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Addressing Sexual Violence against Men, Boys, and LGBTQ+ Refugees: Learnings from Pilot Projects in Bangladesh, Kenya, and Italy/Bulgaria

July 2021

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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Cover photo

Linguistic and cultural mediator training, Calabria, Italy © Sarah Martin

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Summary of Pilot Learnings

In 2018 and 2019, the Women's Refugee Commission (WRC) undertook exploratory qualitative research on sexual violence against men and boys (including those with diverse sexual orientations and/or gender identity/expression) in three refugee settings: Bangladesh (Cox's Bazar), Italy, and urban Kenya.¹ During the data collection process, in-country partners were identified to pilot projects to support uptake of sexual violence services for male and LGBTQ+ survivors. This report presents a synthesis of the key learnings from the pilots and outlines top recommendations.

Top Learnings

From Cox's Bazar, Bangladesh

- Through comprehensive training supplemented with intensive trust-building, mentoring and support, selected members of a crisis-affected community can effectively respond to and refer survivors of sexual violence to services.
- In order to effectively build awareness and understanding of sexual violence against men and boys, power and gender must be discussed in depth within the cultural context, including gender inequality, violence against women and girls, transphobia, and homophobia.

From urban Kenya

- Distrust, misconceptions, and competition between host and refugee LGBTQ+ communities can act as a barrier to services for LGBTQ+ refugees. Solidarity-building efforts, such as empathy-building activities and identification of mutual experiences and struggles, can help to build cohesion between and among host and refugee LGBTQ+ communities.
- Facilitated and well-coordinated safe transportation is important for LGBTQ+ survivors to access sexual violence-related health care. A sustainable transportation voucher system may be effective in urban settings, but should be available for all LGBTQ+ refugees to access health care and should not target sexual violence/gender-based violence (GBV) survivors alone.

From Italy/Bulgaria

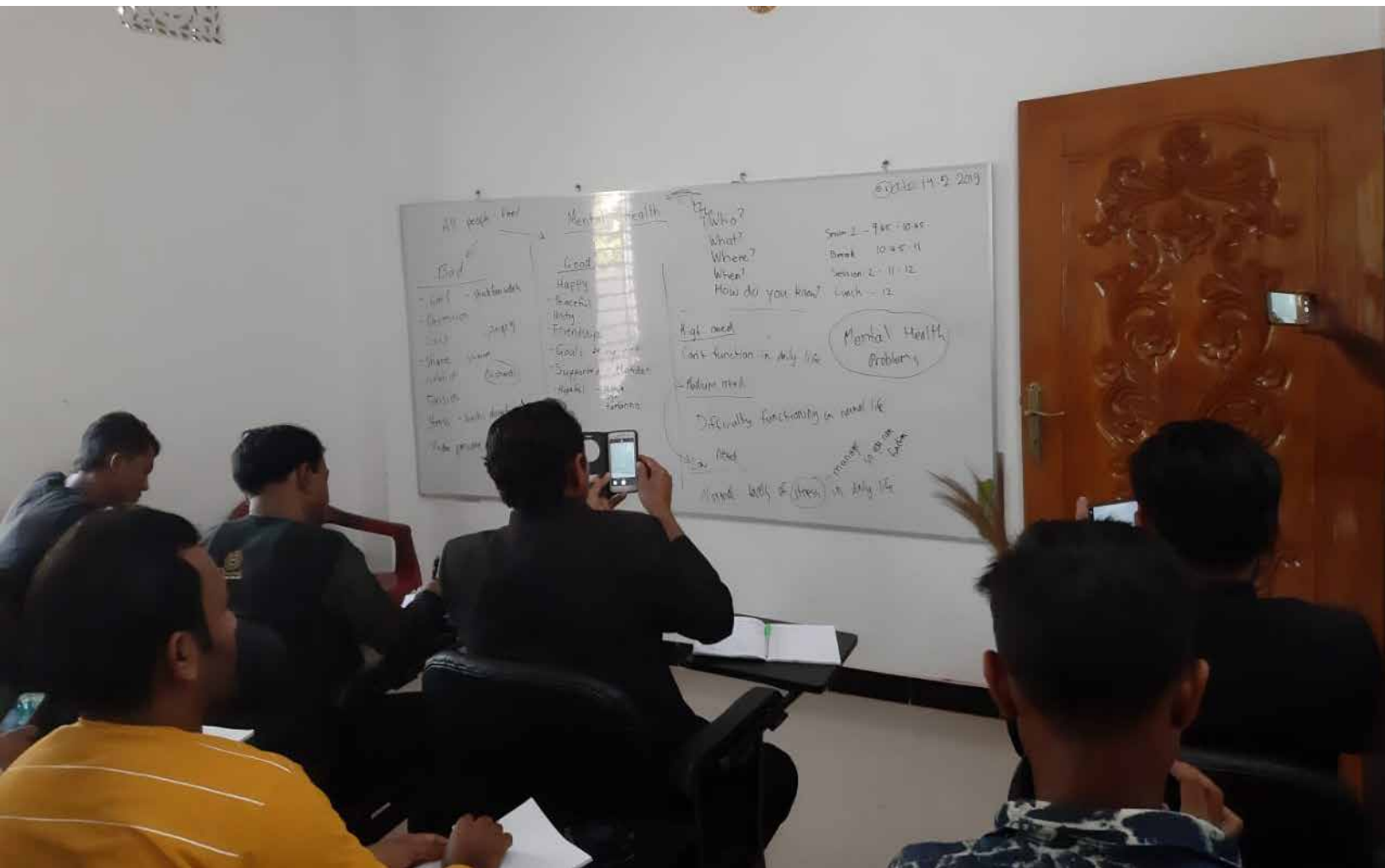
- Linguistic and cultural mediators (LCMs) facilitate mutual understanding between a person or a group of people (e.g., the migrant/refugee population) and a caregiver (e.g., a doctor) by providing two-way verbal translation (interpreting) and helping them overcome cultural barriers. LCMs and interpreters play a key role in facilitating survivors' access to services, and they can be trained to effectively respond and refer survivors in line with GBV guiding principles.
- Many LCMs have had personal experiences with loss, trauma, and violence, and are vulnerable to cumulative stress and secondary traumatization from their work. Supervision and self-care techniques can help LCMs manage stress.

1 Reports and papers detailing the research findings can be found at www.womensrefugeecommission.org/svproject.



Top Recommendations

- 1. In Cox's Bazar:** Donors and humanitarian actors should prioritize establishing and strengthening sensitized response services—especially medical and mental health care—for men/boy and *Hijra* survivors, in addition to strengthening and expanding services for women/girl survivors.
- 2. In urban Kenya:** Donors and service providers should include access to safe transportation in programming to facilitate LGBTQ+ refugees (including survivors of sexual violence) to access health care and other essential services.
- 3. In the European refugee/migrant response:** Humanitarian agencies should train and support LCMs to better respond and refer survivors of sexual violence, given their critical role in the community and their frequent encounters with survivors.



Male survivor advocate training, Bangladesh pilot.



Bangladesh Pilot: Supporting Male “Survivor Advocates”

Background

In August 2017, Myanmar military forces initiated widespread human rights abuses against the Rohingya people in northern Rakhine state, Myanmar. Around 900,000 Rohingya fled to Cox's Bazar, Bangladesh, where they remain. Military forces perpetrated rape and other forms of sexual violence against thousands of Rohingya women and girls. Research and investigations by WRC and the Independent International Fact-Finding Mission on Myanmar, among others, revealed that Rohingya men and boys were also targeted for sexual violence. Despite this, WRC's 2018 study found that service providers in Cox's Bazar were largely unaware of male sexual victimization, and few male survivors were accessing services.²

Project summary

WRC collaborated with an implementing partner, Legal Action Worldwide (LAW), to implement a pilot with the aim of strengthening access to services for male Rohingya survivors of sexual violence in Cox's Bazar. Given the low service uptake among male survivors, the pilot entailed intensive training and mentoring of Rohingya “male survivor advocates” to raise awareness of sexual violence against men and boys and to share information about available services for male survivors. The original project timeframe was November 2018 to November 2019; formal project activities were undertaken from January to August 2019.

In January 2019, 24 Rohingya men were recruited to participate in the male survivor advocate training. Trainees were selected based on interest, basic literacy skills, some professional experience, and an openness to discussing sensitive issues such as sexuality and sexual violence. Participants were identified across the 20 camps to uphold confidentiality and ensure coverage. By the end of the 2019, 18 male survivor advocates remained engaged.

Between February and July 2019, survivor advocates participated in weekly training, mentoring, and trust-building sessions, which were complemented by three intensive technical trainings. The project lead (Eva Buzo, a consultant to LAW) delivered an initial two-week training on gender-based violence (GBV) to build the foundation for subsequent training on male sexual violence and the guiding principles for working with victims/survivors. An external consultant with knowledge of sexual violence against men and boys conducted two separate, three-week trainings. A final training by the external consultant was planned in late 2019, but was cancelled in part due to visa restrictions.

The trainings addressed:

- GBV guiding principles
- Violence against women and girls
- Definitions of sex and sexual violence
- Understanding consensual sex between adult men, including safe sex practices
- Trauma of war-related sexual violence
- The importance of believing survivors and negative consequences of victim-blaming

² Women's Refugee Commission, *“It's Happening to Our Men As Well”: Sexual Violence Against Rohingya Men and Boys* (2018).

- Principles of outreach and community engagement
- Psychological first aid
- Referral process for survivors of sexual violence
- Self-care and vicarious traumatization
- Access to justice in principle and in practice within ICC processes

The weekly training sessions also served as a space for mentoring and discussions. As the competency and confidence of the survivor advocates grew, the training sessions became more interactive and participatory, and trainees took increased ownership of the project. During periods without formal training sessions, the survivor advocates continued to meet weekly to provide peer support, discuss issues or challenges, and meet with staff.

In addition, a particularly vulnerable group that was identified by the survivor advocates were *Hijra*, third gender or transgender (male to female) Rohingya. Due to their high vulnerability to sexual violence and unique needs, a weekly “*Hijra*-friendly” day was established in which *Hijra* could visit the LAW office space, safely express themselves and their identity, discuss their concerns, and learn more about access to services. Trust-building between the different groups who used the office space was also initiated to improve relations.

In July 2019, survivor advocates began community outreach.³ They worked to develop friendships and trust with fellow refugees and discussed their work as survivor advocates, provided psychological first aid, and shared information about services for male survivors. Self-reporting by survivor advocates indicated that they were able to interact with between 40 and 100 people every month, as well as with large groups at the mosque and other events. Between February and August 2019, the survivor advocates referred 14 male survivors to LAW for legal documentation purposes to support access to justice.

Preliminary learnings

Project approach

- Through intensive, sustained training and mentoring, survivor advocates were supported to own and drive much of the project, including defining their role as survivor advocates, thus spotlighting leadership capacity among Rohingya refugees.
- The training and mentoring highlighted that, in order to effectively build awareness and understanding of sexual violence against men and boys among survivor advocates, gender and power must be discussed in depth, including gender inequality, violence against women and girls, and trans/homophobia.
- Regular communication, discussion, and troubleshooting between LAW’s project lead, WRC’s sexual violence project director, and a monitoring and evaluation (M&E) consultant (until August 2019) contributed to an iterative and evidence-informed process. The mix of subject matter and contextual expertise, complemented by an intensive M&E process, sought to ensure that no harm was being done.

³ Survivor advocates did not attempt to proactively identify survivors, which can bring about harm, including from retraumatization, poor responses to disclosures, and repercussions from breaches of confidentiality. Identification or seeking out of survivors is not recommended. See [Inter-Agency Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies](#), 2019.



Recruitment of survivor advocates

- The recruitment process combined pre-established criteria and personal interviews to identify individuals who were interested in addressing sexual violence against men and boys. Investment in the selection process was important to identify individuals with capacity and interest to learn and engage in the sensitive subject matter.

Training and mentoring

- The training was a flexible process, largely guided by the participants, and topics and questions that the participants raised were iteratively explored. As understanding of sexual violence deepened, knowledge gaps (such as sexual health, gender identity, sexual orientation, and response services after sexual violence) were proactively addressed. This contributed to a collaborative, collective process of overcoming taboos and challenging misconceptions.
- Consistent, longer-term, hands-on training accompanied by intensive mentoring and values clarification exercises were necessary to begin to address sexuality, gender, power, and violence. It was important that project staff, trainers, and participants remained open to explore sensitive issues and were prepared to be challenged.
- Repeated, supervised role-playing before community outreach began helped build communication and psychological first aid skills.
- The external training consultant was a Muslim man, which appeared to be helpful to facilitate trust with the male, Muslim participants and to address sensitive topics concerning sexuality, violence, power, and religion.
- Weekly meetings for debriefing, reflection, mutual learning, and support were essential to develop trusting relationships among participants and between participants and project staff.
- While understanding of conflict-related sexual violence appears to have deepened, recognition and understanding of GBV against women and girls and sexual abuse of boys and young men in the Rohingya community were difficult to facilitate. More training and mentoring are needed on vulnerabilities associated with gender, sexuality, patriarchy, and harmful traditional practices in the Rohingya refugee community before survivor advocates are sufficiently equipped to raise awareness about sexual abuse and violence within their communities.



Voices of male survivor advocates

"First, we visit the block—a friend's house or an area with many people. We make friends with the help of other friends. We discuss what we do and the activities. We use friends to build trust."

"We encourage them to talk about what happened in Myanmar. Sometimes we speak separately with individuals who want to talk about violence they experienced in Myanmar. We cannot ask many things, because victims will be shy. We refer them to the [LAW] office and we refer to the medical clinic. After one, two weeks we give psychosocial support."

"We visit friends or relatives. [We] cannot do this [talk about sexual violence] the first time, [we] must visit three times, many times. We discuss what happened [in Myanmar]. After that, when they trust us, then we talk about what we do [as male survivor advocates]. Only then we go and sit privately."

"We meet victims individually, in groups we discuss generally what happened in Myanmar, about LAW and the [male survivor advocates] activities."

"Sometimes I meet with victims two to three times a week, I speak to them individually."

Community awareness-raising and peer-to-peer support

- Survivor advocates were supported to develop their own approach to community engagement. This refugee-led approach aided in the development of appropriate outreach strategies, such as a "community ownership" approach to the experience of war crimes, which survivor advocates reported helped to support open dialogue.
- Community work conducted by the survivor advocates reflected the capacity present in the Rohingya refugee population to constructively contribute to and support survivors of trauma, including sexual violence. With few service providers that delivered accessible, good quality mental health support—in conjunction with the large refugee community with high mental health needs—supporting the capacity development of refugees themselves to provide community-based psychosocial support may be helpful. To this end, specific training is needed for the Rohingya to develop skills in providing community-based, peer-to-peer psychosocial support. Robust evaluation of such efforts are needed to assess efficacy and ensure that "do no harm" is maintained.

Voices of male survivor advocates

"The [survivor advocates] support each other as much as possible. The victim might be crying and we cry too. We educate them about being a victim and a survivor of the same thing [that happened to the women]."

"Every week we sit with them, give them psychosocial support to understand their difficulties. We give practical help to go to the medical clinic, we give options, and help to the family."



Additional enablers

- The project demonstrated a promising approach to using the legal redress process as an entry point for addressing sexual violence against men and boys within the Rohingya context. The legal application process sought to ensure that survivors felt heard and supported.
- The identification of a secure and safe space for training and mentoring was essential. The implementing agency established a solid physical presence in the camp that improved the training and mentoring process as it included private training rooms with walls and doors. It offered confidentiality in the camp, where bamboo structures are the norm and auditory and visual privacy is rare. The space was light and inviting and located in a stand-alone villa on its own block in Kutupalong.
- Project staff and consultants were held accountable to the survivor advocates. Short-term consultants were carefully selected and invited to the space that the project participants had ownership over. In some instances, consultants were dismissed when survivor advocates felt that they were not treated with respect, or if their ability to determine the pace and topics of training was disregarded.
- Rohingya project officers were hired to provide day-to-day management and translation.
- Trust was a central aspect for developing cohesion among survivor advocates as well as community engagement activities. Trust was developed in multiple ways:
 - » Selecting survivor advocates from the affected population contributed to establishing trust with community members.
 - » The project lead brought with her contextual knowledge and pre-existing positive relationships with the community at the outset of the project. She was also known for having successfully helped female survivors of sexual violence. This established trust was essential for ensuring effective selection of staff and project participants, and for gaining community acceptance.
 - » Hiring Rohingya staff members was essential to facilitating trust and ease among the Rohingya participants. Participants perceived that the cultural and language barriers between Bangladeshi staff and Rohingya refugees undermined trust-building and group cohesion.
 - » The trainers engaged in trust-building activities with participants, which was essential before addressing sensitive topics such as sexual abuse.
- LAW's submission on behalf of male Rohingya survivors to the ICC helped advance efforts to access justice—which was one of the motivating factors for Rohingya survivors to come forward—and raised the profile of the survivor advocates in the camps.

Voices of male survivor advocates

"If he [the survivor] feels very happy, we are very happy too. The victim is explaining to the world that sexual violence did not only happen to women, it happened to men, too."

"The victim, the male survivor feels happy when they can share. Until today [there is] no opportunity to share what happened to them."

"It is the first time that male victims tell about their stories. The community is also supporting us. It is the first time they hear about sexual violence against men. The community think it is good to get justice."

"[When] the [survivor advocate] attended the ICC, this information spread through Kutupalong. The community understood it was going to court and it became very aware. We were very shy, but we know, to get justice we must describe [the experiences of sexual violence] to everyone. The community is supporting [our work as survivor advocates]."

Conceptualizations of sex, violence, and sexual violence among the Rohingya

- The commonly accepted view in the Rohingya community that a man cannot be penetrated created a situation where male survivors are generally not believed, impeding survivors from disclosing rape.
- Creating an open and safe place to discuss sensitive topics that are not often talked about in the Rohingya community enabled the participants to learn about and discuss sexuality and sex. For example, at the outset of the project, the training participants (survivor advocates) defined sex as vaginal penetration only. Consensual sexual intercourse between men was perceived as an impossibility. At the same time, survivor advocates reported that sexual intercourse between heterosexual, cisgender Rohingya men and *Hijra* occurred in the community and was acknowledged. This challenged assumptions about how Rohingya men conceptualize sex and offered a window of openness in the training to address complexities around sex, sexuality, and sexual violence.
- The survivor advocates lacked shared language regarding sexual matters, including consensual sexual relations between adult men, sexual abuse within the Rohingya community, and child sexual assault. This was addressed by introducing terms and concepts to develop a shared vocabulary.
- While training participants recognized sexual violence committed against men and boys in Myanmar as war crimes, they struggled to recognize GBV against women and girls and sexual abuse against boys and young men that is perpetrated within the Rohingya refugee community and in Bangladesh. The understanding of sexual violence against men and boys in war/ conflict and perpetrated by armed forces did not easily translate into increased understanding/ awareness of sexual violence and GBV perpetrated by Rohingya community or family members.
- Religious beliefs played an important role in forming attitudes toward sex between men and by extension to the challenges in acknowledging sexual violence against men. Participants considered same-sex sexual relations a sin and therefore any acts associated with it "cannot exist." Many training participants labelled sex between men as "violence" by definition, regardless of consent, with consensual sex between men seen as implausible.
- According to survivor advocates, non-penetrative forms of sexual activities are not considered sex in the Rohingya community, and therefore other forms of sexual violence that do not include penetration are generally regarded as less serious.



Motivation to disclose sexual violence

- Survivor advocates emphasized that shame, self-blame, and victim-blaming were primary deterrents to disclosure and seeking support.
- From the project outset, survivor advocates adopted a strong legal focus (in part due to the focus of the implementing agency, LAW) and expressed being motivated by the prospect of seeking legal redress for the violence committed by the Myanmar military against the Rohingya people. Survivor advocates reported that when someone disclosed sexual victimization, they referred them to LAW for an interview, documentation, and possible inclusion in the case application to the ICC. The legal submission process on behalf of male survivors to raise global awareness about the atrocities was seen by the survivor advocates as part of their recovery, suggesting that the justice-seeking efforts can potentially assist in survivors' healing process.

Challenges

The key challenge the pilot encountered was the lack of accessible sexual violence services for male survivors. During WRC's data collection, some service providers reported that they provided care for male survivors. However, the pilot revealed that the quality of care was frequently poor, and few providers were equipped to care for male survivors specifically.⁴ Although the aim for the project was to strengthen access to response services, the predominant focus came to be on helping male survivors access a legal process, with identifying and interviewing survivors for the ICC application driving much of the survivor advocates' work. This was largely due to the dearth of accessible, sensitized health and mental health services for male survivors in Cox's Bazar, the implementing agency's focus, and the strong interest of male Rohingya refugees in access to justice.

- 1) **Failed medical referrals.** Several attempts were made to assist male survivors to access medical care from established service providers across the camps, including by the project lead. Survivors would follow through with the referral and were either denied services or received inadequate responses from service providers. According to key informants and survivor advocates, the reasons that service providers gave for denying services included triage procedures or the inability to treat chronic conditions ("we treat only acute injuries") and not prioritizing male survivors ("the clinic is very busy").⁵ Inadequate or inappropriate response to male survivors included, for example, health service providers using a system designed for female survivors to access a provider that male survivors felt uncomfortable with.⁶ The issues about inappropriate/inadequate care were raised at the health cluster coordination meetings. To address these shortcomings, in March 2019, WRC developed and implemented a training for selected health care workers in Cox's Bazar on the provision of sensitized clinical care for male survivors. Despite these efforts, capacity did not meaningfully increase and more robust efforts by health cluster members are needed to build capacity to respond to male, female, and *Hijra* survivors.

4 Stakeholders reported that humanitarian actors' lack of recognition of sexual violence against Rohingya men and boys resulted in poor or extremely limited service provision for male survivors (in addition to limited services for women and girls). During the project timeframe, GBVIMS data showed that approximately 2% of survivors seeking services in Cox's Bazar were male, a figure that was often misinterpreted as incidence and which was used to prioritize interventions. Stakeholders reported that without specific entry points and specialized services for men, service uptake from male survivors will remain low.

5 Note that some survivors may not perceive their medical issues as resulting from sexual violence. Explicit disclosure of sexual violence may be extremely difficult and should not be a requisite for accessing care. This requires service providers to be responsive and sensitive to the complex needs of survivors of sexual violence.

6 Survivors were provided a card with a flower that they could present to clinic staff to send them directly to a health provider for clinical management of sexual assault. Male survivors reported being uncomfortable using this system.

Learnings related to *Hijra* Rohingya

Hijra are third gender or transgender (male to female) persons. They are common in the Rohingya community; at the same time, they frequently experience harassment and discrimination.

Challenges

- *Hijra* have few, if any, spaces to gather and be themselves and meet others like them.
- The *Hijra* involved in the pilot reported feeling unsafe in their communities and were subjected to harassment. Due to these negative social responses, they did not feel comfortable dressing in their preferred clothes (feminine clothing) or presenting as feminine.
- Some security forces have reportedly sexually assaulted *Hijra* who apply for permits to attend activities outside the camp.

Hijra inclusion in the pilot

- As a result of the training, survivor advocates deepened their understanding of vulnerability to sexual violence, and identified *Hijra* as potentially vulnerable to sexual violence and in need of support. Subsequently, a number of Rohingya *Hijra* were invited to use the training premises for regular support meetings.
- The flexible, iterative design of project allowed for the training curriculum to be adapted and a small group of *Hijra* participated in specialized trainings. As part of this process, the *Hijra* met with humanitarian protection actors and advocated to be recognized as a third gender.
- The training office provided a safe space for Rohingya *Hijra* to meet and support one another. The group included individuals of different ages, some of whom were caring for young children. The group appeared to provide a sense of safety and belonging to younger *Hijra* who might not be accepted by or protected in their families and neighborhoods. At the same time, some project staff were concerned that the children may be at increased risk of sexual exploitation. These concerns were based on the fact that a number of *Hijra* sell sex (and the children may be exposed to this work), *Hijra* elders typically mentor younger members (and selling sex may be part of the mentoring relationship), and due to the sexualization of *Hijra* by community members. Staff tried to sensitively address the issue with adults in the group and highlight the children's protection needs.
- A joint *Iftar** party with male and female survivor advocates and *Hijra* positively impacted the group, with members sharing that they had gained new empathy for *Hijra* individuals after interacting with them directly and the exposure helped to develop a sense of kinship and common humanity.
- Service providers sought to establish additional safe spaces for the *Hijra* community, and *Hijra* were supported to establish criteria for the spaces and assess the spaces before service provision commenced.
- *Hijra* trainees reported that safe sex is a priority. They were aware of the need to use condoms and expressed wanting better access to condoms.

**Iftar* is the meal taken by Muslims after sunset to break the daily fast during Ramadan.



Dear UNHCR,

We are a group of Hijara Rohingya living in the camps. ~~with #~~ We have a problem with the current identification card. If we are travelling somewhere we have to travel as men because our card identifies us as men. As Hijara, we prefer to dress according to our identity. It would be very useful to have the option to identify ourselves as Hijara on the card so our movement is not restricted.

We meet at the LAW office in Kutapalong every Sunday. We invite you to discuss this matter with us.

Kind regards,

Letter sent by a group of *Hijra* Rohingya to UNHCR, Bangladesh pilot. The letter reads:

Dear UNHCR,

We are a group of *Hiraja* Rohingya living in the camps. We have a problem with the current identification card. If we are travelling somewhere, we have to travel as men because our card identifies us as men. As *Hijara*, we prefer to dress according to our identity. It would be very useful to have the option to identify ourselves as *Hijara* on the card so our movement is not restricted.

We meet at the LAW office in Kutapalong every Sunday. We invite you to discuss this matter with us.

Kind regards,

- 2) **Limited good quality mental health services.** At the outset of the project, a number of agencies providing mental health and psychosocial support self-reported being able to provide care for male survivors. However, quality of care for survivors of all genders was reportedly very low and there were no sufficiently equipped referral points identified during the course of the project. Discussions were held with global experts with experience in providing mental health care for male sexual torture survivors. However, the trainers were unable to come to Cox's Bazar during the project time period.
- 3) **Staff turnover.** The turnover of key staff before the pilot completion further challenged the full implementation of the project.

Voices of male survivor advocates

"We took four survivors to [an NGO providing health care]. They even told us there is no treatment for this type of victim. We shared with LAW, many times. Victim asked for treatment. We have the biggest clinic here, but no treatment. They say, 'We don't have this type of medicine [to treat male survivors].'"

"My victims describe everything, the injured places in his body. [UN agencies, NGOs] check him, but they said there is no proper treatment for this type of injury. They only give paracetamol and sleeping tablets."

"When we took the victim to medical treatment, he was very happy he would get treatment. But when he was told there is no treatment, he felt very disappointed."

"We say [to the medical service] 'Bring him to hospital,' but they don't. The survivors don't get satisfactory treatment."

"If possible, help support the survivors with what they need—medical, psychosocial support."

"There is no psychosocial support [available in the camps]. We just try to happy them, small talk. We try, we try to do what we can. We always ask if anything is needed."

"We visit them, listen, talk. There are no services."

Key recommendations

1. Donors and humanitarian actors, particularly health and mental health providers, should prioritize the strengthening of specialized services for men/boy and *Hijra* survivors before additional outreach is undertaken, in addition to strengthened and expanded services for women/girl survivors.
2. Inter-agency coordination to address male and *Hijra* survivors, including referral pathways and entry points for survivors, should be strengthened.
3. Once services are strengthened and entry points established, further capacity development of survivor advocates should be considered to support peer-to-peer psychosocial support and awareness-raising about available services.



Kenya Pilot: Supporting LGBTQ+ Refugees

Background

Kenya has long served as a regional haven for refugees fleeing conflict and persecution, including lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) refugees with diverse sexual orientation and gender identity/expression. WRC's research (among others) found that LGBTQ+ refugees residing in Nairobi and Mombasa were particularly vulnerable to sexual violence in their home countries, during flight, and after arrival in Kenya.⁷ Yet they struggled to access protection and care due to discrimination, limited safe housing, and ongoing insecurity, among other barriers. Tensions with the Kenyan LGBTQ+ community—including competition over scarce resources, divergent advocacy tactics, and exploitation by some members of the host community—exacerbated these challenges. Additional tensions were reported within the LGBTQ+ refugee community, particularly between those from differing countries of origin and between queer men and queer women, as well as other members of the LGBTQ+ community.

Project summary

In 2019, WRC partnered with HIAS Kenya to develop and implement a pilot focused on increasing solidarity and social cohesion among LGBTQ+ refugees and Kenyans, as well as facilitating access to services for LGBTQ+ refugee survivors in Nairobi. The project was based on the premise that strengthened solidarity among LGBTQ+ refugees and Kenyans could augment their collective voices to enhance service uptake for survivors of sexual violence. The project did not solely focus on queer men and boys, and included lesbians, trans women, women who have sex with women, and nonbinary/gender nonconforming persons to avoid creating further divisions with the community. Due to delays resulting from COVID-19, formal project activities commenced in August 2020 and continued until December 2020.

The pilot comprised four key activities:

1. Holding consultations and participatory sessions with refugees of different nationalities and Kenyan LGBTQ+ community-based organizations (CBOs) to better understand the causes of the tensions, followed by a four-day Solidarity Forum to support bridge-building between and among the LGBTQ+ communities.
2. Collaborating with CBOs to develop information, education, and communication (IEC) materials to raise awareness about sexual violence services for LGBTQ+ refugees of differing nationalities and disseminating these on social media.
3. Providing financial support to enhance protection for LGBTQ+ refugees, including support for safe housing, food items, sanitary materials, and personal protective equipment against COVID-19.
4. Facilitating a transportation voucher system, through the use of a taxi hailing app (Uber), to support LGBTQ+ refugees' safe access to health care, including post-sexual violence health care.

The Solidarity Forum included 20 Kenyans and 20 refugees, including refugees from Uganda, South Sudan, the Democratic Republic of the Congo, Burundi, and Somalia. Participants identified as non-binary/gender nonconforming persons, lesbians, queer men, queer women, gay men, transgender

⁷ Women's Refugee Commission, *"We Have a Broken Heart": Sexual Violence against Refugees in Nairobi and Mombasa, Kenya* (2019).

men, men who have sex with men, and women who have sex with women. The Solidary Forum was facilitated by external partner agency staff and covered:

- The perceptions of the refugee and Kenyan LGBTQ+ communities of each other
- The relationship between the Kenyan and refugee LGBTQ+ communities
- Challenges/protection concerns of LGBTQ+ refugees living among the host community
- Lived realities and experiences of Kenyan and refugee LGBTQ+ individuals
- Approaches that LGBTQ+ urban refugees can learn from LGBTQ+ Kenyans to better integrate into the host community
- Brainstorming ways to resolve existing challenges and tensions and to move forward collectively
- Services (including sexual violence services) offered to LGBTQ+ refugees in greater Nairobi
- Support structures and services that LGBTQ+ Kenyans access that LGBTQ+ refugees could benefit from (e.g., support groups, networks, collaborative spaces, LGBTQ+ friendly health care facilities, legal aid services, etc.)

Three collaborative IEC development sessions were conducted with LGBTQ+ led CBOs. IEC materials were developed that detailed where, how, and why to access sensitized sexual violence services, which reached at least 246 LGBTQ+ persons via social media and WhatsApp. A total of 130 LGBTQ+ refugees received financial assistance to cushion them from the effects of COVID-19: 61 were assisted for three months and 69 for two months. In total, 41 LGBTQ+ refugees were supported with transport to access health care facilities.

Preliminary learnings

Tensions between refugee and host LGBTQ+ communities

- Refugees described instances of violence and exploitation by LGBTQ+ Kenyans, including rape, blackmail, extortion, outing, and intimate partner violence, that contributed to tensions, distrust, and anger. Some refugees perceived that LGBTQ+ Kenyans “felt superior” to refugees due to their citizenship and associated rights, and used their status to undermine and abuse LGBTQ+ refugees.
- Many Kenyans were unaware of the challenges that the refugees faced. They had misperceptions that refugees did not grapple with similar struggles since they believed that refugees were eligible for resettlement and financial support from NGOs and UNHCR.
- LGBTQ+ Kenyans expressed frustration at some LGBTQ+ refugees’ advocacy tactics, which they felt were too aggressive and undermined their long-term work to advance LGBTQ+ rights.

Tensions among LGBTQ+ refugees

- Language, religion, and cultural differences among LGBTQ+ refugees of different countries of origin were cited as barriers to cohesion and community-building. Language differences were particularly challenging for minority LGBTQ+ refugees from the Francophone and Somali communities. Many did not speak Kiswahili or English and were isolated from refugee programs, LGBTQ+ programs, and the host and refugee communities generally.
- Some LGBTQ+ refugee communities were identified as particularly isolated, such as the Somali community. Others were perceived to be exclusive and unwelcoming to refugees of different nationalities.



- Lesbian, bisexual, and other queer women, as well as trans men, expressed feeling overshadowed by the predominantly gay male refugees. These groups were perceived by some gay and other queer, cisgender men as not having “legitimate” sex because of the lack of male genitalia.
- A number of lesbian and other queer women, as well as some trans men, among others, have children. They expressed feeling particularly overlooked and misunderstood by other LGBTQ+ refugees as well as service providers, and said that their needs as caregivers were not addressed.

Voices of LGBTQ+ refugees: Tensions within the LGBTQ+ refugee community

“I have tried to connect with Ugandan CBOs and they are looking for their own interests. I have tried [connecting] with Kenyan organizations and they are not really supportive. We feel like we [Somali refugees] are on the outside. So I went to the Solidarity Forum. I even raised the issue about how Kenyan organizations don’t receive me in a friendly manner. They [Kenyan organizations] said, ‘We will help you register your CBO as a Somali, I will let you know who can help you.’ But it didn’t happen. It has been delayed... We still feel like we are not really connected to the other NGOs. For us Somalis, it’s a big challenge. It’s not only Kenyans—we are being excluded by the Ugandans and Congolese as well.”

“Being a trans man, mostly people see you and focus on lesbians and women’s group, but I do not define myself as a woman. I am a man. But I see that women are being prioritized.”

“As a mother, I feel I should be considered more as a parent. I don’t get any assistance for my children. I can’t go for work because I’m afraid of leaving my children behind and go for work, they might come to harm. I am thinking that we should prioritize parents in the LGBTQ+ community. We need to take care of kids, and looking for jobs is really hard.”

Service access barriers

During the Solidarity Forum, refugees described some service access barriers, which aligned with those documented in WRC’s study⁸:

- Refugees noted that urban service providers need to be better educated on the challenges of refugee documentation. Some service providers demanded refugee ID cards, which many LGBTQ+ urban refugees do not have, preventing them from accessing services.
- Because Kenya is perceived as more LGBTQ-tolerant compared to other countries in the region, some refugees do not understand the various risks that they may face there.
- Using public transport to access services may put LGBTQ+ refugees at risk for verbal and physical assault, particularly masculine-presenting (“butch”) women and trans men.
- A dearth of interpreters at service points, as well as cost-prohibitive transportation, limited access to services in Nairobi.
- Service providers and refugees shared that health services are especially important for LGBTQ+ refugees, who are vulnerable to violence, HIV, and general poor health due to poverty. However, access to health care during COVID-19-related lockdowns and curfews was particularly difficult, and many sexual and reproductive health programs had their resources diverted to address COVID-19.

⁸ Ibid.

Programmatic gaps

- A number of LGBTQ+ persons have children, particularly women but also some men (including trans men and bisexual men) and nonbinary persons. They are often single parents, struggle economically, and lack support from extended family. LGBTQ+ adolescent parents are especially vulnerable and often struggle with their identity. Yet addressing parenting and child-care is not common in LGBTQ+ programming, and programs for adolescent LGBTQ+ parents are scarce.
- “LGBTQ-friendly” services are often geared toward gay men and men who have sex with men, and may not be inclusive of queer women and trans men. Trans men in particular expressed feeling unwelcome in traditional women’s spaces as well as LGBTQ+ services geared toward gay men.
- According to participants in the Solidary Forum, GBV services for refugees target cis-gendered heterosexual women and tend to ignore lesbian and other queer women survivors, who expressed feeling unwelcome in these spaces. GBV services specific to queer women were lacking.

Voices of urban service providers serving LGBTQ+ refugees

“We need more research and support. Can we have a parenting formula on how to support queer people as parents? Or how to parent queer adolescents? Or even for the children of queer parents? They may ask, ‘Can I be born straight and live with the stigma of queer parents and put in the box by the society? How do I accept my LGBT parent?’ It creates a lot of tension.”

“Childcare for queer adolescents, who are very vulnerable and they are left out, [is a gap]. They are struggling with their identity. People are reluctant to include them with adult LGBT individuals, because programmatically it may look like...they are promoting promiscuity around children, but people need to think about that gap.”

“During COVID, most LGBT refugees have had to resort to survival sex. They have gone into transactional sex and survival sex, so they are even more vulnerable. All the systems we had were even more stretched now. The lockdown is at 8 p.m. and now they do not have the nights in which to work. HIV and STIs are going high. We need to manage reproductive health so we now see some areas that we can get more evidence based from the exercises that we did during the WRC pilot project.”

Solidarity building

- The CBO consultations, the IEC design sessions, and the Solidarity Forum were helpful to identify common needs among LGBTQ+ refugees and brainstorm ways to address them. They created space for people of the same (and different) sexual orientation, gender identity and/or expression to meet each other. Many LGBTQ+ refugees face isolation and stigma. Opportunities to meet with others served as an opportunity to break their isolation and find connection, acceptance, and support.
- The Solidarity Forum helped Kenyan and refugee LGBTQ+ communities identify their similar challenges as well as better understand each others’ struggles and perspectives. Empathy-building exercises helped the communities recognize that they share more commonalities than differences. Learning about intersectionality and the challenges that refugees face also appeared to help Kenyan LGBTQ+ persons develop more empathy toward refugees.



CBO GBV participatory group session, Kenya pilot.

- The Solidarity Forum provided a space for marginalized LGBTQ+ persons—such as Somalis, queer women, and trans men—to voice their challenges and experiences, and provided a platform for them to be heard and understood by other members of the community.
- At the end of the Solidarity Forum, representatives from both the Kenyan and refugee communities agreed to create or strengthen common spaces and activities in an effort to improve cohesion. Many expressed a strong interest in joint programming and additional bridge-building activities.
- Three months after the Solidary Forum, participants who were interviewed continued to report improved relationships between the communities and a desire for additional opportunities to work together. At the same time, miscommunication and misperceptions continued to fuel problems between and among the LGBTQ+ communities.
- Solidary Forum participants developed recommendations for service providers in Nairobi, including to:
 - » Create more spaces for interaction and more joint programs and trainings to strengthen cohesion and inclusion between refugee and host LGBTQ+ communities. Support leaders from both communities to meet regularly. Help the communities to identify their strongest unifying factors and build on those. Address organizations and individuals who seek to erode, abuse, or undermine solidarity-building efforts.
 - » Support joint advocacy efforts to advance LGBTQ+ rights in Kenya. Support LGBTQ+ Kenyans to share knowledge with refugees about their rights, the local laws, and effective advocacy channels in Kenya.
 - » Support joint fundraising efforts, including complementary fundraising to benefit the LGBTQ+ community in Kenya at large.

Voices of LGBTQ+ refugees and Kenyans: Changing perceptions after the Solidarity Forum

Kenyans

“There was a lot of miscommunication between the LGBTQ refugee and the Kenyan communities. There was hostility. They were forgetting that we are all stigmatized and suffering as LGBTQ... There was distorted communication about the Kenyans, and vice versa. There was a notion that LGBTQ people in Kenya were treated well. This notion that the Kenyans thought that the refugees received lots of money from the donors, but it was not the case. It was around this miscommunication that was the biggest barrier.”

“I come from western Kenya, where stigma is very high and the same as what refugees face. Most of the time I meet those from the refugee camps. We have a stereotype about urban and rural refugees. Then I learned [at the Solidarity Forum] about how they all suffer. Because of their own stigma and living in silence, that may make them suffer. That changed my notions [about refugees]. I learned about intersectionality. The facilitator was very precise about this and pointing out how we all suffered the same. It was the foundation for everything. When we realized that we were all vulnerable regardless of our nationalities, [that] really was the take home message for me. Over the years, we’ve been working in silos and not supporting each other.”

“The [Solidarity] Forum helped me to see the light more clearly. First, I realized that [the refugees’] trouble are the same as queer people living in Kenya, but their alien status hurts them and doesn’t let them have an ID which causes stigma. If they need government services or to access health care—anywhere where an ID is required—they get a lot of backhanded reactions. That was new to me. People told me that queer people get resettled but the consequences is so lacking—it takes six months, a year, and that they don’t have much support. They get abandoned and left to their own devices. They are leaving the war and falling into the lion’s den.”

“The Solidarity Forum worked if you ask me! I can connect my struggles to their struggles and helped me see their world as they see it. It helped me empathize with them. We, Kenyans, didn’t know much about refugees and how they live. We would hear stories about random refugees, but we rarely met them. But it really helped me to understand how we are related. I love connecting with other queer people, which will help me move towards decolonizing our world.”

Refugees

“The Solidarity Forum was a very helpful experience. We came to understand the problems that Kenyans and refugees faced, it was almost the same. We formed a connection. The Kenyan community has a connection that is stable, and through them we can partner with them and Kenyan CBOs through the community. We can get funds when they have some. We are all interacting, through the meetings, and know each other. We had a training for all at GALCK [Gay and Lesbian Coalition of Kenya] and they invited the refugees through the connections [made] through the forum.”

“They told us at the Solidarity Forum if I wanted to raise an issue about not being treated equally at the hospital, they told us where we can go to [access] the LGBT agencies. They can help us raise the issues. I have met [Kenyans] at these meetings and in case I want to raise something, I tried to follow up with some of the Kenyans. They have helped me in some places like the hospital, they try to help me.”



- » Raise awareness among Kenyans about refugee-specific challenges, and conduct training for both Kenyan and refugee LGBTQ+ communities on what it means to seek asylum and how policies work.
- » Support language learning (such as Kiswahili and English) among LGBTQ+ refugees to help them access services, better integrate into the community, and advocate for themselves.

Electronic IEC messaging

- During the pilot, many COVID-19 messages did not address or include the refugee population (and were produced in English and Kiswahili) and GBV messages did not address LGBTQ+ individuals.
- During the COVID-19 pandemic, CBOs recommended using WhatsApp and social media to promote the electronic IEC messages rather than face-to-face community outreach and IEC sessions that were originally planned. Electronic IEC messages detailing where, how, and why to access LGBTQ+ friendly health care (including sexual violence services) reached at least 246 people. More people likely received the WhatsApp messages, which continued to be forwarded after the project concluded.
- Although the electronic messages reached a number of LGBTQ+ persons, some refugees were unreachable due to their lack of smart phones or lack of money to continuously pay for data. This highlights how technology alone may not be able to reach some of the most vulnerable populations.

Voices of LGBTQ+ refugees: IEC development sessions

"Before [the IEC development sessions with HIAS], I did not know at all where to go if a survivor [of sexual violence] asked me. It gave us an opportunity to get to know it. We only knew to call the police, but we know that the police are not good. So, we learned that there were specific numbers to call for specific issues. I sent it to many people."

"I was in the meetings [to develop the IEC materials]. We learned about GBV services in that meeting. That meeting was so helpful. I came to know my rights all alone. Naturally, I am someone who feels weak. I am not someone who is upstanding. It changed my perspective, and because I am a woman, a Muslim woman, and women are put behind men, that meeting helped me so much that I am equal to anyone. It showed me that I can come out like any other person to fight for my rights. It helped me to know who to call or follow if I had any problems like rape – where to go and how to go about it."

"There was a WhatsApp message about GBV and COVID-19 that I helped to translate to Somali. And I shared it with my group. Most of the 15 members of the group could receive it, but five are not on WhatsApp. It's a very helpful way, but not everyone has smart phones."

Financial support

- The LGBTQ+ refugee population in Nairobi is extremely economically vulnerable. They struggle with food insecurity and unsafe housing, and have limited access to livelihood programs. The COVID-19 pandemic exacerbated their vulnerabilities. Meeting basic needs such as food, shelter, and essential medical care is essential before commencing interventions addressing peacebuilding, advocacy, and similar efforts.

Transportation vouchers

- The provision of transportation vouchers improved some LGBTQ+ refugees' ability to access healthcare, including sexual violence services, during the duration of the project.

While voucher users were not asked the purpose for accessing care, follow-up interviews with service providers indicated that some were sexual violence survivors.

- Refugees reported that even when LGBTQ+ refugees were aware of free, LGBTQ-friendly health care, lack of safe and inexpensive transportation was often a key barrier. These transportation barriers can lead to delayed care and missed or delayed medication use, contributing to poorer health outcomes.
- The transportation vouchers were a short-term intervention. A sustainable intervention is needed to address transport barriers for the long-term.

Voices of LGBTQ+ refugees: Transportation vouchers

"[My CBO] used the transportation vouchers for beneficiaries to go to the hospital. There is a public hospital that is far away for refugee treatment but we could support them with transport—they took it from the shelter to hospital and back. Some of them faced GBV during the time and used the voucher during this time. Before, they would make appointments but didn't have transport—they would not be able to visit the hospital. The funds motivated them to visit the hospital."


"[The transportation voucher] was a good project that tackled the problems we had—the things that made it difficult for us to go to the health centers, to get medical care. It addressed most of our challenges. Someone can go to the hospital and have a document that UNHCR has given them to get free treatment, but if they live very far from the hospital, they have to go to a nearby hospital where they are forced to pay. This way they were able to use the hospital that was free and get good care. They came back very happy. There are many challenges—even emotionally and psychologically—because of the way they are treated at other hospitals. This helped them that they can go, get the care, come home safely, and it really helped them emotionally."

"It would have been hard to go to the clinics without [the transportation voucher]. The transport cost had gone high during COVID. Safety is a big concern—I got assaulted in a public transport and it took me months to use it again."

Challenges

- *COVID-19*. The original project design was significantly modified due to the COVID-19 pandemic. Face-to-face consultations and discussion groups had to be revised and the launch of the pilot was delayed. The evaluation was originally designed to be conducted in-country, but was ultimately undertaken remotely due to travel restrictions. In addition, the lockdown in Nairobi exacerbated the already precarious circumstances that many LGBTQ+ refugees face. A number of CBOs closed due to lack of funds, and many LGBTQ+ refugees were unable to work and thus unable to meet their basic needs. The registration of asylum seekers and refugees was suspended, resulting in expired documentation that increased anxiety and fears of arrest. As such, the pilot was modified to include a small financial aid component.





WOMEN REFUGEE COMMISSION (WRC) PROJECT - TRANSPORT ACKNOWLEDGEMENT FORM

CBO NAME: _____ MONTH _____

	NAME	DOCUMENT REGISTRATION NUMBER	PHONE NUMBER	NAME OF MEDICAL FACILITY AND APPOINTMENT DATE	SERVICE SOUGHT DUE TO SGBV INCIDENT: YES/NO	AMOUNT INCURRED	CLIENT'S SIGNATURE

Blank transport log for voucher project, HIAS Kenya.

Key recommendations

1. Interventions to support LGBTQ+ survivors of sexual violence to access health care and other essential services should include access to safe transportation. Interventions should be inclusive of all LGBTQ+ refugees and should not target sexual violence or GBV survivors alone.
2. Donors and service providers should establish joint programs for both LGBTQ+ refugees and Kenyans, as well as cohesion-building efforts to reduce tensions and enable service uptake.
3. Service providers should develop sensitized, inclusive services that explicitly include trans men, lesbians and other queer women, and LGBTQ+ parents.

Italy/Bulgaria Pilot: Training Linguistic and Cultural Mediators

Background

Sexual violence along the central Mediterranean migration route into Europe appears widespread. WRC⁹, among others, has documented this violence against men and boys, including persons with diverse sexual orientation and gender identity. In Italy, Bulgaria, Greece, and other countries, reports of refugee and migrant adolescent boys and young men being sexually exploited in the context of selling sex have been documented. Yet access to sexual violence care for survivors remains limited, due to a variety of barriers including poor referral networks and under-trained staff. A dearth of linguistic and cultural mediators¹⁰ (LCMs) trained in responding to survivors of violence was also identified as a key gap during WRC's research. LCMs facilitate mutual understanding between a person or a group of people (e.g., the migrant/refugee population) and a caregiver (e.g., a doctor) by providing two-way verbal translation (interpreting) and helping them overcome cultural barriers.

Project summary

Although the original intent of WRC's pilots was to trial innovative interventions to facilitate service uptake among male and LGBTQ+ survivors, partners and key informants in Italy cautioned against such an approach. At the time of data collection, services and reception centers for refugees and migrants were being curtailed and shut down. Service providers caring for sexual violence survivors reported being unable to cope with the demand. Given the potentially high numbers of male survivors among the refugee and migrants in Italy, concerns were raised that such a project could cause harm by spurring male and LGBTQ+ survivors to seek care from service providers that were too overburdened to respond effectively. As a result, WRC revised its approach to instead focus on developing a tool to support the capacity of existing frontline responders to better respond to survivors. This project, therefore, focused on tool development and differs from the Bangladesh and Kenya pilots.

In 2019, WRC partnered with UNICEF Europe and Central Asia Region to develop a training curriculum to improve LCM responses to sexual violence against men and boys, as well as GBV against women and girls.¹¹ The training was piloted in collaboration with Médecins du Monde in Calabria, Italy, in July 2019, and in collaboration with the Council of Refugee Women in Sofia, Bulgaria, in January 2020. A third pilot, which was planned for Greece in March 2020, was not completed due to the onset of the COVID-19 pandemic. An advisory group was convened to provide expert guidance and inputs.¹²

The objectives of the curriculum included to:

- raise awareness among LCMs about GBV against women and girls and sexual violence against men and boys;
- explain the principles for the provision of survivor-centered services, including the

9 WRC, *"More Than One Million Pains": Sexual Violence Against Men and Boys on the Central Mediterranean Route to Italy* (March 2019).

10 A cultural mediator is someone who "facilitates mutual understanding between a person or a group of people (e.g., the migrant/refugee population) and a caregiver (e.g., a doctor) by providing two-way verbal translation (interpreting) and helping them overcome cultural barriers." Translators Without Borders, *Field Guide to Humanitarian Interpreting and Cultural Mediation* (2017), p. 4.

11 WRC/UNICEF, *Supporting Survivors of Violence: The Role of Linguistic and Cultural Mediators—With a Focus on Gender-Based Violence and Sexual Violence against Men and Boys. A Training Curriculum* (2021).

12 Advisory group members included UNHCR in Italy, UNICEF in Greece, Médecins du Monde in Italy, University of Roma Tre, CIES Onlus (an NGO in Italy), and Centro PENC (an NGO in Italy).



importance of the GBV guiding principles: confidentiality, safety, respect, and non-discrimination;

- promote self-reflection to understand and, where necessary, address personal values, attitudes, and beliefs around GBV and sexual violence against men and boys;
- clarify the roles and responsibilities of LCMs in the context of service provision and the provision of support to survivors;
- explain how LCMs should handle disclosures of violence, provide psychological first aid, and refer survivors to services; and
- share self-care practices to help minimize the impact of stress on LCMs, including potential vicarious traumatization, and promote well-being among LCMs.

In total, 40 LCMs (20 in Italy and 20 in Bulgaria) participated in the pilot trainings run by WRC and UNICEF. After the completion of each pilot training, the trainers established virtual support groups for LCM participants to keep in touch, facilitate peer-to-peer support, and reinforce learnings from the training, such as self-care techniques. The trainers also led two post-training webinars on stress management and intimate partner violence for Italian and Bulgarian LCM training participants. Several months after the pilots were conducted, eight participants (five from Italy and three from Bulgaria) were approached for follow-up interviews to explore the application of the training and discuss any additional suggestions for improving the curriculum.



LCM training participants, Sofia, Bulgaria.

Preliminary learnings

Training assessment

- Evaluation of the training:
 - » In Italy, participants rated the training a 4.8 out of 5 and in Bulgaria, participants rated it a 4.93 out of 5.
 - » In Italy, the large majority (93%) of participants reported that the workshop achieved its objectives, and 90% felt that they had learned something new. In Bulgaria, 93% reported that the workshop reached its objectives, and 100% felt that they had learned something new.
- Positive aspects of the training (as reported by participants) included role-playing, learning more about gender and sex, information on stress and burnout, meditation exercises, the opportunity to reflect on their values and feelings, tips on how to be a better LCM, the participatory and practical nature of the training, learning about how LCMs work in other contexts compared with their own, and the chance to talk about sexual violence against men and boys.
- Participants wanted to know more about meditation and stress management, how survivors “signal” abuse, how to support child survivors, and how to provide peer support.

LCMs responding to survivors of sexual violence

- LCMs play a key role in responding to survivors of all genders. Disclosures of loss and violence (including sexual violence) to LCMs are common during formal interpretation and after or during private one-on-one conversations due to:
 - » their connections to the refugee/migrant community and their status as a community “insider”; and
 - » the trust many of them build with community members.
- Many LCMs have had personal experiences with loss, trauma, and violence, including sexual violence. Many are refugees themselves. These experiences can exacerbate stress and increase their vulnerability to secondary traumatization. In general, LCMs are vulnerable to secondary traumatization due to the nature of their work.
- LCMs, like all persons, may have some biases, discriminatory feelings, or harmful beliefs about sexual violence, LGBTQ+ persons, and persons who sell sex, among other topics. These should be addressed in order to help LCMs understand their own biases and abide by the non-discrimination aspects of a survivor-centered response, which will help them to better respond if/when a survivor discloses.
- It is not “too sensitive” to talk about sexual violence against men and boys with LCMs. Most of the LCM participants were well aware of sexual violence against men and boys in home countries and during the journey to Europe, but were not sure how to respond and support them. Providing LCMs with more information about potential signs or symptoms of sexual victimization improved their confidence to respond effectively to a survivor.
- LCMs may not be seen by supervisors as part of the service provision team, and often lack adequate support and supervision in their work context, despite highly stressful working conditions. The participants were eager to learn ways to manage stress as well as support one another. For some, the training was the first time that they had addressed the stress that they encountered in their jobs.
- Language choices are very sensitive. Certain words may have negative connotations in some languages (e.g., gay) while others may not have precise translations (e.g., transgender). Service providers who are using LCM services should discuss this with LCMs before interpretation begins to identify the most accurate, accessible, and respectful language.



Voices of LCM training participants

"The role plays that we used [in the case study], I really use this a lot. It really helped me. I met a lot of cases who were like [the survivor in the case study]. Maybe seventy percent were like that. I use the field technique that [one of the trainers] taught us when I meet them. I reflect about it and I think about what we did that day. It really helped me."

"We had one male refugee from Afghanistan who is in Bulgaria with part of his family. Not married but with his brothers. He had a number of somatic problems—back, stomach, different sufferings, difficult for him to explain why. We started to meet regularly. He shared his problems and the terrors he suffered in Pakistan, Afghanistan, and in Bulgaria. He shared that his stomach and back pain have disappeared. We have serious concerns that he experienced sexual violence, but he has not confided in it. But he is someone we can work a lot with because he's willing to share and willing to continue visiting us for care."

"There has been one boy who told me that he experienced sexual violence. He is suffering a lot mentally, he has had some breakdowns, and I have helped him. After one day, he told me about what happened in Libya—he told me that they raped him there. He cried. I told him that if he wanted to, I could help him and that I would not break his confidentiality, it's a secret. He told me that because he trusted me. I don't want to break his confidentiality—I told him if he wants I can take him to a doctor to help him and after that he will be fine. He said no, that he didn't want anyone to know, maybe someone would tell. I told him if he wants to go to see the doctor, I can go with him."

"Sexual violence against men was not new to me. I had heard of it before the training.... The pattern about the physical and psychological consequences of the violence, I saw many things that I knew from the stories I had heard. It is very difficult for them to express their emotions. It's difficult for them to speak with women about this, too."

"The case study really helped me more to understand how to [address] this in my work and with the police. I work with the police a lot. I often meet boys and girls and have to do interpretation for them. I meet more girls who have problems of this kind [GBV]. I give them all the things that we learned—the psychological first aid, the healing statements. I give my number to them if they want to talk at a later time to help them to find someone [a service provider] who can help them."

Application of the training

Several months after the pilots were conducted, eight participants were approached for follow-up interviews to explore the application of the training and discuss any additional suggestions for improving the curriculum. They reaffirmed the value of the hands-on nature of the training, particularly the case study and the breathing techniques, and they reported using the knowledge gained in their work.

Supporting male survivors of sexual violence

- The training includes a module on signs that a man or boy might be a survivor of sexual violence. It also includes a practical case study that involves role-playing to demonstrate how LCMs can appropriately respond to and support an adolescent boy survivor. These components were consistently cited as useful by trainees that informed their current work.
- Participants in Italy and Bulgaria reflected that they knew that sexual violence against men

Applying the training: Supporting male survivors who disclose

One LCM, a West African man living in Italy, was able to effectively apply the learnings from the training to support male survivors. Here are two examples that he shared:

A 20-year-old man from Sudan

During a visit to one of the sites [to offer services to refugees and migrants] in Rome, we met a guy from Sudan, 20 years old. Every week we go to that site. He arrived in Italy two months ago. He would come just to talk to us [LCMs] without going to the doctor. He wanted to go to Germany and got blocked in Rome due to the lockdown—he didn't find a bus to continue his travel. He would come and visit our team every time and talk and talk and talk. He was complaining about stomach aches, and he complained about it for two weeks. Last week, he came again and saying the same thing and the doctor didn't find anything that was a real cause for this. [While he was talking to the doctor,] I understood immediately that there was something that he was hiding. I remembered that when a man wants to hide some violence, they may have backaches that doesn't have a cause. Something that they are complaining about that is never found. I thought—this is a sign! After the visits, I called him to follow up with him, started talking with him, and I asked him if he wanted to talk. At the first moment, he didn't want to tell me exactly what was going on. [He looked like] someone who stole something and I caught him and he was ashamed of being caught. He put his head down and didn't like to look at me in my face. I reassured him, I said, "You can tell me, I promise that I will not say it to anyone if you have something that I can help you with because I'm here for that." [He told me] that he was ashamed in front of the doctor because she was a woman. He was ashamed to tell her what was happening. He was raped in Libya. He was beaten in his stomach because he refused to obey an order. It was a period of his life that he will not forget. Every time he is ashamed to even talk about anything because he's afraid that this topic will come out and he is always shy. He doesn't even want to talk to his friends. I told him that I believed him, and that he was strong, and I told him that I would see what I could do to help him. I told him that if he wants to see another person who can talk to him about it and help him. He said, "Really, I'm ashamed to talk to someone. Especially if it's a lady or a woman, I cannot—I will be blocked when I am in front of her." The psychologists on our team are all women. So I brought the case up in our meeting, without mentioning his name, so we are now looking for a male psychologist to propose to him. We are trying to find someone.

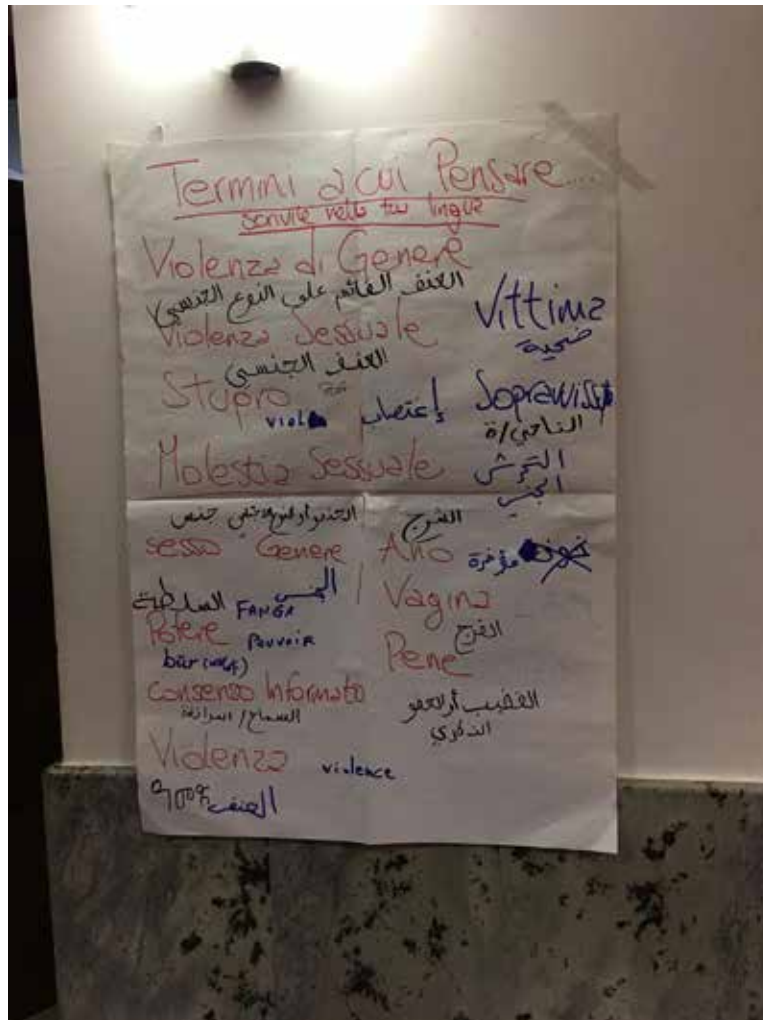
An 18-year-old man from Cote d'Ivoire

The men want help, but [are] afraid to come forward. We met a man who is living in an informal settlement in a train station right now with four friends together. They are all together and he's the shy one, he's the one who doesn't talk a lot. He said he had a stomachache. The first time the female doctor gave him some pills. The following day he came again, then again. It triggered to me that he was hiding something. I could tell in the group he's shy and quiet. I went in the van to get him and took him to the center. During the intake interview with the social worker, he related his story without any logical order, he was confused, and he was confusing us. I asked for a break. He was saying that something was entering his bottom. We couldn't understand. When I asked for the break, I took him with me. I asked him what do you mean exactly—I am with you, you can tell me, I'm not the case worker and I reassured him he could tell me what he meant. He told me that when he first came to Italy, he was placed in a shelter [for unaccompanied minors] run by Catholic nuns. He tried to tell them that he had been raped in Libya and they told him he was a sinner and must pray for forgiveness and never to speak of it again. He told me, "I was really ashamed to say what is going on in front of her [the social worker]. I am afraid that these [women] are like the nuns and they will say that this is a sin and I will have to seek forgiveness from God. In Libya, I was violated. When



I went to Paris, I sought help from a family there. The woman in the family, used to treat me like a slave. This makes me confused.” When he told me what happened in Libya, I told him I was really sorry and I told him, “This was not your fault, you cannot blame yourself.” And that I told him that what he said was true, it was not something that he created or invented. I understood, and I believed him. He was 17 when he came to Italy, and when he asked for help from the nuns, they judged him and she [the nun] burned him and threw him away, far away. She told him it was a sin, and he had to seek forgiveness. It made me very sad.

and boys was a significant issue among community members, but they hadn't known how to support them or approach the issue. After the training—particularly the role playing—they reported that their confidence in speaking with men/boys and potential male survivors had improved, including their ability to give “healing statements” and to refer survivors to psychologists and other service providers for additional support. LCMs in Italy reported effectively supporting and referring at least three male survivors for sexual violence care as a result of the module on potential signs of sexual violence in male survivors and the discussions about how men disclose.



Words to think about in your language, Italy LCM training.



Voices of LCM training participants

“Even when my friend is feeling down and tired, I use the tools I learned in the Managing Stress section of the workshop with them. Everyone is so tired and filled with stress and we are taking breaks to help ourselves. After I came back from the course, me [and another LCM who participated] showed and talked to the other colleagues about the new things that they learned in the course. There were new techniques to help keep the work moving.”

“I have practiced lots of the things...taught [to] us. I walk now and take my bicycle, I take more time for me, I go to my friend’s house and play with her baby, and I sing to relieve stress. I was developing a social anxiety because I hadn’t gone out in so long [due to being unemployed before the training]. I wasn’t talking to anyone.”

“In the office, we do not have time for [meditation], but we try to practice these meditation tricks at home to combat our high blood pressure. I divide my stress in two parts now: walking to release it from my body, or I distract myself after work by playing video games or playing chess, so as not to ruminate.”

“My stress—the coronavirus is making it so much worse. I am having it. But I am sporty, so I have a place in my house where I can train and do sports and I can run. The other people who live with me, we do some laughing. I appreciated the part of the training on how to pass stress out of myself. I do the relaxation exercises. I do the breathing to relax myself, to think about other things, to fight stress.”

“I started running to manage the stress that I was feeling. I used to pray a lot, a lot, to read and run and work. I work a lot. After a sad story or an event that traumatizes me a little bit, I would walk to [relax].”

“We have a lot of procedures [to prevent COVID-19 transmission]—wearing our clothes, mask, gloves, how to take it off, and you have to follow it step by step. Before starting all these steps, I use the meditation and stop and do it. One of my colleagues, asked me, ‘What are you doing?’ I said, ‘I am meditating so in order to do these steps well.’ I meditate even before leaving the center to go out—three to five minutes to be concentrated to know that I’m going out to do something. I’m really proud and happy about what I am doing.”

Understanding the roots of GBV

- The training explored the root causes of GBV and touched on issues of domestic/intimate partner violence, sexual harassment, and other topics that predominantly impact women and girls. Several participants reported that deeper understanding of gender disparities helped them to better support women and girls in their work. In Bulgaria, an LCM noted that they were better able to work with psychologists and GBV specialists after the training as their understanding of the dynamics of intimate partner violence had improved. Another LCM related how he tried to mediate between a survivor and a perpetrator in a domestic violence situation, but recognized that the perpetrator was trying to manipulate him; he extracted himself and immediately sought out a psychologist to support the survivor instead.



Applying the GBV guiding principles

- Participants appreciated the discussion and case study on applying the GBV guiding principles¹³ to their work. Survivors who do not wish to be referred for further services or are reluctant to disclose to service providers and prefer to rely on the LCM as a form of “counselor” can be particularly challenging for LCMs. The training allowed participants to explore ways to address the survivor’s reluctance while still respecting the survivor’s right to self-determination.

Using self-care techniques

- The LCM interviews took place after the COVID-19 pandemic began. This was a highly stressful time, as many LCMs could not work. Particularly in Italy, there were high caseloads of COVID-19 and a strict lockdown. Those who did secure work were sometimes not provided sufficient protective equipment during community outreach to refugees and migrants. In order to manage their increased stress, some LCMs described using the breathing or meditation techniques that they had been taught, or reflected on the questionnaire on stress that they took during the training. The webinar that was conducted after the training, which included stretching and breathing exercises and sharing stress management tips, was also appreciated to help them manage their stress.
- All interviewees appreciated that the training provided time and space to discuss stress and to learn how to support each other in managing stress. Several reported sharing with colleagues the self-care and stress management techniques that they had learned during the training. Some mentioned appreciating the post-training Zoom workshop, grateful that the training participants could spend time together once again and that there was concrete follow-up after the training to reinforce learnings.

Challenges

The project encountered a few challenges:

- **Timeframe:** The original training was designed to take place over three days; however, due to logistical and scheduling challenges, the pilot training in Italy was rolled out in two days. This was insufficient to adequately address the various topics and facilitate knowledge transfer. Condensing the training into two days resulted in the stress management module often being rushed. The Bulgaria pilot training was expanded to two and a half days, but due to use of interpretation, the amount of time for the stress management module was again too short. The time constraints also made it difficult to delve deeper into the core concepts of GBV. While some of the participants were social workers who had received GBV training in the past, shortening the module on GBV core concepts meant that opportunities were limited to further explore issues of stigma, abuse of power, and myths around gender. To address this, the finalized training curriculum was re-expanded to three full days.
- **COVID-19:** The outbreak of COVID-19 resulted in the postponement and eventual cancellation of the pilot in Greece. The situation for LCMs and interpreters is unique in the Greek context, and piloting the training there would have been beneficial to further refine the training. To address this, inputs from Greek advisory committee members were incorporated into the final curriculum. In addition, the COVID-19 pandemic exacerbated and intensified stressors among LCM as well as limiting their access to support. Although WhatsApp groups had been set up to provide remote peer support—and were appreciated by participants—LCMs needed more support to effectively manage their stress levels during the pandemic.

13 The GBV Guiding Principles include ensuring the safety of the survivor, ensuring confidentiality, respecting the survivor’s preferences and decisions, and practicing non-discrimination.



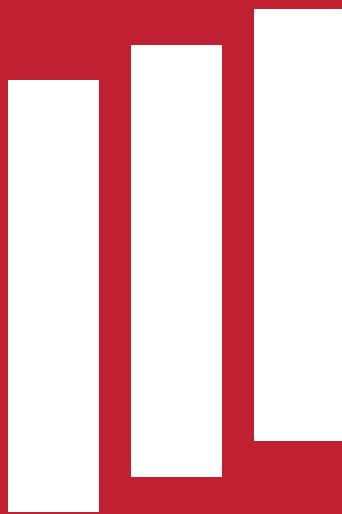
Key recommendations

1. Humanitarian agencies should train and support LCMs to better understand key concepts such as the GBV guiding principles in order to better respond to survivors, given LCMs' critical role in the community and their frequent encounters with survivors.
2. Humanitarian service providers should include provision of support and supervision to LCMs when providing support to frontline workers, as many LCMs suffer from highly stressful working contexts. Virtual support groups for LCMs could be considered to help those who work freelance benefit from the peer learning and support from their colleagues.
3. Humanitarian actors should provide guidance and support to LCMs in settings without GBV or sexual violence services for LCMs to refer survivors to. Consider using the [*Pocket Guide: How to support survivors of gender-based violence when a GBV actor is not available in your area.*](#)



Acronyms and Abbreviations

CBO	Community-based organization
GBV	Gender-based violence
GBVIMS	Gender-Based Violence Information Management System
ICC	International Criminal Court
IEC	Information, education, and communication
LCM	Linguistic and cultural mediator
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, and other persons with diverse sexual orientation, gender identity and gender expression
NGO	Nongovernmental organization
UNHCR	United Nations High Commissioner for Refugees
WRC	Women's Refugee Commission



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