's.

In Rabat and Casablanca we came upon many valuable initiatives promoting the integration of transmigrants into the Moroccan healthcare system. Most of these initiatives were organized by and in collaboration with the Moroccan government. We consider the improvement of governmental support for these initiatives as essential.

Needs of the healthcare sector regarding sexual violence

ur interviews revealed a current absence of prevention measures, as well as an unequivocal wish for prevention initiatives. The most prominent need reported is adequate training of healthcare workers. Many participants working only with transmigrants seem uninformed about existing initiatives for Moroccan victims of sexual violence. Hence these existing initiatives are not optimally being used for transmigrants. However, the assistance for Moroccan victims is not problem-free either. These projects for Moroccan victims only started recently and need further development.

Recommendations

Our proposed recommendations encompass actions taken by healthcare workers within the three stages of prevention and on the micro, meso, exo and macro levels of the socio-ecological model. These recommendations were developed based on the results of the KAP study and inspired by the UNHCR [13] and UNFPA [10] guidelines. They have been scrupulously reviewed and modified by local actors and transmigrants at the seminar 'Sexual Violence and Sub-Saharan Transmigrants in Morocco' (University of Mohammed V, Rabat, May 6th 2009). Because of the active participation of the target population and due to the application of the socio-ecological concept of violence and the three-tier prevention model during the whole research project, the proposed recommendations fulfil the criteria of desirable prevention to a great extent.

Tertiary prevention

Provide accessible, immediate and reliable care that inspires confidence

- Provide the ability for direct registration, or by way of a community health worker, in an accessible first-line health centre or reception centre for sexual violence. Communicate the confidentiality to the sub-Saharan community.
- A standardized protocol should encompass all aspects of immediate care and long-term follow-up.

Secondary prevention

Aim at early identification of victims of sexual violence

- Be aware of potential barriers (such as shame, anxiety, culture, language) that hinder victims from speaking spontaneously about their experience of violence.
- Gain insight into personal barriers to dealing with sexual violence.
- Provide an immediate and appropriate response after the identification of victims.
- Avoid stigmatization of the sub-Saharan population in the field of sexual violence.
- Incorporate the identification of hidden victims of sexual violence in community health projects.

Primary prevention

Prevention is better than cure

- Operate with community health workers to disseminate messages of prevention and protection.
- Exert pressure on the government by reporting data.
- Identify factors that contribute to vulnerability, and adopt prevention campaigns.
- Organize activities in the field of reproductive health.Awareness-raising and information campaigns on the topic of HIV/AIDS could be extended with activities and discussions in the sphere of gender, sexuality and gender-based violence. Men also have to be involved in these activities.

All stages of prevention

Create a specialized and multidisciplinary structure/ network for an inclusive approach to sexual violence

- Collaborate with staff operating in the field of health, protection, education, psychology, law, community work etc.
- Form networks consisting of the target population, community health workers, reception centers, health centers, the police and specialized organizations.
- Optimize the activity and the number of existing reception centers for victims of sexual violence.
- Include transmigrants in the national strategy for combating sexual violence against women.
- Identify Moroccan organizations engaged in the struggle against sexual violence that are willing to include transmigrants in their activities. Collaborate with organizations that have transmigrants as a target population and currently work principally on HIV/AIDS.

Integrate sub-Saharan transmigrants into the Moroccan public health sector

- Train healthcare workers to be competent to deal with transmigrants: awareness of the influence of culture and origin on health; knowledge of the possibility of (sexual)

traumatization during migration and the impact of this over the long term; knowledge of the context of living in Morocco; awareness of the unstable character of a transmigrant population.
- Organize an approach that takes linguistic, social, economic and administrative problems into account.
- Confer with the Ministry of Health and NGOs on mediation between the target group and hospitals/ health centers.
- Formalize access to care in the form of an official report by the Ministry of Health.
- Analyze other barriers to care for transmigrants and eliminate them.

Operate with adequate trained, specialized, diverse and sufficient staff

- All staff coming into contact with potential victims of sexual violence need to be informed about themes such as gender, sexual violence, migration, sexuality and cultural differences. Sympathy and respect are essential in dealing with sexuality and reproductive health.
- Diversify staff regarding to language, origin, religion, gender etc.
- Develop and organize an adequate training for all healthcare workers.
- Specific capacities:
  Community health workers:
  - are recruited out of different sub-Saharan communities;
  - speak the language of the target population;
  - have a mutual relationship of trust with the target population;
  - are competent at applying a screening tool;
  - are able to offer first-time psychosocial support;
  - have knowledge of procedures of reporting and referral to appropriate centres; and
  - participate in awareness-raising.

  Physicians/Nurses:
  - know the protocol of the immediate approach to sexual violence;
  - are aware of the long-term consequences of sexual violence;
  - are aware of the importance and the urgency of HIV prophylaxis;
  - have knowledge of procedures of follow-up and further referral;
  - are competent at applying a screening tool; and
  - follow a specific code of conduct, with respect for anonymity.

Conclusions

Violence against women is a rising subject of attention in Morocco. Numerous initiatives for prevention and response are starting up. In contrary to the inclusive approach of a desirable prevention, current prevention initiatives have limited accessibility for sub-Saharan transmigrants. At the same time, transmigrants, NGO's and healthcare workers engaged with transmigrants express a strong wish to develop desirable prevention of sexual violence against transmigrants. All agree that, in order to set up sustainable and effective interventions, a framework and/or initiator is required. Phenomena like these could become the foundations of a productive collaboration between the current Moroccan policy on sexual violence, the population of transmigrants and the healthcare workers. Taking into account the aspects discussed in above recommendations, this collaboration should evolve into a multidisciplinary approach considering the global context of a transmigrant in Morocco.

This research provides an impression of the knowledge, attitudes and practices of healthcare workers experienced in the field of sexual violence and/or sub-Saharan transmigrants in Morocco. We are convinced that it can serve as a leverage for further research on more specific topics such as screening-practices in Moroccan healthcare, cultural difficulties for Moroccan healthcare workers confronted with sub-Saharan patients, methods of awareness-raising, and, development and efficacy of training programs. However, the results of this research can already be considered as a call for the urgent creation and evaluation of pilot interventions as proposed in the above recommendations.

Discussing prevention in general remains incomplete without reflection on primary prevention. Primary prevention of sexual violence against transmigrants needs drastic changes in politics, economics, ethics and migration policies of African and European countries. The authors are convinced that, before developing and setting up secondary and tertiary prevention initiatives, the feasibility of primary prevention initiatives should be considered, as they are the basic condition for sustainable and effective change.

Abbreviations

CAB: Community advisory board; DRC: Democratic Republic of Congo; KAP: Knowledge, attitudes, practices; MDM: Médecins du monde; NGO: Non-governmental organization; STI: Sexual transmittable infection; UNFPA: United Nations Population Fund; UNHCR: United Nations High Commissioner of Refugees; WHO: World Health Organization.

Competing interests

The study is part of a larger research project funded by the National Lottery of Belgium. The authors assure the absence of competing interests.
A preliminary version of this paper was presented at the project seminar 'Sexual Violence and Sub-Saharan Transmigrants in Morocco' in Rabat in May 2009. Research findings are extensively described in the Master's dissertation 'Role and position of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco' by SVDA.

Authors' contributions
SVDA contributed to the study design, acquisition of data, analysis and manuscript writing. IK supervised the study process from design to manuscript editing. IK, KR and MT critically reviewed the manuscript for intellectual content. AR participated in study design and acquisition of data. All authors read and approved the final manuscript.

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Author details
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APPENDIX 2: CV

Europass CV

Personal information

First name(s) / Surname(s)	**INES KEYGNAERT**
Address(es)	ICRH, De Pintelaan 185 UZP 114, 9000 Ghent, Belgium
Telephone(s)	+32 (0)485 96 14 04
E-mail	Ines.keygnaert@ugent.be
Nationality	Belgian
Date of birth	05.03.1976
Gender	Female, Mother of 2 sons: Aaryan (2009) and Rayman (2012)

Work experience

Dates	May 2006 - current
Occupation or position held	**Researcher & Senior Project Coordinator Sexual, Gender-Based and Interpersonal Violence & Migrant Health. Ghent University-ICRH**
Main activities and responsibilities	Research: - Determinants in: migrant health, sexual and reproductive health, sexual, gender-based, interpersonal, intimate partner & domestic violence, prevention of and response to violence - Health promotion in vulnerable groups and hidden populations a.o. refugees, asylum seekers, (undocumented) migrants, people in poverty - Health care management of patients with violence experiences - Intercultural communication on sensitive topics - Community Based Participatory Research, Mixed methods - PhD on Sexual violence determinants and desirable prevention in Medical Sciences Coordination of research projects: - Belgian research project: "A holistic response to sexual violence: is the "one-stop" centre for sexual violence a desirable model in the Province of East-Flanders?" (5/2014- 11/2014) - European research project: "Senperforto: Prevention of Sexual Violence in the European Reception & Asylum Sector" in 8 European Member States (12/2008-12/2010) - European research project: "EN-HERA!: European Network for the Promotion of Sexual and Reproductive Health & Rights of Refugees and Asylum seekers" in 4 EU MS (8/2007-2/2009) - Belgian-Moroccan research project: "Sexual violence and Transmigrants in Morocco: a participatory partnership for prevention" (12/2007-6/2009) - Belgian research& community development project: "Hidden worries" (15/05/2008-14/05/2009) - European Seminar on participatory prevention of sexual violence against refugee women and girls (3/2006- 2/2008) - European research project "Hidden Violence is a Silent Rape: Development of a prevention tool to combat sexual and gender-based violence against refugee women and girls in Europe: a participatory approach" in Belgium & the Netherlands (5/2006-4/2008) Extensive experience in proposal writing Editor BMC Conflict & Health -Reviewer for international peer-reviewed journals: Social Science & Medicine, BMC International Health & Human Rights; Culture, Health & Sexuality. Education, capacity building & policy support: - UNFPA Kosovo: Review of the GBV clinical guidelines for Kosovo (05-06/2013) - Coordination, mentoring and provision of "Dealing with interpersonal violence in hospitals: Basic and advanced training for doctors, nurses and other healthcare workers in Belgian hospitals + violence protocol development and coaching" for Belgian Federal Agency of Public Health (2010-2012) - Round table on addressing sexual violence holistically in Belgium (2013-2014) - Lecturer/trainer addressing sensitive topics as violence experiences to healthcare providers - Lecturer, Co-promoter & Tutor for BA & MA students in Medical & Health Sciences, Midwifery, Nursing, Sexology, Social Policy & Work Studies, Cultural Sciences - Effective Scientific Communication- coach practice sessions doctoral schools university (2010-2012) - Development of training manuals, participatory prevention tools & trainings (see attachments) - WHO Europe: Improving Sexual Health Expert meeting – invited expert sexual health migrants (2010) - Member of various (inter)national expert groups and committees WHO, Y-SAV, national action plan violence Belgium, federal public health agency

Name and address of employer	ICRH-Ghent University, De Pintelaan 185 UZP114, 9000 Ghent, Belgium
Dates	March 2005 – April 2006
Occupation or position held	**National Coordinator local social policy, advocacy & participation of vulnerable groups**
Main activities and responsibilities	Research: - Political participation of vulnerable groups from a rights-based approach - local social policy development - Participatory methodology Coordination of research projects: - "Participation of vulnerable groups in local social policy" by order of the Flemish Minister of Welfare, Health and Family Inge Vervotte (12/2004 – 11/2005) - 7 pilot projects: setting up and guidance of local community participation processes with vulnerable groups and 7 local governments in Flanders (12/2004-11/2005) Tools and manuals development: - "Participatiehefboom": bipartite toolkit with a in depth assignment on participatory methods - "Participatie-Wijzer": manual on the Local Social Policy Law - "Participatieplan-Leidraad": manual on strategic planning of participation - Development 'Participatory Help Desk' website - Development of strategic 'Reference Framework of advocacy' for Flemish community development Seminars & Training organization: - Seminar on political participation of vulnerable groups (+350 participants from local and regional Flemish governments) - Seminar on Reference Framework of advocacy, sector Community Development (300 p) - Training of community workers on political empowerment and participation of vulnerable groups - Training of federal and local police men on interaction with vulnerable groups within the framework of Community Oriented Policing Services: - Advising governments and partner organization on participation of vulnerable groups - Methodological input Research project on advisability and feasibility of equal participation in the Federal Plan of Sustainable Development (Institute for the Government, University Leuven) - Steering committee Research project on Children and youth participation in Flanders (Flemish government & Prof De Rynck, University of Antwerp& College of Ghent) - Steering committee Research project on role of Provincial authority of Eastern Flanders in Local Social Policy Law implementation (Province council Eastern Flanders& University of Ghent)
Name and address of employer	Samenlevingsopbouw Vlaanderen/VIBOSO**,** Vooruitgangstraat 323 b2, 1030 Brussels
Dates	March 2003 – February 2006
Occupation or position held	**Senior Policy adviser and regional coordinator community development**
Main activities and responsibilities	Research: Political participation of vulnerable groups from a rights-based approach & Participatory methodology Policy advice: - developing covenants with local authorities for community development of vulnerable groups - Outlining the regional action plan and policy objectives regarding participation, empowerment, active citizenship and social cohesion - Developing these objectives into feasible instruments, methods and projects - Reorganization process for the institute to enhance communication, efficiency and quality management - Methodological input to the Federal Plan of Sustainable Development Coordination: - All community development projects related to above-mentioned objectives - Coordination of community development workers in the field - Self-sufficiency project of community development, resulting in an association funded by the Flemish and local government, vzw PAROL, Aalst - Lobbying, networking and setting up partnerships Training: - Political participation of vulnerable groups in practice - Coaching of Masters students

Name and address of employer	Samenlevingsopbouw Oost-Vlaanderen/RISO, St Jacobsnieuwstraat 50, 9000 Gent, Belgium
Dates	September 2002 – March 2003
Occupation or position held	**Researcher & Policy adviser Intercultural Management of health care**
Main activities and responsibilities	Research: Diversity and intercultural drug aid Coordination: - Development of diversity scan and a reference frame on intercultural management of drug aid sector - Pilot project on intercultural management and communication of regional drug aid associations - Defining the main objectives of the women and refugee department of the institute
Name and address of employer	Intercultureel Netwerk Gent (Intercultural network), Dok Noord 7, 9000 Gent, Belgium
Dates	September 2001 – January 2002

Education and training

Dates	September 2009 – June 2012
Title of qualification awarded	**Certificate of Doctoral Training Programme Medical & Health Sciences** (training programme completed in 2012, certificate upon PhD defence, foreseen June 20 th 2014)
Principal subjects/skills covered	Forensic Psychiatry, Risk Studies, Medical Sociology, Qualitative Research
Name and type of organisation	Ghent University, Ghent, Belgium
Level in classification	ISCED 8
Dates	September 1999 -June 2000
Title of qualification awarded	**Post Graduate Degree in Contemporary Middle-Eastern studies**
Principal subjects/skills covered	Arabic, Middle-Eastern social, societal and political issues, history and literature, practice with gynaecologist– Great distinction
Name and type of organisation	Nederlands Vlaams Instituut in Cairo (NVIC), (Dutch-Flemish Institute in Cairo)
Level in classification	ISCED 6
Dates	September 1998-June 1999
Title of qualification awarded	**Third Cycle Degree in Development Studies (Diplôme des Etudes Spécialisées en développement social, économique et politique)**
Principal subjects/ skills covered	Thesis: "The process of economical liberalization in India and its impact on social development", Majors: Social and political development of Arab world, Asia, Africa, Health policies, medical anthropology - Distinction
Name and type of organisation	Catholic University of Louvain La Neuve
Level in classification	ISCED 7
Dates	September 1994-September 1998
Title of qualification awarded	**Master in Eastern languages and cultures**
Principal subjects/ skills covered	Thesis "Possession: the Moroccan etiology and cures": thesis on the traditional Moroccan logic of body and psyche, illness and medicine. Majors: Arabic, Islamic, Hebrew and Jewish languages and cultures, anthropology, social & political development – Distinction-Pass-Distinction-Pass
Name and type of organisation	University of Ghent + INALCO, Paris, France for Erasmus program (September 1997-June 1998)
Level in classification	ISCED 6
Dates	July 1996, March 1997
Title of qualification awarded	1: **Certificate** of Intensive Interuniversity Erasmus Program in Jewish studies 2: **Certificate** of Intensive Arabic course
Principal subjects/occupational skills covered	1: Contemporary issues in European Jewish studies 2: Modern Standard Arabic
Name and type of organisation providing education and training	1: Complutense Universidad, Madrid, Spain (3/1997) 2: University Muhammed V, Rabat, Morocco (7/1996)

Other language(s)

Self-assessment	Understanding		Speaking		Writing
European level (*)	Listening	Reading	Spoken interaction	Spoken production	
English	C2	C2	C2	C2	C2

French	C2		C2		C2		C2		C1
German	B2		B2		B1		B1		A2
Arabic	B1		B1		B1		B1		A1

Social skills and competences	Excellent intercultural communication skills, Effective Scientific Communication coach Good coaching and motivational skills, Good experience in negotiation and advocacy Founder and board member of EN-HERA!: European Network for Promotion of Sexual and Reproductive health of Refugees, Asylum Seekers and Undocumented Migrants in Europe and beyond
Organisational skills and competences	Good Leadership skills, Extensive experience in research project writing and in international project and team management, Excellent experience in organising trainings, seminars and conferences
Other skills and competences	Voluntary positions of responsibility: - Founder and board member of EN-HERA!: European Network for Promotion of Sexual and Reproductive health of Refugees, Asylum Seekers and Undocumented Migrants in Europe and beyond (2009-…) - Expert in Y-SAV, European Network on youth sexual aggression and victimisation (2011-…) - Expert in Sensoa Expert group on sexual violence (2007-…) and migrant health (2007-…) - Effective Scientific Communication coach practice sessions, Ghent University & Principiae (2010-…) - Board Member of "Friends of Patricia Claeys vzw" (2009-…) - Board member of Partners in Reproductive Health vzw (2007-2009) - Board member of El Ele –Yid fil Yid vzw: refugee & migrant women association, Gent (2003-2008) - Board member PAROL vzw: Community development Aalst (2004-2006) - Board member Dulcisona vzw: semi-professional choir (2005-2007) - Principal monitor Degree, Youth movement Nature & Environment Courses: - Forensic Psychiatry (2012) - Leadership Foundation (2012) - Effective Scientific Communication, Ghent University & Principiae (2009) - Qualitative research skills, University of Antwerp (2008) - English Academic Writing Skills, Ghent University (2007) - Directorate-General of Development Cooperation-Cycle, Ministry of Foreign Affairs and Development Cooperation, Brussels (2001) - Intensive Strategy and Negotiation course, Brussels, (2004)
Computer skills and competences	Good command of Microsoft Office tools, SPSS, Nvivo
Artistic skills and competences	- Music: Cum Laude in music and flute, Governmental Medal & Summa Cum Laude in Music History - Singing: Mezzo Soprano, singing in semi-professional choirs since 1982 - Argentine Tango: teacher and performer since 2002
Driving licence	Category B

ATTACHMENT

1. Publications

Articles A1 published:

- Keygnaert I, Dias SF, Degomme O, Devillé W, Kennedy P, Kovats A, De Meyer S, Vettenburg N, Roelens K, Temmerman M (2014) Sexual and gender-based violence in the European asylum and reception sector: a perpetuum mobile? *European Journal of Public Health, 2014, doi: 10.1093/eurpub/cku066.*

- Keygnaert I, Dialmy A, Manço A, Keygnaert J, Vettenburg N, Roelens K, Temmerman M (2014): Sexual violence and sub-Saharan migrants in Morocco: a participatory assessment using respondent driven sampling. *Globalization & Health, 2014, 10:32*

- Keygnaert I, Vettenburg N, Temmerman M, Roelens K (2014) Sexual health is dead in my body: Definition and Perception of Sexual Health Determinants by Refugees, Asylum Seekers and Undocumented Migrants in Belgium and the Netherlands. *BMC Public Health 2014, 14:416*

- Keygnaert I, Guieu A, Ooms G, Vettenburg N, Roelens K, Temmerman M (2014) Sexual and reproductive health of migrants: does the EU care? *Health Policy, Vol. 114, pp 215-225.*

- Van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M (2013) The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. *BMC Health Services Research 2013, 13:77*

- Keygnaert I, Vettenburg N, Temmerman M (2012) Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *Culture, Health & Sexuality, Vol. 14, issue 5, May 2012, pp 505-520.*

Articles A1 submitted:

- Keygnaert I, Guieu A, Vettenburg N, Roelens K, Temmerman M (2014) What the eye doesn't see: A critical interpretative synthesis of European policies addressing sexual violence in migrants.

Articles A2 published:

- Keygnaert I, El Mahi N, Van Egmond K, Temmerman M (2011) Verborgen Zorgen: Beeldessay- *Tijdschrift voor Genderstudies n3, pp40-41*
- Keygnaert I, Deblonde J, Leye E (2011) Sexual health of migrants in Europe: Some pathways to improvement – *Entre Nous n 72, WHO Regional Office for Europe, pp 20-21*
- Leye E., Roelens K., Keygnaert I., Claeys P & Temmerman M. (2008) Research in an ivory tower? How Research on Sexual and Gender-Based Violence can make a difference. *Entre Nous n° 67, WHO Regional Office for Europe, pp 22-23*
- Keygnaert I. & Temmerman M. (2007) Between theory and practice: Gender-based Violence against Refugees, Asylum Seekers and Undocumented Migrants in Europe. *Entre Nous n°66, WHO Regional Office for Europe, pp 12-13.*

Books/Manuals published (B1):

- Keygnaert I., Vangenechten J., Devillé W., Frans E. & Temmerman M. (2010) Senperforto Frame of Reference for Prevention of SGBV in the European Reception and Asylum Sector. *Magelaan cvba, Ghent. ISBN 978-9078128-205*
- Frans E. & Keygnaert I. (2009) Make it Work! Training Manual for Prevention of SGBV in the European Reception & Asylum Sector. 150 pp, Academia Press, Ghent. *ISBN 978 90 382 1575 4.*
- Keygnaert I., El Mahi N., Pourmirzajan B., van Egmond K.& Temmerman M.(2009) Verborgen Zorgen Fotoboek. *Academia Press, Ghent, Belgium. ISBN 978-90-382-1438-2*
- EN-HERA! (2009) Framework for the identification of good practices in Sexual & Reproductive Health for Refugees, Asylum seekers and Undocumented Migrants. *Academia Press, Ghent, Belgium. ISBN 978-90-75955-69-9.*
- Keygnaert I. (2005) *Participatiehefboom: Methodes*, Ministerie van de Vlaamse Gemeenschap, D/2005/3241/276, 124 pp.
- Keygnaert I. (2005) *Participatiehefboom: Handvatten*, Ministerie van de Vlaamse Gemeenschap, D/2005/3241/277, 124 pp.
- Keygnaert I. (2005) *Participatieplan-Leidraad*, Ministerie van de Vlaamse Gemeenschap, 16 pp.
- Degreve H. & Keygnaert I. (2005) *Participatie-Wijzer*, Ministerie van de Vlaamse Gemeenschap, D/2005/3241/216, 42 pp.

Chapters in Books published (B2)

- Keygnaert I. (2010) Seksueel geweld tegen vluchtelingen, asielzoekers en mensen zonder wettig verblijf in België en Nederland. Hoofdstuk *4 In: Vrouwen onder Druk. Schendingen van de seksuele gezondheid by kwetsbare vrouwen. Eds Leye E & Temmerman M., Lannoo Campus, pp69-89.*
- Van Egmond K., Keygnaert I., Dias S. & Nöstlinger C.(2009) Literature review on Sexual and Reproductive Health and Rights of Refugees, Asyhlum Seekers and Undocumented Migrants. *In: EN-HERA! Report 1, Academia Press, Chapter 4, pp 21-59.*

Abstracts published & presented at International Conferences (C3):

- Keygnaert I, De Meyer S, Frans E, Demyttenaere T, Temmerman M (2013)"Make it Work! Training Manual for Sexual Health Promotion and Prevention of Sexual and Gender-based Violence in the European Reception and Asylum Sector" *European Journal of Public Health, Vol. 23, Supplement 1, p 196*

- Keygnaert I., Anastasiou A., Camilleri K., Degomme O., Devile W., Dias S., Field CA., Kovats A., Vettenburg N. and Temmerman M. (2011) « Senperforto : determinants for effective prevention and response actions of SGBV perpetration and victimization in the European asylum reception system », *Tropical Medicine and International Health, 16 (SuppII), p 96* .

- Keygnaert I., Manço A., Dialmy M. & Temmerman M. (2010) Sexual Violence against sub-Saharan Trans-migrants in Morocco. *Abstractbook International Conference on Migrant & Ethnic Minority Health, 27-29th 2010, Pécs, Hungary*.

· Keygnaert I., Vettenburg N., Temmerman M. (2010) Hidden Violence is a Silent Rape: A Participatory assessment of sexual & gender-based violence determinants in female and male refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Abstractbook *International Conference on Migrant & Ethnic Minority Health, 27-29th 2010, Pécs, Hungary.*

· Keygnaert I., Keygnaert J., Vettenburg N., Bosmans M. & Temmerman M. (2009) Sexual Violence against and among Trans-migrants in Morocco: A Participatory Assessment of Determinants. *Abstractbook 6th European Congress on Tropical Medicine and International Health -1St Mediterranean Conference on Migration and Travel Health, 6-10 September 2009, Verona, Italy*

· Keygnaert I., Vettenburg N., Temmerman M. (2009) Hidden Violence is a Silent Rape: A Participatory assessment of sexual & gender-based violence determinants in female and male refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *12th World Conference on Public Health, Turkey, April 27th- May 1st 2009, abstract 78.01*

· Keygnaert I., Vettenburg N., Temmerman M. (2009) Hidden Violence is a Silent Rape: GBV determinants in Refugees, Asylum Seekers and Undocumented Migrants in Belgium and the Netherlands. *Abstract book International Conference on Gender-based Violence and Sexual & Reproductive Health, Mumbai, 15-18th February 2009*.

· Keygnaert I., Claeys P., Vettenburg N., Temmerman M. (2007) Hidden Violence is a Silent Rape: Sexual Violence against Refugees, Asylum Seekers and Undocumented Migrants in Belgium and the Netherlands. *Abstract Book Sexual & Reproductive Health Research: Making a Difference, Ghent 19th of October 2007, p 51*.

Reports published (V):

· Keygnaert I, Van Parys A, Verpoest B, Temmerman M, Offermans A (2012) Aanpak van intrafamiliaal geweld in de ziekenhuiscontext: vormingsacties voor zorgverleners: Eindrapport 2012.

· Keygnaert I, Offermans A-M (2011)Aanpak van Intrafamiliaal Geweld in de Ziekenhuiscontext- Eindrapport FOD Volksgezondheid

· Keygnaert I., van den Ameele S., Keygnaert J., Manço A. & Temmerman M. (2009) La Route de la Souffrance : la Violence Sexuelle parmi et contre les Trans-Migrants au Maroc – Un Partenariat Participatif pour La Prévention: Rapport de recherche. ICRH-UGent, July 2009.

· Keygnaert I., van Egmond K., El Mahi N. & Temmerman M. (2009) Verborgen Zorgen Wetenschappelijk Rapport. ICRH-UGent, May 2009.

· Keygnaert I., van Egmond K & Temmerman M. (2009) EN-HERA! Report 1. *Academia Press, Ghent, Belgium. ISBN978-90-38214-09-2*

· Keygnaert I., Wilson R., Dedoncker K., Bakker H., Van Petegem M., Wassie N. & Temmerman M. (2008) Hidden Violence is a Silent Rape: Prevention of Sexual and Gender-Based Violence against Refugees & Asylum Seekers in Europe: A Participatory Approach Report. *Academia Press, Ghent, Belgium. ISBN 978-90-382-1327-9*

· Keygnaert I. & Temmerman M. (2008) Preventie-agenda 2008. *Lannoo Uitgeverij, Tielt, Belgium. ISBN :978-9078128-168*

Articles A3 Published:

· Keygnaert I. (2005) *Participatie van groepen met minder behartigde belangen aan het lokaal sociaal beleid*, OCMW-VISIES, 20e jg/3, pp 20-26.

· Keygnaert I. (2005) *Participatie van groepen met minder behartigde belangen aan het lokaal sociaal beleid*, RISO-Krant West-Vlaanderen, jg 10/3, p 8.

· Keygnaert I (2005) Tweemaandelijkse bijdrage in het Berichtenblad van de sector Samenlevingsopbouw

· Keygnaert I (2006) *Project uit de doeken, kaderstuk,* Ter Zake Cahier Lokaal Sociaal Beleid, Die Keure, maart 2006.

· Keygnaert I. (2006) *Instrumenten voor participatie van groepen met minder behartigde belangen,* TerZake Cahier Lokaal Sociaal Beleid, Die Keure, maart 2006.

· Keygnaert I. (2006) *Niet op een hoopje, maar hoop voor iedereen: verschillende groepen participeren samen*, TerZake Cahier Lokaal Sociaal Beleid, Die Keure, maart 2006.

2. Oral Presentations at international scientific conferences and seminars since May 2006

(2014) "Sexual violence against sub-Saharan migrants in and around Morocco: collateral damage from the European Neighbourhood Policy?" 5th European Conference on Migrant and Ethnic Minority Health, April 10-12 2014, Granada, Spain

(2014) Chairing of Session A10:-Economic crisis, 5th European Conference on Migrant and Ethnic Minority Health, April 10-12 2014, Granada, Spain

(2012) " Sexual and Reproductive Health of Migrants in the EU: Does Anybody Care?", INSEP 2012 - Connecting Sexual Ethics and Politics conference, 29-31 August 2012 / Ghent, Belgium

(2012) « Senperforto : determinants for effective prevention and response actions of SGBV perpetration and victimization in the European asylum reception system », 4th European Conference on Migrant and Ethnic Minority Health, 21-23 June 2012, Universita Bocconi, Milan, Italy

(2011) « Senperforto : determinants for effective prevention and response actions of SGBV perpetration and victimization in the European asylum reception system », 7th European Congress on Tropical Medicine and International Health, 3-6th October 2011, Barcelona, Spain

(2010) "Senperforto: preliminary results of the study on sexual and gender-based violence prevention in the European asylum and reception sector", International Senperforto Seminar, December 19th 2010, De Markten, Brussels

(2010) "Hidden Violence is a Silent Rape: a participatory assessment of SGBV determinants in refugees, asylum seekers and undocumented migrants in Belgium & the Netherlands", International Conference on Migrant and Ethnic Minority Health, 27-29 May 2010, Pécs, Hungary

(2010) "Sexual violence against and among sub-Saharan Transmigrants in Morocco: a participatory assessment of determinants", International Conference on Migrant and Ethnic Minority Health, 27-29 May 2010, Pécs, Hungary

(2009) "Sexual violence in sub-Saharan Transmigrants in Morocco", 6th ECTMIH-1st Mediterranean conference on Migration and Travel health, 6-10th September 2009,Verona, Italy

(2009) "Preliminary results on sexual violence experiences in sub-Saharan Transmigrants in Morocco", International Seminar on Violence Prevention & Transmigrants in Morocco, May 8th 2009, University Mohammed V, Rabat, Morocco

(2009) ""Hidden Violence is a Silent Rape: a participatory assessment of SGBV determinants in female and male refugees, asylum seekers and undocumented migrants in Belgium & the Netherlands", 12th World Congress on Public Health, April 27th-May1st 2009, Istanbul, Turkey

(2009) ""Hidden Violence is a Silent Rape: a participatory assessment of SGBV determinants in refugees, asylum seekers and undocumented migrants in Belgium & the Netherlands", International Conference on Gender-based violence and Sexual and Reproductive Health, 15-18 February, Mumbay, India

(2008) "EN-HERA! Project Results, Vision & Future Objectives", EN-HERA! Seminar, Ugent, 21st & 22nd of November 2008, Ghent (60 participants)

(2008) "Hidden violence is a Silent Rape: research results", EU Seminar "Hidden Violence is a Silent Rape: Prevention of Gender-based Violence against Refugees & Asylum Seekers in Europe", Ugent, 14th & 15th of February 2008, Ghent (150 participants)

(2007) "Hidden Violence is a Silent Rape: Prevention of SGBV against refugees, asylum seekers and undocumented migrants in Europe: preliminary research results" ICRH Symposium: "Sexual & Reproductive Health Research: Making a difference", Ugent, 19th of October 2007 (150 participants)

(2007) "Community-Based Participatory Research in SGBV prevention", ICRH workshop: "Sexual & Reproductive Health Research: Making a difference", Ugent, 17-18th of October 2007 (75 participants

3. Oral Presentations at national conferences or seminars since May 2006

(2013) "Violence in the life-course, from baby to elderly", ICRH lectures, May 28th 2013, Vredeshuis, Ghent, Belgium

(2013) "Violence, societal tendencies and context", Symposium Violence & Care, May 16th 2013, Jan Yperman Hospital, Ieper, Belgium

(2012) "Violence: What is it and how do you address it as a midwife?", Midwifery Skills, Internationale Leerstoel Francine Gooris, November 22-23rd 2012, Ghent, Belgium

(2012) "Tips, tricks and tools for sexual health promotion and prevention of violence in the asylum and reception centres (Senperforto)", Netwerkdag Kwetsbare Migranten en Seksuele Gezondheid, October 5th 2012, ITG, Antwerp

(2011) "Tips, tricks and tools for sexual health promotion and prevention of sexual violence", Symposium Mental Heatlh of Unaccompanied Minors- Platform Mineurs en exile, October 26th, De Factory, Brussels

(2010) "Sexual and gender-based violence of vulnerable people" National Conference on publication of "The experience of men and women with psychological, physical and sexual violence in Belgium", June 15th 2010, Brussels

(2010) "Sexual and gender-based violence against refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands", Panel Book Release "Vrouwen onder Druk", March 8th 2010, Ghent

(2007) "Prevention of violence against refugees in Europe, participatory method and preliminary results", Conference "Begeleiding op Vreemde Maat", Red Cross Flanders, 21st of November 2007, Brussels (200 participants)

(2007) "Prevention of violence against refugees in Europe, participatory method and preliminary results", Networking day Migrants & Sexual health, Sensoa, Antwerpen, 23rd of October 2007 (100 participants)

(2007) "Prevention of violence against refugees in Europe, participatory method and preliminary results" Flemish week of peace, Amazone, Brussels, 4th of october 2007 (15 participants)

4. Poster Presentations at international scientific conferences since May 2006

(2013) Impact of Humanitarian Crises on Public Health: Home and Abroad. Degomme O, Keygnaert I, Altare C, Guha-Sapir D. Science for Peace: Trauma and Transformation Conference, Flemish Government, November 4 2013, Brussels

(2013) Make it work!: Training Manual for sexual health promotion and prevention of sexual and gender-based violence in the European reception & asylum sector. (8 European MS, 2008-2010), 6th EUPHA Conference,13-16 November 2013, Brussels, Belgium (moderated poster)

(2008) "Hidden Violence is a Silent Rape: A Participatory assessment of sexual & gender-based violence determinants in female and male refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands" Because Health Colloquium: Primary Health care in Times of Globalisation. 26-27/11/2008, ITG, Antwerp, Belgium.

5. Organisation and coordination of international scientific seminars since May 2006

(2010) "Senperforto: Frame of Reference for the Prevention of SGBV in the European Reception and Asylum Sector", European Seminar, December 10th 2010, De Markten Brussels

(2009) "Prevention of Sexual violence in trans-migrants in Morocco", May 8th 2009, ICRH-Ghent University & University Mohammed V, Rabat, Morocco

(2008) "EN-HERA! Promotion of Sexual and Reproductive Health of Refugees, Asylum seekers and undocumented migrants in Europe & beyond", international seminar, November 21-22nd 2008, Monasterium, Ghent University

(2008) "Hidden violence is a silent Rape", International Seminar, February 14-15th 2008, Het Pand, Ghent University

(2007) "Sexual and reproductive health Research: Making a Difference", October 19th 2007, Monasterium, Ghent University

6. Training & Lectures at Ghent University & partner institutions since May 2006

(2014) "Violence, women and human rights" Medicine & human rights 1, 3rd Bach Medicine Ghent University, 2 hours, April 4th 2014, Ghent, Belgium

(2014) "Violence and the young childbearing family" Guest Lecture Postgraduate Degree in Pedagogics of the young child, Artevelde Hogeschool, 1.5 hours, April 1st 2014, Ghent, Belgium

(2013) "Pregnancy and violence: some tools to recognize and address domestic violence as midwife and buddy", Guest lecture Buddies near the crib-training, Artevelde Hogeschool, November 20th 2013, Ghent, Belgium

(2013) “Access to SRH care for undocumented female migrants in Belgium” Guest Lecture Mother & Child Care: intercultural aspects, October 25h 2013, Ghent University

(2013) “Migrant mother & child health in Europe” Guest Lecture Mother & Child Care: intercultural aspects, October 18th 2013, Ghent University

(2013) “Sexual violence, migration and human rights” Guest lecture Mother & Child Care: intercultural aspects, October 11h 2013, Ghent University

(2013) “Sexual violence, migration and human rights” Guest lecture summer school “Health and migration, Faculty of Medicine, Ghent. July 16 2013, Ghent University

(2013) “Sexual and Reproductive Health & Migration: ethical issues in a World Café”, Guest lecture summer school “Health and migration, Faculty of Medicine, Ghent. July 12 2013, Ghent University

(2013) “Violence, migration and intercultural care” Guest Lecture Postgraduate Degree in Pediatrics & Neonatology, Artevelde Hogeschool, 2.5 hours, April 25th 2013, Ghent, Belgium

(2013) “Violence, women and human rights” Medicine & human rights 1, 3rd Bach Medicine Ghent University, 2 hours, April 19th 2013, Gent, Belgium

(2012) Workshop “Pregnancy and violence: what now? Some tips & tools for midwives in recognizing, treating and referring patients in violent situations” Midwifery Skills, Internationale Leerstoel Francine Gooris, 3 hours, November 22nd 2012, Ghent, Belgium

(2012) “Access to SRH care for undocumented female migrants in Belgium” Guest Lecture Mother & Child Care: intercultural aspects, October 31th 2012, Ghent University

(2012) “Sexual violence a risk in migration?” Guest Lecture Mother & Child Care: intercultural aspects, October 10th 2012, Ghent University

(2012) “Dealing with IPV in Belgian hospital context: advanced training”, 28 hour accredited training ICRH Ghent University, March 19th, April 25th, May 25th& September 17th 2011, Federal Service Public Health, Ghent University

(2012) “Sexual violence a risk in migration?” Guest lecture summer school “Health and migration, Faculty of Medicine, Ghent. July 9 2012, Ghent University

(2012) “Sexual and Reproductive Health & Migration: ethical issues in a World Café”, Guest lecture summer school “Health and migration, Faculty of Medicine, Ghent. July 7 2012, Ghent University

(2012) “Sexual violence and refugees”, Guest lecture 3rd Bach Medicine, Medicine & Human Rights Ghent University, 2 hours, April 20th 2012,

(2011) “Access to SRH care for undocumented female migrants in Belgium” Guest Lecture Mother & Child Care: intercultural aspects, October 19th 2011, Ghent University

(2011) “Sexual violence a risk in migration?” Guest Lecture Mother & Child Care: intercultural aspects, October 12th 2011, Ghent University

(2011) “How to deal with IPV according to the Ghent University Hospital violence protocol”, Mini-symposium Ghent University Hospital Professionals, September 29th 2011, Ghent University Hospital

(2011) “Dealing with IPV in Belgian hospital context: advanced training”, 24 hour training ICRH Ghent University, May30th, June 24th & September14th 2011, Federal Service Public Health, Ghent University

(2011) Coaching of doctoral school students in practice sessions of “Effective Scientific Communications” Principiae-Ugent, 4x 8 hours, May 23rd –June 6th 2011, November 29th & December 13th, Ghent University

(2011) “Sexual violence a risk in migration?” guest lecture summer school “Health and migration, Faculty of Medicine, Ghent. July 8 2011, Ghent University

(2011) “Creating slides according to Effective Scientific Communication”, Guest Lecture ICRH scientific lunch meeting, June 21st 2011, Ghent University

(2011) “Sexual violence and refugees”, Guest lecture 3rd Bach Medicine, Medicine & Human Rights, April 24th 2011, Ugent

(2010) Coaching of doctoral school students in practice sessions of "Effective Scientific Communications" Principiae-Ugent, November 3Oth –December 14th 2010, Ghent University

(2010) " Access to SRH care for undocumented female migrants in Belgium" Guest Lecture Mother & Child Care: intercultural aspects, November 24th 2010, Ghent University

(2010) "Sexual violence in migrants" Guest Lecture Mother & Child Care: intercultural aspects, November 10th 2010, Ghent University

(2010) "Prevention of SGBV in refugee context: a participatory approach", Guest Lecture UNFPA & Ghent University Course on Coordination of SGBV in emergencies, November 8th 2010, Ghent

(2010) "Sexual violence and refugees", Guest lecture 3rd Bach Medicine, Medicine & Human Rights, April 19th 2010, Ugent

(2009) "Sexual violence and refugees", Guest lecture Gender & diversity, Masters cultural sciences, December 4th 2009, Ugent

(2009) Training Community Researchers "Senperforto: prevention of SGBV in the European asylum reception sector", 24 hour training, ICRH-Ghent University & Sensoa, July 1-3 2009, SOI Gent Verapa, Ghent

(2009) Training Community Researchers "Senperforto: prevention of SGBV in the European asylum reception sector", 24 hour training, Menedek Hungary,ICRH- Ghent University & Sensoa , May 18-20th 2009, Budapest, Hungary

(2009) Training Community Researchers "Senperforto: prevention of SGBV in the European asylum reception sector", 24 hour training, JRS Malta, ICRH-Ghent University & Sensoa, April 15-17th, 2009, Malta

(2009) Training key women Hidden Worries project, 16 hour training, December 2008 & January 2009, ICRH-Ghent University, Ghent

(2008) Training Community Researchers "Sexual Violence & sub-Saharan Trans-Migrants in Morocco: a participatory Partnership for Prevention", 5-day training June 2008, University Mohammed V, Rabat, Morocco, 15 participants

(2008) Tutorial: "Health & Society: Human Rights: Hunger strike", third Bachelor Medicine, Ugent. 6 hours

(2008) Lecture: "Introduction to Gender and Gender-based Violence", first Masters Health services and Policy & Management, Capita Selecta Health & Society, Ugent.

(2007) Lecture: "Sexual and Gender-based Violence against Refugees, Asylum seekers and Undocumented Migrants in Belgium: research results and health care response needs", third Bachelor in 0bstetrics, Intercultural health care services,Ugent.

(2007) Tutorial: "Health & Society: Human Rights: Hunger strike", 3ebachelor Medicine, Ugent. 6 hours, Ugent

(2007) Training Community Researchers SGBV Prevention refugees Europe, 5-day training January 2007, Utrecht, 10 participants

(2006) Training Community Researchers SGBV Prevention refugees Europe, 5-day training, November 2006, Ghent, 13 participants

7. <u>Mentoring Masters Students in dissertations and fellowships</u>

(2015-2013) Co-promotor & Mentoring dissertation Masters Student in Medicine, Leni De Mulder, "Sexual violence against men in Europe: types, prevalence and determinants", Ghent University

(2014-2013) Co-promotor & Mentoring dissertation Masters Student in Medicine, Abdulkader Srouji, "Determinants in Sexual Health of sub-Saharan Transit Migrants in Morocco", Ghent University

(2014-2013) Co-promotor & Mentoring dissertation Masters Student in Nursing & Midwifery, Lies Cas, "Knowledge, Attitude and Practice Study on contraception and undocumented couples in Ghent", Ghent University

(2014-2012) Co-promotor & Mentoring dissertation Masters Student in Health Promotion, Mona Clauwaert, "The effectiveness of IPV screening in the emergency care of the Ghent University Hospital", Ghent University

(2013-2011) Co-promotor & Mentoring dissertation Masters Student in Medicine, Ruth Debeuckelaere, "The role of health locus of control on sexual and reproductive health of migrants in Europe", Ghent University

(2012) Coordination & Mentoring Fellowship: Masters Student European Political Studies, Sciences-Po, Paris, France, Aurore Guieu, "Sexual and reproductive health of migrants in Europe: does anybody care. Literature Review of Sexual violence prevention & response in European & national policies", February 27-June 30th 2012

(2012-2011) Co-Promotor & mentoring dissertation Masters Student in Nursing & Midwifery, Katrien Scheerlinck, "Research on lacunes in perinatal care of women with a history of eating disorders" Ghent University. Nomination for the EOS science award 2012.

(2011-2010) Mentoring Fellowship: Masters Student Nursing & Midwifery, Katrien Scheerlinck "Prevention of Violence in the European asylum reception sector", Ghent University

(2010-2009) Co-promotor & Mentoring dissertation Masters Student in Social Work, Liselotte Bekaert "Screening of SGBV prevention tools according to the concept of Desirable Prevention", Ghent University

(2009-2008) Menitoring fellowship 7 Social Work students in Intercultural Prevention of violence in women with and without residence papers in Belgium, Project "Verborgen Zorgen", Ghent University

(2009-2008) Co-promotor & Mentoring thesis Masters Student in Medicine, Seline van den Ameele "The Role of the health care providers in Sexual Violence prevention against trans-migrants in Morocco", Ghent University

(2008-2007) Mentoring Spanish Erasmus Masters Student Social Work "Screening of SGBV prevention tools according to the concept of Desirable Prevention", Ghent University

8. External service delivery in training, mentoring and chairing on behalf of ICRH-Ugent since May 2006

(2012) Training of midwives on how to communicate with maternity patients in violent situations, OLV Aalst Hospital, 16 hours, October 11th & 18th 2012

(2012) Chairing of 2 workshops on Senperforto: tips & tools for SRH promotion and SGBV prevention in migrants, Migrant Health Networkday October 5th, ITG, Antwerp

For the Belgian Federal Public Health Agency:

- (2012) Mentoring protocol development IPV hospitals, AZ Sint Jan, Brugge, March 13th, June 25th & September 11th 2012
- (2012) Mentoring protocol development IPV hospitals, St Vincentius, Deinze, March 15th, July 3rd & August 22nd 2012
- (2012) "Dealing with IPV & violence protocols in hospital contexts", BIGPAG Meeting VVOG, July 4th 2012, Sint Niklaas, Belgium
- (2012) Mentoring protocol development IPV hospitals, AZ Lokeren, February 28th 2012
- (2012) Coordination of Ghent University Hospital Violence coordination working group, March 1, August 7, August 14 & October 23rd
- (2011) Chairing of a workshop on SRH in migrants, Round Table Vulnerable Migrants, October 25th 2011, De Markten, Brussels
- (2011) Basic training IPV hospitals, St Jan, Brugge, September 12th 2011
- (2011) Basic training IPV hospitals, UZ Leuven September 8th 2011
- (2011) Basic training IPV hospitals, ZNA Middelheim, Antwerp, September 7th 2011
- (2011) Basic training IPV hospitals, St Vinctentius Deinze, September 6th 2011
- (2011) Basic training IPV hospitals,AZ Lokeren, September 2nd 2011
- (2011) Mentoring protocol development IPV hospitals, Virga Jesse, Hasselt, August 31st 2011 & April 26th 2011
- (2011) Mentoring protocol development IPV hospitals AZ Oudenaarde, August 30th 2011 & May 3rd 2011
- (2011) Mentoring protocol development IPV hospitals, Jan Yperman, Ieper, August 29th 2011& April 27th 2011
- (2011) Basic training IPV hospitals, AZ Tlenen, August 26th 2011
- (2011) Mentoring protocol development IPV hospitals – UZ Gent, August 25th 2011& March 30th 2011
- (2011) Mentoring protocol development IPV hospitals- UZ Brussel , August 23rd 2011& May 10Th 2011
- (2011) Basic training IPV hospitals, AZ Klina Brasschaat, August 17th 2011

- (2011) Mentoring protocol development IPV hospitals- OLV Aalst, July 6th 2011& May 4th 2011
- (2011) Mentoring protocol development IPV hospitals- AZ Groeninge, Kortrijk, July 5th 2011 & April 13th 2011
- (2011) Mentoring protocol development IPV hospitals- OLVL Waregem, June 28th & May 10th 2011
- (2011) Basic training IPV Hospitals, Heilig Hart Ziekenhuis Roeselare, June 29th 2011
- (2011) Basic training IPV Hospitals, Ziekenhuis Oost-Limburg, June 14th 2011, Genk

(2011) Sensoa expert meeting sexual violence, June 8th & November 23rd 2011, Sensoa, Ghent

(2011) Introductory lecture to the violence exposition "Hidden Worries", Amazone, June 1st 2011, Brussels

(2010) Invited Expert Sexual Health of Migrants in Europe, guest lecture, background paper & chair panel & workshop at WHO Sexual Health expert meeting National Counterparts, October 20-22nd, Madrid, Spain