PROTECT

PREVENTING GBV AGAINST MIGRANTS AND STRENGTHENING SUPPORT TO VICTIMS

Recommendations for Dutch Standard Operating Procedures (SOPs)

This report was funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020). The content of this report represents the views of the author only and is his/her sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

This project was funded by
the European Union's Rigths, Equality
and Citizenship Programme (2014-2010)

Publisher: International Organization for Migration 17 route des Morillons P.O. Box 17 1211 Geneva 19 Switzerland

Tel.: +41 22 717 9111

Email: hq@iom.int

Website: www.iom.int

This publication has been issued without formal editing by IOM. This publication was issued without IOM Publications Unit (PUB) approval.

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RECOMMENDATIONS FOR DUTCH STANDARD OPERATING PROCEDURES (SOPS)

IOM the Netherlands works together with partners Arq National Psychotrauma Centre, Rutgers and Pharos to better include refugees, migrants and asylum seekers in the existing support services for GBV (sexual and gender-based violence) and to build capacity for professionals who work with these groups, such as professionals in the regional Sexual Assault Centers. The PROTECT project partnership trained and worked with 15 individuals with migrant backgrounds, to provide free and confidential information sessions to help to raise awareness, to empower and to inform the targeted migrant communities about GBV and where to seek help. These 15 *migrant ambassadors* play a critical role in providing two-way information between migrant communities and professionals. By working to empower all migrants affected by GBV, PROTECT activities in the Netherlands support Sustainable Development Goal 5 "Achieve gender equality and empower all women and girls".

The below recommendations were compiled through the implementation period of the PROTECT project. Based upon feedback, insights and challenges expressed by over two hundred stakeholders (migrants, integration experts, health professionals, LGBTQI+ representatives, protection representatives and many others) IOM has developed a set of multi-disciplinary recommendations which aim to empower migrants, and build the capacity of professionals and policy makers in the Netherlands to better identify, treat and prevent GBV in migrant communities.

Globally, the lack of data about GBV in migrant communities is an immense obstacle to sufficiently achieving Sustainable Development Goal 5. This lack of available data can be seen as both cause and effect, in which the invisible and elusive nature of GBV poses vast challenges to researchers to uncover more about the issue; concurrently, without adequate data; first responders, policy makers and public authorities lack the necessary justification to provide funding, policy and action to investigate and address the issue. While some data is available in the Netherlands about GBV rates generally, the absence of basic data relative to migrant communities forms the basis for most, if not all the recommendations below.

1. THE GREAT DIVIDE:

While the Netherlands is home to a wealth of information and services that seek to support victims of GBV; with reference to the specific needs of migrants, there are substantial gaps in terms of awareness, service provision and data. The paradox lies herein, whereby professionals in the Netherlands lack access to information to better cater to the needs of migrants, and thus, migrants are not accessing available services, which only leads to wider information and knowledge gaps on behalf of both the service provider and the migrant.

Fear, distrust, shame, stigma, a lack of resources and a lack of knowledge are commonly quoted reasons for low rates of self-referral. Many of these factors are underpinned by an intersection of social-cultural-linguistic-religious-familial-gendered norms. Certain groups are referred to more commonly when we discuss fear, shame and stigma – namely Eritrean groups, Shia Muslims and LGBTQI+ persons. PROTECT migrant ambassadors mentioned a great need to provide information to migrants about basic concepts and broader themes such as gender roles, respect, relationships, family planning, balancing cultures and traditions, identity in a new country and basic health care. There is no overnight solution to address this complex topic within the intersection of social-cultural-linguistic-religious-familial-gendered norms; it requires conscious, ongoing efforts to enable and empower individuals, families and communities to seek information, and to seek help.

While a lack of knowledge and a lack of resources leads to more practical challenges, PROTECT's migrant ambassadors reported rather concerning discussions with migrants who had no knowledge of the Dutch health system, despite having

lived in a reception centre and in a municipality for years. With reference to a lack of resources, migrants may not have the time, energy, motivation or financial resources to prioritize health care, especially when it comes to mental health. Migrants face many competing priorities during their reception and integration phases – processing their asylum claim, learning Dutch, finding employment, facilitating family reunification and navigating day to day tasks takes a high priority, and is strongly encouraged as priorities by the Dutch government. Mental health and addressing trauma or conflicting social norms are generally not granted the necessary attention during the first years in the Netherlands. While personal finances are tight (as most migrants with asylum and refugee backgrounds are dependent on social welfare in their first years in the Netherlands), budgeting may not extend as far as to allow individuals to use their insurance policy's personal excess (eigen riscio) to cover health costs. Currently, victims of sexual and gender-based violence are required to cover their personal excess from their own funds if they require medical or psychological support. While there are indications that this will change at policy level, thus allowing victims of GBV free access to support by health providers, until then, the associated costs pose a considerable disincentive to low income earners to seek help. PROTECT migrant ambassadors and migrant support organizations alike report on the tendency for migrants to ignore GBV (and associated) concerns for the sake of conserving money and dignity, even where serious inflictions of GBV are present.

The Netherlands is home to high quality and innovative support for victims and their families. The introduction of the Centers for Sexual Violence has streamlined communication and support, as well as enhanced data collection for first responders. While case managers at the Centers for Sexual Violence and other professionals are aware of the gap between service providers and migrant groups; a lack of knowledge, data, funds and capacity impairs the development of sustainable solutions. A number of professionals mentioned to IOM that it is a group often regarded as so challenging to reach, that time and budgetary limitations faced by medical and social support organizations simply do not allow for the necessary attention. Significantly more research and evaluation of migrants as a target group is critical for the development of tailored, sustainable solutions which also respect the various social-cultural-religious-linguistic aspects in migrant communities.

RECOMMENDATIONS:

For Municipalities and Policy Makers:

- From a national, strategic level, pursue comprehensive approaches which underline the significant linkage between GBV and integration. Address GBV with reference to integration, and vice versa. Mitigate service provision silos whereby GBV is treated as a separate issue to integration and empowerment;
- At the local level, prioritize mental health, sexual health and gender empowerment into the Dutch integration system though training of migrants, training of integration agencies (municipalities), creative and respectful awareness raising, and provision of resources at individual and municipal levels;
- Enhance the knowledge base of first responders, GP's and mental health professionals toward migrant patterns, integration priorities and the factors which influence attitudes/behaviors/knowledge of GBV in migrant communities;
- Intergenerational and cross-cutting issues such as GBV require long term solutions. Funding for GBV solutions should recognize the cross-cutting nature of this theme and provide structural support beyond immediate support provision i.e. Long-term funding to structurally enhance preventative care.

For Reception and Integration Professionals:

- Provide factual information to migrant groups in a way that is timely, tailored, consistent and respectful. Ensure that information is available to all migrants (taking into account linguistic and literacy capabilities, as well as gender and age factors) and remains available throughout the reception and integration phases;
- Facilitate greater exchange of personal insights, personal stories and feedback from migrant victims and migrant representatives to Dutch support providers to enhance knowledge and cultural insight;
- Allow meaningful space for migrant voices and expertise. Capitalize on the mutual benefits of working with migrant representatives as solutions to the divide between service providers and migrant communities;
- Supplement factual information about migrants and migration with conceptual components such as personal bias and intercultural understanding in both migrant groups and Dutch support providers.

2. REFERRAL:

Case managers at Dutch municipalities meet with migrants in person, with the goal of guiding newcomers toward active integration and (financial) independence. They are not specifically trained to identify GBV-related concerns. In Amsterdam, the public health service (GGD) recognized the crucial role that municipal case workers could play in the identification and referral of (potential) victims of GBV, without placing such a responsibility on untrained staff. The GGD designed a questionnaire of 10 simple questions, available in various languages, which case managers issue to newcomers during a face to face meeting. The 10 non-intrusive questions are to be completed confidentially, by just the individual (without the influence of accompanying family members or the case manager). The questionnaire inquires to the individual's sleep patterns, the last time they visited a doctor etc. Once completed, migrants place the questionnaire in a sealed envelope which is not shared with the municipality, rather it is shared directly with the GGD. From this, the GGD can determine whether a consultation with the individual and psychological support is necessary.

Other municipalities in the Netherlands rely heavily on the identification and referral of migrants by GPs. The Dutch health care system ensures that GPs are gatekeepers to referral to specialists. Before seeking specialist help, patients must first secure referral from their GP. Fortunately, within many migrant communities, the barriers associated with visiting the GP are less than seeking specialized care for GBV related concerns. While migrants may not be forthcoming regarding their GBV concerns, they are more likely to seek health care from a GP than from the Centers for Sexual Violence. The challenge here lies with the capacity of GPs to accurately identify a (potential) victim of GBV. Stakeholders and PROTECT migrant ambassadors indicated that GPs generally lack the time, linguistic support and cultural sensitivity to accurately identify, treat and refer migrants, which thus leaves a huge wasted opportunity to refer migrants to appropriate care.

In terms of mental health and trauma, the Dutch population struggles with a shortage of available psychologists. The waiting period prior to seeing a professional is between four and eight months. Regardless of how affected an individual is, they will likely have to wait up to eight months. The local psychological support available at all GPs is a stop gap in the meantime, though for many cases, especially those with post-traumatic stress disorder (PTSD), longer term and intensive psychological help is needed beyond what GP-based psychologists can offer during their sessions.

Efforts are made to ensure timely referral to the Centers for Sexual Violence, however not all cases are acute or require follow up at the Centers for Sexual Violence. Similarly, PROTECT migrant ambassadors reported that migrants themselves only want to tell their story to someone who they trust as a means of release; in these cases, the migrant did not see the need to visit a professional. Simply telling their story to someone trusted, was – to them – a sufficient form of therapy. The common themes of migrant awareness toward available services, fear and stigma, and the divide between migrants and service providers are very relevant in terms of referral.

RECOMMENDATIONS:

For Municipalities and Policy Makers:

- Recognize the vital role that GPs play in terms of referral, and inject resources into GPs to allow for tailored, sensitive and respectful support to (potential) victims.
- Grant first responders (such as municipal case workers) with information and tools to support referral, without overburdening staff who are not trained to identify (potential) victims of GBV. The questionnaire administered by the Municipality of Amsterdam can be considered as a good practice in this regard. When combined with greater awareness/knowledge, the questionnaire could also be used by school teachers, language coaches, integration support staff, reception officials, border security etc.

For Reception and Integration Professionals:

- Provide informal routes of referral to migrants which are less confronting/stigmatizing than specialized care for GBV victims. Digital self-referral, chatlines, Facebook groups, migrant ambassadors and informal consultations allow migrants to request help, without compromising their dignity, resources, cultural norms or confidentially.

3. REPRESENTATION OF THE TARGET GROUP

Migrant ambassadors are active in many sectors and organizations in the Netherlands. This also includes within the private sector. When well-supported, migrant ambassadors can serve as a reliable source of information and advice for both service providers and migrant beneficiaries.

While organizations in the Netherlands welcome migrant representation into services that support migrants, there are barriers which limit the contribution and impact that representatives can make within these roles. Generally, migrants are low income earners who for the first three to five years in the Netherlands are dependent on social welfare to cover their basic expenses. Individuals who earn more than a certain threshold of income and non-financial benefits through employment, will see a reduction in their social benefits. According to Dutch policy on volunteer stipends (vrijwilligersvergoeding)[1], a welfare beneficiary can earn no more than 170 Euro per month without it impacting their social benefit. While this model is not unique or surprising, it does however result in migrants needing to either be employed in an organization and paid a wage that allows them to be financially independent from social welfare or limit their paid income (generally by working less) to avoid affecting their main source of income which is their social benefit.

One of the biggest challenges for organizations that wish to provide a formal role to migrant ambassadors is the threshold of 170 euro. Particularly for non-profit or smaller organizations which cannot offer fulltime, paid employment to migrant ambassadors. Consequently, migrant ambassadors tend to work within the threshold that allows them to be paid no more than 170 euro, which restricts their contribution and representation. The policy places a cap on the contribution from migrants, which represents wasted potential. Migrants reported feelings of demotivation due to the limitation of their roles while also being aware of the critical role that they played in project activities. Others mentioned the slippery slope in which tasks such as translation, meeting attendance, administration and working overtime became the norm – largely due to the great demand for skilled migrant representation – but without the increase in pay due to the payment restriction. This places migrant ambassadors in a vulnerable position, in which they are at risk of exploitation. Naturally, greater representation of migrants in recognized, paid employment is ideal.

Unfortunately, the concept of migrant ambassadors is not widely understood. PROTECT migrant ambassadors reported one of their greatest challenges to build their network was their perceived lack of credibility when meeting with professionals. This was a challenge for the ambassadors to conduct their tasks as they lacked a formal title to gain the credibility, network and access to opportunity that an official employee of an organization may enjoy.

RECOMMENDATIONS:

For Municipalities and Policy Makers:

- Address the restrictions of the *vrijwilligersvergoeding* which limits payment to volunteers, to incentivize both migrants and host organizations to allow for greater (paid) contribution of migrants without compromising their social welfare.
- Promote the role of migrants and migrant ambassadors as critical bridge builders. Create and disseminate examples of good practices, and measurable impacts that ambassadors can make within the public and private sectors.
- Formalize the rights and expectations of ambassadors at a national level. A centralized body which represents migrant ambassadors could lobby on behalf of ambassadors, provide culturally sensitive trainings, provide support and credibility and uphold their rights. Similarly, a centralized body could support organizations that (are interested to) work with migrant ambassadors by offering cultural sensitivity training, coaching and recruitment support.

1 *www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/prive/werk_en_inkomen/werken/werken-als-vrijwilliger/vrijwilligersvergoedingen*

4. A COORDINATED APPROACH:

The Netherlands hosts an array of networks, working groups and task forces that address different aspects of migrant protection as well as GBV more generally. Stakeholders remarked that there are so many different networks that it's hard to keep track; made worse by the changing of names, merging of organizations, cessation of funding and changing of activities. From a migrant's perspective, the plethora of available organizations and projects, and the rate of turnover can beoverwhelming.

Unfortunately, migrants reported to IOM that there is a significant lack of information about the basics of health care and gender roles in the Netherlands. More than three migrants mentioned that they had not received any information about health or the available health care providers when they resided in the asylum center. Documented and undocumented migrants seem to lack information about the organizations who can support them and whether there are costs associated with treatment. One cannot assume that information is not provided to migrants about health care in the asylum center; however, coordination between agencies is required to ensure that information is provided in a way that is clear, consistent and accurate to fit each person's situation; and importantly, is also retained by migrants and applied in practice.

During PROTECT roundtables, representatives of different sectors and organizations expressed immense frustration at the conflicting and completing activities, interests and mandates of service providers. While the ultimate goal of supporting migrants is unanimous, the way to reach this goal depends on each organization's priorities, capacity and partnerships. The recently drafted 'Violence Belongs Nowhere' programme is an encouraging development toward coordinated, national action to address domestic violence and child abuse. Though in a pilot phase, the multi-year program facilitates multi-disciplinary cooperation and includes migrants as part of the target group. One of the most significant priorities for the programme is the establishment of regional networks within the Netherlands where integration management of cases of violence will take place through a collaboration of key institutions.

RECOMMENDATIONS:

For Municipalities and Policy Makers:

- Streamline information provision to migrants and enhance coordination between agencies within the asylum and integration phases;
- Streamline service provision with adherence to national programmes, such as the Violence Belongs Nowhere programme, to promote a coordinated approach;
- Provide opportunities for multi-disciplinary discussion, information exchange and problem solving. Disseminate information widely, including to institutions which are not typically involved in discussions on GBV in migrant communitiesbut are, nonetheless, relevant i.e. schools, language cafes, judiciary.

For Reception and Integration Professionals:

- Ensure information is provided on a continuous basis and adjusts to the competing priorities of migrants in the differing stages of their integration. During the reception phase, topics such as social norms, respect and identity are often given lesser importance by migrants as they seek to address their basic needs such as housing, language, food, family reunification and education/employment.