REACH OUT

Communication & Advocacy Guidelines

GENDER-BASED VIOLENCE
LGBTQI+
HUMAN RIGHTS
PRECARITY
SUPPORT SERVICE
MIGRANTS
EMPOWERMENT
CARE
EQUALITY
JUSTICE
HELP
PUBLIC HEALTH
INFORMATION
DISABILITY
%

This document is a deliverable (WP 5.1) of the project REActing to sexual and gender-based violence against migrants and refugees through Coordinated Help, advocacy and OUTreach actions (REACH OUT).

Excerpt from the grant agreement

“1 document detailing the approaches, key messages and methods of building awareness on GBV issues facing migrants; in English; printed as 5 copies.”

“The national teams in coordination with MdM BE will establish overall communication messages, key data and information that will gain attention, and long-term goals relating to GBV against migrants. Based on this work, the partners will adjust current initiatives, publications and materials in order to ensure that the wider public is fully aware. The dissemination materials and activities will be adapted based on the outcomes/findings of this activity. Some reference points for this work include MdM’s global action EVAM and the previous project WE ACT. Within the monitoring and evaluation in WP1, the partnership will assess the impact of these messages/ information (i.e., number of web visits, downloads, feedback from participants at dissemination events, etc.)”

Participating partners
Belgium – Coordination – Médecins du Monde Belgique (Brussels)
Belgium – Médecins du Monde Belgique - Dokters van de Wereld België (Antwerp)
Germany – Ärzte der Welt
Netherlands – Dokters van de Wereld
Serbia – Red Cross of Šid

Co-funded by the Rights, Equality and Citizenship Programme of the European Union (2014-2020).

The content of this document represents the views of the authors only and is solely their responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

Table of contents

Terminology ... 6
Executive Summary ... 7
List of Acronyms ... 8
Introduction ... 10
Gender-Based Violence and Migration ... 16
Advocacy context ... 18
At the European Union level ... 18
At national levels ... 21
Belgium ... 21
Germany ... 24
The Netherlands ... 27
Serbia ... 31
Advocacy Strategy ... 34
Bibliography ... 56
Annex 1 – List of stakeholders ... 59
Annex 2 – Template for stakeholders' assessment ... 61
Annex 3 – Template for advocacy plan ... 62
Annex 4 - Template for monitoring meetings ... 63

Terminology

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

In this document, the term *'survivor'* of gender-based violence is preferred to 'victim' of gender-based violence, to reflect the resilience and the autonomy of individuals who have experienced gender-based violence, rather than their legal status. This does not deny nor diminish the feelings of individuals who have experienced gender-based violence. Ultimately, the best terminology for designating persons who have experienced gender-based violence is the terminology they themselves choose.

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

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

Executive Summary

This document details the advocacy strategy established as part of the REACH OUT project. REACH OUT, for REActing to sexual and gender-based violence against migrants and refugees through Coordinated Help, advocacy, and OUTreach actions, is a project co-funded by the European Union dedicated to empowering migrant survivors of gender-based violence in accessing care and exerting their fundamental rights. The project was launched in December 2019 in four countries, namely Belgium, Germany, the Netherlands, and Serbia. Due to the COVID-19 pandemic, a limited number of outreach activities has been pursued. Despite the restricted implementation of REACH OUT activities, desk research and findings based on existing fieldwork have made possible the elaboration of the present strategy.

Gender-based violence is any harmful act perpetrated against a person's will and based on socially ascribed differences between males and females. It is rooted in the structural inequality between genders and conflates gender norms and harmful abuse. Even though most gender-based violence survivors are women and girls, men, boys, and non-binary people might also face such harmful acts. Along with other types of violence, gender-based violence is widespread at each step of the migratory path. In 2018, 58% of migrants arriving in Europe had been subjected to gender-based violence, 69% of whom were women.[1] Survivors require inclusive and holistic care to deal with the physical and mental consequences of gender-based violence. However, they have limited access to health services during their journey and throughout the whole process of resettlement because of legal, administrative, financial, informative, and cultural barriers.

As part of the REACH OUT project, this strategy first identifies key issues hampering the effective access of migrant survivors of gender-based violence to protection, care, and reparation. Such issues include the legally restricted access to health care for non-citizens, the absence of training regarding gender-based violence for all staff in contact with migrants, and the general lack of awareness of the intersectional vulnerabilities to gender-based violence faced by migrant populations. To address those issues, this strategy establishes advocacy priorities and key actions to implement to trigger change. Such change is aimed at improving access of migrant survivors of gender-based violence to quality support services and at raising awareness on the issue of gender-based violence in a migration context. This document also highlights the necessity for adjusting advocacy tools and messages to the people targeted by the actions previously suggested. Finally, this strategy proposes evaluation devices to monitor the actions implemented and ensure their transformative power.

1. De Schrijver, L., T. Vander Beken, B. Krahe, and I. Keygnaert, "Prevalence of Sexual Violence in Migrants, Applicants for International Protection, and Refugees in Europe: A Critical Interpretive Synthesis of the Evidence", *International Journal of Environment and Public Health* 15, no.9 (September 2018).

List of Acronyms

ACODEV Fédération francophone et germanophone des associations de coopération au développement – *French and German-speaking Federation of Development Cooperation Associations*

ADRION Adriatic Ionian

ANKER Ankunft, Entscheidung und kommunale Verteilung bzw. Rückführung – *Arrival, Decision and Municipal Distribution or Return Center*

AMU Aide Médicale d'Urgence – *Urgent Medical Assistance*

AZC Asielzoekerscentrum – *Asylum Seekers' Centers*

CCE Conseil du Contentieux des Étrangers – *Council for Alien Law Litigation*

CEDAW Convention on the Elimination of All Forms of Discrimination Against Women

COA Centraal Orgaan opvang asielzoekers – *Central Institute for Reception of Asylum Seekers*

COVID-19 Coronavirus Disease 2019

CPAS Centre Public d'Action Sociale – *Public Center for Social Action*

CSO Civil Society Organization

EU European Union

EVAM Ending Violence Against Migrants

FEDASIL Agence Fédérale pour l'Accueil des Demandeurs d'Asile – *Federal Agency for Asylum Seekers*

FGM Female Genital Mutilation

GBV Gender-Based Violence

GP General Practitioner

GREVIO Group of Experts on Action against Violence against Women and Domestic Violence

IASC Inter-Agency Standing Committee

IEWM Institute for the Equality of Women and Men

IND Immigratie- en Naturalisatiedienst – *Immigration and Naturalization Services*

IOM International Organization for Migration

JENV Ministerie van Justitie en Veiligheid – *Ministry of Justice and Security*

LGBTQIA+ Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual persons +

MDM Médecins du Monde

MUM Münchner Unterstützungsmodell – *Munich support model*

NGO Non-Governmental Organization

PTSD Post-Traumatic Stress Disorder

RC Red Cross

REACH OUT REACting to sexual and gender-based violence against migrants and refugees through Coordinated Help, advocacy and OUTreach actions

REINSER Refugees' Economic Integration through Social Entrepreneurship

RRA Regionalna razvojna agencija – *Regional Development Agency*

SOP Standard Operating Procedures

STD Sexually Transmitted Disease

SWOT Strengths Weaknesses Opportunities Threats

TFEU Treaty on the Functioning of the European Union

UNHCR United Nations High Commissioner for Refugees

VNG Vereniging van Nederlandse Gemeenten – *Association of Netherland Municipalities*

VWS Ministerie van Volksgezondheid, Welzijn en Sport – *Ministry of Health, Welfare and Sport*

WE ACT Empowering Women and ChildrEn in the migrant population to take ACTion against sexual and gender-based violence

Introduction

MIGRATION, HEALTH, AND GENDER-BASED VIOLENCE

From their country of departure, during their journey, and after their arrival, migrants face a state of increased vulnerability with regard to their health. Each step of the migration path may amplify migrants' exposure to health threats. First, in countries of origin, the functioning of the health care system and the existence of conflicts and/or violent situations may affect migrant populations' health and especially mental health. Second, whether they are initially in good health or not, migrants' health frequently deteriorates along their migration journey. Although some routes taken by migrants might present more risks than others, the state of migration automatically means that individuals are rendered more vulnerable. Living and traveling conditions during the migration both expose migrants to violence, whether physical, psychological, or sexual, and limit their ability to access health care centers. Third, in destination countries, many explicit or implicit barriers based on legal status hamper effective access to health care for migrant populations, which may worsen their health condition. Legal and administrative obstacles restrict the possibility for migrants to get health insurance. Moreover, because of the social isolation and economic precarity migrants can face, their access to information about health care is significantly limited. Finally, the lack of informed cultural mediators, interpreters, or trained staff in health care centers curtails the possibility for migrants to exercise their right to health care. Therefore, the complexity of health care pathways, the lack of knowledge of health care systems, and the failure to take into account people's experiences can lead to breakdowns in the continuity of care for migrants. Those factors, in turn, make migrant populations especially at risk of being exposed to violence. Women and girls in particular face disproportionate exposure to gender-based violence (GBV).

Gender-based violence is defined by the Inter-Agency Standing Committee (IASC) as *"any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females"*. It is rooted in the structural inequality between genders and conflates gender norms and harmful abuse. It is estimated that one in three women in the world will experience GBV in her lifetime.[2] Even though women and girls are the majority of GBV victims, men and boys might also face GBV, especially in conflict settings, as well as non-binary people. However, figures regarding the prevalence of GBV against males remain scarce.

Along with other types of violence, gender-based violence is widespread at each step of the migratory path. During their journey, migrants are exposed to a higher risk of facing GBV. It was estimated in 2018 that 58% of migrants arriving in Europe had been subjected to GBV, 69% of whom were women.[3] Examples of GBV include, among others, domestic abuse, sexual exploitation, rape, sexual assault, threats and verbal assault, intimidation, or forced marriage. Children are particularly at risk: 2018 figures indicated that 42% of the children reaching Europe by crossing the Mediterranean were unaccompanied.[4] Isolated from their families and peer groups, they are also poorly tracked by the authorities and little data is available on their health and wellbeing.

Therefore, GBV migrant survivors often require medical care and/or psychological support to deal with the physical and mental consequences of GBV. As mentioned before, they have limited access to health services during their journey and in the countries of destination because of legal, administrative, financial, informative, and cultural barriers. The explicit restrictions in migrants' access to health care, which reflect States' focus on immigration control rather than human rights and public health, are of even greater importance when it comes to GBV. This has been exemplified by the rise of xenophobia, with many political movements warning about an alleged 'invasion' of migrants. This rhetoric has also developed through discourses such as femonationalism, which pleads for the expulsion of migrants committing sexual assaults without proposing adequate reparation for survivors of GBV.[5] Moreover, the lack of systematic gender-sensitive and culturally-specific training in the education of health professionals and social workers hinders the possibility of understanding the intersectionality of GBV against migrant populations. This limits the effectiveness of GBV survivors' care. Finally, additional internalized drivers, such as cultural barriers regarding health care and the fear or shame associated with sexual abuse, can prevent GBV survivors from seeking medical attention.

THE IMPLEMENTATION OF REACH OUT

Acknowledging these numerous difficulties, REACH OUT, for REActing to sexual and gender-based violence against migrants and refugees through Coordinated Help, advocacy and OUTreach actions, was launched in December 2019 by Doctors of the World Belgium, Doctors of the World Germany, Doctors of the World Netherlands, and the Red Cross of Šid in Serbia. The selection of participating countries was guided by the objective of including both countries of arrival, i.e., Germany and the Netherlands, and countries of transit, i.e., Belgium and Serbia. It seemed crucial to intervene at both steps of the migratory journey, during migration and in its direct aftermath, to best accompany migrants. REACH OUT was co-funded under the European Union's Rights, Equality and Citizenship program 2014-2020. It marks the continuation of a previous project, WE ACT, which was conducted in 2018-2020 in Belgium (Brussels), Bulgaria, Croatia, France, and Italy with similar goals. REACH OUT is in line with the European Union (EU) directive 2012/29/UE which requires specialist support services to be developed by public bodies to help GBV survivors.

2. World Health Organization, "Devastatingly pervasive: 1 in 3 women globally experience violence", *World Health Organization Joint News Release*, Mar. 29, 2021, accessible at: https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence.

3. De Schrijver, L. and al., "Prevalence of Sexual Violence in Migrants", *supra* note 1.

4. United Nations High Commissioner for Refugees (UNHCR), United Nations International Children's Emergency Fund (UNICEF) and International Organization for Migration (IOM), *Refugee and Migrant Children in Europe. Overview of Trends January-December 2018*, UNHCR, UNICEF and IOM (2019).

5. Farris, Sara, *In the name of Women's Rights? The Rise of Femonationalism* (Duke University Press: 2017).

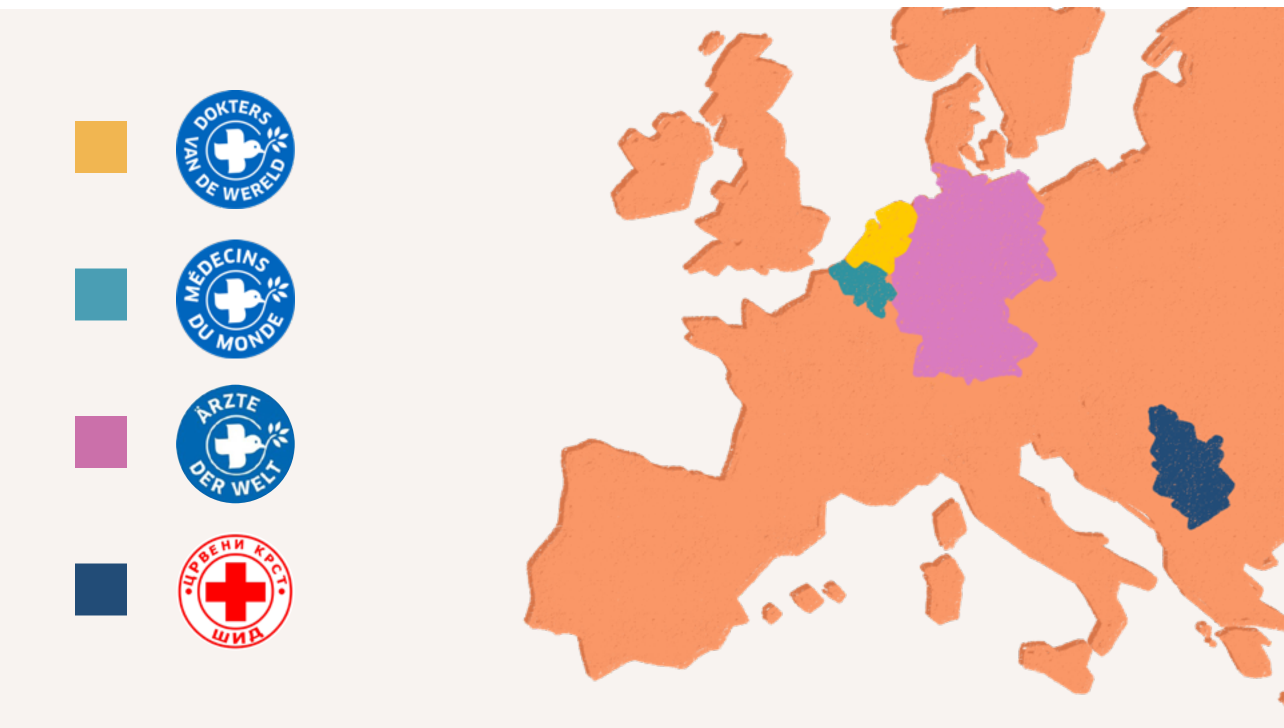


Figure 1. REACH OUT participating partners

REACH OUT aims to raise awareness of gender-based violence faced by migrants and to empower them in accessing care and exerting their fundamental rights. The objectives of the project are to better inform migrants about the services they can access, to improve the coordination of the different actors involved in GBV prevention, mitigation, and care, and to improve the protocols in force regarding care and GBV. The project is based on four pillars:

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

These four main objectives were then expressed in several activities implemented in the four countries participating in the project. Figure 2 represents the strengths, weaknesses, opportunities, and threats (SWOT) faced by the participating partners in implementing the REACH OUT project.

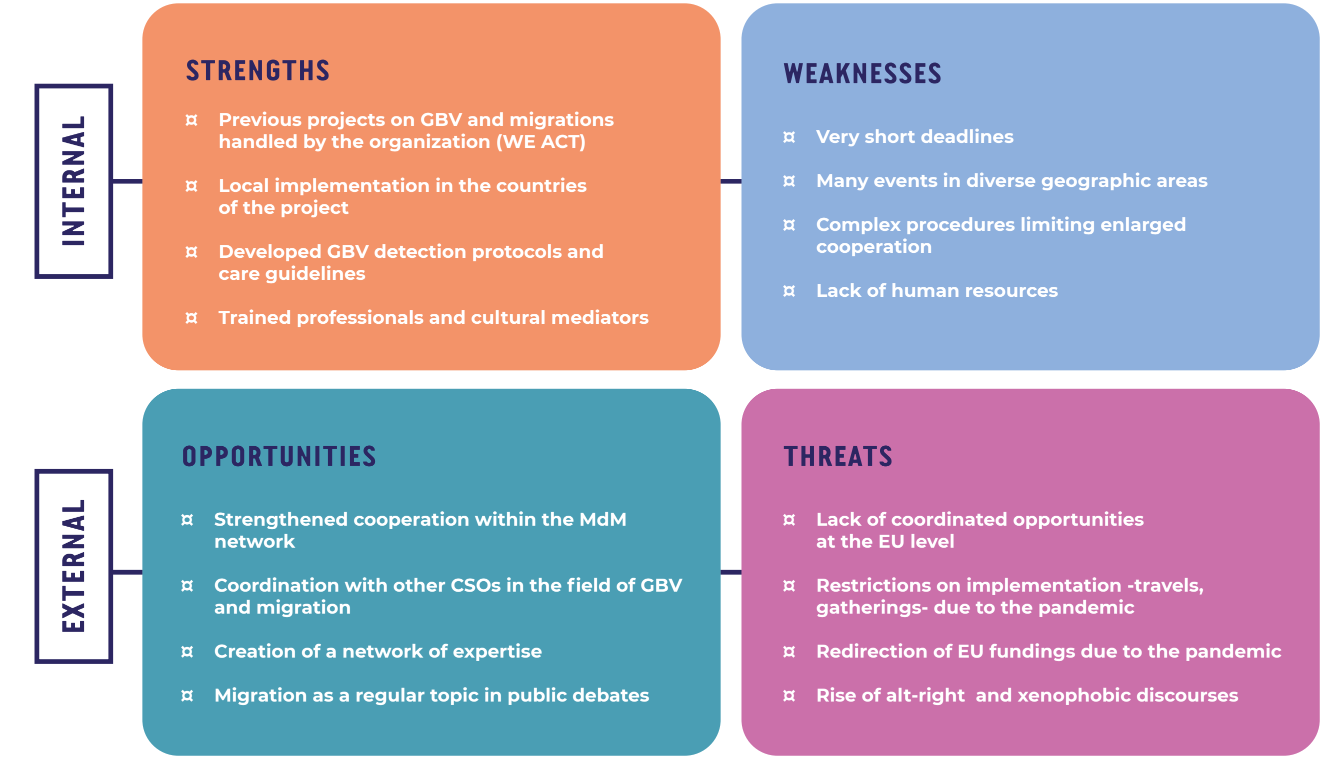


Figure 2. SWOT Analysis

MIGRATION AND COVID-19

Meanwhile, the COVID-19 pandemic, which has spread across the world since the end of 2019 and remains a major issue at the time this report is drafted, has significantly affected migrants' access to care.

The first and most important impact is the exacerbation of migrants' vulnerabilities. The closure of borders, the limitations on travel, and the increased security presence to enforce the restrictive measures adopted by public authorities have put an additional strain on the situation of migrants. Moreover, migrants can face higher risks of COVID-19 infection because of precarious housing (when they can have accommodation), a higher incidence of poverty, and difficulties in implementing social distancing considering their living conditions.[6] The lack of inclusion of undocumented migrants in COVID-19 income and housing support schemes has also en-

6. Organization for Economic Cooperation and Development (OECD), *What is the impact of the COVID 19 pandemic on immigrants and their children*, OECD (October 2020), accessible at: http://www.oecd.org/coronavirus/policy-responses/what-is-the-impact-of-the-covid-19-pandemic-on-immigrants-and-their-children-e7cbb7de/.

hanced their vulnerability.[7] Furthermore, the lockdowns and movement restrictions have increased tensions at home, risks of partner violence, and child abuse for everyone. The impacts of COVID-19 on migration also include forced immobility and higher dependency on smugglers, while financial deprivation entails increased risks of accepting dangerous work for survival, notably due to the stark decrease in job opportunities since the pandemic.[8]

The barriers in accessing health services for migrants have been reinforced by the pandemic. Health care centers are the main points of access to health care for migrant populations; the reorganization of inpatient care to manage the influx of COVID-19 patients seriously affected the functioning of services.[9] More generally, the closure of borders and offices had dire consequences on the legal situation of migrants, who have been compelled to remain in place, have overstayed their visas, or have seen their regularization procedures stopped. The various lockdowns and restrictions on social gatherings also affected working conditions for care providers and cultural mediators, while the pandemic increased their workload.

Finally, the pandemic had a significant impact on the implementation of REACH OUT activities, especially when it came to outreach activities. These limitations are exposed in the subsequent section.

7. Guadagno, Lorenzo, “Migrants and the COVID-19 pandemic: an initial analysis”, *International Organization for Migration (IOM) Research series*, no. 60 (2020).

8. Mixed Migration Center (MMC), L’impact de COVID 19 sur les réfugiés et les migrants en mouvement en Afrique du Nord et de l’Ouest, MMC (February 2021).

9. Guadagno, Lorenzo, Migrants and the Covid-19 pandemic, *supra* note 7.

METHODOLOGY

REACH OUT is dedicated to empowering migrant populations facing gender-based violence in accessing their human rights through a holistic approach. One of its pillars relies on the establishment of a coordinated advocacy strategy taking into account specific vulnerabilities linked to gender and immigration status. The project is framed in the ‘do no harm’ principle, which means that all interventions conducted must avoid exposing people to additional risks because of those interventions. Those risks are notably related to access to fundamental rights and representations of the targeted populations.

This document aims to present such an advocacy strategy, which will contribute to improving protection, access to health services, and reparation for migrant survivors of GBV while raising awareness on the specific vulnerability to GBV that migrant populations face. To achieve those aims, desk research and literature review were first performed to understand the specific vulnerability to GBV faced by migrants. Then, relying on the contributions of the participating partners, this document presents a country-by-country analysis of the political context of migrations and the existing systems for addressing GBV. This research work has allowed setting both a European and a local advocacy context in which advocacy recommendations can be defined. In particular, this strategy identifies advocacy priorities, means of implementation of such priorities, relevant actors to conduct advocacy activities, and key communication messages to be disseminated. Finally, this document includes a list of relevant indicators aimed at monitoring and evaluating the relevance and efficiency of the advocacy strategy.

However, it has to be noted that the COVID-19 pandemic has restricted REACH OUT activities, which—as a European project between four countries—included several coordination activities involving travel and/or gatherings. For example, the grant agreement provided for study visits to locations of implementation of the project which could not be organized, as borders were closed and public health restrictions slowed down the work of the teams working on the project. Similarly, individual counseling sessions, which were meant to be finished by Summer, had to be rescheduled for Fall 2021. Fieldwork has also been mostly postponed to Summer and Fall 2021, which has limited the informational impact of the project on migrant populations.

The pandemic also affected specific in-country activities. In Serbia, lockdown measures limited access to reception centers to emergency situations, which made it almost impossible to reach out to migrant populations. This in turn affected all other project activities in the country. In the Netherlands, the pandemic restricted outreach activities towards GBV survivors; because contacts and communication were limited, no sufficient trusting relationship could be established to conduct interviews about their experiences. Similarly, in Belgium, the reliance on online contact alone made it challenging to maintain communication with the different actors working within migrant communities and to establish a relationship of trust. It has therefore not been possible yet to interview survivors of GBV apart from need assessment sessions on access to health care. In Germany, many activities were also postponed and/or held digitally. Online training for professionals did not allow for informal gatherings favoring cooperation and the exchange of good practices. Finally, the bad WiFi connection in some refugee centers prevented proper participation and involvement of participants.

As the pandemic restricted outreach activities and dialogue with the different publics identified by REACH OUT, advocacy activities were also affected. The project included coordinated work with all partners and actors to jointly identify priority activities, implementation tools, and communication strategies. Because of the COVID-19 restrictions, it was not possible to organize structured participation of beneficiaries without organizing face-to-face events.

Therefore, at the time this report is written, only a few lessons or good practices have been identified. Despite the restricted implementation of REACH OUT activities, findings based on desk research and existing fieldwork have allowed to determine the desired changes in the practices and regulations governing the support provided to migrant survivors of GBV by a wide range of actors, including Civil Society Organizations (CSOs), governments, and the European Union.

Gender-Based Violence and Migration

As stated in the introduction, migrants face increased risks of being subjected to violence, first because of the vulnerability inherent to the state of migration but also because 'aggravating' factors such as sex, age, level of integration within a community, or employment might cause higher exposure to gender-based violence. Therefore, the vulnerabilities to GBV migrants can face have to be understood from an intersectional perspective. The risk of GBV is present prior to, during and after migration; it is thus necessary to attempt to both prevent GBV and to offer protection and mitigation for survivors. In order to develop an adequate and efficient strategy to counter gender-based violence against migrants, it is essential to understand the nature of the challenges faced by migrants, and the forms of gender-based violence taking place.

Under international law, numerous rights of migrants are recognized. General human rights safeguards such as the Universal Declaration on Human Rights and the International Covenant on Civil and Political Rights explicitly confer human rights on all human beings regardless of their nationality and their immigration status. With regard to the specific topic of health, the International Covenant on Economic, Social, and Cultural Rights prohibits any discrimination based on national origin or legal status in access to health services. More recently, in 2018, the Global Compact for Safe, Orderly, and Regular Migration was adopted by the United Nations General Assembly in Marrakech. This pact aims to address the root causes of migration but also to create safer migration routes and ensure that all migrants' fundamental rights are respected. Finally, the reasons for migrating can be the source of migrants' specific rights. Migrants can be granted international protection and refugee status under the 1951 Convention relating to the Status of Refugees. Migrant workers are the object of a specific convention, the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Finally, in addition to these international law provisions, EU law and principles also apply to migrants in EU territory.

Although there were attempts to directly protect the rights of women as early as the 1950s, with for instance the 1953 Convention on the Political Rights of Women, the scope of these first advances was very limited. In 1979, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was adopted. CEDAW embodies a substantive vision of equality between women and men and makes it possible for States to implement 'corrective measures' to reach gender equality. In its General Recommendation no. 19, the CEDAW Committee defined gender-based violence as a form of discrimination based on gender stereotypes. In 2011, the Convention on Preventing and Combating Violence against Women and Domestic Violence, better known as the Istanbul Convention, was drafted and became open to signature. It was adopted by the Council of Europe the same year. The Convention aims to prevent violence, protect victims, and end the impunity of perpetrators, who can be either public or private actors. It acknowledges in its preamble that equality between women and men *"is the key element in the prevention of violence against women"*. The Convention also mentions that *"women and girls are exposed to a higher risk of gender-based violence than men"*.

Despite these attempts to protect both migrants' and women's rights, gender-based violence remains a widely recurrent issue with which migrants are significantly more often confronted. In this project, gender-based violence stands at the intersection of many factors: gender, sexual/romantic orientation, migration situation, age, disability, etc. Therefore, it calls for appropriate specific measures taking into account this intersectionality.

To define an effective advocacy strategy, it is necessary to comprehensively understand the specific issues migrants face. The REACH OUT partners believe that an effective and comprehensive way to support migrants should focus on protection, (health)care, and reparation for the harm they suffered. These are the general objectives that should guide the support provided to migrants. However, numerous difficulties prevent survivors from getting access to the relevant services. Some obstacles are directly linked to the state of migration; without a fixed location or because of the language barrier, it is difficult to ensure health care continuity or to provide judicial reparation. Specific obstacles also arise in relation to reporting the abuse and seeking help. These risks include risks related to migration status, such as the risk of deportation for undocumented persons reporting GBV. Such obstacles also include considerations related to gender norms, shame, and fear of stigmatization. Finally, "external" or structural factors, related in particular to the difficulty of proving claims of GBV and getting protection also have an impact on the help provided to GBV survivors.

REACH OUT attempted to palliate these difficulties at its level. Training was offered to professionals and cultural mediators in all countries of implementation of the project to improve their ability to provide care to migrant survivors of GBV. The project also had an outreach component, with hundreds of migrants who benefitted directly from the program, with, in particular, psychological support sessions and workshops on rights and available services. Finally, REACH OUT aimed to improve the information of the general public and the beneficiaries. While REACH OUT was conceived to empower and support migrants in the exercise of their rights, the project did not directly cover issues related to administrative and judicial proceedings, which were referred to external partners. REACH OUT remained focused on access to health care, empowerment, and awareness-raising.

Comprehensive support for survivors of GBV should go further. Non-Governmental Organizations (NGOs) are intended neither to provide legal or administrative assistance nor to create a parallel health care system for migrant survivors of GBV. Consequently, the aim of REACH OUT and similar projects is to train professionals and to raise awareness so that populations vulnerable to GBV and GBV survivors can properly access the general health care system to seek protection, care, and reparation. Such access is conditioned on a proactive stance of public authorities in preventing GBV and ensuring that migrants' rights are respected.

Advocacy context

AT THE EUROPEAN UNION LEVEL

CONTEXT

According to the International Organization for Migration (IOM), the international migrant population in Europe in 2020 stood at 86.7 million people (these figures include Eastern European countries).[10] However, it is worth noting that most international migrants remain in the same region as their country of origin.[11] The same year, there were 15.8 million international migrants in Germany, 2 million in Belgium, 2.4 million in the Netherlands, and 823,000 in Serbia. The increase in the number of migrants in Germany and the Netherlands has been particularly strong, showing respectively a 15.6% and a 2.8% increase over ten years. This indicates that these countries are mostly countries of arrival, i.e., the final destination of migrants, whereas Belgium and Serbia are rather considered as countries of transit. In the two countries of arrival, the surge in the number of international immigrants between 2015 and 2020 can be linked to conflict areas in Northern Africa and the Middle East. In 2016, an agreement was struck between the EU and Turkey to prevent migrants from reaching Greece via the Eastern Mediterranean route. Since the deal remains in place as of today, migrants still cross the Mediterranean Sea through the Central Mediterranean route, mostly from Libya towards Italy, and via Morocco to Spain.

10. "Migration data portal", International Organizations for Migration (IOM), accessed on June 11, 2020. https://migrationdataportal.org/?i=stock_abs_&t=2020.

11. United Nations High Commissioner for Refugees (UNHCR) Global Data Service Statistics Section, *Global Trends. Forced displacement in 2019*, UNHCR (2020).

IN THE AREA OF IMPLEMENTATION OF THE PROJECT

In terms of migration, Article 67 of the Treaty on the Functioning of the European Union (TFEU) gives the EU the competence to implement "a common policy on asylum, immigration and border control". In particular, the European Union is competent to regulate entry at the external borders of the EU territory and short stays (less than three months) and to establish norms regarding asylum procedures. Regulations such as the current Dublin agreement establish the ground rules for the treatment of migrants at the borders of European territory. The reaction of the European Union has been deemed insufficient by various observers and members of civil society to offer a response to the 'welcoming crisis' that respects the fundamental rights of migrants. On the other hand, populists and alt-right parties have blamed the EU for not imposing stringent enough measures to bar the entry of migrants into EU territory. As a result, a legislative proposal, the "*New Pact on Migration and Asylum*", was introduced by the European Commission in September 2020.[12] Although its discussion was delayed by the COVID-19 pandemic, the Pact indicates the general orientations and future changes considered by Brussels in its policies regarding borders and refugees. It is designed to (re)define the criteria governing entry and distribution of migrants across European countries. It does not address nor mention health issues and access to care for migrants. Finally, it is worth noting that the Pact makes no mention of gender-based violence.

12. European Commission, "A fresh start on migration: Building confidence and striking a new balance between responsibility and solidarity", *Press release*, Sept. 23, 2020, accessible at: https://ec.europa.eu/commission/presscorner/detail/en/ip_20_1706.

With regard to health care, the EU has only a complementary competence to regulate public health.[13] Its role is limited to the adoption of regulations to harmonize the systems in place in all Member States.

With regard to the topic of GBV, the EU is strongly committed to supporting and funding projects aimed at preventing and mitigating GBV, which indicates its willingness to tackle the issue. Moreover, challenges related to gender equality seem to be more and more acknowledged by EU policies. In November 2020, the EU updated its third Action Plan for Gender Equality and Women's Empowerment in External Action,[14] running from 2021 to 2025, one of the main challenges of which is "*freedom from all forms of gender-based violence against women, girls, men and boys*". The plan contains various measures dedicated to promoting gender equality through external action. This Action Plan is part of a wider Gender Equality Strategy[15] 2020-2025, which calls for ending gender-based violence and harassment in an intersectional perspective and aims to introduce a gender perspective in all new policy areas of the EU, i.e., gender mainstreaming. Since the 2012 EU directive on victims' rights,[16] which clarifies the EU perception of gender-based violence, a new strategy on victims' rights (2020-2025) was adopted in June 2020 with five key priorities, very much in line with the objectives of REACH OUT. However, it remains to be seen how efficient the EU directive is when applied on the ground, as it is lacking, for instance, proper enforcement mechanisms in preventing abuses and infringement on basic human rights concerning GBV and migrants.

13. Consolidated Version of the Treaty on the functioning of the European Union, Articles 4, 114, and 168, Official Journal of the European Union (1957).

14. European Commission, "Gender Action Plan – putting women and girls' rights at the heart of the global recovery for a gender-equal world", *News*, Nov. 25, 2020, accessible at: https://ec.europa.eu/international-partnerships/news/gender-action-plan-putting-women-and-girls-rights-heart-global-recovery-gender-equal-world_en.

15. European Commission, *Striving for a Union of Equality. The Gender Equality Strategy 2020-2025*, European Commission factsheets (March 2020).

16. Directive 2012/29/EU of the European Parliament and the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, article 17, Official Journal of the European Union (2012).

Therefore, the European Union seems to be aware of gender issues and ready to tackle them, although it is limited by its competencies, which are most often shared with States or complementary to States' policies. With regard to the health of migrants, activities in the field remain limited. The new Pact on Migrations and Asylum seeks to introduce health screenings at external borders, and a public health record project was drafted in 2020 in collaboration with the IOM. It remains to be seen whether these measures will allow for the implementation of an adequate continuum of health care for migrants once they have passed through the external borders of the Union. However, it is worth noting that the COVID-19 pandemic has led the EU to acknowledge how critical the issue of migrants' health is.[17] In addition, the EU has a role to play in nudging national governments to adapt their immigration policies to be consistent with basic fundamental rights by including health care.

However, some factors opposing these positive changes need to be taken into account when considering advocacy from an EU-wide perspective. The following factors have been identified: the rise of far-right nationalist parties across European countries promoting identity closure and xenophobia and sustaining an 'us vs. them' relation-

17. European Center for Disease Prevention and Control (ECDC), *Guidance on infection prevention and control of COVID-19 in migrant and refugee reception and detention centres in the EU/EEA and the UK – June 2020*, ECDC (2020), accessible at: https://www.ecdc.europa.eu/en/publications-data/covid-19-guidance-prevention-control-migrant-refugee-centres.

ship; the continued marginalization of migrants, which contributes to maintaining their role as 'scapegoats'; the underfinancing of health care systems, which was highlighted by the COVID-19 pandemic; and the fact that migrants have little knowledge of and access to information on health care possibilities. Finally, the constant evolution of regulatory frameworks in countries of transit or destination makes it difficult to adopt common advocacy positions across the European continent.

AT NATIONAL LEVELS
BELGIUM

CONTEXT

In 2019, approximately 28,000 individuals filed a request for international protection in Belgium, an increase of 18.3% compared to 2018. The most important reason for this increase is the rise in secondary movements within Europe. Out of the nearly 28,000 requests in 2019, 31.4% or 5,776 individuals were granted refugee status; 5.5% or 943 individuals were granted subsidiary protection. Most originated from Afghanistan, Syria, Turkey, and Iraq.[18] In October 2020, the new Asylum and Migration Secretary of State, Sammy Mahdi (Flemish Christian Democrats) ranked as a top priority the return policy, in order to increase the percentage of applicants for international protection whose application was rejected.

Once an individual applies for international protection in Belgium, the Federal State becomes responsible for them. **Applicants for international protection are entitled to medical and psychological support, as well as material assistance**—housing, social, legal, and administrative support—for the whole duration of their asylum procedure. This is provided by a law adopted on 21 November 2017, which modified the Belgian Immigration Act following Directive 2013/33/EU establishing minimum standards for the reception of applicants for international protection. In the case of undocumented migrants, adults are not allowed to work and subsequently **do not have access to the social security system in Belgium**. However, there are some exceptions if the spouse, parents, or children are entitled to health insurance if they were once documented and had a job, if they had health insurance but lost their legal status, or if they are studying at a recognized school for higher education. In contrast to adult undocumented migrants, undocumented unaccompanied minors are always entitled to health insurance in Belgium. In all remaining situations, **undocumented migrants have the right to access "urgent medical assistance" free of charge** (AMU). The AMU is an assistance of an exclusively medical nature, for which the necessary character must be certified by a medical doctor. The care provided can be preventive or curative and the help given can be mobile or in a health post.[19] However, the situation in practice may be different from the law; cities' stance on the possibility of obtaining a certificate for AMU differs. It is influenced by, among other things, the political constellation of the city council. Obtaining such a certificate is noticeably difficult in Antwerp, where the local regulations form a barrier for migrants' and refugees' access to health care. Therefore, applicants for international protection and undocumented people are not integrated into the compulsory national health insurance scheme for Belgian citizens. Such a parallel system leads to variations and inequalities in accessibility, organization, availability, coverage, and quality of care. Moreover, this dual functioning prevents continuity of care for applicants for international protection in

18. "International bescherming", Statistiek Vlaanderen, accessed on July 5, 2021, https://www.statistiekvlaanderen.be/internationale-bescherming.

19. Platform for International Cooperation on Undocumented Migrants (PICUM), *Access to health care for undocumented migrants in Europe, PICUM* (2007).

cases of transfer between reception facilities, negative decisions, voluntary or forced repatriation, or when applicants for international protection are eventually granted refugee status.

The authorities seem to have taken a **proactive stance in combating gender-based violence**, beginning in 2001 with a first "*national action plan*"(NAP). The plan is coordinated and implemented by the Institute for the Equality of Women and Men (IEWM) and is supported by the Federal State, the Communities, and the Regions. Up to now, five NAPs have been implemented with the aim of banishing all forms of GBV. The sixth NAP (2020-2024) was expected in May 2021 but has not been published at the time this report is written. The scope of understanding of GBV by public authorities has also expanded over the past years and decades, gradually including issues such as street harassment (2014), Female Genital Mutilation/Cutting (FGM/C), honor-related crimes, or forced marriage (2017).[20] However, such plans **do not address the specific vulnerabilities faced by migrant populations**. Control mechanisms and policies have been implemented both at federal and federated levels, providing several interlocutors to reach out to in advocacy activities. In 2017, the International Center for Reproductive Health (ICRH) and the University of Ghent designed a model for Sexual Assault Care Centers in Brussels, Ghent, and Liège. These care centers provide free holistic care (psychosocial, medical, and legal support) to survivors of sexual violence, without distinction based on legal status. In November 2020, it was officially announced that three more Sexual Assault Care Centers would be established in Leuven, Charleroi, and Antwerp by the end of 2021.

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

IN THE AREA OF IMPLEMENTATION OF THE PROJECT

Antwerp, where the project is implemented, has a large number of both health care and specific GBV response services. The main aim of those services is to reduce GBV-related morbidity and mortality. However, due to structural restraints, professionals are limited in the care they can provide to migrant survivors of GBV. MdM Belgium conducted interviews with employees of more than seventy organizations who either regularly come into contact with refugees, undocumented persons, and/or applicants for international protection, and/or have expertise on the topic of GBV. Throughout these interviews, a deep understanding of the actors' capacities and capabilities has been gathered. As the health care system in Antwerp is extremely fragmented, stakeholders expressed their need for clear information provision, especially regarding the referral of GBV survivors with varying residence statuses. Furthermore, the majority of the stakeholders expressed that they are not yet familiar with providing the appropriate care for survivors of GBV and lack the knowledge and self-confidence to do so. Since most of the interviewed stakeholders frequently come into contact with refugees, undocumented people, and / or applicants for international protection, it is important that they are capable of identifying, supporting, and referring GBV survivors to specialist services.

Advocacy work on these topics has been undertaken by GAMS, a Belgian NGO working on FGM/C as part of a European project named ACCESS, which has been identified as a potential ally for REACH OUT partners' advocacy actions. This project identified a further issue regarding survivors' identification and access to care: **a significant number of the victims of GBV are isolated, unaware of their rights, and unknown by social services**. Consequently, there is a critical need for outreach activities, information dissemination, and dedicated medical consultation.

Furthermore, access to support services, including mental health care, for migrant survivors of GBV **should be free of charge without status condition**. However, the current reality on the ground is that access to services is strongly influenced by immigration status. Undocumented people only have access to AMU, which requires undergoing a complex administrative procedure.

The Istanbul Convention states that all women should be protected against any form of GBV, regardless of their migration status. However, practices vary greatly from the state's national law. **Undocumented survivors also fear persecution such as imprisonment or deportation when filing a complaint** with public authorities. By not being able to report the violence they experienced without immigration consequences, survivors are often stuck in a violent situation, which allows aggressors to go unnoticed. Police officers find themselves in the following dilemma: on the one hand, they should protect those who are in danger, but on the other hand, they must detain those who are not in the possession of an identification card or any document required by regulation.

Even though undocumented survivors should also always have access to safe residence shelters, **they do not have automatic access to accommodation at this time**. This makes advocacy all the more important in addressing the issue of GBV faced by migrants in Belgium.

GERMANY

CONTEXT

Germany hosted significant numbers of applicants for international protection compared to other European countries, the country being one of the most important destination countries for migrants. However, there has been around an 84% decrease in the number of applications since 2015, when more than 745,000 asylum applications were filed.[21] Several federated states—namely Bavaria, Saxony, and Saarland—have developed their reception capabilities by relying on what is known as AnkER centers, opened in the periphery of cities in order to manage the influx of migrants in Germany. In these accommodation facilities, applicants for international protection wait until their asylum application is processed. Theoretically, they are granted access to health care, accommodation, and social and administrative help. However, the living conditions in AnkER centers have been largely characterized as inadequate, with overcrowded facilities and bad hygiene conditions.[22] In addition, 128 attacks against accommodation centers were reported in 2019. There is a high estimated number of unreported cases while regular reports mention violations by security forces.[23]

The German law on the rights of applicants for international protection (Asylbewerberleistungsgesetz) grants applicants for international protection and refugees free access to health care services in all 16 federated states.[24] Similarly, applicants for international protection whose application was denied but whose expulsion has been suspended (Duldung) can freely access health services. On the other hand, undocumented migrants have access to emergency care only.

Germany has adopted numerous legal provisions since the turn of the millennium in order to work towards gender equality and to root out gender-based violence. Two action plans designed to eradicate violence against women were drafted in 1999 and 2007, and continuous efforts have been undertaken by federal and federated states since then. Locally-based initiatives addressing GBV have also been implemented. In 2004 in Munich, the victim counseling center of the police launched the "Münchner Unterstützungsmodell" (MUM) project, which allows for victims of domestic violence to be proactively oriented towards appropriate support services offering counseling and care. The MUM project is ongoing and is considered a big success. More recently, a federally funded program, "Together against Violence towards Women", was launched on 18 February 2020. Up to 120 million euros in funding has been allocated for the period 2020-2023. Therefore, the issues of GBV and migration have been on the German political agenda even though some observers[25] have pointed out a lack of political will and community support to address them.

21. Bundesamt für Migration und Flüchtlinge (BAMF), *Schlüsselzahlen Asyl 2020*, BAMF (2021), accessible at: https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/SchluesselzahlenAsyl/flyer-schluesselzahlen-asyl-2020.pdf?__blob=publicationFile&v=3.

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

23. Ibid.

24. World Health Organization (WHO) Migration and Health Programme, *Report on the Health of refugees and migrants in the WHO European Region*, WHO (2018).

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

IN THE AREA OF IMPLEMENTATION OF THE PROJECT

A central political demand is to ensure access to health care services for all migrants. In Munich, where the project is implemented, there is a general lack of mental health care services for both persons with regular access to the public health care system and for persons with limited access. The EU Directive 2013/33 grants vulnerable persons like GBV survivors the right to psychological support. However, in practice, they face great challenges when trying to access mental health services.[26] Moreover, there are very few services for applicants for international protection that work with a culturally sensitive approach and with language mediation. Affected persons are hardly ever able to undergo the procedure without legal and social support.[27]

Since many applicants for international protection and refugees live in state-run refugee centers, the nature of these centers is crucial for ensuring adequate violence prevention and protection. In Munich, MdM Germany worked until 2019 to offer psychiatric counseling in the biggest AnkER center in Oberbayern (in Ingolstadt/Manching). For the REACH OUT project, MdM Germany conducted information workshops online due to the pandemic. They could determine that protection measures for vulnerable persons are insufficient. Indeed, **centers are often isolated, with limited access to CSOs, health professionals, and social workers.** Therefore, applicants for international protection have limited access to services, in centers that are overcrowded and characterized by bad living conditions. In some AnkER centers, the sleeping rooms and sanitary facilities are not lockable. There is also a general lack of protected areas for women, mothers, and families.[28] It has been underlined that the construction of mass accommodation facilities at the periphery of the cities undermines violence protection and prevention. Consequently, refugee centers should be located close to existing services, and transportation to those services should be accessible for migrants, in order to ensure their right to medical services, independent legal consultation, and counseling centers. It is the responsibility of the federated authorities, in charge of applicants for international protection accommodation and integration to ensure this. Building smaller accommodations rather than large refugee centers would also favor the reconstruction of social links migrants may have lost during their migratory journey. In order to promote this sense of belonging, the involvement of residents in the management of centers also seems to be a good starting point. This is also about violence prevention: people who have the right to organize their own everyday lives are more likely to speak up for themselves and are therefore less vulnerable to GBV.

Within refugee centers, Professor Susanne Nothhafft emphasizes the necessity of fully implementing the Istanbul Convention and the EU Directive 2013/33 in national legislation. As Article 60 §3 of the Istanbul Convention determines that *"parties shall take the necessary legislative or other measures to develop gender-sensitive reception procedures and support services for asylum-seekers as well as gender guidelines and gender-sensitive asylum procedures"*, national legislation should require the institutions responsible for refu-

26. Offe, Johanna and al., *Parallel Report to the CESCR on the Right to Health for Non-Nationals*, Ärzte der Welt e.V., (July 2018).

27. Ibid.

28. Umbrella Association of Migrant Women's Organisations, *GREVIO-Shadow Report, supra* note 25.

gee accommodation to **implement binding concepts of violence protection for all targeted groups.** Such concepts exist in the form of Standard Operating Procedures (SOPs), but there is **currently no harmonization of those protocols, which cannot consequently be used properly by relevant stakeholders.** These harmonized guidelines would include, notably, standardized procedures in cases of suspected or proven violence; inclusion of an efficient sanction mechanism; information for all residents about their rights to medical services, legal and social counseling; internal contact persons for GBV survivors, whose services include language mediation; information for all residents about external support services for GBV survivors; conditional standards and requirements for all staff working in the accommodation (e.g. certificate of good conduct, adequate training and professional experience), etc.

Another priority identified is related to immigration proceedings: under German law, there is **no right to a resident status independent from their partners** for survivors of domestic violence who came as a result of familial reunification within the three first years of arrival. Survivors of domestic violence only have the right to an independent resident status if their marriage has been legally binding for at least three years, which puts individuals in a violent relationship at risk. Indeed, Germany reserved the right not to apply the provisions laid down in Article 59 paragraphs 2 and 3 of the Istanbul Convention, which ensure the right to a resident status independent from their partners for survivors of domestic violence.

Finally, survivors of GBV are currently not automatically recognized as vulnerable persons when applying for international protection. Articles 21 and 22 of the EU Directive 2013/33 state that the Member States should assess which applicants for international protection should be treated as vulnerable persons. This status entails the acknowledgement of special needs and the provision of adequate support to meet these needs. Gender and culturally sensitive procedures for identification should be carried out upon arrival in refugee accommodation centers. These procedures should never lead to re-traumatization, stigmatization, and/or discrimination. In a second step, state legislation should ensure access to adequate, need-based, confidential, and culturally sensitive services with language interpretation—including medical services, psychotherapeutic and psychosocial support, and legal consultation—for all vulnerable groups and access to shelters for persons at risk of violence.

THE NETHERLANDS

CONTEXT

The Netherlands is usually a country of destination for migrants. The majority of migrant communities live in or in the vicinity of big cities. Since 2005, there has been a clear upward trend in the number of migrants coming to the Netherlands; the annual number of immigrants has now more than doubled. The composition of migration flows has also changed considerably since the turn of the century. Since the expansion of the European Union in 2004 toward Central and Eastern European countries, migration within the EU has significantly increased. According to the Dutch Council for Refugees, around 200,000-250,000 refugees currently reside legally in the Netherlands. They come from countries such as Afghanistan, Iraq, Iran, Somalia, and Syria. In 2015, the number of asylum applications peaked at 58,880. From 2016 onwards, this number decreased to approximately 30,000 a year and has remained around that level since then.[29]

The influx of applicants for international protection in 2015 has put migration higher on the political and social agenda. The surge in applicants for international protection in various cities resulted in civil unrest and strong negative reactions. This sentiment was also fed by increasingly popular right-wing political parties. However, research commissioned by the Central Bureau of Statistics in 2017 showed that more than 75% of the adult Dutch population is in favor of receiving refugees. There is less support for so-called economic migrants, especially when they come from countries outside the European Union and from countries considered safe, such as Tunisia and Morocco. Municipalities have also increasingly started to initiate dialogue with their residents about migration in order to create support for different types of shelters.

Upon arrival, applicants for international protection are received in one of the three reception centers in the Netherlands, run by the Central Institute for Reception of Asylum seekers (COA) under the Ministry of Justice and Security (JenV). Theoretically, within the first one or two weeks following their arrival—in practice many months—people register with the police and receive legal support so they can submit their application for asylum with the Immigration and Naturalization Service (IND). After the procedure is started, people are placed in one of the forty Asylum Seekers' Centers (AZC) to wait for the results from the IND. In this period, people have limited rights to study, work, and integrate into Dutch society. However, they are granted basic health insurance similar to that of Dutch citizens, though access to services is often restricted, especially when it comes to mental health services. Then, migrants who are granted a residence permit or refugee status have access to the health care system under the same conditions as Dutch citizens.[30] However, undocumented migrants with a rejected asylum claim are only entitled to emergency care and medically necessary care.[31] They cannot purchase health insurance and usually have to pay for the

29. Immigratie- en Naturalisatiedienst, Ministerie van Justicie en Veiligheid, *Aslyum Trends. Monthly Report on Asylum Applications in The Netherlands*, IND Business Information Center (December 2020).

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

31. Ibid.

care they receive. When undocumented migrants cannot afford medically necessary care, health care providers can, under certain conditions, get a refund from the government[32] under the Health Insurance Act.

With regard to GBV, the Netherlands has taken appropriate steps to comply with the Istanbul Convention and to include GBV prevention and protection in national legislation. A National Action Plan on Sexual Health and sexually transmissible diseases (STD) control was launched in 2017 by the Dutch Ministry of Health. The document mentioned sexual violence and unwanted pregnancies. In 2018, the program "Violence does not belong anywhere" was presented by the Ministries of Health, Welfare and Sport (VWS), and Justice and Security, and the Association of Netherlands Municipalities (VNG). It outlines the government's ambition to improve the training of professionals with regard to gender-based violence and takes into account specific groups such as survivors of human trafficking and survivors of honor-related violence. In parallel, there are 16 centers for sexual violence distributed across the country, accessible within less than one hour from any location in the Netherlands, to help in reporting GBV and to provide medical and psychological care. Additionally, 26 Safe Houses provide information, security, and legal advice.[33]

As a result of the COVID-19 pandemic and the subsequent lockdown measures, there has been growing attention to the topic of domestic violence and child abuse among the whole population. This trend might facilitate and support the awareness-raising activities planned by REACH OUT on GBV against migrants in the Netherlands.

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

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

IN THE AREA OF IMPLEMENTATION OF THE PROJECT

The project is implemented in four cities in the Netherlands: Amsterdam, Rotterdam, The Hague, and Nijmegen, where there is a higher concentration of undocumented migrants than in the rest of the country. Although the Netherlands has developed a rather inclusive stance towards migrants and implemented adequate policies aiming to decentralize competencies to municipalities in terms of services offered to deal with GBV, **work remains to be done to ensure that migrants are informed and have access to health services.** Indeed, migrants still face various barriers in accessing care services, which could be solved by better information and outreach to target groups.

Many applicants for international protection and refugees are dealing with traumatizing experiences resulting in physical injuries, stress, depression, and sometimes post-traumatic stress disorder (PTSD). They can access public health care services and receive health education from the public health department. Only general health topics are discussed and no special attention is given to GBV issues and consequences on physical and mental health. **Mental health care is accessible, but due to very long waiting lists, necessary treatment is much delayed.** Moreover, the policy of many mental health institutions is that **patients must be recipients of residence permits so that treatment cannot be interrupted by transfer or deportation.** Combined with the sometimes very long waiting lists, access to mental health care appears limited for GBV survivors, in spite of the efforts and services deployed by CSOs.

With regard to public policies, the Dutch government has taken far-reaching and comprehensive actions to deal with migrants and ensure their access to health care. However, some regulations and practices could still be improved. **Detection of signs of GBV is not included in the medical screening of applicants for international protection that takes place upon arrival.** Furthermore, there is a lack of coordination between the different agencies and organizations providing care to migrant survivors of GBV. First, the information given by GBV survivors is not always shared properly, forcing survivors to recount their experiences several times. Secondly, **there is limited cooperation between professionals of the national support services and staff members of migrant-led organizations,** mostly working as volunteers. Professionals do not always acknowledge the important role played by those organizations in supporting survivors by 'building a bridge' between them and the Dutch health care system. In addition, the services provided by these cultural mediators are not always valued by public authorities, as they are usually deployed as volunteers or might receive a maximum reimbursement of 170€ per month.

Furthermore, survivors of domestic violence who arrived in the Netherlands as a result of family reunification and who **divorce within the first five years after their arrival need to start an asylum procedure to stay in the country**. In order to avoid this situation, survivors might choose to stay in an abusive relationship for this period of time. With regard to housing and accommodation facilities, the number of places available remains insufficient in spite of a significant number of shelters having been set up in different cities. Undocumented migrants with a rejected asylum claim may stay at 24-hours shelters run by local municipalities, where the living conditions are very difficult and stressful. They can stay in these shelters only if they participate in a special program to explore the limited possibilities to remain in the Netherlands. Moreover, access to shelters and other support services by migrants is hampered by limited information about their rights, further complicated by illiteracy or insufficient command of the Dutch language and culture. As the government states that people are responsible for asking for help, this stance constitutes an obstacle if there is no information on available services for GBV survivors.

There is also a lack of a common national fund or a common procedure to ensure the provision of free translation. State-paid interpreters are only present in asylum centers, in reception centers for survivors of GBV, and in cases of human trafficking or exploitation. Apart from these cases, people have to arrange for an interpreter themselves. Although some municipalities have a special fund from which general practitioners can be reimbursed for telephone interpreters, there is little awareness about this initiative among medical staff. With regard to GBV, care providers of the telephone helpline of the Center for Sexual Violence speak only Dutch and English, which renders contact difficult for those speaking another language. In general, there is also a lack of data on the prevalence of GBV, especially among migrants. The allocation of additional resources and the creation of a system to collect data on GBV seems to be needed.

Finally, it appears that the limited time allocated to each beneficiary during general practitioners' (GPs') consultations (around 10-20 minutes) is not sufficient for beneficiaries to enter into a confidential conversation and to address GBV issues, especially given the cultural and language barriers. The **lack of cultural training and information of health professionals on the different patterns of GBV** migrants

might have been exposed to remains a key issue. It prevents detection of GBV during a consultation when there are no evident external signs of violence. Practitioners might not be keen to approach the topic with patients, precisely because of this lack of knowledge and sensitization. Training on the rights of migrants in accessing health care services regardless of their administrative status is still needed, so that migrants can access the services they are entitled to.

SERBIA

CONTEXT

Serbia is not part of the European Union but is a country of transit for migrants who seek to reach the EU or the United Kingdom. The temporary living situation of migrants makes it even harder to provide assistance and ensure continuity in health care. However, this geographical position, as an intermediate step in the migratory journey of migrants taking the Balkan route between Turkey and the EU, offers an opportunity to initiate physical and psychological care and to organize the health continuum of migrants.

The legislative framework applicable in Serbia includes the New Law on Health Care protection, which came into force on April 11, 2019, as a new version of the former Law on Health Protection. It grants medical care to "*persons who spent time in war or refugees, who are unemployed with a low monthly income and a residence on the territory of the Republic of Serbia*"[34] and "*young unemployed persons who are not involved in education up to the age of 26*". However, undocumented migrants remain deprived of free health care other than urgent medical care.[35]

With regard to gender-based violence and violence against women, Serbia ranked 19th out of 156 countries in the 2021 Gender Gap Index of the World Economic Forum.[36] As such, it is one of the five most-improved countries in the index which narrowed their gender gaps by at least 4.4 percentage points in a year. A protocol for the protection and treatment of women victims of violence was also implemented in 2014,[37] along with four other protocols, after the involvement of three UN agencies[38]. A Law on Prevention of Domestic Violence was also adopted in 2017,[39] but its application for Roma women and migrants remains insufficient. Serbia is a signatory of the Istanbul Convention, but its implementation had also been shown to be partial in view of the limited number of shelters, the funding and maintenance of 24/7 SOS helplines, or the lack of training of prosecutor's office employees with regard to gender-based violence.[40] Eventually, studies have highlighted that significant proportions of migrants traveling through Serbia have experienced violence either on their migratory journey or directly in the country.[41] Moreover, a review conducted by the GREVIO, the international body monitoring the implementation of the Istanbul Convention, highlighted several issues related to the prevention of violence against women. The first one is that there are not many unigender specialist support services, which are mostly run by CSOs with budget constraints, therefore limiting the scope of the support provid-

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

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

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

37. Integrated Response to Violence against Women in Serbia, *Republic of Serbia Ministry of Health – Special Protocol for the Protection and Treatment of Women Victims of Violence*, United Nations Development Program (2013), accessible at: https://serbia.un.org/sites/default/files/2020-07/SOP_brochure_ENG_web.pdf.

38. Integrated Response to Violence against Women in Serbia, *Multisectoral cooperation – Institutional Response to Violence against Women*, United Nations Development Program (2013).

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

40. Ibid.

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

ed. The second one is the lack of coordination between police services, which are largely uninformed about GBV, and shelters or referral centers. Finally, the GREVIO report highlights the limited efficiency of the judiciary in punishing GBV, although GBV has mostly been criminalized under Serbian law. Little guidance in judiciary proceedings, limits on the beneficiaries of free legal aid, as well as partial application of the sanctions punishing GBV, are the main factors hampering the effectiveness of the judiciary in addressing GBV.

The general attitude towards migrants in Serbia is similar to the one in other European countries. Most citizens see migrants as a burden and/or threat, and they would rather have them move to other countries or go back to their home countries. However, within the Srem Region in Serbia and in Šid, there have been positive actions to promote the integration of migrants. The most successful one has been to allow children of applicants for international protection to attend primary and secondary schools in Šid. Migrants have been more humanized by having children integrated into regular classes; the wider community has learned that migrants have hopes and dreams for their families similar to those of other citizens. This action was a big step toward social inclusion in the region. In addition to this action, the regional development agency of Srem (RRA, located in Ruma, Serbia) is currently implementing the INTERREG ADRION project "REInSER- Refugees' Economic Integration through Social Entrepreneurship", which aims to provide seasonal work opportunities to refugees residing in Serbia while also promoting the skills and capacities of migrants coming to Europe.

IN THE AREA OF IMPLEMENTATION OF THE PROJECT

Within the Srem Region and the Municipality of Šid, there are approximately 2,500 persons registered as applicants for international protection. They are located in two reception centers in Šid. These persons are mainly from the Middle East (Iraq, Iran, Syria, etc.) and Central Asia (Afghanistan, Pakistan). The vast majority of the registered applicants for international protection are men (approximately 80%) coming from diverse backgrounds (i.e., different cultures, language groups, religions). GBV has been recognized as a concern, but no concrete measures have been taken by the Serbian authorities to track and report cases of GBV among migrant populations. Furthermore, no concrete measures are in place to ensure that persons exposed to GBV are supported and taken care of (i.e., provided with safe spaces, psychological support from experts, translation support, etc.). At this time, there are **no concrete statistics on GBV faced by migrants.** The Red Cross (RC) Šid believes that a specific service needs to be established to track cases of GBV and provide details on specific cases. With such a service, authorities would at the very least have data/information that would allow them to take the appropriate course of action on each case.

Despite the existence of Standard Operating Procedures for the prevention of and protection from GBV against migrants, there is **little knowledge and coordination between actors in applying those guidelines.** Support services have mainly been implemented by CSOs. Public bodies involved in preventing GBV at reception centers are the Center for Social Work of the Republic of Serbia (conducted by the local office in Šid), the Commissariat for Refugees and Migration of the Republic of Serbia, and in some cases the police (local branches—the police is under the control of the Ministry of Interior of the Republic of Serbia). The main body controlling all matters relating to immigration is the Commissariat. Any new proposal relating to support of migrants facing GBV needs to go through this body.

Currently, the main way in which victims are supported is by separating women and children (who are overrepresented among victims) from men (who are overrepresented among perpetrators). This is being done by the Center for Social Work. RC Šid also provides victims with psychological support services when persons come forward with their testimonies. However, **most persons facing GBV do not come forward due to fear of reprisals and a lack of confidence in the system.** It has been noted that although the initial support provided by RC Šid may lead to a positive impact, more training for RC volunteers and staff and mediators is needed.

Although there are some initial efforts, no concrete coordinated advocacy actions have been implemented to address GBV faced by migrants, which is seen as a secondary concern. To push the previously mentioned public bodies, citizens have to be sensitized to the needs and realities faced by the migrant population. There have been cases of citizens **spreading misinformation about migrants via Facebook and social media.**[42] On these sites, alt-right groups spread stereotypes about migrants in which they say that they intend to launch terrorist attacks, destroy local traditions, and murder citizens. An advocacy campaign should consider citizens' attitudes towards migrants, and counter these attempts to demonize migrant populations. By considering citizens' attitudes, the project will be able to change current attitudes towards migration and enhance support for actions addressing GBV against migrant populations. Local governments and NGOs promoting the social integration of migrants could be engaged in dissemination measures to reach out to citizens in the best way.

42. Pejic, Irena, "Boosting the anti-migrant right", *Masina*, Mar. 6, 2020, accessible at: https://www.masina.rs/eng/boosting-the-anti-migrant-right.

Advocacy Strategy

Based on this context, the present document aims to formulate an advocacy strategy tackling the main issues encountered by migrant survivors of gender-based violence. The objectives of such a strategy are:

- To ensure access to health care services for migrant survivors of GBV at all steps of their migratory journey
- To make the issue of GBV acknowledged all across Europe
- To provide protection and legal remedies to migrant survivors of GBV

Although these objectives remain very general and need to be adapted to each country's specificities, they should guide the implementation of projects and activities related to migration and GBV. It is also important to stress the necessity of including a gendered perspective in all projects related to migration.

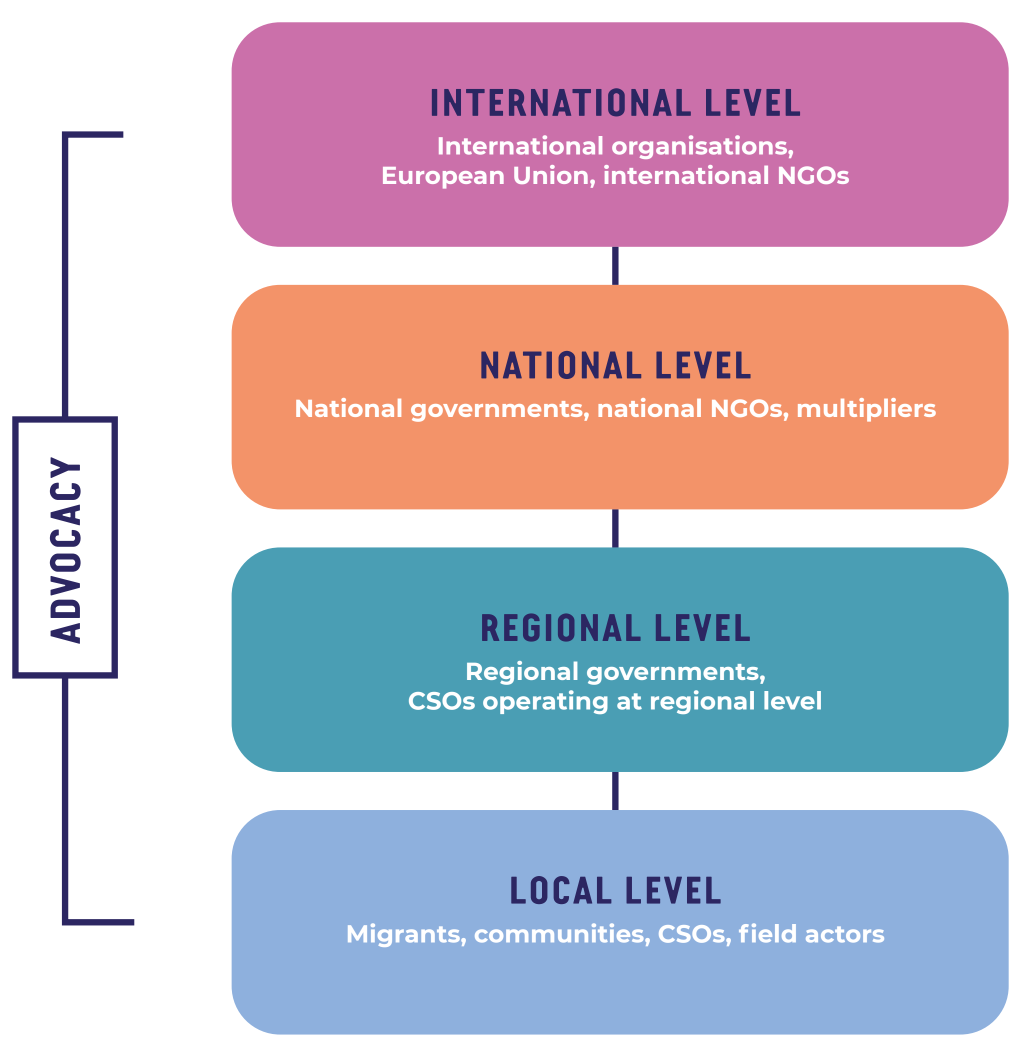


Figure 3. Levels of advocacy

In order to fulfill those objectives, this strategy identifies:

- Priority actions and relevant tools to implement those actions
- Key communication messages tailored to targeted groups
- Monitoring and evaluation tools assessing the strengths and risks of the following strategy

Having stated these objectives, it is now necessary to assess the resources available and the actors who could be mobilized in each country where the project is conducted. The proposed actions should be implemented through a holistic approach taking into account the mobility of migrants. The advocacy strategy should also target a wide range of actors at all levels of society: the international level, which includes international organizations; the national level, where national governments, but also public opinion, CSOs, and other organizations operate; and the local level, in which migrant communities, shelters, CSOs, multipliers, and migrants are primarily important actors.

The role of international institutions

As mentioned above, European institutions are key actors in terms of migration policy: they decide notably the ground rules regarding entry and international protection. They play a major role in terms of protection, care, and reparation for GBV migrant survivors. Moreover, EU actors are less constrained by national sovereignty concerns, which can create strategic opportunities to promote uniform rights between citizens and migrants at a supranational level. The EU has also presented itself as a pioneer in fighting discrimination and achieving gender equality. EU institutions may then be particularly inclined to proactively put the issues faced by migrant survivors of GBV on the legislative agenda. Finally, the EU can propose a harmonized approach of GBV and migration based on effective coordination with advocacy actors at other levels.

The role of national institutions

States are significant actors for triggering change and ensuring sustainability. First, States are the primary actors in terms of human rights implementation. Consequently, the elements outlined in this advocacy strategy aim to allow migrant populations to become effective beneficiaries of State-run services. Second, as policy-makers, national governments and legislators have the power to embed advocacy priorities and actions into the national legal framework, therefore allowing change to be sustainable and long-lasting. Indeed, protection, care, and reparation for all survivors of GBV should be identified as an objective of national interest. Finally, States are relevant actors in ensuring liaison and communication between those at different advocacy levels, such as community representatives, CSOs, and international institutions.

The role of CSOs in countries of implementation

While implementing the actions detailed in Figure 6, CSOs should develop a network approach to increase the impact of their actions by ensuring they cooperate and adopt complementary stances. The development of partnerships between organizations across Europe seems necessary for several reasons. First, acknowledging the influence and the work of other organizations will enhance the public resonance of CSOs' advocacy actions. Second, working in networks enables CSOs to adapt to the geographical mobility of migrants by developing shared common tools, us-

ing similar protocols, and ensuring smooth contacts between organizations. It also enhances the quality of action and avoids duplication of activities. The usefulness of developing such networks has been shown by several successful health initiatives. For instance, the Hep-C network operating in Brussels provides complete medical care, from outreach to medical treatment and health monitoring. Sharing good practices and disseminating information would be easier with increased communication between partners. Finally, working in networks proves more efficient in collectively weighing on decision-makers, by launching joint European advocacy initiatives.

ADVOCACY PRIORITIES AND TOOLS OF ACTION

Several priorities should guide the advocacy work conducted in each country of implementation of the REACH OUT project to provoke significant changes in access to health care for survivors of GBV. These priorities have been identified by examining the situation at the EU level and country-by-country. MdM Belgium notably conducted a needs assessment so that the REACH project could address the priorities the beneficiaries identified. The needs assessment included three online focus groups, 12 individual interviews, and one duo interview. The participants were selected through various stakeholders in the network of MdM Belgium and presented a wide range of age, gender, country of origin, length of residence in Belgium. The needs assessment focused on one topic: how are care services in Antwerpen perceived by applicants for international protection, refugees, and undocumented migrants? The semi-structured interviews provided a series of questions related to the availability and accessibility of care services, the experience of migrants with those services, and the barriers identified in the provision of care. The needs assessment enriched and confirmed some of the previously identified factors affecting migrants' access to care services and the quality of the care provided.

The matrices of priorities presented below identify key tools for action on prevention, care, and reparation for migrants at risk or survivors of GBV. These matrices have been designed following the prioritization method outlined by Caritas' advocacy manual.[43] According to this methodology, a key issue is first identified. Then, possible tools of action for tackling this issue and achieving desired outcomes are presented and ranked on a scale from 1 (least interesting) to 3 (most interesting), using previously defined criteria. The action with the highest score ought to be given priority in implementation to achieve the desired outcome.

The three matrices below propose tools of action to address three of the issues previously identified in the advocacy context section: the lack of information for service providers on how to deal with migrant survivors of GBV (1), the lack of information migrants have about their rights (2), and the lack of awareness of the general public on the issue (3). This methodology can then be extended country-by-country for each issue. A summary of key issues identified, possible tools of action, and desired outcomes is available at the end of this document (Figure 6).

43. Caritas, *Manuel de plaidoyer pour les jeunes sur les questions de migration et de développement dans le monde*, Caritas International Belgique (2021).

Key issue identified #1:
service providers lack information on how to deal with GBV migrant survivors.

	Provide regular training on GBV and intersectionality to all staff in contact with migrant populations	Set up a network of actors and services available to create a referral pathway for survivors that professionals can rely on	Reinforce cultural mediator services at key entry points for migrant populations
Social acceptability	3	2	1
Accuracy in addressing the issue	2	3	1
Feasible implementation	1	3	2
Human dignity	3	1	2
Subsidiarity to State action	3	2	1
Score	11	10	9

Hierarchization of strategy	1 = least interesting 3 = most interesting
Score	Total score for each strategy

Key issue identified #2:
migrant populations at risk or survivors of GBV lack information about their rights and the possibilities they have for protection, care, and reparation.

	Dissemination of brochures in places frequented by migrants (waiting rooms of health care centers or shelters, online devices)	Outreach activities with mobile services going to places where people live and socialize	Specific consultations creating an environment where it is easier and safe to talk about GBV
Social acceptability	2	1	3
Accuracy in addressing the issue	1	3	2
Feasible implementation	3	1	2
Human dignity	1	2	3
Subsidiarity to State action	2	1	3
Score	9	8	13

Hierarchization of strategy	1 = least interesting 3 = most interesting
Score	Total score for each strategy

Key issue identified #3:
people are not sensitive to the vulnerability of migrant populations to GBV.

	Small fact-based articles and brochures to be disseminated in key locations (health care centers, schools, public spaces)	Targeted communication on specific days: International Migrants' Day, World Refugee Day, Women's Equality Day	Awareness campaign on social media based on the initial attitudes of citizens towards migrants
Social acceptability	1	3	2
Accuracy in addressing the issue	2	1	3
Feasible implementation	1	3	2
Human dignity	2	1	3
Subsidiarity to State action	3	1	2
Score	10	9	11

Hierarchization of strategy	1 = least interesting 3 = most interesting
Score	Total score for each strategy

ON KEY COMMUNICATION MESSAGES

Despite the development of advocacy roadmaps that are adapted to the local situation in every place the project is implemented, common messages should underpin the advocacy effort. These messages vary according to target groups. In general, the "voice" of the migrant populations at risk and of survivors of GBV should always be given prominence in the advocacy work undertaken by the partner organizations. This is intended to acknowledge their agencies, put them first, and respect their experiences, but also to bolster feelings of empathy in the general public and to remind them that the will, the rights and the needs of migrants are and should be guiding the work of CSOs. Unfortunately, we have been unable to let survivors of GBV act as leaders in communication messages. This is due to the societal and public health context of the countries of intervention, which has created a climate of fear among migrants. Likewise, the legal context does not provide us with protection for migrants without a residence permit who testify.

Designing key communication messages

General key communication messages have been used in REACH OUT communication materials to raise awareness about GBV. These messages were inspired by the previous EU-funded project WE ACT. They are focused on the nature of GBV, such as "GBV is a human rights violation", "GBV can happen to anyone". Messages targeted more specifically to survivors are focused on exculpation and support: "GBV is never your fault", "You are not alone, and help is available for you".

Specific key communication messages for each issue previously identified can be determined through the "house of messages" methodology outlined by Caritas' advocacy manual.[44] Taking a previously identified key issue (see Figure 6), a desired outcome is defined, which will be the roof of the "house of messages". Then, key communication messages, which are the walls of the house, are elaborated and adjusted to a specific target group to support the desired outcome. Finally, those messages rely on the work previously performed (factsheets, country reports, publications, etc.), which are the foundations of the house.

This report provides an example of key communication messages for one of the issues identified in this advocacy document: "migrants' access to health care systems is conditioned and limited by immigration status". The desired outcome is to allow access to health care for migrant populations, independently of legal status. The target here is the general public. Our key messages will have to tackle the preconceptions and prejudices citizens can have towards migrants' living conditions, migrants' health, and migrants' rights. They will also have to rely on solid foundations such as scientific publications, declarations from recognized organizations, and convincing data. Taking into account those elements, the following "house of messages" has been designed. This methodology can be adjusted to all issues highlighted in Figure 6.

44. Ibid.

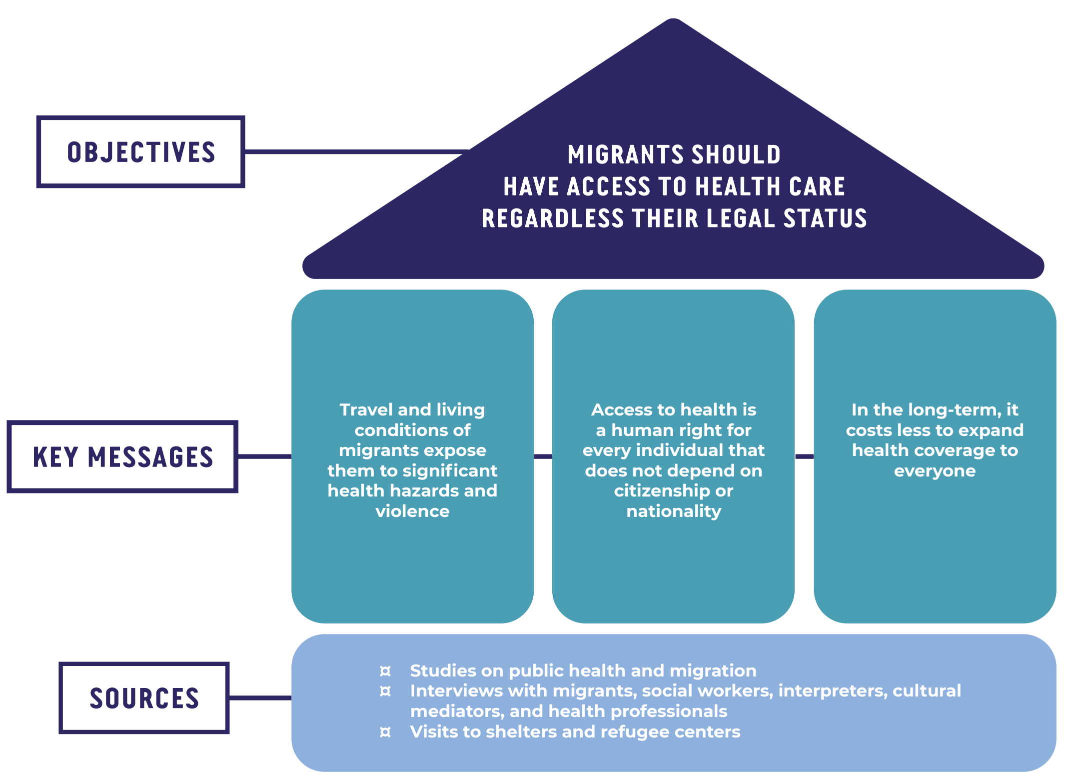


Figure 4. House of messages

Adjusting key communication messages

As previously stated, it is critical to adjust key communication messages to the targeted group for advocacy. The following figure, the communication pyramid,[45] presents the possible adaptation of one of the messages selected in Figure 4. The base of the pyramid is the message directed to the general public and must be short and clear. The middle of the pyramid includes a message dedicated to an informed public, with key supporting elements. The top of the pyramid is intended for an expert public and provides specific and detailed information. Such methodology can then be extended to all key communication messages.

45. Ibid.

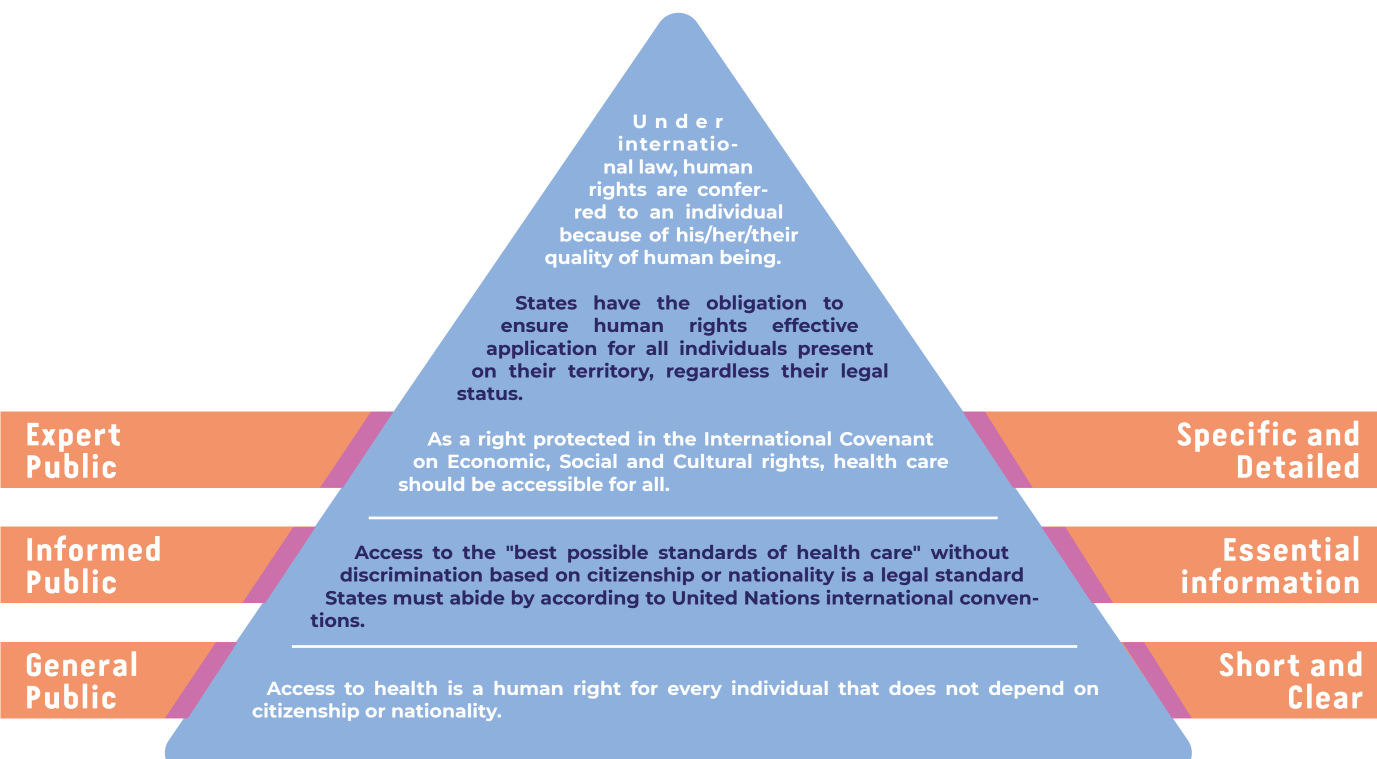


Figure 5. Communication pyramid

Monitoring and evaluation

As outlined in the previous project WE ACT led by MdM Belgium and MdM France on GBV against migrants, it is critical to strengthen mechanisms for the monitoring and evaluation of all advocacy actions implemented. The REACH OUT project provides for comprehensive monitoring and evaluation indicators that have to be adjusted to the kind of activities conducted. The following categorization of indicators of progress has been elaborated based on the provisions of the grant agreement and the methodology established by the Open Forum for CSO Development Effectiveness[46] and Acodev.[47] It is a non-exhaustive list of the main categories of action tools identified in Figure 6.

46. De Toma, Costanza, Advocacy Toolkit. *Guidance on how to advocate for a more enabling environment for civil society in your context*, Open Forum for CSO Development Effectiveness (2011).

47. Mainenti, Carline and Richardier, Benjamin, *Guide pour l'élaboration, la mise en œuvre et l'évaluation d'une stratégie de plaidoyer pour accompagner des partenaires Sud dans leurs actions de plaidoyer*, Agronomes et Vétérinaires sans Frontières (2011).

Type of activity	What is to be monitored and evaluated?	Possible indicators to be used
Lobbying to local, national, and European institutions	¤ Issues included in the agenda ¤ Change of rhetoric in public communications ¤ Change of opinion in legislation	¤ Topics of the projects financed by the institution ¤ Frequency of key words in debate minutes ¤ Amendment proposals
Training of professionals and relevant actors	¤ Greater sensitivity and awareness ¤ Change in stakeholders' skills in their professional area ¤ Greater coordination between stakeholders' groups	¤ Quantitative: number of people trained ¤ Qualitative: survey to evaluate the content of training ¤ Qualitative: regular follow-up questionnaires to evaluate the impact of the training activities conducted
Awareness campaigns to the public	¤ Change in public perceptions ¤ Greater mobilization of the public ¤ Enhanced listening capacities	¤ Quantitative: volume/range of the issue in the media ¤ Qualitative: analysis of media content ¤ Qualitative: surveys of samples of the population (through social media or during open day events)
Outreach activities	¤ Targeted populations more aware of their rights ¤ Greater use of services by targeted populations	¤ Quantitative: number of people reached by workshops and individual counseling sessions ¤ Quantitative: number of identified GBV survivors ¤ Quantitative: number of persons attending specialized consultations/centers

Other support tools can be used to assess the impact of the advocacy strategy, such as regular reports summarizing the findings and the main actions implemented for one objective. Such reports include the biannual country reports planned in the grant agreement, but also minutes of meetings with relevant stakeholders to follow coordination activities. The following list, elaborated with the Open Forum for CSO Development Activities toolkit, identifies the main points to consider when monitoring a meeting. An evaluation template is provided in Annex 2 of this document.

- Meeting title
- Meeting place, date, and time
- Participants
- Objectives of the meeting
- Main points of the meeting
- Progress of the meeting: realization of the stated objectives
- Follow-up actions to implement
- Additional comments

Finally, a monitoring table for dissemination and communication will allow for a precise follow-up on the impact of the project. Below is the sample indicator table presented by the European Commission for evaluating such an impact. This table is used by all REACH OUT partners and has been considered a useful tool to follow up on the diversity of activities.

	Number for the reporting period	Comments
Dissemination and communication activities		
Organization of a conference		
Organization of a workshop		
Press release		
Non-scientific and non-peer-reviewed publication (popularized publication)		
Exhibition		
Flyer		
Training		
Social Media		
Website		
Communication campaign (e.g. Radio, TV)		
Participation in a conference		
Participation in a workshop		
Participation in an event other than a conference or a workshop		
Video/Film		
Brokerage event		
Pitch event		
Trade fair		
Participation in activities organized jointly with other projects		
Other		

Estimated number of persons reached in the context of all dissemination and communication activities in each following category	
Socio-professional category	**Number of persons**
Scientific community (higher education research)	
Industry	
Civil society	
General public	
Policy makers	
Media	
Investors	
Customers	
Others	

Summary of the key issues, tools of action, and desired outcomes at the EU and country levels

Below are presented the main issues identified through the EU and country-by-country context analysis, the main changes expected, and the actions to be implemented in order to trigger those changes.

EUROPEAN UNION

Issues identified	Tools of action	Type of action	Desired outcome
People are not sensitive to the vulnerability of migrant populations to GBV, rhetoric of 'us vs. them'	Awareness campaigns based on the initial attitudes of citizens towards migrants: ¤ art exhibitions: pictures, theatre plays ¤ short film to be broadcast on social media ¤ small fact-based articles and brochures to be disseminated in key locations (health care centers, schools, public spaces) ¤ open day events ¤ targeted communication on specific days: International Migrants Day, World Refugee Day, Women's Equality Day	Public campaigns	The general public is informed about GBV faced by migrant populations and can become an ally in advocacy campaigns toward public authorities
No coordination of advocacy at the EU level, superposition of projects	Creation of a common platform integrating all CSOs working on GBV in a migration context to exchange best practices and coordinate advocacy	Creation of alliances	Coordinated advocacy on GBV and migration at the EU level

BELGIUM

Issues identified	Tools of action	Type of action	Desired outcome
Service providers lack information on how to deal with GBV survivors and cannot provide them with proper (information) care	Provide regular training on gender stereotypes, GBV, and intersectionality between migration and GBV to all staff in contact with migrant populations (police, health care providers, psychologists, volunteers, social workers, reception staff, security, cultural mediators, interpreters)	Training of professionals	All staff in contact with migrant populations have guidelines allowing them to better detect GBV cases and to present to GBV survivors the options they have in terms of protection, care, and reparation
	Map available actors and services to create a referral pathway for survivors that professionals can rely on	Expertise/ Counseling	Coordinated advocacy on GBV and migration at the EU level
Survivors of GBV and vulnerable populations are not informed of their rights	Dissemination of brochures in available places frequented by migrants (waiting rooms of health care centers, shelters, online devices)	Outreach activities and capacity-building	Populations vulnerable to GBV and GBV survivors are informed about their rights and their options with regard to protection, care, and reparation
	Organization of workshops with migrants where participants decide what they need to talk about, during moments of availability (such as key entry points: medical consultations, shelters), and including professionals with a migrant background.		

	Outreach activities with mobile care services going to shelters where people live and socialize		
	Specific medical consultations creating an environment where it is easier to talk about GBV		
Undocumented people risk to be deported or imprisoned if they report GBV	Lobbying the government so that GBV survivors can file a complaint without risking to be deported or imprisoned	Lobbying	All people can report GBV to public authorities and get reparation without consequences linked to immigration status
	Involvement of the general public against GBV faced by migrant populations	Public campaign	
Access to health care is conditioned on immigration status (parallel systems)	Lobbying the government, emphasizing how universal access to health care is a public health issue, to decouple migration from security concerns, and to integrate public health and human rights concerns for migrants in countries of transit and destination, through: ¤ shared expertise: publications, conferences, counseling, open roundtables ¤ coordination with other stakeholders to design a strategy at the EU level to include GBV and health concerns in migration debates ¤ awareness campaign to gain public support	Lobbying	Access to health care is not limited by legal status, migrants have access to health care and health-related services with no legal residence-based condition

GERMANY

Issues identified	Tools of action	Type of action	Desired outcome
National legislation does not include binding concepts of violence protection in refugee centers	Lobbying to implement fully the provisions of the Istanbul Convention and EU Directive 2013/33	Lobbying	Protection measures such as unigender safe spaces and facilitated signalling are implemented in refugee centers
Standard Operating Procedures are fragmented	Mapping of existing services and procedures to create a harmonized protocol centralizing existing guidelines	Expertise and Counseling	Harmonized SOP for protection and care of GBV survivors
Refugee centers and shelters are isolated, preventing access to medical services, legal consultations and counseling centers	Advocate for smaller accommodations in cities rather than large refugee centers, through the involvement of residents and action of public authorities	Lobbying	Refugees living in state-run centers have facilitated access to health, social and legal services
	Improve transportation between refugee centers and services	Expertise and Counseling	Refugees living in state-run centers have facilitated access to health, social and legal services

THE NETHERLANDS

Issues identified	Tools of action	Type of action	Desired outcome
Limited access to mental health services	Coordination with the partners identified during the mapping exercise to provide mental health services in places accessible to migrants	Creation of alliances between professionals	Mental health professionals working in health care centers and refugee centers along with other practitioners
Cultural mediators and interpreters are not sufficiently promoted and recognized as actors of the health care system	Encourage the government and other stakeholders to involve cultural mediators and interpreters to improve access to and quality of care	Training of professionals	Cultural mediators and interpreters are available at each step of the referral pathways for GBV survivors
	Listing of contact information for existing cultural mediators and interpreters so they can be reached easily		
	Creation of a central fund to reimburse interpreters		
	Place cultural mediators and interpreters in the key entry points for migrants: in shelters and refugee centers, at medical screenings, in health centers		
Fragmented organization of the care system leads to survivors recounting their experience several times during the procedure	Advocate for a new system organized around a care manager to centralize care and improve coordination between organizations	Creation of alliances	Holistic and centralized care with a single referral per person
General practitioners and other health professionals have limited training to recognize survivors, to discuss GBV with their patients and to refer them to appropriate services	Organization of training sessions directly targeting general practitioners and health professionals	Training of professionals	General practitioners have guidelines allowing them to better detect GBV cases among migrant populations and to present to GBV survivors the options they have in terms of protection, care, and reparation
	Mapping of available actors and services, relying on country reports, to create a referral pathway for survivors that professionals can rely on		
	Dissemination of "best practice" information		
Some migrant communities do not resort much to the services offered	Dissemination of brochures in available places frequented by migrants (waiting rooms of health care centers, shelters, online devices)	Outreach activities and capacity-building	Populations vulnerable to GBV and GBV survivors are informed about their rights and their options with regard to protection, care, and reparation
	Organization of workshops with migrants where participants decide what they need to talk about, during moments of availability (such as key entry points: medical consultations, shelters), and including professionals with a migrant background.		
	Outreach activities with mobile care services going to shelters where people live and socialize		

Limited attention is given to GBV in asylum procedures and medical screenings	Provide regular training on gender stereotypes, GBV, and intersectionality between migration and GBV to all staff in contact with migrant populations (police, health care providers, psychologists, volunteers, social workers reception staff, security, cultural mediators, interpreters)	Training of professionals	Staff is responsive to GBV signs and can refer survivors to appropriate services
	Dissemination of GBV detection guidelines to all staff in contact with migrant populations		
Access to free health care limited by legal status	Lobbying the government to emphasize that universal access to health care is a public health issue, to decouple migration from security concerns, and to integrate public health and human rights concerns for migrants in countries of transit and destination, through: ¤ shared expertise: publications, conferences, counseling, open roundtables ¤ coordination with other stakeholders to design a strategy at national and European levels to include GBV and health concerns in migration debates ¤ awareness campaign to gain public support	Lobbying	Access to health care is not limited by legal status, migrants have access to health care and health-related services with no residence-based condition

SERBIA

Issues identified	Tools of action	Type of action	Desired outcome
Limited data on GBV among migrant populations, which makes it difficult to assess the extent of the problem	Implementation of a specific service tracking cases of GBV	Expertise and Counseling	Improved data collection on GBV among migrant populations
Low level of reporting because of fear of reprisals and lack of confidence in the system	Organization of workshops with migrants where participants decide what they need to talk about, during moments of availability (such as key entry points: medical consultations, shelters), and including professionals with a migrant background.	Outreach activities and capacity-building	Migrants feel a climate of trust in reaching out to services in refugee centers
	Outreach activities with mobile care services going to shelters where people live and socialize		
	Specific medical consultations creating an environment where it's easier to talk about GBV		

<table>
<tr><td rowspan="2">Small number of shelters and limited accessibility</td><td>Advocate for smaller accommodations in different locations that are more accessible, rather than a few isolated large refugee centers, through the involvement of residents and action of public authorities</td><td>Lobbying</td><td rowspan="2">More accessible and safer shelters

Refugees living in state-run centers have facilitated access to health, social and legal services</td></tr>
<tr><td>Implement unigender safe spaces in refugee centers</td><td>Expertise and Counseling</td></tr>
<tr><td rowspan="2">No clear guidelines given by the authorities on how to deal with migrant survivors of GBV</td><td>Training of public authorities about the specific vulnerability of migrants to GBV and GBV in general</td><td rowspan="2">Training of professionals</td><td rowspan="2">Authorities are responsive to GBV, have guidelines allowing them to better detect GBV cases and can present to GBV survivors the options they have in terms of protection, care, and reparation</td></tr>
<tr><td>GBV protocols to be shared</td></tr>
<tr><td rowspan="3">Misinformation spread on social media and websites</td><td>Awareness campaigns on social media based on the initial attitudes of citizens towards migrants</td><td rowspan="3">Public campaigns</td><td rowspan="3">Public awareness of GBV faced by migrant populations</td></tr>
<tr><td>Articles in informal media on GBV and migrants</td></tr>
<tr><td>Open public events</td></tr>
<tr><td rowspan="3">Lack of accessible specialized support services in refugee centers</td><td>Provide unigender services in refugee centers</td><td rowspan="3">Training of professionals</td><td rowspan="3">Practitioners in refugee centers are responsive to GBV issues faced by migrants

Migrants feel a climate of trust in reaching out to services in refugee centers</td></tr>
<tr><td>Provide unigender safe spaces in refugee centers</td></tr>
<tr><td>Provide regular training on gender stereotypes, GBV, and intersectionality between migration and GBV</td></tr>
<tr><td>Process and reforms are conditioned on the approval of the Commissariat</td><td>Involve public to mobilize around the issue of GBV against migrants and make it more visible</td><td>Public campaign</td><td>Commissariat is aware of the sensitivity of GBV in migrant populations and is inclined to implement specific measures presented above</td></tr>
</table>

Figure 6. Key issues and tools of action

Bibliography

"Germany. Events of 2020". Human Rights Watch, accessed on June 11, 2021. https://www.hrw.org/world-report/2021/country-chapters/germany#39f1f6.

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

"International bescherming", Statistiek Vlaanderen, accessed on July 5, 2021, https://www.statistiekvlaanderen.be/internationale-bescherming.

"Migration data portal". International Organizations for Migration (IOM), accessed on June 11, 2020. https://migrationdataportal.org/?i=stock_abs_&t=2020.

Bundesamt für Migration und Flüchtlinge (BAMF). *Schlüsselzahlen Asyl 2020*. BAMF (2021), accessible at: https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/SchluesselzahlenAsyl/flyer-schluesselzahlen-asyl-2020.pdf?__blob=publicationFile&v=3.

Caritas. *Manuel de plaidoyer pour les jeunes sur les questions de migration et de développement dans le monde*. Caritas International Belgique (2021).

Consolidated Version of the Treaty on the functioning of the European Union C 326/49. Official Journal of the European Union (1957).

De Schrijver, L., T. Vander Beken, B. Krahe, and I. Keygnaert. "Prevalence of Sexual Violence in Migrants, Applicants for International Protection, and Refugees in Europe: A Critical Interpretive Synthesis of the Evidence". *International Journal of Environment and Public Health* 15, no.9 (September 2018).

De Toma, Costanza. *Advocacy Toolkit. Guidance on how to advocate for a more enabling environment for civil society in your context*. Open Forum for CSO Development Effectiveness (2011).

Directive 2012/29/EU of the European Parliament and the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, article 17. Official Journal of the European Union (2012).

European Center for Disease Prevention and Control (ECDC). *Guidance on infection prevention and control of COVID-19 in migrant and refugee reception and detention centres in the EU/EEA and the UK – June 2020*. ECDC (2020), accessible at: https://www.ecdc.europa.eu/en/publications-data/covid-19-guidance-prevention-control-migrant-refugee-centres.

European Commission. "Gender Action Plan – putting women and girls' rights at the heart of the global recovery for a gender-equal world". *News*, Nov. 25, 2020, accessible at: https://ec.europa.eu/international-partnerships/news/gender-action-plan-putting-women-and-girls-rights-heart-global-recovery-gender-equal-world_en.

European Commission. "A fresh start on migration: Building confidence and striking a new balance between responsibility and solidarity". *Press release*, Sept. 23, 2020, accessible at: https://ec.europa.eu/commission/presscorner/detail/en/ip_20_1706.

European Commission. *Proposal for a Regulation of the European Parliament and of the Council on asylum and migration management and amending Council Directive (EC)2003/109 and the proposed Regulation (EU)XXX/XXX [Aslyum and Migration Fund*], SWD(2020) 207 final (2020).

European Commission. *Striving for a Union of Equality. The Gender Equality Strategy 2020-2025*. European Commission factsheets (March 2020).

Farris, Sara. *In the name of Women's Rights? The Rise of Femonationalism* (Duke University Press: 2017).

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

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

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

Immigratie- en Naturalisatiedienst and Ministerie van Justicie en Veiligheid. *Asylum Trends. Monthly Report on Asylum Applications in The Netherlands*. IND Business Information Center (December 2020).

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

Integrated Response to Violence against Women in Serbia. *Multisectoral cooperation – Institutional Response to Violence against Women*. United Nations Development Program (2013).

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

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

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

Mainenti, Carline and Richardier, Benjamin. *Guide pour l'élaboration, la mise en œuvre et l'évaluation d'une stratégie de plaidoyer pour accompagner des partenaires Sud dans leurs actions de plaidoyer*. Agronomes et Vétérinaires sans Frontières (2011).

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

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

Offe, Johanna and al.. *Parallel Report to the CESCR on the Right to Health for*

Non-Nationals. Ärzte der Welt e.V., (July 2018).

Organization for Economic Cooperation and Development (OECD). *What is the impact of COVID 19 pandemic on immigrants and their children?* OECD (October 2020), accessible at: http://www.oecd.org/coronavirus/policy-responses/what-is-the-impact-of-the-covid-19-pandemic-on-immigrants-and-their-children-e7cbb7de/

Pejic, Irena, "Boosting the anti-migrant right", *Masina*, Mar. 6, 2020, accessible at: https://www.masina.rs/eng/boosting-the-anti-migrant-right.

Platform for International Cooperation on Undocumented Migrants (PICUM). *Access to health care for undocumented migrants in Europe*. PICUM (2007).

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

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

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

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

United Nations High Commissioner for Refugees (UNHCR) Global Data Service Statistics Section. *Global Trends. Forced displacement in 2019*. UNHCR (2020).

United Nations High Commissioner for Refugees (UNHCR), United Nations International Children's Emergency Fund (UNICEF) and International Organization for Migration (IOM). *Refugee and Migrant Children in Europe. Overview of Trends January-December 2018*. UNHCR, UNICEF and IOM (2019).

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

World Health Organization. "Devastatingly pervasive: 1 in 3 women globally experience violence". *World Health Organization Joint News Release*, Mar. 29, 2021, accessible at: https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence.

World Health Organization (WHO) Migration and Health Programme. *Report on the Health of refugees and migrants in the WHO European Region*. WHO (2018).

Annex 1 – List of stakeholders

A non-exhaustive list of relevant stakeholders, based on the organizations identified in the mapping reports provided for each country of implementation of the REACH OUT project, is presented below. project, is presented below.

EUROPEAN UNION	
Asylum working party (Council of the EU)	Institution
Council of Europe – Health panel	Institution
European NGO Platform on EU Asylum and Migration Policy (EPAM)	Alliance of NGOs
European platform on refugees and exiles	Alliance of NGOs
European Public Health Association (EUPHA)	Umbrella Organization of public health associations
PICUM	NGO
Red Cross EU office	NGO

BELGIUM	
Centre d'Accueil de Soins et d'Orientation	Institution
Centres de Prise en charge des Violences Sexuelles – Sexual Violence Care Centers (CPVS)	Institution
Fedasil	Institution
GAMS	NGO
Office de la Naissance et de l'Enfance - Birth and Children's Office (ONE)	Institution
Payoke center	NGO
PPS Social Integration	NGO
Public Center for Social Action (CPAS)	Institution

GERMANY	
Bundesamt für Migration und Flüchtlinge	Institution
DaMigra	Umbrella Organization of migrants' organizations specialized in women's issues
German association of Psychosocial Centers for Refugees and Victims of Torture	NGO
Münchner Aktionsbündnis für geflüchtete Frauen (Munich action group for refugee women)	NGO

THE NETHERLANDS	
ARQ National Psychotrauma Center	Psychological Treatment Center
Nisa4Nisa	NGO
Safe at Home	NGO
Sexual Assault Centers	Institution
The Bridge2Hope	NGO
Victim Support Netherlands	NGO
VluchtelingWerk Nederland - Dutch Council for Refugees	Institution

SERBIA	
Center for Social Policy	Think Tank
Commissariat for Refugees and Migration of the Republic of Serbia	Institution

ANNEX 2
Template for stakeholders' assessment

The relevance of a stakeholder as an ally or a target for an advocacy objective or activity can be evaluated with the following assessment template, based on the methodology of the Open Forum for CSO Development Activities toolkit.

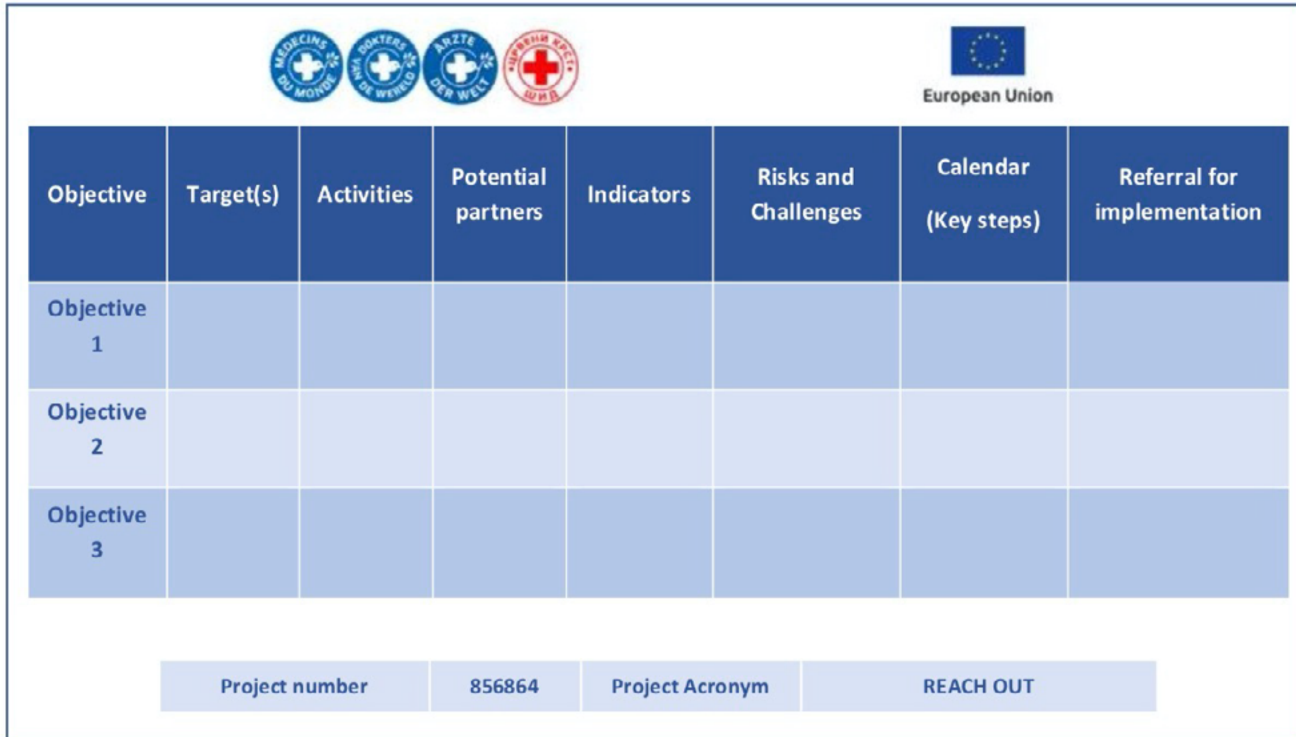
European Union

Objective of change	Name of the stakeholder	Attitude towards the issue	Importance of the issue for the stakeholder	Power to trigger effective and sustainable change
Objective 1	Actor 1.1			
	Actor 1.2			
	Actor 1.3			
Objective 2	Actor 2.1			
	Actor 2.2			
	Actor 2.3			
Objective 3	Actor 3.1			
	Actor 3.2			
	Actor 3.3			

Project number	856864	Project Acronym	REACH OUT

ANNEX 3
Template for advocacy plan

This template to plan advocacy actions has been inspired by the monitoring methodology set out in the Open Forum for CSO Development Activities toolkit.



European Union

Objective	Target(s)	Activities	Potential partners	Indicators	Risks and Challenges	Calendar (Key steps)	Referral for implementation
Objective 1							
Objective 2							
Objective 3							

Project number	856864	Project Acronym	REACH OUT

ANNEX 4
Template for monitoring meetings

This template has been inspired by the monitoring methodology set out in the Open Forum for CSO Development Activities toolkit.

European Union

PROJECT NAME	
MEETING TITLE	
MEETING PLACE, DATE AND TIME	
PARTICIPANTS	
OBJECTIVES OF THE MEETING	
MAIN POINTS OF THE MEETING	
PROGRESS OF THE MEETING: REALIZATION OF THE STATED OBJECTIVES	
WHAT HAPPENED IN TERMS OF TARGETS' ATTITUDES, MOTIVATION, INFLUENCE	
FOLLOW UP ACTION WHAT: WHEN: WHO:	
COMMENTS	

Project number	856864	Project Acronym	REACH OUT

HUMAN RIGHTS

JUSTICE

EQUALITY