



A Summary of Assessment Findings and Recommendations The Situation of Refugee and Migrant Women

Greece 2016

Overview

Since the EU-Turkey Agreement came into effect in March of 2016, over 60,000 refugees remain stranded in Greece. Over half of refugees entering Greece between January and June of 2016 were women and children, with women comprising 22% of the total number of new arrivals.¹ Many of these women are pregnant, have infants or young children, are heads of households, or are single women traveling on their own to reunite with family members in other countries.

Inadequate protection and promotion of women's health, safety, and rights has been a concerning feature of the crisis, reflected in both the current conditions of open temporary reception structures (sites) in Greece as well as the insufficient long-term legal protection options. In many of the sites, the level of security and service provision falls short of meeting international minimum standards. This leaves women exposed to gender-based violence, including domestic violence, sexual assault and exploitation, and trafficking and lacking adequate access to sexual and reproductive health care. Women have limited access to legal protection and there are urgent concerns about the particular obstacles women face in navigating the asylum process due to low literacy, language barriers and their care responsibilities that reduce both their time and mobility. The absence of a clear and sufficiently-resourced and staffed legal protection system compounds the challenges women face, especially in cases of family reunification.

This briefing paper was developed by UNFPA and Oxfam and consolidated the findings and recommendations from assessments by: the International Medical Corps (IMC) and Diotima who conducted a rapid SGBV assessment to identify protection risks and service gaps in the camps; the Women's Refugee Commission who analyzed the impact of the EU-Turkey deal on refugee women and girls in Greece; and by Oxfam who conducted a gender analysis to understand the different impacts of the situation on migrant and refugee women as well as the way which humanitarian actors address gender differences and inequalities within the response. For more detail on each assessment, see Table 1 below.

Assessment report content was analyzed thematically to identify common, priority findings and recommendations outlined below. The intention is to ensure that assessments directly inform advocacy, programming and humanitarian planning for 2017. Each assessment involved direct feedback from refugees and migrants, soliciting their time, opinions, and concerns. It is the responsibility of humanitarian actors and the Greek government to ensure that the information gathered is urgently translated into actions to promote women's health and rights in the Greece response.

Key Findings

Assessment findings can be categorized into three main themes: gender-based violence, sexual reproductive health, and women's participation and empowerment.

Gender-Based Violence (GBV)

Although data on incidents of GBV is not systematically collected, service providers and refugee and migrant community members alike report that women and girls experience various forms of GBV in the sites, including domestic violence, sexual abuse and exploitation, forced prostitution, survival sex, early marriage, and trafficking.

The design and layout of many sites fails to prevent and mitigate GBV in compliance with international guidelines². Across research sites, women expressed concerns for their safety and security. Many sites have no police or security presence. The lack of security at the entrance to some of the sites enables anyone to enter the grounds. Poor lighting, facilities, and overcrowding were of particular concern in the warehouse and factory sites north of Thessaloniki. Women, particularly female-headed households and unaccompanied women, reported that they do not walk around at night or go to the toilets because of fear for their personal safety. In addition, there is no consideration of vulnerability in accommodation placement in some sites, and separate accommodation for single women or female-headed households is not provided.

Women reported that toilet and shower areas are not safe for women and girls. In many assessment sites, showers and toilets for men and women were not in separate locations and men use all facilities. Further, many showers do not have functional locks or changing areas that afford adequate privacy. Toilets and showers are often located far from accommodate areas and are dark, increasing safety risks at night. Women requested better lighting around toilet and shower areas, improved lighting in the sites overall, and flashlights.

In terms of response, there are few organizations present with GBV capacity and GBV services in the sites are limited; the majority of sites have no case management services for survivors of GBV. Most sites lack a functional referral pathway for connecting survivors to services, and a mechanism for responding to emergency cases after hours. Further, there is no clear system for referrals to safe shelter for survivors seeking immediate protection from harm. State GBV shelters are often full and most do not admit survivors to facilities on evenings or weekends when the majority of incidents occur.

Regarding access to medical care, public hospitals do not have facility-level protocols for the clinical management of sexual violence, lack staff trained in the clinical management of rape, and often do not have post-exposure prophylaxis (PEP) available. Mental health and psychosocial support services in the sites are insufficient.

Further, barriers to accessing public health and shelter services include a lack of female interpreters, documentation requirements that vary by facility, and the fact that many sites are located in remote areas, with limited services within reach. Lack of trust in service providers, limited community awareness of available services, and the fear of stigmatization by community members also actively deter GBV survivors from seeking help.

Sexual and Reproductive Health

Sexual and reproductive health services are not available in most sites, and there is an urgent need to ensure access to the minimum initial services package (MISP) for reproductive health.³ Minimum reproductive services must include the prevention of sexual violence and assistance for survivors, measures to reduce the transmission of HIV, and the prevention of excess maternal and newborn morbidity and mortality. It also requires a plan to integrate comprehensive reproductive health into primary health care that is accessible to refugees and migrants in the sites. Assessments highlighted the lack of available antenatal care for pregnant women as well as postnatal care for women following deliveries in public hospitals. Women often return to sites shortly after C-section procedures without adequate accommodation and support. The food provided in the camps is considered to be insufficient in nutritional value for pregnant and lactating women.

Women expressed dissatisfaction with the quality of health services in the sites, with some sites providing limited or no access to a female doctor or female nurse – rendering access impossible for some. Further, public health services outside of sites are often under-resourced and understaffed. Vaginal infections were noted as a primary health concern for women, in part due to challenges in maintaining hygiene under current living conditions. In some sites women reported needing additional personal hygiene items, including menstrual hygiene products and underwear.

Assessments highlighted the unmet need for family planning. Contraceptives are not available in all sites despite a high demand. Where contraceptives are available, women are often not aware that they can access them. Information regularly provided to site residents about available services does not include sexual and reproductive health services. Further, there is a significant demand for long-acting contraceptives, but these options are not available.

Women's Participation and Empowerment

Women have limited time and mobility to participate in community consultations and to influence decision-makers, which results in insufficient recognition of their particular and differentiated needs, interests, and aspirations in the humanitarian response. The absence of childcare and lack of access to activities and schooling for young children were highlighted as key barriers to women's participation in activities, information sessions, and community meetings. In addition, women bear a heavy burden of household responsibilities, washing clothes by hand and cleaning without sufficient supplies. Female-headed households face particular challenges in caring for their children and household responsibilities on their own, without the support of their husbands and communities.⁴

These care responsibilities inhibit both women's participation in community consultation processes and their ability to receive information. When women are unable to participate in information sessions, they are left without access to information about their legal options and available services. They also have less access to information shared by word of mouth given their limited presence in public spaces.

In addition, language and literacy barriers impose additional challenges on women's ability to collectively organize, discuss their issues and concerns, and advocate to influence the decisions of site authorities and other duty-bearers. In cases where duty-bearers are able to reach women as part of their consultations and monitoring, an absence of female interpreters is often an obstacle to women's meaningful participation.

The dominant narrative of women as vulnerable has further excluded women from public life and decision-making as duty bearers consistently fail to recognize and harness women's skills, resilience and capacities. This narrative of women as vulnerable, compounded by their childcare responsibilities, might prove particularly problematic should EU Member States look to prioritize people who are able to contribute to their workforce as part of the EU Relocation Scheme selection process.

Key Recommendations:

1) Improve gender-based violence prevention and response as a life-saving intervention.

- Identify and implement sector-specific action plans to mainstream GBV into site planning, site coordination and management, in line with the IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action.
- Increase financial and human resources to ensure GBV case management services are available in all sites, and that refugees and migrants have access to adequate health, legal, psychosocial, and safe shelter services either on site or by referral.
- Ensure access to clinical management of rape services for all field sites by supporting health providers with requisite medicines, commodities, and training to deliver survivor-centered care.
- Increase the presence of gender-balanced security forces who have been trained and sensitized on GBV issues to increase safety within the sites. Monitor security threats.
- Strengthen the capacity of the health and social welfare systems to meet the needs of refugee and migrant survivors of GBV, including ensuring that female interpreters are available for refugee and migrant survivors of GBV accessing public health, shelter, and counseling services.

2) Increase access to sexual and reproductive health services.

- Increase financial and human resources necessary to ensure the delivery of sexual and reproductive health services in all sites. Strengthen the capacity of the public health system to address the sexual and reproductive health needs of refugees and migrants, including ensuring that female gynecologists and doctors are available to provide services both on site and in public hospitals.
- Ensure female cultural mediators and interpreters are available to provide accompaniment and interpretation for refugees and migrants seeking health services both within and off sites.
- Provide a range of options of contraception to meet demand. Make free condoms available in all sites, in areas where they can be accessed privately.
- During food distributions, ensure the availability of shelter and seating for pregnant and breastfeeding women if there is a long wait, or establish priority queues if necessary.
- Provide supplementary feeding for pregnant and lactating women or additional high nutrient density food items either in-kind or through vouchers.
- Provide safe and appropriate complementary foods for children 6-23 months (vouchers/in-kind), accompanied by practical guidance and demonstration on their preparation.

3) Promote women's participation and empowerment.

- Ensure close monitoring of cash programmes to ensure women have equal access to, and control over, cash to increase women's voice and decision making. Adapt the programme accordingly.

- Expand women’s empowerment activities to enable women to gain the skills and capacity necessary to access the workforce, and increase their confidence to participate in site and community-level decision-making. Provide childcare and organized activities for children during implementation of programs and activities to enable full and meaningful participation by women with care responsibilities.
- Establish more women’s safe spaces and centers to foster social support and cohesion among women.
- Support the establishment and functioning of community structures, such as councils or committees, to identify community concerns, engage in advocacy, and implement community led initiatives. Ensure women’s participation in community committees and / or women-only committees. Ensure that women’s and men’s committees have equal capacity to influence.
- Expedite family reunification cases and ensure legal processes and protection mechanisms are gender-sensitive and respect family ties.

Table 1: Summary of Assessment Methods

Title	Organization	Date	Methods	Locations
Rapid Protection / SGBV Assessment	IMC and Diotima	June 2016	-19 key informant interviews with stakeholders -16 focus groups with women, men, boys, and girls	Attica: Oinofyta, Malakasa, Ritsona Epirus: Katsikas Central Greece: Thermopyles
EU Turkey Agreement Failing Refugee Women and Girls	Women’s Refugee Commission	August 2016	-25 interviews with refugee women -Key informant interviews with representatives of UN agencies, government, national and international NGOs -Desk research	Attica: Pireaus Port, Victoria Square, Eleonas, Elliniko Lesvos: Kara Tepe, Moria Northern Greece: EKO gas station, Alexandria, Diavata
Gender Analysis: the Situation of Refugees and Migrants in Greece	Oxfam	August 2016	-12 focus groups with refugee women and men -Key informant interviews with representatives of UN agencies, national and international NGOs -Desk research: reports, program documents	Attica: Ritsona Epirus: Doliana, Katsikas, Konitsa, Tsepelovo

¹ UNHCR. “Regional Refugee and Migrant Response Plan for Europe.” 2016.

² UN Inter-Agency Standing Committee. “Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action” Reducing Risk, Promoting Resilience, and Aiding Recovery.” 2015.

³ Interagency Working Group on Reproductive Health in Crisis. “Minimum Initial Service Package (MISP) for reproductive Health in Crisis Situations.” 2011. <http://iawg.net/minimum-initial-service-package/>

⁴ Oxfam. “Gender Analysis: The Situation of Refugees and Migrants in Greece”. August 2016.