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

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

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

Introduction

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

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

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

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

Methods

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

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

Table 1. SGBV determinants, socio-ecologically clustered.

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

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

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

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

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

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

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

Analysis

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

Results

Socio-demographic characteristics

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

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

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

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

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

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

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

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

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

Overview of reported cases of SGBV

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

Table 2. Socio-demographic profile of respondents.

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

Table 2 – *continued*

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

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

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

Table 3. Characteristics of victims and perpetrators.

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

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

Sexual violence

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

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

Table 4. Nature of SGBV cases.

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

Emotional-psychological violence

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

> Hitting is better than talking. What he said hurt me more than getting slapped. Sometimes being hit is easier to cope with than psychological torture. (Esrin, 26, Kurdish asylum seeker)

Physical violence

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

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

Socio-economic violence

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

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

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

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

Consequences of victimisation

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

Emotional-psychological consequences

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

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

Socio-economic consequences

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

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

Physical consequences

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

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

Sexual and reproductive consequences

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

> He came back and raped me … I became pregnant and I tried to abort the child with alcohol and other means. I lifted heavy things. Nothing worked, so I asked a friend to penetrate my uterus with an awl. I lost a lot of blood and was transferred to a hospital. The doctor told me: after this torture, you cannot get children any more. That is the worst thing that could happen to me. (Olga, 23, Ukrainian refugee)

Perceived risk factors linked to victimisation

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

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

Individual level

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

Interpersonal level

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

Societal level

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

> I don't think refugees choose to become victims of violence. They are thrown into it by society itself, inhuman treatment, bad policy and a lack of guidance. (Arun, 31, Kurdish refugee)

Desired prevention measures

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

Individual level

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

Interpersonal level

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

Organisational level

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

Societal level

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

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

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

Discussion

Victimisation

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

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

Prevention

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

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

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

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

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

Conclusion and future research

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

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

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

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

Limitations

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

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Résumé

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

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

Resumen

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