



Women's Refugee Commission
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Mean Streets: Identifying and Responding to Urban Refugees' Risks of Gender-Based Violence

February 2016



**WOMEN'S
REFUGEE
COMMISSION**

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The Women's Refugee Commission 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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Acronyms & Abbreviations

CBO	Community-based organization
DPO	Organization of persons with disabilities
DRC	Democratic Republic of Congo
GBV	Gender-based violence
HIAS	Hebrew Immigrant Aid Society
LGBTI	Lesbian, gay, bisexual, transgender and intersex
LCRP	Lebanon Crisis Response Plan
NGO	Nongovernmental organization
NSWP	Global Network of Sex Work Projects
OGERA	Organization for Gender Empowerment and Rights Advocacy
SOP	Standard operating procedure
SWIT	Sex Worker Implementation Tool
TRANSIT	Trans Implementation Tool
UNHCR	United Nations High Commissioner for Refugees
WRC	Women's Refugee Commission

Executive Summary

An increasing majority (nearly 60 percent) of refugees live in cities, a figure that will continue to rise as camps become an option of last resort. This new reality necessitates a monumental shift in humanitarian response, requiring policy makers, donors, and practitioners to develop new programming that addresses the protection concerns of refugees in urban contexts.

Urban refugees face gender-based violence (GBV) risks as a result of multiple and complex unmet social, medical, and economic needs, as well as intersecting oppressions based on race, ethnicity, nationality, language, class, gender, sexual orientation, and disability. Misperceptions further contribute to discrimination toward refugees, which in turn heightens their vulnerability.

Throughout 2015, the Women's Refugee Commission (WRC) conducted research in urban settings, the first phase of a multi-year project to improve the humanitarian community's understanding of and response to GBV risks in urban contexts. Quito, Ecuador; Beirut, Lebanon; Kampala, Uganda; and Delhi, India, were chosen because they are host to diverse refugee populations, have different policy environments for refugees, and are at different stages of humanitarian response.

The project looked separately at the GBV risks of different urban refugee subpopulations: women; adolescent girls; lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals; persons with disabilities; and male survivors of sexual violence. Refugees engaged in sex work were added as a subpopulation, due to their invisibility and the heightened GBV risks they face.

Findings

A deeper understanding of the nuances and complexities of urban risks is essential to addressing violence and bridging the protection gaps affecting marginalized groups who have been traditionally overlooked in humanitarian response.

UNHCR's 2009 Urban Policy unequivocally affirmed its protection mandate but limited itself to setting forth "the broad contours and underlying principles" of engagement with urban refugees. There remains a need for more specific guidance, as well as capacity building for field staff.

Additionally, more creative and agile use of donor funding is necessary, bolstered by more formal opportunities to share information about what works, or is showing promise, in different cities worldwide.

Key Recommendation #1: Systematize and broaden engagement of local actors.

Among the key research findings is the need for urban humanitarian practitioners to move beyond traditional partners, engaging a broad network of police departments, school boards, hospital administrators, local shelters, health clinics, civil society groups, and local community-based organization (CBOs). It is critical to leverage the skills, expertise, and social or political capital of local actors in urban protection. This engagement must be approached systematically and tailored to account for the particular needs of refugee subpopulations. Diversifying UNHCR's partner base and referrals is key to ensuring that at-risk populations can access appropriate services.

Key Recommendation #2: Develop proactive, targeted strategies for addressing GBV risks related to shelter and livelihoods.

Shelter and livelihoods are the two greatest areas of GBV vulnerability for urban refugees. Addressing urban refugees' difficulty in obtaining safe and stable housing and livelihoods is a foundational component of urban protection and GBV risk mitigation. Exploitation, discrimination, and various forms of GBV are routine. Direct advocacy is needed at the local level to assist refugees seeking housing and to identify potential employers and develop a multifaceted response to the exploitation of refugee workers.

Key Recommendation #3: Prioritize, and earmark resources for, targeted actions and proactive outreach tailored to meet the needs of different at-risk subpopulations.

Mainstreaming alone cannot address interlocking social, political, and economic systems that give rise to GBV risks for refugee subpopulations. Targeted actions are imperative and must be tailored to address the particular needs, concerns, and realities of different refugees; they must also be designed and implemented with refugees' meaningful participation.

UNHCR should issue more specific operational directives, recommendations, and sample interventions for urban field staff on how protection principles can be translated into practice. Concrete guidance is especially needed for staff who lack subject matter expertise in engaging at-risk groups. Providing protection to refugees at heightened risk of GBV due to their intersecting identities requires deliberate, thoughtful effort; this includes reaching out to relevant host community CBOs and identifying sensitive, specialized service providers.

Key Recommendation #4: Formalize nondiscrimination and standards of care for engaging all refugee subpopulations, put accountability mechanisms in place for UNHCR partners, and take a proactive approach to eliminating discrimination.

UNHCR's local partners can be sites of intense discrimination for certain groups of urban refugees. Where local laws and social norms support discriminatory practices, UNHCR partners have a special responsibility to not only sensitize staff, but also provide training and operational guidance on engaging at-risk groups and on what meaningful feedback and accountability mechanisms can be put in place for their implementing partners.



Rohingya refugees in Delhi.

Introduction

Today, an increasing majority of people fleeing conflict and persecution take refuge in cities, rather than in refugee camps or settlements. They gravitate to urban areas for the same reasons many of us do: for the opportunities, infrastructure, services, and autonomy cities can provide, for ourselves and for our families.

Refugees are continuing to find their way to cities, even in the face of restrictive host government and encampment policies. Nearly 60 percent of all refugees currently reside in cities, a figure that will keep rising as camps are relegated to an option of last resort and phased out wherever feasible. UNHCR's recent Policy on Alternatives to Camps promotes avoiding the establishment of camps,¹ and does so in concert with its earlier commitment to affirming the rights of refugees to reside, safely and with dignity, in cities.²

This commitment, articulated in UNHCR's 2009 Urban Policy,³ set the stage for understanding that urban migration would have a transformative impact in humanitarian response. The Policy unequivocally affirms UNHCR's protection mandate in urban settings, while recognizing that cities bring a new set of challenges toward fulfilling that mandate. By its own terms, the Policy limited itself to setting forth "the broad contours and underlying principles" that govern humanitarian actors' engagement with urban refugees. More specific guidance for operationalizing those principles would have to be forthcoming.

Experience since 2009 has shown that implementing UNHCR's Urban Policy will require nothing less than a complete rethink and restructuring of traditional humanitarian response.⁴ Established ways of channeling donor funds and providing services must be re-examined. Assumptions that have proven useful in the past, existing knowledge about refugees' needs, and even best practices around service provision must be interrogated afresh.

Humanitarians, donors, and practitioners must collectively "go back to the drawing board" for urban contexts, taking a critical eye to policies, programs, and strategies that were largely developed during the era of camp-based response. Approaches to protection, in particular, must be rethought from the ground up. Urban refugees often live dispersed throughout cities, and encounter myriad protection concerns in their daily lives that were either not pertinent, or less pertinent, in camp settings.

Identifying Urban GBV Risks

This report looks to build the knowledge base and guidance around a particular component of urban protection: gender-based violence prevention and response. Gender-based violence (GBV) is defined as:

“[A]n umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.”⁵

While it is known that urban refugees face special GBV risks – risks that derive from, or are heightened by, their urban surroundings – much remains to be learned about the precise nature of these risks and how humanitarian response can support refugees in mitigating them.⁶

The Inter-Agency Sanning Committee *Guidelines on Gender-based Violence Interventions in Humanitarian Settings* acknowledge that most refugees live outside camps and that this reality needs to be reflected in GBV prevention and response interventions. To build on this foundation and ensure effective implementation of the Guidelines, the humanitarian community must deepen its understanding of the nuances and complexities of urban risks and develop innovative programming and partnerships to address them.

Similarly, with the new Sustainable Development Goals,⁷ possible outcomes of the World Humanitarian Summit happening in May 2016, and increased understanding that humanitarian financing mechanisms must support host communities as well as refugees, this is an especially compelling time to be looking at gaps in urban protection and collaborative ways forward for bridging them.

Against this backdrop, in late 2014 the Women’s Refugee Commission embarked on a multi-year project dedicated to improving the humanitarian community’s understanding of GBV risks in urban contexts.ⁱ With support from the Bureau of Population, Refugees, and Migration at the U.S. Department of State, the first year of the project was research driven, focused on learning what GBV risks refugees are facing and

i. Whether a particular act of violence has a gendered component, or how strong that component is, can be context dependent. For some types of violence discussed in this report, the link to gender may be more or less obvious. In the case of school bullying, for instance, which is discussed in the section on Children and Adolescents, some instances of bullying are more gender driven than others. For the purposes of this report, the WRC defines violence as GBV if it has a clear or strongly plausible gender dimension, based upon how it was described to us by refugees and stakeholders in the field.

current and potential risk mitigation strategies.

Four cities were selected as target sites for field research: Quito, Ecuador; Beirut, Lebanon; Kampala, Uganda; and Delhi, India.ⁱⁱ They were chosen not only for their geographic diversity, but also because they are host to diverse refugee populations, have different policy environments for refugees,⁸ and are at different stages of humanitarian response.

Mindful of the diversity of refugees living in cities, and categorical differences in their respective vulnerabilities and protection needs, the project looked separately at the GBV risks of the following refugee subpopulations: women; girls; men; boys; lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals; and persons with disabilities. Given the prevalence of commercial sex, or sex work,ⁱⁱⁱ being reported by refugees and stakeholders in all cities, across all subpopulations, and the heightened risks of GBV related to it, refugees engaged in sex work were added as a target subpopulation.

Targeting these subpopulations individually was necessary because many of them often remain hidden. Tailored, proactive outreach was essential to engaging these groups and identifying their particular GBV risks, and a key finding of this report is that such outreach should be a hallmark of urban response writ large. Proactive outreach is imperative for giving refugees with wildly different experiences a voice in shaping programming that affects their security and well-being, and facilitating and mainstreaming their participation across humanitarian response.

Through conversations with a wide range of stakeholders in each city, including refugees, UNHCR, and its partners, researchers identified:

- Key GBV risks faced by urban refugee subpopulations. These include risks faced at home, in public, at workplaces, and in schools.
- Current and potential GBV risk mitigation strategies.
- Gaps in service provision linked to GBV prevention and response.

ii. In Ecuador, the WRC also visited the cities of Esmeraldas and San Lorenzo, which are along the Ecuadorian-Colombian border.

iii. This report adopts the definition of 'sex work' and 'sex worker' used by WHO, UNFPA, UNAIDS, Global Network of Sex Work Projects and The World Bank, in *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions* (also known as the "SWIT") (2013). As set forth there, 'sex workers' are "female, male, and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally." Ibid. at xiii (internal citation omitted). The authors go on to clarify that "sex work may vary in the degree to which it is 'formal' or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities." Neither that publication nor this report addresses the sexual exploitation of minors.

- Good practices in urban GBV prevention and response.
- Challenges and opportunities for strengthening community-based protection in urban areas, including current and potential linkages between humanitarian actors and host community nongovernmental organizations (NGOs), governmental actors, and civil society.

The next phase of this project will involve piloting risk mitigation actions in each of the four target cities, and providing support to humanitarian actors in those cities on implementing the recommendations set forth in this report. The WRC will also disseminate further guidance to stakeholders in cities worldwide that host refugee populations, including guidance tailored to the particular needs and vulnerabilities of urban refugee subpopulations.

This report has resonance beyond the four assessment cities. In this new era, in which a majority of refugees are fleeing to cities, trying to carve out lives for themselves alongside the host community urban poor, humanitarian response must adapt, innovate, and program more creatively than it ever has. The first step in this process, and what this report seeks to do, is to give a voice to the urban refugees themselves, and listen to what they say are their biggest risks, their primary concerns, and their most promising pathways toward resilience.

Cross-cutting Recommendations for Mitigating Urban GBV Risks

A number of recommendations for actors involved in urban response are made throughout this report. Importantly, recommendations specific to mitigating the key risks encountered by refugee subpopulations – women, children and adolescents, LGBTI individuals, persons with disabilities, and men – are included in their respective subsections.

We summarize our four key recommendations below. They are based on cross-cutting themes that emerged across cities. Implementing them will require a nuanced understanding of not only the underlying risks faced by different refugee subgroups, but also the challenges practitioners face trying to implement UNHCR urban protection policy in cities with complex political and social ecosystems of their own.

Key Recommendation #1: Systematize and broaden engagement of local actors.

Effective urban protection and GBV prevention cannot be achieved by humanitarian actors alone. It requires engaging a broad network of nontraditional partners, such as police departments, school boards, hospital administrators, local shelters, health clinics, civil society, and local community-based organization (CBOs).

Engagement with local actors is currently uneven and ad hoc across urban contexts.

Different UNHCR field offices and partners engage different sets of local actors; this engagement is often inconsistent, initiated only after a particular protection concern has arisen multiple times, or else on a one-off basis to address a particular case. Engagement with local actors must be approached systematically, sector by sector, and tailored to account for the particular needs of refugee subpopulations. A systematic approach is essential for building the personal and financial (e.g., cost sharing) relationships that will enable refugee integration into local service provision and facilitate their access to protective peer networks. At best, failing to leverage the local knowledge, skills, and capacities of host community actors can leave valuable urban resources untapped. At worst, it can leave refugees facing urgent risks without referral or service options, while sidestepping the reality that certain sets of local actors – state and non-state actors, from police to business owners – often play a role in generating GBV risks for urban refugees.

A systematic approach will involve assigning responsibility to field staff for mapping and engaging local actors across sectors. Targeted mapping must also be done to identify and build linkages with local organizations relevant to the protection environments of particular refugee subgroups, such as adolescents and LGBTI individuals. Such an approach will also involve changing how donor funds are channeled and used, so they can go directly to supporting a network of impacted host community institutions. Diversifying UNHCR's partner base and referrals is key to ensuring that at-risk populations have options for service provision, especially where they feel vulnerable accessing mainstream services.

Key Recommendation #2: Develop proactive, targeted strategies for addressing GBV risks related to shelter and livelihoods.

Shelter and livelihoods are the two greatest areas of vulnerability for urban refugees and underlying causes of GBV-related risk.

Shelter. The vast majority of urban refugees are responsible for finding and affording their own shelter. Addressing urban refugees' difficulty in obtaining safe and stable housing, and their lack of access to emergency shelters, is a foundational component of urban protection and GBV risk mitigation. More funding for shelter assistance is needed, including for GBV survivors and those needing emergency accommodation. Humanitarian actors must map safe and viable options for refugees, and take a targeted approach to identifying options for at-risk subpopulations, like LGBTI persons, who are routinely turned away by landlords and local shelters. Direct advocacy is needed at the local level to curb the exploitation of, and discrimination against, refugees seeking housing.

Livelihoods. Securing a source of income is key to refugees' survival in cities, with the vast majority of refugees finding and looking for work in informal economies.

Exploitation, discrimination, and various forms of GBV are routine in both the search for a job and in the course of a workday. Refugees are especially vulnerable to livelihood-related GBV risks because employers and clients understand they have little access to recourse and/or are unlikely to seek it; for various reasons refugees do not report substandard working conditions or GBV to authorities, and they are often so desperate for income they will continue working in high-risk jobs.

Promoting safe livelihoods for refugees is a cornerstone of urban protection, including GBV risk mitigation. More funding for livelihoods programming is needed, along with more strategic thinking about how to best prioritize resources given local markets, work restrictions, and refugees' skills and capacities. Tailored job placement is essential, especially for refugees who do not speak a host community language or who face intersecting discrimination, such as LGBTI individuals and persons with disabilities. A wide variety of livelihood-related risk mitigation strategies have been tried in humanitarian and development contexts; these must be mapped, adapted, and piloted as part of broader urban protection. Direct advocacy with local actors is also needed, to identify potential employers and develop a multifaceted response to the exploitation of refugee workers.

Key Recommendation #3: Prioritize, and earmark resources for, targeted actions and proactive outreach tailored to meet the needs of different at-risk subpopulations.

Cities are complex environments, with interlocking social, political, and economic systems that give rise to GBV unique to different refugee subpopulations. Mainstreaming alone cannot address these particular GBV risks, nor can it generate or promote the risk-mitigation strategies that will be most effective, feasible, and favored by different groups. This is why targeted actions are imperative. Targeted actions must be tailored to address the particular needs, concerns, and realities of different refugees and they must be designed and implemented with their meaningful participation in design and delivery. These actions must also acknowledge that certain at-risk groups, including adolescent girls, persons with disabilities, sex workers, male survivors, and LGBTI individuals, encounter particular barriers – even additional GBV risks – when trying to access mainstream services and facilities.

Targeted actions will ensure refugees are provided with information tailored to their needs and risks. This should include pre-identified options or suggestions for accessing services safely, finding shelter and employment, and meeting other basic needs (e.g., food). Targeted actions will also facilitate at-risk refugees' access to peer networks – including peer networks in the host community – and local organizations that have specialized knowledge relevant to their protection, health, and safety needs. Targeted actions will also include encouraging and supporting refugee-led support groups and CBOs; examples of such groups abound in urban settings. While their

activities are diverse, their role in reducing refugees' isolation and mitigating GBV risk is consistent.

Dialogues and targeted actions must take place across urban response, and not be limited to a GBV frame. Often, issues pertaining to LGBTI refugees are considered or made the purview of GBV working groups. This precludes important conversations and operational decisions from being taken up in other areas (e.g., livelihoods, health, education) integral to a refugee's protection.

At the global policy level, UNHCR should issue more specific operational directives, recommendations, and sample interventions for urban field staff on how protection principles can be translated into practice. Concrete guidance – standardized, but adaptable for local contexts and presenting a range of options – is especially needed for staff who lack subject matter expertise for engaging at-risk groups, like LGBTI individuals and persons with disabilities.⁹ UNHCR should also participate in inter-agency conversations that are happening around the development and implementation of guidance for engaging transpersons, sex workers, and other at-risk groups in interventions. Dialogues around the forthcoming Trans Implementation Tool (TRANSIT)^{iv} and the recent Sex Worker Implementation Tool (SWIT)^v are two such examples.

Key Recommendation #4: Formalize non-discrimination and standards of care for engaging all refugee subpopulations, put accountability mechanisms in place for UNHCR partners, and take a proactive approach to eliminating discrimination.

UNHCR's local partners can be sites of intense discrimination for certain groups of urban refugees, namely LGBTI individuals, persons with disabilities, male survivors, sex workers, and, in certain contexts, refugees of certain races, ethnicities, religions, or national origin.

Nondiscrimination principles and UNHCR's Age, Gender, and Diversity policies are not taken up and/or enforced at the field level. This was found across cities, especially

iv. The TRANSIT, which is slated for release in early winter 2016, is a practical guide to implementing policies and programs around the specific health needs of transgender populations. A consultative meeting around the content of the TRANSIT was held in Bangkok in July 2015, supported by USAID, UNFPA, UNDP, and the International Reference Group on Trans* and Gender Variant and HIV/AIDS Issues. <http://cliniq.org.uk/2015/08/23/bangkok-transit-consultation-trans-people-hiv/>

v. In 2013, the World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work Projects, and the World Bank jointly authored a resource manual for designing and implementing programming that engages sex workers. The manual, *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions*, includes separate chapters on promoting community empowerment; addressing violence against sex workers; community-led services; and good practices. Colloquially, this manual is known as the Sex Worker Implementation Tool, or SWIT. http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/

among local partner staff who are new to humanitarian response and ill-experienced at recognizing or setting aside their own biases and prejudices. Where local laws and social norms support discriminatory practices, UNHCR partners have a special responsibility to not only sensitize staff, but also provide training and operational guidance on engaging at-risk groups. This is essential to enforcing codes of conduct and ensuring meaningful adherence to the human rights frameworks and standards of professionalism that govern humanitarian practice.

From the onset of urban response, UNHCR must consider which potential local partners currently have the skills, capacities, sensitivities, and personnel to serve all refugees and/or particular subpopulations; what additional training and recruitment is needed to bring local partners' service provision and GBV case management up to humanitarian standards, including the survivor-centered approach called for in the IASC Guidelines;¹⁰ and what meaningful feedback and accountability mechanisms can be put in place for their implementing partners, mindful that certain groups of refugees may have greater or less access to any one mechanism.



Afghan women in Delhi participating in a group activity run by the Refugee Community Development Project.
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Report Roadmap

This report follows the structure outlined below. Certain themes and recommendations are repeated in different places throughout the report, particularly within the subsections on individual refugee subpopulations. This is so readers who are mainly interested in the findings around a particular group can read them as stand-alone chapters.

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Methodology

Between February and August 2015, the WRC undertook field assessments in four urban settings with large refugee populations: Beirut, Lebanon; Delhi, India; Kampala, Uganda; and Quito, Ecuador.¹¹ Each was done in partnership with a local refugee service provider, an NGO that was usually an implementing or operational partner of UNHCR.

At the core of each assessment were two research components, both of which were qualitative. The first engaged refugees directly, through in-person consultations. The second involved consultations with a wide range of organizational stakeholders, from humanitarian actors to local civil society groups whose services or expertise could potentially be integrated into urban protection.

Gathering Refugees' Perspectives

The WRC consulted with 509 refugees across the four cities, gathering their perspectives on their GBV risks, access to services, and suggestions for change. In most settings the WRC disaggregated consultations to speak separately with refugees from different subgroups: women; men; girls; boys; LGBTI individuals; women with disabilities and female caregivers; and men with disabilities and male caregivers. Where possible, the LGBTI group was disaggregated for lesbians, gay men, and transwomen.¹²

Refugees were identified and invited to participate in field assessments through UNHCR staff and NGOs working with urban refugees. Consultations took place through a combination of focus groups and individual interviews, which took place in community centers, shelters, and local partners' offices. In addition, several individual interviews were conducted during home visits. A total of 47 group discussions and 28 individual interviews were conducted across the four contexts. Most were conducted through an interpreter. Transportation or an allowance was often provided to refugees to facilitate access to the group discussion or interview.

Group discussions and individual interviews were semi-structured: facilitators used discussion guides to ensure that conversations touched upon the core research questions, while also encouraging participants to speak freely on issues that resonated with them and to pose their own questions to the group or raise additional subtopics. The consultations were geared toward eliciting refugees' perspectives about their safety in the city; their own GBV risks, as well as those of their friends, family members, and community members; what risk mitigation strategies they are

currently using; and what suggestions they have for refugee service providers going forward. Discussion guides were modified for different refugee subpopulations to gather information about their particular risks and concerns.

Previous field research conducted by the WRC in urban areas suggested that a number of urban refugees engage in sex work, either regularly or on occasion.¹³ At the same time, however, little to no evidence exists – beyond the occasional anecdotal report – about the experiences of these refugees, including their exposure to GBV risks and access to services. To fill these gaps and bring this issue further to light, while accommodating sensitivity around the topic, the WRC designed a qualitative survey on the topic of refugees and sex work. Refugees were invited to take the survey, which was anonymous and voluntary, at the end of focus groups and interviews. The survey was only introduced where it had been translated beforehand into refugees' local languages, which was not always possible given the diversity of languages spoken by refugees, and was given only to individuals 18 years and over. The survey asked a basic question about whether urban refugees in their community engage in selling sexual services as a form of income, and asked for recommendations for service providers. The survey also included a question related to sexual coercion, asking whether refugees in their community experience sexual coercion in the form of being pressured to exchange sex for rent, safety, employment, or goods. Survey respondents were offered the opportunity to write their answers or share them verbally with a facilitator who would write them in, or to leave without doing the survey.

All participants were provided with background information about the WRC, the nature of the project, and the aims of the field assessments. Participation was voluntary, with opportunities for refugees to learn about the project before deciding whether or not to participate. Everyone who participated gave verbal consent at the start of each session, as well as permission for a note-taker to transcribe what was said. For those under 18 years old, consent was also sought from the parent or guardian, and those with intellectual disabilities were invited to have a trusted friend or family member of their choice join them for the consent process and/or the consultations. Participants who expressed an interest in receiving counseling or medical treatment due to GBV or GBV risks were referred to appropriate service providers.

Consulting Humanitarian Actors and Nontraditional Urban Stakeholders

As noted in the Introduction, creating effective protection networks for urban refugees will require engaging a range of nontraditional actors in humanitarian response. To demonstrate the need and potential of this engagement, the WRC met with both humanitarian actors and nontraditional urban actors as part of each assessment.

Humanitarian actors. Humanitarian actors were consulted for their perspectives on the GBV risks facing different groups of refugees, as well as refugees' access to services and social peer support. Information was gathered through one-on-one interviews and group discussions. Participants were identified through UNHCR staff and referrals from key informants, and included representatives from UN agencies and NGOs, especially refugee service providers and GBV prevention and response programming partners.

Nontraditional urban stakeholders. Respondents from outside the humanitarian sector were consulted for their perspectives on refugee vulnerability and inclusion. This included host community NGOs or civil society groups, such as local LGBTI organizations or organizations of persons with disabilities (DPOs). It included UN and international development agencies involved in local urban poverty initiatives and governmental actors like municipal councils and police departments. The WRC identified actors through stakeholder mapping conducted in advance of each assessment, as well as through referrals by local partners and individual refugees.

Some of these stakeholders were aware that their work touches the lives of urban refugees, or overlaps in some way with the needs of refugee subgroups. Others were unsure of any connection, and either wanted to learn more about refugees in their community or expressed a lack of interest.

Consultations sought to answer a few essential questions, to assess what role these stakeholders were currently playing in humanitarian response, if any, and the potential for bringing them into response in the future. Questions included:

- Does this organization currently engage the refugee community, and in what way?
- Does this organization have interest, resources, skills, capacities, or expertise that could be leveraged or integrated in urban humanitarian response, for any refugee subgroup(s)?
- What are the challenges and barriers to facilitating this integration, or to building linkages with refugees or humanitarian actors?

Limitations

Despite efforts, the WRC was unable to speak directly with refugees from every subpopulation in every city. In these cases, we relied upon consultations with stakeholders – humanitarian actors as well as host community groups – to gather information about GBV risks and service gaps affecting a particular subpopulation. For instance, in Delhi, where we were unable to access LGBTI refugees, we collected

information from service providers and case managers with experience working with LGBTI refugees. The WRC conducted no group discussions or interviews with children under 15 years of age in any location, so we triangulated information based upon consultations with parents, siblings, and service providers.

Refugees' familiarity with the concept of GBV, and comfort in talking about GBV, also varied across locations and subpopulations. Where LGBTI refugees were forthcoming about GBV risks, other men and boys^{vi} were often less so. These differences are reflected in our findings and in the length of respective subsections of the report.

Some refugees were reluctant to talk about GBV because they felt other issues were more pressing and essential to their survival, such as access to basic necessities like food, shelter, and hygiene. A social worker at a UNHCR partner in Kampala referred to refugees' "hierarchy of needs" to describe their relative disinterest in discussing GBV prevention and response in such circumstances.

She noted further that rape survivors are known to wait days before seeking medical care, and some never come for psychosocial support, because they have to work or want to save the money they would otherwise spend on transportation to and from services. An underlying message here is that until refugees have meaningful access to housing, electricity, health care, potable water, firewood, and education – efforts to discuss or address GBV may be met with frustration.

vi. Findings and recommendations relating to gay and transgender men are grouped under *LGBTI*; findings related to cisgender, heterosexual males are grouped under *Men and Boys*.

Short Background on Each Target City

Quito, Ecuador

More than 133,000 persons of concern currently reside in Ecuador; over 120,000 are refugees, constituting the largest refugee population found in any Latin American country.¹⁴ Nearly two-thirds of refugees and asylum-seekers in Ecuador have sought safety and security in urban areas.¹⁵

Ecuador is a party to the 1951 Convention on the Status of Refugees and has ratified its 1967 Protocol. A Presidential Decree passed in May 2012 (No. 1182) has created additional barriers to refugees' right to work in Ecuador, as well as access to health and other services.

The UNHCR operational budget for providing services to refugees in Ecuador increased by over USD 1 million between 2014 and 2015, with the entire budget prioritized for refugees and asylum-seekers. Although USD 1.5 million is allocated specifically toward prevention and response to sexual and gender-based violence, resources constraints continue to limit the ability of these and other programs to meet the needs of growing refugee and asylum seeker populations.¹⁶

Delhi, India

Currently more than 200,000 refugees and asylum seekers live in India.¹⁷ India does not have legal frameworks or institutions that provide specific services or protections for refugee populations. UNHCR has no formal agreement with the Government of India, but operates under the agreement of the United Nations Development Programme.

More than 33,000 refugees and asylum seekers are registered with UNHCR as residing in Delhi.¹⁸ The largest groups among the persons of concern are Afghan (Hindu Sikh Afghans and "ethnic Afghans" who are Muslim) and Burmese, primarily Burmese Chin.

The Government of India has a restrictive policy on the issuance of work permits for foreigners, including refugees. As a result, it is very unlikely that refugees will receive work permits from the government, even if they possess residence permits. Refugees are, however, allowed or tolerated to work in the informal economy. Refugees in Delhi reside largely in impoverished areas of West Delhi and in the less well-to-do neighborhoods of more affluent South Delhi.

Beirut, Lebanon

Since 2011, an estimated 1.5 million families and individuals fleeing the Syrian crisis have taken refuge in Lebanon.¹⁹ The mass influx of people has strained resources that were already spread thin across Lebanese poor, including land, schools, water resources, and health centers. As of May 2015, per instructions from the Government of Lebanon, UNHCR Lebanon has temporarily suspended registering new refugees.²⁰

The Lebanon Crisis Response Plan (LCRP) lays out a framework for channeling international financing to strengthen national services and infrastructure in ways that will benefit not just displaced Syrians, but also poor Lebanese and Palestinians living in Lebanon.

Refugees are not allowed to work, which forces them to find jobs in the informal sector, often in agriculture or construction for a few days each month. An estimated 70 percent of all refugees in Lebanon are living below the national poverty line of \$3.84 per day. Of the 1.2 million Syrians who are registered with UNHCR, an estimated one-third lack legal documentation for residing in the country, which under national law must be renewed every six months.²¹ This further constrains refugees' mobility and, with it, their ability to access services and provide for their well-being.

Kampala, Uganda

The 2006 Ugandan Refugee Law allows refugees to settle in Kampala or other noncamp areas; however, in doing so, forgo their access to most humanitarian assistance which is concentrated in camps, referred to as 'settlements' in Uganda. Some 80,000 refugees are said to live in Kampala, with the majority having fled conflict in the Democratic Republic of Congo (DRC).

Refugees are scattered across the city's slums. They face many of the same barriers as the Ugandan poor in accessing services, finding employment, and staying safe. However, they also face additional constraints, such as language barriers, discrimination, lack of legal documentation, and limited access to credit and formal sector employment.

Uganda is a signatory to the 1951 Refugee Convention, the 1967 Protocol, and the 1969 Organization of African Unity Convention Governing the Specific Aspects of the Refugee Problem in Africa. Despite refugees' legal rights, Ugandan attitudes towards refugees are generally negative. UNHCR and its implementing partners provide refugees with legal aid, health care support, language classes, psychosocial counseling, and minimal livelihood interventions, such as micro-credit and vocational training.²²

For more details on these four urban contexts, see Appendix, page 138.

GBV Risks Common to All Urban Refugees^{vii}

Urban refugees face GBV risks as a result of multiple and complex unmet needs that cut across social, medical, and economic dimensions. They also face intersecting oppressions based on race, ethnicity, nationality, language, class, gender, sexual orientation, and disability. Many members of host communities misperceive who refugees are, mistaking them for wealthy foreigners or for economic migrants who have come to “steal” jobs and other urban assets that are “rightfully theirs.” Refugees are also prejudged as bringing illness, crime, and economic downturns to their host cities. All of this fosters animus and discrimination toward refugees, which in turn heightens their vulnerability to GBV and inhibits their access to health, education, and employment opportunities – all of which are essential to GBV prevention.

A common theme in the sections that follow is the interrelation between GBV risks, urban poverty, and lack of access to basic necessities like food and shelter. Resulting GBV can be broken down into the following general categories:

- Risks related to livelihoods
- Risks related to shelter
- Risks related to urban isolation, fear of the police, and a lack of access to justice.

Risks related to livelihoods

Refugees consulted reported find it next to impossible to find jobs in their adopted cities, regardless of whether they are legally permitted to work. Some refugee service providers have job banks, but demand for jobs far outstrips what they have in their supply. Many refugees reported showing up to apply for a job and being told it is not open to foreigners. Jobs where their rights are respected and they are treated with dignity are even harder to come by. Withheld wages are a ubiquitous problem; so are sub-minimum wages, forced unpaid overtime, and sexual harassment by employers. Employers are aware that refugees are unlikely to file complaints for a variety of reasons: fear of losing their job; a lack of knowledge about their legal rights or how the legal system works; language barriers; fear that doing so will negatively affect their legal status in the country; and/or fear of being disbelieved when it is the word of a local versus that of a “foreigner.”

vii. Although GBV prevention and response are often discussed together, this report decouples prevention from response and focuses largely on the former. It addresses urban refugees' key GBV risks and their access to community-based protection, which is understood as fundamental to GBV prevention and risk mitigation. It touches upon, but does not explore in depth, the GBV response architecture and case management models that exist in each city.

Refugees reported taking whatever job is available, but patterns emerged among refugees in different cities: it is common for Congolese women in Kampala to sell jewelry on the street and pick cassava leaves, whereas Rohingya, Afghan, and Burmese women in Delhi tend to rag-pick, work as retail clerks, and as servers at parties, respectively. Domestic work and sex work are common in all cities. Most refugees reported living hand-to-mouth, and going hungry often. They forage through garbage for food, and visit markets late at night to look for overripe fruits and vegetables that sellers have discarded.

Many engage in sex work, either occasionally or regularly, as a means of livelihood, which comes with its own set of GBV risks. Although our first instinct may be to picture adult women engaging in transactional sex, we find that this occurs across all subpopulations, including men, youth (boys and girls ages 18-24), LGBTI individuals, and persons with disabilities.

Getting to and from work also gives rise to GBV risks. Refugees reported that public and private modes of transportation, from buses and trolleys to taxis and motos, are rife with verbal abuse and unwanted touching, both by other passengers and by drivers.²³ Many refugees are also pressured to take night jobs or nighttime shifts, which heightens their vulnerability to violence when traveling home late at night or before dawn, often alone, along dark and empty city streets. Refugees reported being mugged, sexually assaulted, and raped by passersby in these circumstances.

Risks related to shelter

Most urban refugees are responsible for finding and paying for their own shelter, and they face numerous barriers to doing so. Landlords discriminate against refugees, either refusing to rent to them or exploiting their lack of options to extract higher rents. Not having steady sources of income and a lack of financial assistance leads to housing instability as well; many refugees reported having to move frequently within a city and cited instances of being evicted abruptly, leaving them homeless. Such instability impedes their ability to form networks with neighbors and establish community ties that could enhance their protection from GBV, both inside and outside the home.

Refugees across subpopulations also reported being at risk of GBV in their homes, not only by family members but also by landlords and neighbors. Many individuals and families can only afford shared occupancy housing, which leaves them vulnerable to physical and sexual abuse by housemates; children are especially at risk when parents leave them at home to go to work.

Addressing urban refugees' difficulty in finding and affording safe and steady accom-

modation – and their lack of access to emergency shelter – is a foundational component of urban protection. More funding for housing assistance is needed, especially for at-risk populations and those needing emergency shelter. Humanitarian actors must also map viable options for refugees, tailoring it for refugees from different subpopulations, and engage in direct advocacy to curb exploitation and discrimination against refugees looking for housing.

Urban Refugees and Sexual Coercion

In response to the survey question asking about urban refugees being pressured to exchange sex for things such as rent, safety, or a job, over 50% of respondents in all four cities said that such coercion has happened to them or to another refugee they know.

	Answered Yes to Sexual Coercion: “Have you, or any other refugee you know, ever been pressured to engage in sexual activities in exchange for things such as rent, safety or a job?”
Quito	63% (of 35 respondents)
Beirut	51% (of 33 respondents)
Delhi	69% (of 32 respondents)
Kampala	62% (of 91 respondents)

Risks related to urban isolation, fear of the police, and a lack of access to justice

Urban isolation

Many refugees reported feeling completely disconnected and alienated from their surroundings, with little to no community of which to speak. They feel at sea in a strange city whose rules, written and unwritten, they do not know. Out of caution, many refugees isolate themselves further: they avoid talking to anyone or going anywhere lest it make them even more vulnerable.

Refugees drew a link between feeling vulnerable to GBV and being “loners” in their community, without social capital and community ties. They reported being targeted for violence – by other refugees and by members of the host community – because it is assumed, often correctly, that as refugees they will not report it. Their lack of stable housing contributes to this sense of isolation, since having to move often means that refugees and their families remain strangers to their neighbors, and vice versa. Peer support is also difficult to maintain where refugees live scattered in different locations.

Members of at-risk subpopulations, especially LGBTI refugees, shared that they feel doubly isolated, estranged once from the host community and again from the broader refugee community; this is especially true in cities where LGBTI refugees lack knowledge of each other and of host community LGBTI organizations.

Reducing refugees' urban isolation therefore goes hand in hand with enhancing their access to community-based protection, which arises where refugees have people they trust, where they know and interact with their neighbors, have access to information, and know where they can meet other refugees and/or host community peers.

Fear of the police and a lack of access to justice

Refugees spoke of living in fear of being reported to law enforcement – “denounced” – by neighbors, acquaintances, employers, and others because of their refugee status. Even those with formal refugee status are wary about engaging with police and having to defend or prove their right to live in the city. Those whose asylum claims are pending are especially fearful. This fear shifts the balance of power against them in many of their interactions and relationships with members of the host community. They feel forced to endure abuse and exploitation because they never know when a threat of “denouncement” is real, and refugees in all locations had heard of police detaining refugees whose papers did not demonstrate unassailable proof of their legal right to be in the country.

Fraught relationships with police were a recurring theme across cities and across refugee subpopulations. Refugees often perceive police as distrusting them, disliking them, or looking for bribes. Refugees in all locations reported fearing the police: they view police not as protectors but as likely aggressors, individuals who can, and do, leverage their state authority to extort money or sex from refugees.

Many refugees consulted had experienced police violence directly; most had heard a story of police brutality and/or sexual violence from a fellow refugee. Even a police department representative in one city, speaking on condition of anonymity, noted that police officers' sexual abuse of refugees and “exploitation of their vulnerability” is common: it happens in refugees' homes, on the street, and when refugees seeking temporary shelter come to sleep at the police station. “Even senior police officers do this,” she said, “to boys, girls, women...it's covered up...and [refugees] don't report it. They weigh it, but they're being threatened.”

Most survivors of GBV do not file formal police reports. They choose not to do this for any of the following reasons: they do not want to draw attention to their legal status in the country (“How can you make a complaint? You have no papers.”); or they believe that doing so could complicate their asylum or resettlement application (for instance, if

a police investigation is pending); or they do not trust the police to care, to treat them with respect, or to follow up on the complaint; or the violence is so ubiquitous, and the law enforcement response so minimal, that reporting it seems futile. The reality is that GBV against urban refugees is often committed with impunity.

Good Practice: Building Relationships with the Police

Refugee service providers in some cities have dedicated time and effort to building relationships with local police departments. They do this to cultivate trust between refugees and the officers that work their neighborhoods, to dispel myths in both directions, and to work with police to address specific GBV risks, including poorly lit and patrolled streets. The Refugee Law Project in Kampala, for instance, recently conducted trainings and mentorship programming with the Ugandan Police Force, to raise awareness around refugees' rights and strengthen officers' role in preventing and responding to GBV.

See Refugee Law Project. *Mentoring Police Officers to End SGBV Tolerance and Complicity* (2015) http://refugeelawproject.org/files/others/Mentoring_police_officers_to_end_sgbv_tolerance_and_complicity.pdf

The Urban Model: Challenges and Opportunities for Mitigating Urban GBV Risks and Strengthening Community-Based Protection

Traditional humanitarian response – where UNHCR and its partners create a new infrastructure of services for refugees – is a poor fit for urban contexts. Instead of trying to transplant programs that have worked in camps to cities, programming must focus on promoting refugee integration into the host community. Doing this requires thinking differently across the board. Whereas humanitarian actors are used to working mostly with each other, in cities they must broker linkages with numerous other partners, public and private, across all sectors, and sometimes for the benefit of only one or two refugee subpopulations.

Protective peer networks must also become a cornerstone of urban protection. These peer networks can be among refugees, for instance, in the form of support groups hosted by UNHCR partners. The Refugee Law Project in Kampala has helped to establish and/or maintain 15 refugee support groups, including ones for GBV survivors, elders, LGBTI individuals, persons with disabilities, and individuals living with HIV.²⁴

Yet protective peer networks can also exist, and need to be supported, between refugees and members of the host community. This is especially true for marginalized subpopulations, such as LGBTI refugees, who often feel a greater kinship with LGBTI members of the host community than with other refugees. The important point is giving space for refugees to voice and cultivate the peer networks that are relevant for them, and offering them support – referrals, introductions, transportation costs, seed funding for a safe space – that will enable these peer networks to germinate.

Over the course of conducting the assessments, the WRC identified a number of common challenges and opportunities around urban protection. We provide a snapshot of these here, in order to draw attention to approaches that are not working well, or as well as they could; and to highlight ways that humanitarian actors can better leverage the resources, social capital, and infrastructure that already exist in many cities.

This section is divided into six parts, organized under the following headings:

- I. Institutional Inertia: “If you want protection, go back to the camp”
- II. Practical Challenges to Integrating Refugees into Local Services and Institutions
- III. Reaching Outside the Humanitarian Circle: Engaging Nontraditional Actors and Embracing a Network of New Local Partners

- IV. Supporting Community-Based Protection and Self-Empowerment
- V. New Advocacy in the City: An Evolved Advocacy Role for UNHCR and Its Partners
- VI. Tailored, Targeted Actions for At-Risk Refugee Subpopulations

I. Institutional Inertia: “If you want protection, go back to the camp.”

Stakeholders across all cities shared that they perceive an institutional culture, within some UNHCR field offices, that regards urban protection as a fool’s errand. This results in a kind of institutional resignation around urban GBV risks, and resistance to putting more human and financial resources behind urban protection efforts.

This attitude is grounded in a belief that providing adequate urban protection – both on a macro level and to individual refugees – is beyond the capacity and budget of UNHCR field offices. UNHCR cannot offer protection to urban refugees the way it can to those in camps, so the thinking goes, especially where refugees’ vulnerabilities seem to mirror those of the host community urban poor, like finding safe shelter or earning enough to afford food. UNHCR is equipped to meet these needs in camps, but not in cities. So the message – which refugees in various cities reported receiving in direct and indirect ways – is that refugees who “choose” to live in cities cannot expect to have it both ways.

Such sentiments run contrary to UNHCR’s 2009 Urban Policy and 2014 Alternatives to Camps Policy. They also suggest that practice in the field and requisite resourcing are not keeping pace with what is needed to fulfill UNHCR’s protection mandate in cities: enhancing refugees’ protection and mitigating GBV risks in urban environments comes across, in this context, as a nearly impossible task.

To be sure, taking the action necessary to recalibrate and fortify urban protection efforts in ways that respond to emerging evidence of gaps will require a surge of resources and effort – at least up front. It will require new allocations of staff time and staff responsibilities. It will require new and varied expenditures, from sizeable grants to host government institutions, to small grants to refugee-led CBOs, to cost-sharing arrangements with diverse host community actors. This is to be expected, and is consistent with UNHCR’s strategic long-term thinking about programming in urban areas:

“Alternatives to camps should ultimately be more sustainable and cost-effective, because they harness the potential of refugees, rationalise service delivery, and allow for more targeted assistance to those most in need. Achieving these objectives, however, may

require greater early investments, in order to realize such efficiencies later. Making alternatives to camps work also calls for strengthened protection outreach and monitoring which may be more labour and resource intensive than in a camp setting.”²⁵

In some countries, host government policies constrain what UNHCR is able to implement in urban areas. This is true in Uganda, for instance, where a longstanding position of the Ugandan government disfavors refugees’ urban migration and tries to discourage it. This conflicts with UNHCR’s urban policy, creating an underlying tension that must be confronted. Yet even in such contexts, dislodging institutional assumptions and attitudinal barriers around what is possible to achieve in cities is critical to meeting minimum standards of care and setting protection priorities.

II. Practical Challenges to Integrating Refugees into Local Services and Institutions

Humanitarian actors are well aware that a key component of urban response is integrating refugees into host communities and host community services. However the extent to which this is happening in a particular city – or is even possible there – depends on a variety of factors. One key factor is the local enabling environment. Each host government has its own laws regarding refugees’ access to basic services, such as educational and health services. Policies around refugees’ mobility and right to work also vary. As one commentator explained, the vulnerabilities that refugees face are heavily “determined by the laws and policies of host governments and by the way these policies are implemented; the public and private institutions devoted to supporting and managing refugees, and the public ethos towards refugees.”²⁶

And yet even where there is a suitable enabling environment on paper, in practice there are often many barriers to refugees’ access to crucial services, such as temporary shelters for GBV survivors, or day care for children whose parents work. The devil is in the details – details that humanitarian actors must identify and take one by one. Some of these barriers can be resolved relatively quickly, so long as they are made plain and given adequate staff attention. Some of them might take more time to resolve, in which case humanitarian actors must think about stopgap measures.

“No parallel services”

This is a guiding principle of UNHCR’s urban protection model, as a field officer in one city put it. And this makes sense. Creating “parallel services” for refugees is the old way of doing things, the camp-based model, which is antithetical to UNHCR’s

new urban approach. Creating separate services for refugees segregates them from the host community. It is also costly, at a time when the budgets of many urban missions – especially those working in protracted displacement contexts, rather than crises – are being cut.

But integrating refugees into host community services cannot be expected to happen overnight. Humanitarian actors cannot assume that host community CBOs or institutions are willing or able to serve refugees. In each city, refugee service providers spoke of the very real obstacles they face in trying to integrate refugees into local institutions.

The following are key challenges to refugee integration:

- **Host community organizations need cost-sharing.** Even where organizations are willing to serve refugees, many of them are struggling financially even to serve the host country nationals it is their mission to serve.

This is true of public institutions, such as schools where teacher-student ratios are already so high that enrolling refugee children angers local parents, sowing tension between refugees and members of the host community.

This is also true of nonprofit organizations and CBOs, from shelters to health clinics. Unless they receive cost-sharing, they will be unable to serve refugees without diverting funds or lowering their standards of care, alienating their core constituents and local funders in the process.

- **Host community organizations are wary of language barriers.** In cities where refugees do not speak the predominant language, host community organizations are reluctant to work with refugees and humanitarian organizations. Humanitarian actors must acknowledge these barriers and find workarounds.
- **Refugees face hidden costs in accessing local organizations, especially transportation costs.** Across cities, refugees reported that hidden costs prevent them from accessing services and participating in activities.

The most significant and common cost barriers are transportation related. These costs deter refugees from accessing psychosocial counseling, job training, medical care, schooling, and support groups. Where transport reimbursements are available, these are often limited to visiting refugee service providers or seeking acute medical care.

Refugees sometimes take modes of transportation they know are unsafe, such as a transwoman taking a public bus to a local LGBTI organization, in order to access services and support groups important to their protection.

Staff at refugee service providers are aware of this barrier, but unsure how to address it. Dedicated staff sometimes pay these costs out of their own pocket when they believe a particular service is vitally important to an individual or family.

Recommendations: Increase funding to reimburse refugees for transportation to and from GBV prevention activities. Where more funding is not possible, humanitarian actors must come up with alternative ways to facilitate access and mitigate risks associated with different modes of urban transportation. Strategies to explore include bringing certain services to high-risk refugees, rather than asking them to come to providers' offices and arranging transportation pools, so that refugees whose appointments are close to each other or who are attending the same activity can share costs.

- **Discrimination, myths, and misperceptions about refugees.** Just as host community members hold intersecting prejudices against refugees, so do the leaders and personnel of host community institutions. These biases influence their willingness to expand their services or memberships to refugees.

Some host community organizations refuse to integrate refugees because of their race, religion, or nationality. Others misunderstand who refugees are and why they are in the country; they mistake refugees for wealthy foreigners, or assume refugees are criminals, or resent them for “taking” resources belonging to the host community.

Where misinformation is identified as a barrier, humanitarian actors can respond with information. Where a barrier is attitudinal, different types of advocacy and negotiation may be warranted, perhaps at higher levels of government or civil society. In some cases, however, a particular host community organization should simply be crossed off the list of potential partners in urban protection/GBV prevention.

- **Local organizations may not meet appropriate international standards for GBV prevention and response.** Humanitarian actors must proactively assess the capacity of local organizations to provide services or support in ways that align with international human rights and humanitarian standards. That assessment must be followed by an analysis of shortfalls and capacity building needs, as well as a context analysis of available alternatives.
- **Local organizations are sometimes rebuffed by humanitarian actors.** Some UNHCR partners may be reluctant to engage local organizations because they feel themselves to be in competition with local organizations for funding, or because they assume local organizations lack capacity or add little value. They may also fear that tapping local expertise or services could potentially undermine their own relevance in humanitarian response. In two of the four target cities, multiple local organizations shared that although they had offered to provide technical assistance or local knowl-

edge to humanitarian actors, and/or to expand their services to include refugees, these invitations were turned down by UNHCR partners. Several of these organizations have expertise working in neighborhoods with high refugee influxes. Others have expertise working with particularly vulnerable urban subpopulations like LGBTI individuals, sex workers, homeless persons, or persons living with HIV.

The majority of UNHCR partners consulted expressed interest in partnering more with local organizations – they just need more human and financial resources to dedicate to mapping these organizations, providing cost-sharing where appropriate, and collaborating to address integration barriers.

Incentives and guidance from UNHCR Headquarters could help alleviate some of these concerns.

In addition to outlining the above challenges, refugee service providers shared success stories – instances where refugees are accessing special services at local organizations. Three common threads in these successes are:

- (i) **The importance of mapping local organizations that specialize in working with individual subpopulations.** Don Bosco, a UNHCR partner in Delhi, has developed special referral pathways for two marginalized, vulnerable subpopulations: refugees living with HIV and refugees who are pregnant as a result of sexual violence. The Refugee Law Project in Kampala currently has 38 local partners with expertise in providing services to different subgroups, including male survivors of sexual violence and sex workers.
- (ii) **The importance of personal relationships, mutual trust, and ongoing communication.** Some of the most enduring relationships with host community organizations exist where a staff member at that organization personally knows their focal point at a humanitarian organization, for instance they are friends or attended university together. This underscores the importance of social capital in fostering linkages between humanitarian and local actors.
- (iii) **The importance of meeting local organizations where they are.** In successful instances of refugee integration, both humanitarian and local actors emphasized the importance of the humanitarian actor's openness to listening to the local organization, *understanding* the reasons for their resistance to engaging refugees, and, where possible, *collaborating to address those reasons*. "We ask them what their needs are, that is the key," a UNHCR stakeholder in Kampala said, when talking about successes they achieved in enrolling refugee adolescents into secondary schools.

Building referral pathways and linkages with host community organizations is a long-

term strategy, and one that will benefit generations of urban refugees. It will take commitment, funding, and patience. It will also require dedicated staff time, as well as technical guidance for staff on how to map different types of local organizations for different refugee subgroups, and how to work with them to resolve whatever barriers they may face in expanding their reach to include refugees. Referral systems must also be appropriate to the protection concerns in question and the capacity of local organizations. Added awareness raising and/or training may also be necessary, including around GBV, to ensure safe identification of survivors and access to GBV case management.

Stop-gap solutions that address pressing GBV risks are not “parallel services”

Where refugees are unable to integrate within host community institutions essential to GBV risk mitigation, stop-gap solutions are needed. For even as humanitarian actors map local institutions and engage in advocacy or negotiations to facilitate integration, refugees are facing immediate GBV risks. Some of these can and must be mitigated in the interim.

Two examples, relevant in multiple cities, illustrate this point: temporary GBV shelters and crèches.

- **Lack of access to local emergency shelters.** Refugees who are GBV survivors, or who face imminent risk of GBV often lack access to local GBV shelters. This is true for different reasons in different cities, but it is common across cities. Where there is a local “women’s shelter,” refugee women and their families get turned away for various reasons: a lack of capacity and a preference to give any open beds to nationals; reluctance to confront language and cultural differences; or discrimination on the basis of nationality, religion, race, disability, or refugee status.

Male survivors and LGBTI refugees face even greater challenges finding emergency accommodation, since many cities lack shelters for them altogether. For transgender refugees who are targeted for violence daily and kicked out of housing regularly, not having a place to take emergency refuge can be deadly.

- **Lack of access to local crèches (child care).** Refugee children are left at home while parents are working, which exposes them to violence. This violence comes from within their households, by fellow occupants of their home, and from without, by landlords and neighbors who target refugee youth because their families have fewer ties to the community and are unlikely to go to the police. Yet even where refugees are legally

able to send their children to public crèches, few do so. Their reasons vary: their hours of operation are too short, or their children are bullied there, or the crèches are too far away.

Both of these situations expose urban refugees to significant GBV risks. Both warrant stop-gap solutions until better integration into host community institutions – in this case, local shelters and crèches – is achieved.

Developing and implementing feasible stop-gap solutions may require funding, but even more importantly, it will require ingenuity, refugee participation, and institutional support from UNHCR. In Delhi, for instance, refugees from the Burmese Chin, Somali, and Afghan communities are at various stages of planning and securing funding for their own crèches – ones that are located conveniently for parents, and where children and their caregivers speak a common language. Rather than viewing such efforts as an attempt to create “parallel” services, humanitarian actors should support these community-based efforts to bridge service gaps.

Refugees are also banding together to try to address gaps in emergency shelter. In Kampala, the refugee-led Angels Support Group has created a makeshift shelter for LGBTI refugees who would otherwise be homeless. The Angels struggle to find funding to keep this shelter going, and upwards of 10 people are living in a space designed for two. This is a community-based solution developed by refugees, for refugees; it responds to an urgent gap, and yet currently receives no financial support from humanitarian actors. Also in Kampala, a refugee-led shelter called Bondeko provides temporary housing for new Congolese refugees, and around 30 live there at any given time; a significant portion of their budget comes from remittances from refugees who have been resettled.

In Beirut, there is talk among UNHCR partners about working with local organizations to create a trans-friendly shelter, one that would host both refugee and Lebanese transwomen and transmen. In Quito, a grassroots trans-rights CBO called *CasaTrans* is trying to secure funding from international donors to reopen the doors of its emergency shelter for transgendered persons. These are all potential avenues that humanitarian actors should explore.

Safe shelter options for persons with disabilities who have experienced violence (with appropriate protection monitoring) and home-based care support for families who are facing challenges caring for persons with disabilities are also critical gaps to be addressed, along with avoiding institutionalization, which poses its own set of protection risks.

III. Reaching Outside the Humanitarian Circle: Engaging Nontraditional Actors and Embracing a Network of New Local Partners

Fostering community-based protection in urban areas requires dynamism. This means agility in forging new partnerships with local actors, adapting programs and strategies to local contexts, and simultaneously engaging different subgroups of refugees whose vulnerabilities and needs may be categorically different.

Beyond the “usual suspects” in humanitarian response: Mapping and engaging new partners

As UNHCR has emphasized, fostering urban protection is a “complex” undertaking that sometimes requires “negotiations with unconventional actors.”²⁷ In practice, however, engaging nontraditional partners has yet to become a central tenet of urban protection.

A first step in building these linkages is mapping host community actors, institutions, and organizations. In some contexts mapping has already been undertaken, particularly in Lebanon during the emergency phase of the response. But overall such mapping is happening inconsistently, in lackluster fits and starts, as something of an ongoing side project: it is not prioritized or treated as central to urban protection, nor is it comprehensive.

UNHCR and its partners must map all of the myriad actors who are currently or potentially relevant to a refugee’s protection environment. This mapping must be done across all sectors, public and private, and include not only governmental actors, but also civil society NGOs and grassroots groups. Even if organizations do not currently engage refugees, they may be willing to do so in the future, or have local knowledge about living safely in that particular city.

The WRC, with support from the U.S. Bureau for Population, Refugees, and Migration (PRM), is currently piloting a Service Provision Mapping Tool for Urban Refugee Response, to assist practitioners in mapping humanitarian and host community organizations relevant to GBV prevention and risk mitigation. In developing this tool, the WRC identified categories of actors with whom linkages should be explored. These actors, public and private, are classified by sector:

- **Employment and livelihood actors:** job placement and job training organizations, microfinance and cash transfer programs, savings clubs, agriculture clubs, merchants’ associations, service unions
- **Health providers:** primary care clinics, sexual health clinics, harm reduction clinics, mobile clinics, trans health clinics

- **Social and psychological support actors:** community centers, support groups, after-school youth programs, organizations for persons with disabilities, LGBTI organizations
- **Education actors:** crèches, bridge classes, primary schools, secondary schools, universities, online learning institutions
- **GBV prevention and response actors:** GBV case management and counseling providers; women's shelters; youth shelters; LGBTI-friendly shelters; survivors' legal assistance

In addition, the following local, national, and international organizations should be mapped and considered for potential partnerships:

- **Municipal agencies** (city councils, neighborhood leaders, police departments)
- **National agencies and ministries**
- **International development aid actors**
- **Private foundations and donors who support local projects and CBOs**
- **UN agencies**

Some of these actors are potential referral pathways for refugees. Others may be potential funding partners, advocacy allies, community influencers, or consultants with local knowledge about facets of urban life.

Mapping and building linkages, by refugee subpopulation

As a subset to this mapping, tailored mapping must be done for at-risk refugee subpopulations, including single women, female heads of households, children, LGBTI individuals, persons with disabilities, sex workers, male survivors of sexual violence, and older persons. An organization that provides health or job placement services may not, for instance, have expertise or interest in serving LGBTI persons or male survivors. But a local sexual health clinic may have expertise in trans health, and a local LGBTI organization may already have a list of LGBTI-friendly neighborhoods, businesses, apartment complexes, or employers.

Once organizations have been mapped, and those willing and able to provide guidance or services to refugees identified, this information should be compiled in a resource for refugees and service providers. This reference guide would lay out the full range of services, support groups, and activities open to refugees living in a particular city. It would be inclusive of humanitarian actors and host community organizations; contain addresses or links to websites; and be cross-listed for different refugee subpopulations (children and adolescents, youth, women, men, persons with disabilities, LGBTI individuals, HIV+ individuals, sex workers, etc.). Pulling this information together in

one place would also assist refugees who may not want to self-identify to service providers as a member of a marginalized group, but who are interested in accessing certain services or peer support.

Barriers to building linkages and referral networks also exist within the humanitarian system

Stakeholders in all cities, including UNHCR staff, noted a tension between trying to forge a network of partners and referrals for refugees and operating within certain norms, habits, and administrative requirements of the humanitarian system. In other words, certain features of urban response, which are sometimes brought over from camp-based modes of working, are unintentionally restrictive. They impede the dynamic, multi-faceted, locally relevant programming that is integral to strengthening community-based protection for urban refugees and mitigating their GBV risks.

Three ways that the humanitarian system constrains agility and innovation in urban response are:

1. Entrenched norms around working with one to two main implementing partners, and having them serve all refugees.

UNHCR explicitly supports a dynamic approach to urban protection, one that engages a range of actors. Yet at the field office level, policies and thinking still promote a lean, supervisory model in which a very small number of organizations are selected as implementing partners, and few more as operational partners. It remains difficult to bring in local organizations that can provide isolated yet important services to particular refugee subgroups.

Stakeholders across cities noted a pattern in urban response: UNHCR moves into an urban context, identifies one or two local partners to work with (in addition to its international partners), and funds them to expand their programming to provide a range of services to refugee communities. Yet in many cases, these local organizations lack the knowledge, skills, capacities, and sensitivities necessary to provide certain services and/or to provide them to marginalized subpopulations.

This may be the usual way urban response begins, but it is not necessarily appropriate in all contexts, or ever. In all cities, UNHCR should do due diligence as it builds the foundations of urban response architecture – including scoping potential local partners' suitability to provide each service to each refugee subpopulation.

It may also be the case that a local organization already specializes in providing a particular service, or in serving a particular subpopulation. LGBTI organizations, for instance, may lack experience working with refugees, but nonetheless provide

a range of services for host community LGBTI individuals. They could potentially be engaged as an alternative service provider for LGBTI refugees – as a primary or secondary option – and this possibility should be explored. Or a local organization may be able to provide technical assistance in creating standard operating procedures or referral pathways for a particular subpopulation. Or they may be able to recommend someone who could be hired by a UNHCR partner, to ensure they have in-house expertise in serving a particular subpopulation.

Throughout stakeholder consultations in different cities, the WRC asked humanitarian actors what they, themselves, would do differently in launching urban response if they knew then what they know now. The two most common responses were:

- (a) They would have, from the very beginning, considered the particular needs, perspectives, and vulnerabilities of different refugee subgroups and integrated them into their GBV framework, rather than waiting until after they had already established an infrastructure, presumably for all refugees. This created problems down the line when gaps affecting certain subpopulations came to light, but retrofitting the existing infrastructure – bringing new organizations into it, or trying to build capacities to serve or overcome biases against certain subpopulations – proved to be extremely difficult.
- (b) They would have engaged local organizations from the very beginning, especially organizations with expertise in serving particular subgroups.

- 2. Unfamiliarity with working with local organizations and accommodating them within the humanitarian system.** Local organizations face barriers to communicating with, and becoming a part of, humanitarian response. They are often unfamiliar with cluster systems, task forces, and UNHCR. They need guidance in understanding these mechanisms, what they do, and how they can participate. Local organizations may also face language barriers to participating in stakeholder-wide meetings, which are sometimes held in English – rather than a common local language – because English is common to both UNHCR and the large, international humanitarian organizations it is used to partnering with.
- 3. Prevailing ways of distributing funds can impede the engagement of new partners and new ways of working.** Enhancing protection and mitigating urban GBV risks will require a shift in how donor funding is channeled and allocated in the field. A model where urban refugees' needs are met primarily through direct service provision and assistance, especially food and cash assistance, is neither politically nor fiscally feasible. Creativity and flexibility are needed to diversify how donor funding is used, in order to maximize its impact across sectors and across

impacted host community neighborhoods and institutions. This means using humanitarian dollars to strengthen, for instance, public services like health clinics and schools, as well as urban infrastructure projects. Doing this efficiently may require channeling funds directly to national government ministries or municipal agencies. It may involve negotiating cost-sharing frameworks with local actors and making it easier for them to apply for, and receive, small grants. Funding must also be directed toward supporting local CBOs and NGOs, including those run by and for refugees. These organizations provide critical peer support for at-risk refugees; they also engage in advocacy and information-sharing, and organize activities that directly and indirectly mitigate GBV risks.²⁸

IV. Supporting Community-Based Protection and Self-Empowerment

Community-based protection is a fundamental principle underlying UNHCR's Age, Gender, and Diversity framework.²⁹ Its core tenets are the prioritization of community engagement and the proactive placement of "people of concern at the centre of all decisions that affect their lives."³⁰

Throughout the WRC's consultations, two key strategies for enhancing community-based protection in cities emerged. These are in addition to the traditional support groups hosted by humanitarian actors, such as those for women and GBV survivors. The first strategy, highlighted throughout this report, is brokering linkages between refugee subpopulations and relevant host community CBOs.

The second strategy is supporting refugees in creating and running their own CBOs. Refugee-led CBOs currently exist in some cities but not others, and they are a potentially powerful approach to enhancing community-based protection, especially for high-risk subpopulations.

"For us, by us": Refugee-led CBOs

The WRC met with several refugee-run CBOs in the cities we visited. They engage in a variety of activities, depending upon members' primary needs and concerns, as well as their access to funds and organizational capacity. Some of them are primarily support groups, where members meet to talk, share experiences, and provide informal peer counseling. Others do a mix of activities, focusing on a core suite of activities while piloting others. These activities include:

- Undertaking grassroots advocacy and public education campaigns;
- Organizing trainings and workshops for their members on different topics, from GBV to language skills to know-your-rights trainings;
- Providing a safe space for at-risk members, or for children whose parents are

- working during the day;
- Running small businesses;
- Providing basic health services, such as STI testing and condom distribution.

The scope of their activities tends to evolve over time, as they achieve recognition by humanitarian actors, grow their memberships, and have funds to work with.

Refugees organize their own CBOs to accomplish different goals. Two groups in Delhi, for instance, the Refugee Community Development Project and the Burmese Women Representatives, serve Afghan-Somali refugees and Burmese Chin refugees, respectively. Other groups serve refugees who hail from diverse countries but bond over other shared identities. In its field visits, the WRC consulted refugee-led CBOs for youth; LGBTI individuals; women; persons with disabilities; sex workers; and male survivors of sexual violence.

Some of these groups emerged organically, through informal conversations among refugees; others were constituted with the support of a humanitarian partner. Even those started by refugees, however, shared that having a humanitarian partner who can provide institutional support — from help with program development and management, to a physical meeting space, to transportation reimbursement — has been essential to their existence.

While some groups receive small grants or in-kind support from humanitarian actors, others survive on funding from private donors, or want to learn how to apply for such funding. The number one barrier they face to increasing their membership and implementing activities related to GBV prevention is a lack of funding. Among their proposed risk mitigation activities are: running their own emergency safe spaces and crèches, conducting home visits to vulnerable families, organizing safety and know-your-rights trainings, distributing safe sex information packets, and organizing group trips to health clinics.

“There used to be more [refugee-run] CBOs, but with budget cuts only two are left, so the problems that we help ourselves tackle – it’s all gone down. We can’t help ourselves as much as we could before. CBOs, women helping each other, is much more effective than UNHCR, so when we talk about funding, the international community should especially consider funding more [refugee-led] CBOs. It’s good if it comes through UNHCR and partners but [they should also consider] funding us directly.”

– Burmese Chin woman in Delhi

For Refugees, By Refugees: The Refugee Community Development Project (RCDP) in Delhi

The Refugee Community Development Project (RCDP), established in Delhi in 2012, arose out of the recognition that refugees have the capacity to address problems and implement solutions themselves, as long as they are able to access resources. It was designed through a consultative process, led by the Centre for Refugee Research (CRR) at the University of New South Wales (UNSW), in which over 200 Afghan and Somali refugees living in Delhi decided on priority areas for an organization staffed by Afghan and Somali refugees in senior management and decision-making positions. Refugees identified education pathways, women's safety and well-being, social isolation, adverse community attitudes, and safe livelihood options as the main focus areas for the project.

Three cornerstone RCDP projects were the Women's Social Support Project, the Education Project, and the Volunteer Program. The Women's Social Support Project engaged 325 women's group members, who paid home visits to women and families they identified to be especially vulnerable or at risk. The Education Project provided 28 classes each week for over 600 women, youth, and children. Classes were developed based on education priorities identified by the community, including adult literacy classes for women. The Volunteer Program was established to enhance RCDP outreach, and provide youth volunteers with community development skills and experience to enhance future work opportunities.

Recent interviews with more than 200 Afghan and Somali women refugees revealed that RCDP's activities led to better education outcomes for refugee children and youth, increased confidence and self-worth for women, enhanced economic opportunities through skills development, and positive psychosocial benefits. The importance of refugees planning, running and monitoring projects for their own communities was raised as the most important success of the project. It has built confidence and led to new partnerships and mutual respect between the refugee community and Don Bosco, other implementing partners and UNHCR. It has shown that refugees have skills and capacities for self-reliance and community-based protection. Most importantly it has helped people to feel that they are making valuable contributions for themselves, their families and the refugee community in Delhi.

RCDP was launched with the support of UNHCR, Don Bosco Association, a UNHCR partner in Delhi, and the UNSW Australia CRR, which provided program management assistance and capacity-building trainings for staff. The Project was funded by the Australian Government through its Displaced Persons Program. In late 2015, due to financial constraints, RCDP had to formally close its doors; the CRR and Don Bosco are currently working to help secure additional funds to continue activities.

RCDP stands as an innovative model of urban community-based protection: empowering refugees to establish and manage their own organization, in partnership with a local UNHCR partner, where refugees lead the planning and implementation of protection activities that are responsive, flexible, and informed by their own first-hand experiences.

For more information on the RCDP model and its transferability to other urban contexts, contact the CRR at crr@unsw.edu.au and see www.crr.unsw.edu.au for project reports.



The RCDP Team in Delhi.

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Recommendations

- **Encourage and support refugee CBOs and support groups as stand-alone components of urban protection; delegate responsibility for facilitating both.** Since stakeholders reported that refugees' interest in some support groups outpaces service providers' capacity to organize and facilitate enough groups, develop alternative ways for helping these groups self-maintain.
- **Fund refugee CBOs with small grants, while working with them to develop sustainability models.** Build their capacities around program management community mobilization. Assist them in understanding and navigating relevant laws, such as what licenses they may need to engage in certain activities. Look to similar models in development, university, and philanthropy contexts, where a handful of donors specialize in providing small grants and tailored technical assistance to nascent grassroots organizations, including those run by and for highly marginalized groups.
- **Support links with existing host community groups and government structures and programs, where appropriate.**
- **Employ more refugees in urban humanitarian assistance.** Currently, to the extent that UNHCR's partners do hire urban refugees to support program implementation, it is usually only as translators or outreach workers earning minimal

stipends. Yet, similar to how it has become the norm for refugees to work in the resettlement sector as salaried employees – and their contributions well regarded as assets – urban refugees can and should be brought in as full staff in humanitarian assistance. Doing so would embody the participatory and human rights-based approach endorsed in UNHCR’s Urban Policy, while supporting much-needed livelihoods. UNHCR should take the lead on promoting and systematizing these efforts, allowing for capacity building where necessary, and articulating how such employment is exempted from any external restrictions on refugees’ rights to work.

- **Map and create a resource guide of services and programs for refugees.** Across locations, refugees reported patchiness in their access to information. Such gaps are a barrier to their accessing a variety of services and types of peer support. A resource manual that lists all service providers in the city, cross-listed by whom their services and activities are tailored toward (women, children, LGBTI, etc.) is needed. This manual should include refugee service providers and host community institutions – from hospitals to civil society groups – with “open doors” to refugees.

In light of emerging trends in how refugees – especially urban refugees – are acquiring and exchanging information, humanitarian actors should explore how this information could also be shared electronically, both online and through mobile/smart phone resource apps.³¹

V. New Advocacy in the City: An Evolved Advocacy Role for UNHCR and Its Partners

New Advocacy Targets

UNHCR field offices have a great deal of experience working with host governments on a range of issues. They advocate for more permissible enabling environments for refugees, and negotiate specifics around access to basic services and asylum claims. Meeting the call to strengthen urban protection, however, will require UNHCR field offices to evolve and expand their advocacy role.

Currently, UNHCR’s main interlocutors, besides its core partners, are national actors, such as host government ministries and agencies. These actors can enact broad policy reforms and issue directives relevant to urban refugees’ survival and GBV risks, and UNHCR must continue to cultivate these relationships.

Less common, however, is advocacy with municipal actors. To be sure, some UNHCR field offices are doing this sporadically to address issues as they arise. Protection officers, community services officers, and even country representatives meet with public and private urban actors to resolve discrete issues, like what types of documenta-

tion will be accepted as proof of refugees' eligibility for a particular service. (This is a common barrier to refugees accessing everything from schools, to bank accounts, to health care, to death certificates, since their identification documents often do not meet existing regulatory requirements.) Yet this advocacy happens on an ad hoc basis and usually long after many refugees have encountered a problem. More strategic planning around local advocacy is needed, including efforts to map advocacy targets and establish relationships during the early stages of urban response. Among municipal actors that should be targeted are those with influence over aspects of city living that give rise to refugees' primary GBV risks. These include:

- local transportation authorities
- police departments and the judiciary
- hospitals
- housing authorities or landlord associations
- merchants' associations or labor boards
- local school boards
- occupational safety departments
- urban development agencies

In some cases, UNHCR's partners can engage in this advocacy alone, as most of them currently do. They meet with school administrators, police departments, councilmen, large chain grocery stores, factory owners, and countless other local actors. But in all cities, humanitarian actors noted that having UNHCR participate in initial meetings can be a powerful leg-up in establishing linkages. UNHCR's presence, authority, and credibility can help set a positive tone where local actors are coming to the table with little knowledge about who refugees are and what humanitarian actors do. UNHCR and its partners must work together to strategize when and where joint advocacy is appropriate.

International development actors are also important potential partners in strengthening urban protection. Currently 86 percent of all refugees are hosted by developing countries, and 42 percent live in countries whose per capita GDP is below USD 5,000.³² Their big cities are impoverished as well, and as a result often host urban planning and urban poor programs funded by multi- and bilateral development aid agencies. Yet urban refugees and the neighborhoods where they live are often excluded from these initiatives – even where they could be included at little additional cost.

Collaboration between UNHCR and other UN agencies can also be improved. The extent to which UNHCR partners with UN HABITAT, UNDP, UNICEF, UNAIDS, and other “sister” agencies varies greatly by city. “We are just not used to doing that kind of [internal] advocacy,” one UNHCR protection officer said, when asked about barriers to integrating refugees into urban projects being sponsored by other UN agencies.

Public education and awareness-raising within host communities

“They talk to us about GBV all the time, but most of the violence comes from [members of the host community]. Why don’t they talk to them too?”

– Woman refugee in Delhi, reflecting on humanitarian actors’ GBV prevention efforts

Across all four cities, refugees and stakeholders reported that misperceptions and biases against refugees are pervasive throughout host communities. These erroneous assumptions and prejudices contribute to refugees’ GBV risks. In Ecuador, for instance, cultural stereotypes about Colombian women and girls as *putas* make them especially vulnerable to sexual harassment, assault, and propositioning in public and, in the case of adolescent girls, at school. In Kampala, Congolese refugees are frequently mistaken for wealthy Nigerians, which makes it difficult for them to find landlords who will rent them an apartment at market price. In all cities, refugees and stakeholders shared that refugees are especially targeted for GBV within the host community because they are widely perceived to be unlikely to report it, or have no recourse for reporting it.

Raising awareness about refugees’ rights among police, and ensuring confidential reporting and accountability mechanisms are in place to report police abuse, is an essential element of GBV risk mitigation for urban refugees. So is building relationships with police departments to support attitudinal and behavioral change amongst officers.

Other awareness-raising campaigns can target, for instance, local council members, school administrators, and private sector actors, such as industry leaders or large employers where refugees work. A local councilwoman consulted in Kampala noted that whereas she originally feared the refugees moving into her community, during a workshop held by a UNHCR partner she learned why they had arrived and what their rights are in Uganda. As a councilwoman, she has since tried to sensitize other host community members: “Before the program, we were all on our own: Ugandans over here, refugees over there. And there was complaining on both sides. But now we, too, Ugandans, have been in wars from time to time. So we could relate to it, and understand.”

Wide-audience public education activities are also happening in some cities. In Kampala, refugees have appeared on radio and television shows to introduce themselves and share their stories of fleeing violence in their countries of origin. In Ecuador, a refugee story line was integrated into in a public television series, *Dialogos Ciudadanos*.

To date, however, efforts to raise host community awareness of refugees – to humanize their stories and disseminate information about their rights – have been limited, usually

one-off projects. Evaluations of such efforts have also been limited. But given the pervasiveness of discrimination and misinformation around refugees, and its links to their urban protection, more attention to the possibility of influencing host community attitudes toward refugees is needed. Different types of public education campaigning are possible, using various media, including mass media and social media. It may also be possible to integrate positive messages about refugees into existing anti-GBV campaigns taking place in certain cities, whether they are being carried out by host governments or local NGOs, or as part of an international initiative, like UN Women's Global Safe Cities Program.

VI. Tailored, Targeted Actions for At-Risk Refugee Subpopulations

Consultations with urban refugees from different subpopulations reinforce that their GBV risks differ in scale and in type. They vary depending upon the norms and traditions that refugee communities take with them to their cities of refuge, and they are influenced by the host community's own social and legal norms. Accordingly, humanitarian actors in urban contexts must take each subpopulation in turn, assessing their respective GBV risks and identifying risk mitigation strategies that are most feasible and promising for *each* subpopulation.

With support from PRM, the WRC is currently piloting Urban GBV Risk Assessment Guidance. This Guidance, which is meant to be used as a complement to existing risk assessment tools, spotlights urban risk factors that are common to all refugees, as well as those which are unique to individual refugee subpopulations.

A dual strategy in practice, not just in theory

When it comes to engaging at-risk or marginalized populations and operationalizing its Age, Gender, and Diversity Policy, UNHCR endorses a twin-track strategy: mainstreaming is meant to be done alongside targeted actions to address specific protection gaps.³³ Consultations reveal, however, that efforts and planning behind targeted actions are inadequate and uneven. In some contexts, mainstreaming is being emphasized to the exclusion of much-needed tailored outreach and programming; this is especially true for LGBTI individuals, adolescent girls, refugees engaged in sex work, and male survivors.

Overall, targeted actions are either not being done, or are being done for certain subpopulations but not others, and often not for those whose GBV risks are highest. Rarely are targeted actions being designed and implemented in partnership with affected individuals and/or relevant host community organizations.

Targeted actions and specialized services are vital in urban settings. First, main-

streaming across local partner staff can take time, especially where it involves overcoming entrenched cultural and personal biases. Meanwhile, at-risk urban subgroups face grave GBV risks, sometimes daily, and sometimes in the course of seeking mainstream refugee services. Humanitarian actors must prioritize and address these risks, even through stopgap measures that may seem unconventional or outside customary humanitarian practice.

Second, mainstreaming is inadequate to address the vulnerabilities and barriers to services experienced by at-risk subpopulations, which are often heightened in urban settings. For instance, mainstreaming overlooks the most vulnerable adolescent girls, such as those who are confined within their homes or married as children. Nor can mainstreaming ensure transgendered refugees have opportunities to access case management or other support services in a location they feel is safe for them.

Striking the right balance between mainstreaming at-risk refugee groups and promoting targeted actions or specialized services may sound complicated, but it is not. The key is giving urban refugees a voice, and providing them with options.

Pursuing an appropriate twin track approach for each subpopulation will require flexibility, context analysis, and direct engagement with refugees. Responding to the particular needs of different subpopulations might call for different areas of emphasis. For persons with disabilities, for instance, mainstreaming disability inclusion across GBV prevention and response is an urgent protection priority.

By contrast, consultations with LGBTI refugees reveal that specialized services and tailored referrals are key to mitigating their most urgent GBV risks. Prioritizing inclusion can therefore be inappropriate where it leaves LGBTI refugees without options for accessing services and does not align with what refugees themselves believe is essential to their immediate safety. Despite ongoing LGBTI mainstreaming efforts, consultations with transwomen in two cities revealed that they experience severe GBV risks whenever they travel to certain UNHCR partners' offices and again at point of service. These women shared that they would feel far more comfortable, and safer, if they were able to access certain services in another location, or from a known and trusted LGBTI-friendly host organization. In such cases, humanitarian actors must acknowledge shortfalls in existing service provision, listen to the affected refugees, and follow up with appropriate targeted actions.

There is no "one-size-fits-all-subpopulations" model for strengthening urban protection and mitigating GBV risks. But all subpopulations deserve to be presented with a full range of options and information when accessing refugee services. This

includes information about inclusionary programs and activities, as well as potential alternatives and referrals. It also includes information about relevant host community service providers and CBOs. These organizations will have already been mapped and engaged by humanitarian actors who identified them as potential partners in enhancing the protection environment for one or more refugee subpopulations.

Targeted actions for at-risk subpopulations in urban areas will look to accomplish three goals:

- (1) Mitigate immediate GBV risks.
- (2) Strengthen their protective peer networks.
- (3) Provide specialized services.

Three key steps humanitarian actors must take in pursuing targeted actions in urban contexts:

- 1) Assign responsibility and channel resources, including staff time and small grants, for targeted actions.
- 2) Directly consult refugees from those subpopulations in design, implementation, and monitoring.
- 3) Convene roundtables with host community organizations that have expertise in serving or engaging, or are *led by*, host community members of those same subpopulations. Some of these organizations might potentially be integrated into service provision or become referrals or safe spaces for refugees; others may have unique knowledge about living safely in the city as a member of a particular subpopulation.



Colombian woman participating in a workshop in Quito.

Urban GBV Risks by Refugee Sub-Population

Women

“There is a lot of violence. If we talk about all of it we will just sleep here because there is so much to discuss.”

– Congolese woman in Kampala

“My protection strategy is to pray.”

– Haitian woman in Quito

“SGBV – it’s everywhere: house, workplace, market, in the neighborhood. We’re not safe anywhere at all.”

– Burmese Chin woman in Delhi

Urban women fleeing violence and conflict often have little choice over their destination city, with few options to choose from. They take these cities as they find them, and learn to cope with – or structure their movements around – forms of gender discrimination that are already entrenched in those societies. Ecuadorian society, for instance, in general has a strong *machista* component, where appropriate gender roles between men and women are largely seen as fixed and where being a woman, by itself, ratchets up GBV vulnerability. In Delhi, where all women, including Indian women, face a high baseline level of violence, that violence is taken to higher levels for refugees living with the additional, intersecting risk factors of language barriers, lack of local social capital, barriers to employment, and racial and ethnic discrimination.

“I live three types of discrimination. One for being Colombian, one for being a woman, and one for being black.”

– Afro-Colombian woman in Quito

Women refugees may also be unable to access some of the services or institutions that offer protection to host community women. One finding across all four cities, for instance, was a shortage of temporary housing – shelters – for women fleeing GBV. In Quito, there is a local shelter that accepts refugee women and their children, but it is currently beyond capacity. In Kampala and Delhi, there are currently no local shelters that accept refugees, for reasons that are discussed further below.

“You’re black, so even going in the road you won’t be safe. Some of them when they see you...they’ll say ‘Do you want an Indian man?’”

– Somali single woman in Delhi

Being single is an aggravating risk factor across all types of violence. Most single women live in the poorest sections of cities, and feel not only stigmatized by other refugees but also at high risk every time they leave their home, whether to go to work or buy groceries. As a single Afghan woman in Delhi put it, her neighbors – who are both Afghan and Indian – are very much aware that she lives alone, which gives her great unease: “They see me walk outside alone every day, and come home alone, and make comments about it.” “I feel alone and without a community, and it’s scary,” said a single Colombian woman living in Quito.

There are emotional costs to feeling so at risk in daily life. Women refugees shared feeling, at times, overwhelmed by the violence and risks of violence they encounter nearly everywhere they go. This burden weighs particularly heavily for women who are attacked by neighbors, people whom they see every day. Having to live among their attackers is a trigger for many women and a source of profound psychological distress.

Women face a variety of GBV risks in their daily lives, as well as a range of types of violence – including physical, sexual, emotional, and economic. Many of these risks can be grouped into the following categories:

Risks related to livelihoods. Refugee women in all contexts reported being sexually assaulted, and even raped, when trying to earn money for themselves and their families. Violence is perpetrated by employers, by clients, and by strangers who accost them on their way to and from work.

“One of us, she’s 20 years old, was raped by her employer, who told her she’s a refugee and he has a lawyer so she can’t complain. What can she do as a refugee?”

– Burmese Chin woman in Delhi

Such violence happens in all cities. And while some working conditions are riskier than others, women reported experiencing GBV in every job, whether working as a clerk in a shop in Delhi, selling goods at a market or on the street in Kampala, Delhi, or Quito, collecting garbage (‘rag-picking’) in Delhi or Beirut, or cleaning houses, which is a common job for refugee women in all four cities. (Many refugee women also engage in sex work; related GBV risks are addressed in that section of this report.) As a general rule, the jobs that pay the most, which is often still not even a living

wage, carry higher risks of GBV. A woman in Delhi explained her situation, which is illustrative: “I choose to work at night at a marriage party [as a waitress] because the payment is quite good...600 rupees (USD 9.18) per night. If I work in a factory, I get 150 per day (USD 2.30), and the work is very difficult.”

“Employers always want to use you in a way that is degrading, humiliating...they usually want a sexual relationship with you.”

– Youth Congolese woman in Kampala

Congolese women in Kampala experience violence when they go to collect cassava leaves to eat or to sell. “If you don’t ask [the owner of the garden] to pick leaves you risk being stoned to death...and they’ll say, ‘I’ll give you as many leaves as you want if you have sex with me.’ And because you have no food at home...”

Afghan women working in pharmacies in Delhi said that in addition to being made to “be fashionable, remove hijabs, and look sexy to attract people,” which makes them feel uncomfortable, employers sexually harass them and explicitly pressure them for sex: “Spend one night with me and I’ll let you keep your job.”

“Rape doesn’t happen always. But we are selling necklaces and you find someone comes, says they’d like to buy some products from you, but I don’t have any money right now it’s at home, let’s go and get the money...When we reach an isolated place he pushes you down and rapes you. This happens all the time when you are doing selling on the street.”

– Youth Congolese woman in Kampala

A common way for young women refugees in Kampala to earn money is selling jewelry on city streets. They experience violence, including rape, while doing this. Their risks of violence are heightened because, as refugees, they are pushed to sell their jewelry on relatively isolated streets or pockets of neighborhoods, in order to avoid encroaching upon Ugandan sellers’ usual “territory,” which would generate another set of GBV risks: “Ugandans have their own space to do their own business. We don’t have our own space that’s why it’s riskier.”

Domestic work is one of the most common forms of employment for adult and young women living in cities. It is also commonly unsafe, a site of violence for many women. They reported employers locking them inside as they work and being sexually harassed, pressured to have sex, and raped. Wage theft by domestic employers is also common.

Risks in and around their homes. Women reported feeling at risk of violence in their homes; single women, especially, encounter regular threats of violence by non-family members. Landlords demand sex in exchange for granting leeway on late rent, or for not raising rent monthly, or for renting an apartment to a refugee in the first place: “Sleep with me and then I will let you live in my house.” Women, especially single women, reported landlords entering their homes without permission. Incidents of neighbors and strangers entering homes and raping or abusing women also occur; this happens to children as well, since working parents, especially single women, often leave them at home alone when they go to work. Refugees emphasized the intersection of poverty and refugee status in exposing them to such risks: slum housing is often insecure, and attackers assume that, as refugees, they are “easy targets” because they have less community protection, or are somehow deserving of violence, or are unlikely to report violence. Women living in urban slums also experience GBV when venturing out of the slum to collect firewood or potable water.

“In a small room we have been renting there is no ventilation so when it’s summertime it’s so hot and we can’t sleep inside the room. So some are sleeping upstairs...or they open the door and the locks don’t work...and in the nighttime locals come in and rape within the room – even if the husband is there.”

– Burmese Chin woman in Delhi

Risks in public spaces. Women are subjected to harassment and verbal abuse, including explicit threats of rape, unwanted sexual touching, and rape, simply while walking down city streets, buying groceries in the market, or waiting in line to use the restroom. Women whose “foreignness” is visible, because of their clothes or their race, for instance, are more at risk than those who can “blend in” as a risk mitigation strategy. There is a marked difference between the experiences of Colombian women and AfroColombian women living in Quito, for instance. Whereas Colombian women said that they can avoid some GBV in public by staying silent (if they talk, their accent “gives them away” as Colombians), Afro-Colombian women are targeted for derogatory remarks and discrimination from the minute they walk outside because of their skin color.

“I feel unsafe everywhere. I feel unsafe at work and on the street. It’s really hard for refugees.”

– Haitian woman in Quito

“The only places I feel okay are [the shelter] and UNHCR.”

– Female survivor of SGBV in Quito

In Delhi, women refugees go to food markets at night to collect over-ripe or bruised vegetables that sellers have discarded, or to buy them at reduced prices. This is a particular site of violence for them, because would-be attackers know this routine and can attack women either at the market or on their way home. As one woman put it, “They’re waiting for us.”

To mitigate risks, women who do not work outside the home try to avoid ever having to leave their house. Those who live with other refugees, including family members, shared that they try to always walk in pairs when they leave the house – preferably with a male. “I feel like a little snail,” an Afro-Colombian single woman in Quito said, referring to how she hardly ever leaves her house in order to avoid GBV. Those who work explained that they try to walk home with colleagues or friends, although it is not often possible, given people’s staggered work schedules and the fact their apartments are dispersed across the city. They also reported taking taxis to avoid the bus, even though they cannot afford them, and also changing their routes to/from home and work in order to avoid people learning their routines.

“Back in the DRC, we had parents, community....Here in Kampala, life is very hard because you have no one to rely on.”

“For us, we wake up and life is very bad. When you sleep you don’t know what you’re going to eat tomorrow. You don’t have any facilities. So we find we sleep and we wake up without having any objective, without having any goals. So we find it’s difficult for us.”

“We don’t know where the future is...of course we want to be resettled but it’s not the primary goal we’re pushing for. We have skills. We want our skills to be established.”

– Quotes from three female refugees ages 16-24 in Kampala, living alone

Family violence. Adult and young women experience domestic violence and other intra-family abuse within their households.

- **Domestic violence.** Women reported that domestic violence happens more to them now, as refugees, than it did in their countries of origin. This is due to increased tension in their households from economic pressures, reversals of traditional gender roles that heighten those pressures (e.g., where displaced women become their family’s primary wage earners), and other emotional stresses associated with being poor in a strange city and having left previous lives and belongings behind. Men confirmed this.

- **Restricted mobility.** Afghan women in Delhi and Syrian women in Beirut reported that, as refugees, their freedom to leave their homes is more constricted than it was in their countries of origin. Young Afghan women in Delhi shared that many parents, as a coping strategy, do not let their adolescent daughters leave home for any reason (“You have to stay at home, always”). This protects them from a number of real urban harms, but also isolates them, preventing them from attending school or participating in other programs and activities.

Service and Funding Gaps Affecting Women Refugees’ GBV Prevention and Response

Knowledge gaps. Women reported not knowing about support groups, services, and local organizations in their communities, both those that are specifically for refugees and those that traditionally serve host community members but which are open to refugees. Even refugees who interact with service providers regularly reported being unaware of programs and activities offered by that same organization, or of only learning about them after the fact. Notably, refugee service providers shared that sometimes they deliberately do not promote certain activities widely – including women’s support groups – because they do not have sufficient resources, including staff time, to meet demand. Women find out about services and programs from a variety of sources: from service providers themselves, by word of mouth from other refugees or from neighbors.

Lack of shelters for women experiencing violence. One of the most significant gaps shared by refugees and service providers is the lack of shelter or temporary housing for women refugees and their children experiencing violence. Both married and single women reported this gap.

Of the four target cities, Quito and Beirut have shelters accessible to refugee women, although they are consistently at capacity and having to turn women away. Service providers in other locations explained that it is very difficult to persuade local shelters to accept refugee women. Many shelters are already at capacity with members of the host community; others request cost-sharing; others are put off by what they assume will be a hassle, given language and cultural barriers. Other shelters have previously accepted refugee women, but had negative experiences – the women refused to leave, or their husbands showed up and made a scene – and have since declined to take in more refugees. (For more discussion on the challenges of bringing refugees into host community services, including shelters, see the introductory section, *Urban Model: Challenges and Opportunities*.)

In some contexts, survivors are also discriminated against on the basis of disability,

with UNHCR staff and implementing partners in Beirut reporting that shelter staff refuse to accept survivors with disabilities, both children and adults, citing “lack of capacity.” With very few options available, UNHCR and partners have sometimes provided individualized options, such as studios with personal caregivers, to ensure protection of survivors with disabilities and avoid institutionalization. These approaches are, however, often not possible given available funding.

Burmese Chin women in Delhi had, at one point, organized for themselves a safe space that served as a makeshift shelter for women and their children needing temporary housing. Both service providers and refugee women talked about the shelter positively, and agreed that its closing was a significant loss for the community. The shelter, which had been funded by an international donor, closed for a variety of reasons, including a lack of funds and a lack of formal management structure. But the experience of having their own shelter continues to resonate for the women, and they talk of trying it again. It also suggests their resilience, and the potential of refugee-run CBOs to bridge gaps that exist in urban GBV prevention and response.

Unmet need for sexual and reproductive health services. In most locations, urban women refugees have inadequate access to sexual and reproductive health services, including STI and HIV testing. Service providers and refugees believe these gaps are due to a number of reasons:

- In some locations, UNHCR’s main implementing partners are faith-based organizations with religious or cultural biases against certain aspects of SRH service provision, such as sexual health education or STI testing for married women; these partners have oversight of, and influence over, funds dispersed for SRH-related subgrants.
- Funds and grants for SRH services are inadequate; sometimes the grants are for less than six months. Local sexual health clinics that have been tapped as referral points for refugees cannot continue expanding their services and conducting outreach to refugee communities without additional cost-sharing.
- Physical access to services and information is difficult given constraints on women’s mobility, logistical challenges, and transportation expenses.
- An absence of mobile clinics to refugee communities.
- Fear of stigmatization, lack of anonymity, and breaches of confidentiality, for instance, if a woman tests positive for an STI, or if she asks for condoms or information related to sexual health.

Lack of support and funding for women’s CBOs. Women refugees are well aware

of the challenges they face in accessing host community services and institutions, including shelters. Women voiced interest in organizing their own community-based solutions, at least as stop-gap measures, but cited a lack of funding available to support these activities. In Delhi, for instance, Burmese Chin women used to have a communal safe space that acted as an informal shelter for survivors of GBV, as well as a crèche (child care) for their children who faced barriers accessing government-run crèches. (See *Children and Adolescents* for a discussion of these barriers.)

Even when these solutions are refugee-run, however, they require financial and other support, such as technical assistance or program management training. Humanitarian actors are challenged to provide this support, given their own staff shortages and strained budgets.

Lack of inclusion in development programs and urban safety initiatives targeting host community women. A current theme in humanitarian discourse is the need to partner more closely with international development actors. Opportunities for this abound in many of the large urban centers where refugees migrate, which are sites of numerous poverty projects funded by multi and bilateral development aid donors.

In several cities, the WRC learned of urban development initiatives targeting host community women. UN Women in Ecuador, for instance, is undertaking a Safe Cities initiative in Quito that involves mapping safe versus unsafe areas in certain neighborhoods, as well as a Safe Transport initiative, addressing violence against women on public transport. Although these programs are not currently inclusive of refugee neighborhoods or violence against refugee women, the benefits of inclusion should be explored. (Excluding refugee women from such programs may also reinforce their marginalization and negative perceptions of refugees as second-class urban citizens.) Integrating activities or messaging relevant to refugee women would promote social cohesion and address negative attitudes toward refugees that are socially pervasive yet widely unacknowledged. Compared to the costs of launching parallel programming for refugee women, such integration would likely be cost efficient as well.

Refugees feel distrusted and blamed by service providers for GBV risks they face. Women in some locations feel disbelieved when talking to service providers about the violence and GBV risks they experience living in the city, or it is presumed they are exaggerating their risks for personal gain. Some women also reported feeling blamed by service providers for the violence they encounter, and it is implied or explicitly suggested to them that they bear responsibility for having “put themselves in a situation” that allowed the violence to occur, whether by taking a night job, going to a market at night to recover discarded food, agreeing to clean a man’s house, engaging in sex work, or rag-picking. Women shared that sometimes their reports of violence are met

with a shoulder shrug, a “what did you expect?” response, as though they chose lesser protection when they moved to the city; more than one woman shared that a protection strategy that had been explicitly suggested to her was to move back to a camp.

“It sounds like we’re making up stories because our numbers are too huge.”

– Burmese Chin woman in Delhi, talking about how they feel disbelieved by service providers when they talk about incidents of violence

That refugee women feel this way – that this is a perception many of them share – is relevant in itself, regardless of whether most service providers feel this way or mean to suggest as much.

“All the refugee women have gone through molestation and harassment. It’s just that we’re facing these problems on a daily basis and we don’t even tell UNHCR about it because it’s every day. They have this judgmental attitude...so imagine if we told them about the daily harassment.”

– Refugee woman

Of course, no matter what the circumstances are in which GBV or GBV risks occur, survivors must not be made to feel at fault, or as though they are not entitled to protection because they live in urban settings rather than camps, or because they take jobs that make sense to them. Women feeling comfortable enough to report GBV risks, and to do so without being judged, is fundamental to the “survivor-centered” approach endorsed in the IASC Guidelines,³⁴ and to safe identification and referral systems.

Good Practices

Individual case management. Women shared that in some cases, a social worker or counselor from a refugee service provider was able to neutralize a particular risk they were facing. In Delhi, for instance, as part of an occupational safety initiative, staff at Don Bosco, one of UNHCR’s partners, used to make visits to individual employers simply to signal that their refugee employee had a supporter “in their corner” – someone official to whom they could turn to report abuse or exploitation. Although no formal evaluation of this program was ever done, staff felt strongly that it deterred abuse and positively influenced outward attitudes and behavior toward woman refugees in their workplaces. (This initiative has since lost its funding.) Other women spoke of the difference it made when staff at a service provider spoke to their landlord or a neighbor on their behalf.

Informal peer networks. Women who have a community of friends, of fellow refugee

women, reported that this is essential to their survival and ability to mitigate some, although not all, GBV risks. Single Somali women in Delhi, for instance, live together in one house, with all of their children. They lend each other money, help each other with food, and provide emotional support to each other. “If you don’t have your community, who will help you?” one woman asked, rhetorically. (The importance women assigned to these networks also highlighted the increased vulnerability of women who do not have such a community. In Delhi, for instance, there are large numbers of Somali, Afghan, Rohingya, and Burmese Chin refugees, and women in these communities can rely on each other for support. This is not the case for Iraqi, Iranian, or Syrian single women living in Delhi.)

Women’s support groups. Refugee service providers are home to women’s support groups. For instance, there is a biweekly support group hosted by Asylum Access Ecuador in Quito. It is a safe space for women survivors of violence to interact, hear talks on different topics, share experiences and information with one another, and participate in wellness activities. Participants shared that it is one of few places they feel safe in the entire city, and their only outlet for accessing peer support.



Somali women in Delhi participating in a Refugee Community Development Project workshop.

© Mary Tran

“When we come together and share our problems, it definitely has an impact on us. It is helpful. But we need big supporters in the background.”

– Afghan woman in Delhi

At the same time, however, not all women refugees know that such groups exist. This corresponds with other gaps in refugees’ awareness about the range of activities and services available to them.

Recommendations for Mitigating GBV Risks Faced by Women Refugees

- **Collaborate with refugee women and relevant host community organizations to come up with creative, multifaceted strategies for mitigating risks related to livelihoods.** There is no single solution or silver bullet for addressing the GBV risks women refugees face in trying to earn money so they and their families can survive in cities. Instead, a range of strategies should be tried and tested, alone and in combination, to build an evidence base around effective risk mitigation programming in urban contexts.

Among possible strategies to draw from are: more thorough vetting of employers; having refugees work in pairs; increasing resources for job banks and job placement programs; building relationships between humanitarian actors and labor ministries/occupational safety boards; facilitating information sharing about dangerous employers; looking for safer venues for similar work (for instance, assisting refugees involved in domestic work transfer over to being housekeeping staff in hotels); staff visits to workplaces to meet individual employers, get wage schedules in writing, and signal refugees’ access to recourse in event of abuse; and public education campaigns to raise awareness about common GBV risks at work, such as unsafe domestic work (this would also benefit host community women doing similar work and facing similar risks). For women for whom mobility in the public sphere is either unsafe or culturally inappropriate, promote marketable options for home-based enterprises.³⁵

- **Group job placement designed to mitigate exposure to GBV risks and increase occupational safety.** Placing refugee women in jobs together and/ or in places where host community women also work in large numbers could help reduce refugee women’s isolation in the work place and their related exposure to GBV at work.
- **Build linkages between humanitarian actors and national, international, and private sector organizations working on development projects that target host community women.**

- **Balance GBV awareness-raising sessions done within refugee communities with sessions in the host community.** Women refugees remarked that while GBV awareness-raising activities are beneficial to refugee communities, it is equally important – if not more important, in some locations – to conduct these activities within the host communities where they feel vulnerable and targeted.
- **Help women refugees form support groups and carry out projects that bridge protection gaps they identify and prioritize.** A Burmese women’s group in Delhi, for instance, is looking to create a safe space for women survivors of GBV in their community, as well as organize a vocational training and sexual health workshop for single women engaged in sex work. The Refugee Community Development Project, which is run by Somali and Afghan refugees, also in Delhi, is looking to secure funding to carry out its women’s social support group and livelihood activities. In Kampala a women’s group of GBV survivors is engaged in microfinance and, also in Kampala, a group of refugee women engaged in sex work are organizing protection trainings for themselves and starting small businesses (catering, beading) to diversify their incomes.
- **Recognize barriers to women’s access to services and activities, including SRH services, and collaborate with women to develop workarounds.** Where transportation costs, for instance, are a barrier, consider bringing services to women by partnering with a local sexual health clinic to bring their mobile clinics to refugee neighborhoods, or by supporting women interested in convening satellite women’s groups closer to their homes.
- **Build relationships with police departments.** Where available, work with women’s groups that have already made initial inroads with police to combat risks affecting host community women. Advocate for assigning a trained focal point within police departments and ensuring the availability of female police officers.
- **Designate case managers to support individual refugees in mitigating discrete risks.** Given the prevalence of GBV risks associated with livelihoods, each urban field office should develop a systematic, strategic response based, in the first instance, around the industries, types of shops, or modes of employment that are most common among women refugees, since trends tend to vary by city and by refugee community. In one city it may make sense to target municipal labor boards and merchants’ associations, whereas in another it may make more sense to target restaurant unions, or raise awareness about unsafe domestic work.

In addition, providing individual protection case management for refugee women who work or who are having tension with their landlords, is a parallel strategy that

deserves further exploration. This would involve having a refugee service provider staff person go to women's places of work, or meet with their landlords, to signal that refugees have institutional support, and a place to report abuse or exploitation. Staff can also monitor occupational safety through monthly or bimonthly visits to employers.

- **Facilitate single women meeting each other and living together.**
- **Provide stop-gap shelter solutions while integration with local shelters is pursued.**
- **Identify and acknowledge the resource limitations that currently constrict activities and services for women**, such as a lack of funding and staff time available for expanding women's groups, vocational or language classes, and develop strategies for resolving them. In some cases, the solution will be a funding one, for instance, where additional programming will require hiring additional staff or renting a physical space. But other cases may lend themselves to in-kind solutions, for instance, pooling information about unsafe versus safe employers, or safe versus unsafe apartment complexes, or roommates for single mothers.
- **Strengthen GBV case management and the application of survivor-centered approaches.** Case management strengthening is needed to address the stigmatization that women experience when reporting GBV. It is important to respect the rights, choices, and wishes of survivors and to ensure the guiding principles for caring for survivors are respected. Safe identification and referral systems must be brought up to humanitarian standards, including the survivor-centered approach set forth in the IASC Guidelines. Develop these in close consultation with women refugees to ensure solutions do not increase their vulnerability to GBV.

Children and Adolescents³⁶

“For our children, there’s no safety. It’s zero... We send our children to go look for something, like at a shop, and on the way to a shop she’s raped along the way.”

– Parent in Kampala

“During the daytime parents go to work...all our neighbors are local...sometimes girls at home during the day face molestation or rape so at home also we are not safe. So many cases of being raped at home. It’s not reported because it’s useless.”

– Burmese Chin woman in Delhi

“Our teacher told us the only reason we come here is to rob the country.”

– Colombian girl in Quito, 11 years old

GBV Risks Experienced by Children and Adolescent Refugees

Children and adolescent refugees – girls and boys – face particular GBV risks. In urban settings, these risks intensify and take on new dimensions. During field assessments, the research team consulted parents, adolescents, and service providers who described risks across the following general categories: (i) risks within the home; (ii) risks at school; (iii) risks related to working; and (iv) heightened risks faced by adolescent girls.³⁷

Risks of GBV experienced by children and adolescents within their homes

GBV risks related to shared tenancy. Urban refugee families often share living quarters with others to save on rent. Sometimes they live with other refugee families, but they may also live with members of the host community. In either case, the economic pressure to live in shared housing, coupled with the discrimination refugees face in renting accommodation, means that families often have little control over whom they live with, and where. The result: homes become unsafe for children.

Two key factors account for the GBV risks associated with shared tenancy in urban settings. First, cheaper housing and rental discrimination funnel refugee families to live in unsafe neighborhoods and buildings. Sometimes families – especially single-headed households that struggle to make ends meet – are forced to live in shared housing, which puts children at risk of abuse, including sexual abuse and rape, by housemates

and neighbors. Parents and service providers reported that children from refugee families are especially targeted for such abuse because it is assumed that their parents will not report it, so as not to draw the attention of law enforcement or their landlord. There is also a lack of privacy in shared housing situations, and as a result, children and adolescents often witness their own parents or other tenants in intimate situations. Parents expressed concern that even when this exposure is unintentional, children in shared housing can be exposed to psychological and emotional harm.

Second, children and adolescents are abused in their homes by family members. This was reported by parents and service providers. These children and adolescents can suffer abuse in silence for long periods before service providers or others learn what has been happening and take measures to intervene. Although all children and adolescents are vulnerable to intra-family abuse, refugees – adolescent girl refugees in particular – are especially vulnerable for several reasons, including a lack of opportunities to report abuse to a trusted adult. Many young refugees are out of school, do not visit refugee service providers, or do not talk to counselors themselves. Additionally, language barriers make communication through hotlines or other avenues available to host community children difficult.

In some cities, it is common for single refugee mothers to enter into relationships with men of the host community. Even if mothers suspect their children may be at risk of harm, they may refuse to believe it or take action due to economic dependence on their partners. Refugee service providers in the border communities in Ecuador, for instance, shared that although they see this type of intra-household abuse often, there is no regional governmental agency responsible for child protection to which they can turn. Instead, service providers focus on convincing mothers to leave their partners, for the safety of their children.

GBV risks related to children being left at home by working parents. Families, especially families headed by single mothers, leave children at home alone when parents are working. Communities shared stories of children being molested and raped by neighbors, landlords, and fellow refugees when left home alone. This happens during the day as well as at night, since many refugee parents work night shifts.

“We lock them in the house when we’re working...and of course it’s dangerous to leave the kids behind...but we have no choice.”

– Mother in Kampala

Parents who work during the daytime spoke of difficulty finding safe and affordable crèches (daycare) for their children. Some UNHCR implementing partners run crèches for refugee children, but the majority of refugees live too far from crèches



Burmese Chin refugee youth, Delhi.

© Don Bosco

to feasibly access them on a daily basis. Parents also spoke of being pressured by humanitarian service providers to send their children to host community crèches, such as those in Delhi which are run by the municipal government. Parents, however, cited a number of factors that made this option impractical for them, or even less desirable than leaving their children at home. These include distance, the costs of transportation, the limited hours of the government crèches, language barriers, and bullying that puts their children at risk.

Risks of GBV encountered by children and adolescents at school³⁸

Within and across cities, young refugees experience violence in school. Nearly all adolescents and parents reported that refugee boys and girls are targets of verbal and physical violence because of their refugee status but also based on their gender, race, nationality, religion, and language.

Such abuse comes from fellow students, teachers, and school administrators. In Quito, parents who have tried to take these issues up with school administrators have been mocked, disbelieved, and told to take their kids out of school rather than complain; some school administrators expressly condoned the bullying. In other loca-

tions, parents have been too afraid to approach school administrators themselves, or else face language barriers to doing so. Mocked, stigmatized, and targeted for bullying, many young refugees drop out. Girls are also targeted by teachers for sex in exchange for grades. This reinforces findings from urban research conducted by the WRC in Cairo, Egypt, and Gaziantep, Turkey, where adolescent refugee girls described themselves experiencing school-related violence and abuse.³⁹

GBV risks related to children and adolescents working

In all locations, children and adolescents are involved in livelihood activities, whether they are unaccompanied or living with their families. In some cases, they are forced by the family to work, while in other cases they have been given a choice to work or attend school, and prefer the former.

“This is a kind of violence we are doing with our children: we force them to work instead of being in school. We have no other choice.”

– Afghan woman in Delhi

Working exposes children to myriad GBV risks. Refugee boys working in hookah bars in Beirut are sexually harassed, abused, and raped by employers and clientele; girls doing domestic work in Kampala experience the same from people whose houses they clean. Burmese adolescents – girls and boys – in Delhi working as caterers and servers at Indian wedding parties are confronted with similar risks, both at work and on their way home at night. Rag-picking, which is common among refugee children in Delhi, exposes boys and girls to GBV from strangers on the street.

Additional GBV Risks Faced by Adolescent Girls

Adolescent girls are uniquely disadvantaged during humanitarian crises, and their aftermath. Pre-existing social and gender norms that stymie girls’ development often persist throughout crises, and as displaced families embark on re-establishing their lives in new and foreign cities, these norms can become even more entrenched and manifest in new ways.

“Domestic work: it’s very risky, you don’t know the family. You’re going to be at people’s houses, it’s not safe. And you don’t know the language.”

– 16-year-old girl in Delhi

Previous WRC urban research shows that adolescent girls are overlooked in urban

humanitarian response. Despite the fact that some key inputs are shown to support girls' well-being and development, humanitarian responses in urban settings are rarely implemented in ways that protect and serve girls, let alone designed to build girls' capacities and resilience to cope with crisis. While Child Protection and GBV guidelines do exist, their application in urban settings is rare and thus less understood. Even less understood is how displacement to urban settings influences harmful practices such as child marriage. The typical urban refugee response passively groups adolescent girls with children or youth, effectively overlooking their unique needs and GBV risks.

Moreover, given the known protective effects of education (especially secondary education), urban humanitarian interventions that fail to prioritize girls' education leave them vulnerable to experiencing GBV and child marriage. Out-of-school girls, unaccompanied girls, girls with disabilities, and girls who work are often the ones most likely to be left out of interventions. Urban contexts also expose adolescent girls to a variety of riskier livelihood options.

Findings from the four assessments affirm and expand upon those findings. Adolescent girls, due to being both female and young, are among the most likely to experience violence. They face many of the same risks that women face, such as rape en route to work and school, as well as those specific to children, such as sexual assault while parents work. Many are also forced to assume adult roles in their new urban environments, working rather than attending school, or marrying and having children while still children themselves.

Inability to leave the home. Adolescent girls are among the least visible urban refugees, and programs targeting girls are rare in urban humanitarian response. Only one of the four locations visited for this report had programming specifically for girls, but even that programming, because it takes place at community centers, is out of reach of many girls who are not allowed outside. Indeed, often the girls who would benefit the most from the skills-building, mentoring, and peer networking that takes places during these activities are often the least likely to be able to attend.

“You have to stay at home, always.”

– Girl in Delhi

As indicated above, in some cities, families rely on coping strategies that isolate their daughters within their homes, protecting them from real urban risks but also thwarting their access to education, services, and activities. WRC findings from Cairo, Gaziantep, and Tripoli accord with the present research that urban girls are often isolated within their homes, which are incredibly small and don't allow for “woman

privacy.”⁴⁰ In Beirut, Syrian girls and their mothers shared that even if they did know about activities at the nearby community center (they did not know of any), their parents would likely not allow them to attend. The girls did express, however, a wish to attend school and continue their education,⁴¹ as well as interest in doing activities like learning to make handicrafts or painting and dancing.

Mothers of adolescent girls with intellectual disabilities especially reported restricting their daughters’ movement due to fear of violence, including physical violence and “kidnapping.” They perceived that girls with intellectual disabilities were also more at risk of sexual exploitation by other community members.

“I am afraid of sending her alone and that someone will sexually exploit her. Maybe someone will hurt her or kidnap her... The girls are more susceptible than boys because of the social issues and expectations.”

– Mother of a girl with intellectual disabilities, Beirut

Lack of safe spaces specifically for adolescent girls. Humanitarian actors rarely prioritize adolescent girls, proactively carving out a safe space just for them. Even girls who are participating in youth programs expressed an interest in girls-only safe spaces and activities, noting that “some things you can only discuss with other girls.” Yet only one urban location had convened safe spaces for girls to safely meet with peers and mentors, and these particular spaces remained unknown to many girls, and too far away to be feasible.

Child marriage. In Kampala, Delhi, and Beirut, urban poverty has influenced marriage practices. Congolese women in Kampala, for instance, shared that whereas a village girl in the DRC might get married at 15 years of age, in Kampala, Congolese girls often marry at 12-13. In some locations, child marriage is viewed as a risk mitigation strategy, a way to protect girls from sexual harassment. In different contexts, the rationales for child marriage may differ – economic reasons may predominate in some places, whereas safety concerns are paramount in others.⁴² Understanding these reasons will be key to responding effectively, and intervening where possible.

Lack of access to SRH information and services. Adolescent girls lack access to information on a range of topics, including sexual and reproductive health. In Beirut, when adolescent girls were asked if there was a place where they could access information related to pregnancy and menstruation, they were surprised that such information could exist.

Three countries, Three Programs Mitigating GBV Risks for Children and Adolescents

After-school programs bring together refugee and host community youth

Refugee Education Trust in Ecuador. RET, a long-term mentoring program, confronts the issue of tension between refugee and host community youth by bringing them together; 70 percent of participants are refugees (mostly Colombian) and 30 percent are Ecuadorian. Both boys and girls participate, and those consulted said the program is “like a family”—the only place where they “feel like equals” with Ecuadorians. They like having an opportunity to “mix” with Ecuadorians and, given a choice, would pick an integrative model over an all-refugee model, since the former allows for a breaking down of distrust and stereotypes.

In addition to activities like sports and theater on the weekends, RET operates a drop-in center during the week, where kids can hang out and get assistance with homework or spend time with staff. Participants learn about RET’s program through word of mouth, not through refugee service providers – and that is by design. RET does not advertise its programs publicly, as demand far exceeds their capacity and they often have to turn applicants away.

Don Bosco in Delhi. The Youth Leadership program is attended by approximately 70 percent refugees, mostly Afghan, Somali, Rohingya, and Burmese Chin refugees, and 30 percent Indians.

Youth leaders receive training on GBV and then go out into their respective communities to do door-to-door awareness raising for parents, adolescents, or elders in small teams. Each team receives a monthly stipend, and presents on their expenditures and activities to the entire club. Although the program has never been evaluated, participants say it allows them to positively influence their communities. Somali girls explained that parents do not let their daughters go to school or to Don Bosco, and girls now understand that this social isolation is a form of GBV. The Youth Leadership program supports them in strategizing how to share gender empowerment messages with friends and family. As youth leaders, “we explain that girls and boys have the same rights. Other girls also have to know that if your parents are doing these things, you can tell them it’s wrong. You should be equal and treated in the same way.”

Targeting children who work the streets

IRC Street Children program in Beirut. Many refugee children beg for money, sell wares like Chiclets or flowers, or provide services like shoe shining. Some are unaccompanied, and send money to their families in Syria. Most, however, live with their families in Beirut.

These children are subject to violence on the street; propositioned for sex, harassed for being refugees, and targeted for rape and sexual assault. The International Rescue Committee (IRC) program takes a multi-faceted approach to supporting these children, providing them with access to a mentor, an accelerated learning program, psychosocial support, trainings on safety and life-skills, and a hotline for emergencies.

This program offers lessons for humanitarian actors in other urban contexts: the benefits of having the same “street manager” work with a particular group of kids, to build rapport; and the importance of having a livelihood component to the program, ideally one that targets parents as well as children. In response to children’s mobility, the program uses QR codes to track children’s participation in activities and case management.

If they have access to health care, it is usually to a primary care physician they attend with a parent. In some cities, adolescent girl-friendly clinics do exist. In one border community visited in Ecuador, girls can access a confidential drop-in clinic for information or testing. The girls who knew of this center had learned of it through word of mouth.

* * *

Boys' access to GBV services. It is important to highlight that boy survivors of GBV encounter unique barriers in accessing GBV support services. The vast majority of such services are purposefully oriented toward women and girls, even located in women's centers. Few boy-friendly options exist and proactive outreach to boy survivors is extremely rare.

Recommendations for Mitigating GBV Risks for Children and Adolescents

The humanitarian field of Child Protection is relatively well-developed, with Minimum Standards vetted by numerous agencies, many of which are instructive for urban contexts, both emergency and non-emergency.⁴³ Inter-agency GBV prevention and response guidance also exists for Child Protection programmers specifically.⁴⁴ The following recommendations are limited to demonstrating how responses can be tailored to respond to the GBV risks encountered by children in cities. In its four assessments, the WRC did not directly consult children under 15 years of age, nor conduct targeted research with children from all refugee subpopulations, such as unaccompanied minors. Accordingly, these recommendations do not address the full range of tailored responses that will be necessary to respond to GBV risks encountered by distinct groups of children and adolescents in urban areas.

- **Partner with child protection actors to conduct comprehensive consultations with children and young people in urban areas, with special attention to identifying their risks of GBV.**
- **Partner with child protection actors to support community-based child protection programming, case management, and family support services, including parenting education.**
- **Strengthen programs to maximize refugee children's enrollment and retention in school and enable their learning and participation in the classroom, including through bridge classes and non-formal education that enables catch-up after years of missed schooling.**
- **Map urban programs for refugee children and adolescents, including those organized by refugee and host community organizations.**

- **Build linkages with urban poverty programs that target children and adolescents**, including programming focused on psychosocial support, sexual and reproductive health, skills building, mentorship, and livelihoods. Ensure that existing refugee services are sufficiently child and adolescent/youth-friendly.
- **Consult with parents and children to develop strategies for ensuring that young children are enrolled in crèches or other forms of daycare, so they are not left at home alone while parents work.** Support alternatives and complements to crèches, including early childhood care and development groups.
- **Engage children, adolescents, caregivers, and communities in a process to identify GBV risk factors faced by girls and boys who are working**, starting with the risk factors present in types or places of work most common among urban refugee girls and boys. Develop a holistic and multi-faceted strategy for addressing these risk factors, one that includes engaging employers, reviewing relevant legal frameworks, mapping alternative safe livelihoods opportunities, and identifying any community-based protection mechanisms that can be mobilized (families and kinship networks, safe spaces, etc.).⁴⁵ Map and consult local organizations that work with children and adolescents engaged in risky livelihoods, as well as stakeholders from outside the humanitarian sector who have expertise and tools specific to engaging vulnerable children and adolescents in urban areas.⁴⁶
- **Strengthen access – for adolescent girls and boys – to comprehensive life-skills and psychosocial programming that builds confidence and self-esteem and includes information about sexual and reproductive health, self-protection, and abuse and exploitation.**
- **Identify and address gaps in boys' access to GBV support**, especially where existing supports were designed to facilitate women and girls' access. Conduct proactive outreach to boy survivors of GBV.
- **Address the bullying of refugee children in schools.** Design and implement programs that involve host community parents and children, as well as teachers and school administrators. Leverage any existing anti-bullying programs in schools, and ensure adequate institutional mechanisms are in place – such as complaint and accountability procedures within school administrations – to address reports of bullying.
- **Work with a diverse cross-section of young people to develop youth programs that integrate refugee and host community youth.** Their particular needs will be context-specific but will likely include some combination of non-formal education, life-skills, platforms for social interaction and mentoring, and vocational skills training.

Recommendations Specific to Adolescent Girls

- **Adopt and implement a two-pronged approach to reducing the particular GBV risks faced by urban adolescent refugee girls:** (i) mainstreaming their needs, concerns, and participation across humanitarian response; and (ii) developing programs that target adolescent girls specifically.
- **Develop targeted education and empowerment programs for girls who are confined at home, including girls with disabilities.**
- **Set up safe spaces for adolescent girls, mindful that in some contexts their families will not let them travel far from home.**
- **Reduce risks to child marriage in an urban context.** Programmers working in urban contexts should understand that meeting the basic needs of families is one of the most effective means of mitigating risks of child marriage. Families must be able to provide for their children in order for there not to be a perceived benefit in marrying their daughters out of the family at early ages. Additional factors contributing to child marriage are diverse and context specific, and a contextual analysis should be undertaken to inform child marriage programming in each setting. Guidance on evidence-based interventions is now emerging from development contexts, and can be adapted to urban environments to address the complex economic, social, protection, or health risks faced by girls at risk or girls already affected by this practice.⁴⁷
- **Establish mentorship programs for girls; build their assets as a means of empowerment and protection; and build social networks with host community girls** through existing platforms, such as Girl Scouts, acknowledging that such platforms usually fail to attract or retain girls from marginalized groups.
- **Adapt and implement existing tools for reaching and engaging adolescent refugee girls.** The WRC has recently developed a framework for field staff. The *I'm Here Approach*, for use in camp and non-camp contexts, is currently being piloted in several cities. The steps and outputs generate actionable information to safely link girls to information and services and to design programming tailored to girls' needs and potential.⁴⁸

LGBTI Refugees

It is by now well known among humanitarian actors that LGBTI^{viii} refugees face particular risks of violence, in both camps and urban contexts. In general, because of their diverse sexual orientation, gender identity or presentation, or bodily diversity, LGBTI refugees face higher levels of discrimination and violence than that experienced by the larger refugee population. Yet most existing official guidance for serving at-risk LGBTI populations centers on how LGBTI status should affect asylum claims, refugee status determination, and resettlement case processing.⁴⁹ Far less attention has been paid to the protection concerns of LGBTI refugees, let alone urban LGBTI refugees, including the GBV risks they face daily and what humanitarian actors can do to help mitigate those risks.^{ix 50}

Among humanitarian field staff, there is an emerging consensus that current guidance, such as UNHCR's *Need to Know Guidance: Working with Lesbian, Gay, Bisexual, Transgender and Intersex Persons in Forced Displacement* (2011),⁵¹ while an important step in LGBTI mainstreaming, offers limited practical suggestions for protection staff operating in the field, including in urban areas where many LGBTI refugees reside. More detailed directives and guidance – standardized, yet adaptable for local contexts and offering a range of potential operational approaches and sample interventions – is needed.^x

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- viii. The WRC uses the LGBTI acronym throughout this report as shorthand for “lesbian, gay, bisexual, transgender, and intersex” persons. For a Glossary of Sexual Orientation and Gender Identity-related Terms, see IASC GBV Guidelines, Annex 2, p. 319. <http://gbvguidelines.org/> However, as others have noted, the rising dominance of such acronyms, which presumptively pool diverse identities under the same banner, poses conceptual and practical problems. For example, it contributes to the conflation of the two analytically distinct concepts of sexual orientation and gender identity. It also fails to adequately distinguish between the different realities faced by, say, transgender individuals compared to bisexual or intersex individuals. Moreover, in many countries throughout the world, individuals with diverse sexual orientations or gender identities do not themselves identify with the LGBTI monolith, or even as being “gay” or “queer.” They might identify as MSM, *hijras*, *metis*, or any number of locally specific terms. Caveats aside, many human rights advocates and humanitarian actors, including the WRC, use ‘LGBTI’ as practical shorthand. Most of the sexual orientation and gender diverse refugees the WRC consulted during the urban assessments self-identified as LGBTI, and many of the host community organizations the WRC consulted – from CBOs to municipal agencies – also use and have a common understanding of the term.
- ix. In December 2015, UNHCR published the findings of a global survey it conducted among UNHCR field operations to assess their current efforts to protect LGBTI asylum-seekers and refugees. The resulting report, which is based on the self-reporting of 106 country and regional operations, reinforces that LGBTI individuals face heightened risks in their countries of asylum and that enhancing their protection will require a multi-dimensional approach that is at once agile and attune to local contexts. The report, *Protecting Persons with Diverse Sexual Orientations and Gender Identities* (hereinafter UNHCR 2015 Protecting Persons), is available at <http://www.refworld.org/docid/566140454.html>
- x. UNHCR's recent report also calls for the development of more concrete guidance, including sample interventions and contextually adaptable standard operating procedures for field offices on various aspects

Fortunately, there is an emerging body of knowledge and resources aimed at improving protection for LGBTI refugees.^{xi} But existing gaps in evidence and programming make it especially challenging for field staff who lack subject matter expertise to embark upon improving protection for them in meaningful and tangible ways. Moreover, in the field, discourse around LGBTI refugees' protection tends to be listed under GBV, or housed within GBV response, which further limits the scope of specialized services to these communities.

As a practical matter, the majority of LGBTI refugees may never be resettled to a third country. Rather, they will remain in situations of protracted displacement for months, years, or even decades. For this reason, it is imperative that humanitarian actors begin to develop a body of best practices and guidance that can help LGBTI individuals fleeing conflict and persecution live safely in the cities where they have sought refuge. Many LGBTI refugees also experience abuse prior to arriving in these cities and are suffering related trauma, further underscoring the need for specialized services.

Use of the “LGBTI” acronym. Although the WRC uses the acronym throughout this report, we recognize that while it is often useful shorthand, it can obscure important distinctions between the L, G, B, T, and I subgroups, including differences in their experiences and needs in accessing services, and differences in appropriate protection strategies. Across all four cities, LGBTI refugees and service providers acknowledged that within the LGBTI refugee population, those whose outward appearances suggests a diverse (i.e., non-heteronormative) sexual orientation or gender identity are most at risk of violence. This is especially true of transgender women, or transwomen.

Since LGBTI refugees are not a homogenous group, considering each letter separately is essential to shining a light on the nature of their respective vulnerabilities and protection needs. For instance, transphobia may exist where homophobia does not, including among members of the LGBTI refugee community. Trends in experiences may also be different: for instance, although gay men in Beirut shared that they do not feel safe walking around certain areas of the city and fear being stopped by the police, they do not, on average, experience anywhere near the level of daily violence faced by transwomen. Lesbians are a particularly hidden population, often targeted

of protection work, such as identifying shelter options and engaging in targeted outreach. UNHCR 2015 Protecting Persons.

- xi. In December 2015, the International Organization for Migration and UNHCR made public a comprehensive five-module training package for all staff who work with refugees, migrants, displaced persons, stateless persons, and other emergency-affected individuals. Available in two versions free of charge (*Working with LGBTI Persons in Forced Displacement* and *Working with LGBTI Persons in the Humanitarian Context*), the package includes a wide range of training materials and webinars for both participants and facilitators. The materials can be downloaded at www.usrap.iom.int/training or www.unhcrexchange.org/topics/15810.

for violence within their families and subjected to “corrective” measures such as rape and forced marriage. These distinctions, and those further discussed below, highlight that enhancing protection for L, G, B, T, and I refugees, respectively, will often require different entry points, tailored action plans, and targeted, proactive outreach.

During field assessments, the WRC met with 74 LGBTI refugees: seven in Quito and San Lorenzo, Ecuador; 49 in Beirut and 18 in Kampala.^{xii} All were gay men, transwomen, bisexual, and lesbian; none self-identified as transmen. Nor did the WRC meet any refugee who identified as intersex, although we spoke with service providers about their experiences serving intersex refugees, their understanding of the term ‘intersex,’ and their awareness of the rights of intersex individuals.^{xiii} Notwithstanding these limitations, our findings here apply to intersex refugees since they are present in all of the regions where we collected data and because it is well established that they face similar types of persecution and discrimination.^{xiv}

In this section of the report we have attempted to draw out differences, wherever relevant, in the perspectives offered by the gay men, lesbians, and transwomen refugees with whom we consulted.^{xv}

Preferring cities to camps. Although some LGBTI refugees continue to live in camps, those with whom the WRC spoke believe that cities are far safer places for them. Many

xii. In Beirut, the WRC conducted two transwomen-only group discussions, with 14 and seven participants, respectively, as well as one group discussion with four lesbian women and another with 24 gay men. In the border city of San Lorenzo, Ecuador, the WRC met with four transwomen (three were in a group discussion); in Quito we met with one lesbian woman and two gay men. In Kampala, the WRC conducted two group discussions with 10 and eight participants, respectively; they were a mix of L, G, B, T, and I and were not asked to self-profile.

xiii. Most service providers reported never having met an intersex individual, or someone whom they knew to be intersex. Few knew precisely what intersex meant or had ever received training on how think about, or respond to, the rights and needs of someone who is intersex.

xiv. Given that 1 in every 2,000 children born is intersex (see Organisation Intersex International <https://oii.org.au/16601/intersex-numbers/>), it is essential for all field staff to have basic information on the rights of intersex individuals and to be able to refer them to trained, rights-respecting medical and counseling practitioners. This is true not only for intersex adults but also intersex infants and children, who are often at risk of receiving unnecessary surgical interventions to which they have not consented or cannot consent, due to parents’ and service providers’ limited understanding of what being intersex means and what types of responses are appropriate, possible, and rights-respecting.

xv. The WRC did not consult directly with any LGBTI refugees in Delhi, although service providers shared their experiences serving LGBTI individuals. The LGBTI refugee population in Delhi remains largely hidden due to a convergence of factors, including high levels of stigma and discrimination against diverse sexual orientation and gender identities in both refugees and host communities. Information in this section that relates to LGBTI refugees in Delhi comes from service providers who relayed information LGBTI refugees had shared with them previously.

Understanding the Rights of Intersex Adults and Children

In Kampala, the WRC met with the parent of an intersex girl, who shared that when her daughter was born with intersex traits, she did not know what to do or what kind of genital surgery, if any, was called for. She turned for advice to the director of a refugee service provider she trusted who, fortunately, knew that empirical evidence and intersex rights advocates counsel against performing cosmetic surgeries on children born with intersex variations. He advised her to simply let her daughter grow up, so that one day she would be able to decide whether she desired any surgical intervention. This story, coupled with general prevalence rates for intersex variations (approximately 1 in 2,000),* underscores the need for all staff to have basic training on the rights of intersex individuals and for appropriate referral pathways to be in place.

* *Organisation Intersex International* <https://oii.org.au/16601/intersex-numbers>

had originally fled to camps, but experienced discrimination, violence, and even rape there, and subsequently moved to a city where they could have greater anonymity and control over their social interactions. A number of LGBTI refugees reported that while they were in transit or at a camp, they had heard through word of mouth or social media of an LGBTI community in the city, which further motivated their urban migration. In Beirut and Delhi, for instance, LGBTI refugees knew of local LGBTI organizations in advance and had sought them out upon arrival. In Kampala, members of an LGBTI refugee CBO said they came to the city because they had heard rumors of a support group for LGBTI refugees existing there. The vast majority of LGBTI refugees reported having fled to a city alone, without friends or family members, because they had either lost their family to violence in their country of origin, been disowned by their family for being LGBTI, or come separately because they believed their LGBTI status would put their family members at risk.

“We have so many people from the camp coming here...because their house [in the camp] was burnt, because they were beaten in the camp...”

– Leader of Angels Refugee Support Group Association,
an LGBTI refugee support group, Kampala

GBV Risks Facing Urban LGBTI Refugees

LGBTI refugees across cities reported facing heightened GBV risks because their sexual orientation and/or gender identity or presentation does not conform to mainstream expectations. The violence they reported ranged from verbal abuse on public buses, to being denied housing and employment, to physical abuse and rape by members of the host community and other refugees, to instances of fellow LGBTI refugees being killed. It is widely agreed that transgender refugees are most at risk, given their visibility and the strong transphobia that exists in many host countries and countries of origin. Transgender refugees highlighted that having gender markers on their identity documents that do not match their gender presentation creates additional risks of violence for them, especially from service providers and police.

“You cannot get a job as an LGBTI refugee. And some of us can survive by some small skills, either hairdressing, or art...but you cannot go anywhere where you can sell your things or your art to survive. We’re just living by begging and if those streets were safe we would be there, everywhere.

There are some of us, they survive by going to be sex workers, but really what they experience there it’s hell. Because you discuss it with one person, but you get a group of people and they don’t pay you.

Really, apart from loneliness, and sometimes the idea of suicide, a lack of hope for tomorrow, no self-confidence, there is no dignity of human beings. It’s just our lives. So we cannot go to the settlements or camps because in those tents, what we [as LGBTIs] experience, is also bad. We are just here in the closed drum without even a small place to escape.”

– Member of Angels, a refugee-led LGBTI CBO in Kampala

GBV risks interlinked with access to basic necessities. Many of the GBV risks LGBTI refugees face in urban areas are inherently tied to their access to basic necessities, including food and shelter. Discrimination against LGBTI refugees often severely constrains this access, which in turn heightens their risk of GBV.

Housing

LGBTI refugees across cities reported experiencing discrimination, and sometimes physical violence, when trying to rent an apartment or secure employment. In addition to being denied housing if they are “visibly” gay in any way, LGBTI refugees feel

pressure to move in situations where they have been “found out”: as one gay man in Kampala put it, “When they discover that you are LGBTI they throw you out.” LGBTI refugees also reported being pressured for sexual favors by landlords, as well as being beaten by landlords and forcibly evicted from their housing overnight, leaving them homeless.

“I don’t have a home, I often don’t have food to eat...even at [a friend’s home] it is so crowded. There are nights without food, I don’t know what to do.”

– Transwoman refugee in Kampala

Employment and livelihoods

LGBTI refugees shared that if they are in any way visibly LGBTI or known to be LGBTI, it is nearly impossible for them to get a job. LGBTI refugees who were currently or previously employed reported experiencing sexual harassment at work, being pressured to have sex with their employer, and not feeling safe at work. When they are “found out” to be gay, their employment is terminated.

Transwomen in Beirut, Kampala, and the Ecuadorian border city of San Lorenzo, reported that realistically, there are only two livelihood options available to them: working in hair salons or sex work. In Uganda, where legal and social norms essentially sanction homophobia and transphobia, keeping a job is especially challenging given an employer’s fear of outsider reprisal (for hiring someone who is LGBTI); this means that jobs, even in small salons, are short-lived. Without access to safe, consistent, and reliable employment, many LGBTI refugees are at risk of losing their homes and going hungry.

Sex work^{xvi}

More than half of all LGBTI refugees consulted in Beirut, Kampala, and San Lorenzo reported doing sex work, either currently or in the past, in order to earn enough money to survive in the city. For example, 95 percent of transwomen consulted in Beirut identified as current or former sex workers. In Kampala, of 18 LGBTI refugees consulted, 10 identified as current sex workers, and another two identified as former sex workers.

xvi. See note iii, p. 6, for the definition of ‘sex work’ used in this report.

Although recent reports acknowledge that LGBTI refugees engage in sex work and incur related GBV risks, policy recommendations consistently emphasize preventing sex work and offering services for individuals who have “previously engaged” in it, overlooking the needs, risks, and stigmatization of those currently doing it. See, e.g., UNHCR 2015 Protecting Persons at 31.

Most of these refugees cited a lack of alternative livelihood options as a key factor in doing sex work. “If I don’t sleep with people I cannot get money to feed myself,” said one LGBTI sex worker in Kampala. (See section on Refugees Engaged in Sex Work for more discussion of the GBV risks and service gaps experienced by refugee sex workers.)

Many LGBTI refugees, including nearly all transwomen, also reported having been in situations where they were coerced to exchange sex for food or shelter.

“A lot of us are beaten up and robbed in the street or even raped just by random people and they destroy our life and move onto the next transperson.”

– Syrian transwoman refugee in Beirut

Violence from host community members and from other refugees. LGBTI refugees feel at risk of GBV not only from members of the host community, but also other refugees, including family members.

Those consulted experience GBV when taking public transportation, especially buses, but also when taking private modes of transport, such as taxis or motos. They are at risk of verbal and physical assault whenever they leave their homes, and transwomen especially reported that every public space is a site of violence for them; they are likely to be verbally harassed or attacked simply when going into a shop to buy cigarettes or crossing an intersection. Transwomen in Beirut, Kampala, and San Lorenzo reported physical violence being a regular, if not daily, occurrence. Transwomen in Beirut and Kampala shared that, within their communities, rape occurs regularly, perpetrated by neighbors, strangers, police, and sex work clients.

Nearly all of the LGBTI refugees consulted expressed fear of being attacked by other refugees, or of being “outed” by refugees who know they have a diverse sexual orientation or gender identity. Depending upon gender norms within refugee communities, certain LGBTI subgroups may be more at risk than others. In Beirut, for instance, Syrian lesbians reported that some of their biggest risks lie within their families, including “corrective” rape and forced marriage; these risks are higher in Beirut than they were in Syria, where they had more mobility to attend university or otherwise put distance between themselves and their families.

Even where diverse sexual orientation and gender identity is not criminalized, like in Ecuador, refugees reported fearing the police and being verbally abused by police on the streets. When asked whether they would ever report any incident of violence to police, the answer was a universal “no”; on the contrary, refugees try to avoid drawing

attention to themselves at all costs, lest they be detained and harassed for being a refugee as well as LGBTI.

“They don’t take care of you because they see you as abnormal.”

– Transwoman refugee in Kampala, describing her experience trying to get medical treatment at a local hospital

Violence when attempting to access services. LGBTI refugees in Beirut, Ecuador, and Kampala reported being discriminated against and experiencing verbal abuse when attempting to access services – from both humanitarian actors and host community service providers – as well as overall feelings of being at risk of GBV whenever visiting providers. Service providers in Delhi reported that LGBTI refugees with whom they have engaged in the past shared similar experiences.

LGBTI refugees shared that based upon their own experiences, as well as stories from peers, they perceive certain UNHCR staff and staff at UNHCR partner organizations to be homophobic and/or transphobic. For these reasons, they are reluctant to visit these organizations, even if they need services; some no longer wish to try. They recounted stories of being harassed and stigmatized while in waiting rooms, in line for services, and interacting with staff, including security guards. Gay men in multiple locations shared that they and/or their peers have been asked to “prove” their gayness for purposes of claiming asylum, with it being suggested (in seriousness or in jest) that they prove this by submitting to anal exams. Gay men looking for safe and low-cost housing reported that service providers suggested they move into group living situations with straight men, or into conservative neighborhoods where gay refugees knew they would be unsafe.

“When you go to services you are asked questions that reduce your dignity. You move around the office and every person looks to see who you are. It’s a shame to move around. Me, I’m wondering if it’s not something I’ve created myself, but this is my nature. So I don’t see where to go. Even if it can be possible to take me out from here, just outside where I can be safe, it would be my wish.”

– Transwoman refugee in Kampala

Transwomen in particular feel stigmatized and vulnerable when accessing mainstream refugee services, especially those at UNHCR’s major implementing partners, both by staff and other refugees. Transwomen also reported being referred to services and housing for straight men. Due to the combination of GBV risks they face – namely, risks in transit and at points of service – they are extremely reluctant to visit refugee

service providers, whether for registration purposes, or to apply for cash assistance, or even to report rape or other GBV: “For what?” one transwoman in Beirut said, cynical about service providers’ motives in serving transwomen. “It’s dangerous, and they only want to intervene after we have been beaten up and raped.” Another transwoman in Beirut said that a counselor at a partner organization chastised her for not “getting a job like a man,” while a transwoman in Kampala reported being told by staff at UNHCR’s main implementing partner: “I can’t help you because you don’t want to leave that life.”

“They will negate your experience because they accuse us and tell us that the problems we have – we are the roots. ‘You can change, you can change your manners, your dress code’... They say this is the solution – to shift. There is no prevention.”

– Transwoman refugee in Kampala

Host community legal frameworks as risk factors. Nearly 80 countries still criminalize consensual same-sex relationships between adults,⁵² and host nation laws and social norms around sexuality and gender play a critical role in LGBTI refugees’ exposure to violence.

Even where having a diverse sexual orientation or gender identity is not explicitly criminalized or proscribed by statute, laws of general application are often used to detain, prosecute, and penalize LGBTI persons. Transgender people, for instance, are often targeted under laws around impersonation, loitering, or public debauchery, while sodomy laws are used disproportionately against gay men.

These restrictive legal and social frameworks can make strengthening protection for LGBTI refugees all the more challenging. At the same time, however, because LGBTI refugees fall under UNHCR’s protection mandate, they also make it all the more essential.

In Kampala, for instance, even though the notorious “kill the gays bill” had been nullified by the time of the WRC’s assessment, both LGBTI refugees and service providers reported it was still being semi-enforced. LGBTI refugees remain at risk of being stopped, detained, and arrested by police on account of their sexual orientation or gender identity. They experience physical and sexual violence at the hands of police and/or while being held in jail. Transwomen, in particular, shared stories of being physically and sexually abused while in custody. In Beirut, where same-sex sexuality is, in practice, largely treated as a crime,⁵³ gay men, lesbians, and transwomen told stories of being targeted by police on account of their gender presentation or their presence near locations known to be popular among LGBTI people. They

reported being detained and, in some cases, physically and sexually assaulted while in custody. Transwomen in Beirut shared that police at checkpoints often ask them to “prove” they are women, for instance by taking their shirts off, and that individuals who refuse are taken to prison.

Not all LGBTI refugees know their legal rights in their host country, or know “what to say” to police in case of arrest; nor do they have “someone they can call” for legal assistance if they are arrested. Service providers in Kampala and Beirut shared that there are no effective protocols or referral systems in place to address these urgent cases, even though it is well known that LGBTI refugees face especially high risks of sexual violence while in custody – a risk that increases the longer they are detained. In Beirut, a local LGBTI organization, Helem, has cultivated relationships with lawyers whom they enlist to represent LGBTI refugees who have been arrested, either for free or for a discounted fee. Helem receives no financial or other support from the humanitarian sector to do this work.

“There is no one to turn to and no one to go to.”

– Lesbian woman in Quito

LGBTI refugees may also face higher GBV risks than LGBTI host community members. This is because of intersecting vectors of discrimination: in addition to homophobia and transphobia, LGBTI refugees are targeted for violence because of their race, ethnicity, disability and nationality. In Beirut, for instance, refugees and service providers understand that Syrian LGBTI refugees are more vulnerable to violence than LGBTI Lebanese, given the fraught history between the two countries and negative stereotypes of Syrians.

Urban isolation as a risk factor. LGBTI refugees feel isolated from larger refugee communities. At best they feel alienated from other refugees; at worst they see or have experienced other refugees as aggressors. In Beirut and Kampala, where the WRC consulted LGBTI refugees who had been identified through local LGBTI organizations and a refugee-run support group, respectively, refugees shared that having an LGBTI peer network is essential to their survival. Transwomen in San Lorenzo, Ecuador, who are part of an informal peer support network, feel similarly. By contrast, in Quito, refugees shared feelings of deep isolation; service providers in Delhi reported this on behalf of their LGBTI clients as well. They know no other LGBTI refugees – “there is nobody else like me” – nor any local LGBTI organizations. Lesbian and gay refugees in Quito reported suffering depression as a result of always having to keep their sexual orientation a secret, even from other refugees.

Not being tapped into host community LGBTI networks can limit refugees’ access to

important security information. In Beirut, for instance, the local organization Helem acts as a clearinghouse for protection-related information. Through its online platform and social networks, Helem learns which police checkpoints are known to detain LGBTI individuals or confiscate cellphones to look for “telltale” LGBTI apps on people’s phones. They then conduct outreach swiftly and widely on social media platforms, to communicate this information throughout the LGBTI community, including to refugees.

LGBTI refugees are often hidden within larger urban refugee populations, since many choose to keep their sexual orientation or gender identity a secret out of fear. In Quito, for instance, there was a consensus among refugee service providers that although there are “many” LGBTI refugees living in urban areas throughout Ecuador who are especially vulnerable to GBV, they remain invisible: *“Ellos son bastante invisibles y vulnerables.”*

Risk mitigation strategies. LGBTI refugees try to reduce their risks of violence in various ways, some of which are negative coping strategies. For instance, they take taxis to avoid public transportation even though taxis cost more than they can afford; they travel together; they do not talk in public; they isolate themselves; they cross the street to avoid police; they tap their informal networks to find housing for each other in dire situations; and, where they have peers, they only socialize in each other’s homes, rather than in public.

“We live in fear and anxiety and we don’t leave the house very much.”

– Syrian transwoman refugee

Another risk mitigation strategy some LGBTI refugees employ is hiding their sexual orientation or gender identity; in other words, trying to “pass” or “stay in the closet.” These strategies come with high personal costs. Most transwomen consulted indicated that on an emotional and psychosocial level, it is actually safer for them to risk physical violence on the street than to dress as they are “supposed to,” repressing their true identity and pretending to be someone they are not.

Additional Service Gaps Affecting Urban LGBTI Refugees

Lack of coordination between host community LGBTI organizations and humanitarian actors. Across cities, LGBTI refugees’ awareness of host community LGBTI organizations was uneven. In Beirut, for instance, some LGBTI refugees had heard of some organizations but not others. In Quito, no LGBTI refugee consulted had heard of any local LGBTI organization, even though Quito has a rich tapestry of LGBTI CBOs (including a lesbian collective and a trans health center, both of which expressed interest in being referral pathways for refugees). Likewise, in Quito, as well as in other

cities, refugee service providers were unfamiliar with these organizations. In some cities, misinformation abounds, such as in Quito where one refugee service provider remarked that “there is no place to be openly gay in Quito” despite the existence of several LGBTI organizations and at least one LGBTI community center.⁵⁴

Integrating Local LGBTI Organizations into Urban Humanitarian Response

Depending upon their own needs and capacities, host community LGBTI organizations may be able to play a variety of roles in the protection of LGBTI refugees. They may fall anywhere along a spectrum of participation. For instance, some organizations may prefer to limit their involvement to providing information or expert guidance to humanitarian actors, such as tips for handling urgent cases. This is the case for a Kampala-based organization that hosts a safe space for gay women; given the organization’s struggles to serve their core membership, they have little room to expand to serve refugees as well.

In Beirut, by contrast, several local LGBTI organizations are key providers of direct services for LGBTI refugees, including Helem, whose staff accompany LGBTI refugees upon request to UNHCR appointments and help them navigate asylum claim procedures; MOSAIC, which provides structured psychosocial support to LGBTI refugees; and Marsa, which provides free, specialized health services to all LGBTI individuals and has expertise working with transwomen.

In the middle, between consultants like the organization in Kampala and direct service providers like those in Beirut, are LGBTI organizations that are open to serving as referrals for LGBTI refugees. In Quito, for instance, multiple local LGBTI organizations expressed interest in serving as referrals, including Asociación ALFIL, which offers a trans health clinic; Fundación Ecuatoriana Equidad, an LGBTI community center and advocacy organization; and Fundación Causana, a lesbian collective.

This lack of exposure goes in both directions. A number of LGBTI-friendly host community organizations, such as trans-friendly health service providers, had never before considered becoming referral pathways for LGBTI refugees in their communities. During consultations, however, nearly all expressed interest in learning more about refugees and exploring ways of including them in their work.

These gaps, especially the lack of referral pathways and reciprocal information-sharing between humanitarian and host community actors, compound the isolation LGBTI

refugees already experience. They also impede LGBTI refugees' access to information that could empower them to better mitigate GBV risks, such as information about local safe spaces, specialized service providers, and potential peer networks.

A number of LGBTI refugees who were not currently linked with an LGBTI CBO expressed a desire to be introduced, but also showed reticence about making themselves known to strangers. They expressed uncertainty over whether they would be accepted, as well as fear that linking up with a local CBO and participating in their activities might, in some way, jeopardize their asylum claim or legal status as a refugee. Confusion over what may be prohibited by law leads some LGBTI refugees to err on the side of isolating themselves. This underscores the importance of humanitarian actors establishing referral pathways in the first instance and ensuring that LGBTI refugees have accurate information about their legal rights in their host country.

Lack of emergency protocols and emergency funds. In most contexts there are no tailored protocols in place to guide practitioners in addressing urgent issues facing LGBTI refugees. No refugee service provider knew of resources they could refer to – global or locally-specific – that could help organize their thinking, or lay out various possibilities, for how to respond when an LGBTI refugee is evicted and rendered homeless overnight, arrested, or evading a threat of violence.

Local LGBTI organizations can become de facto rapid response in these situations – staff at Helem in Beirut, for example, give out their personal mobile numbers for LGBTI refugees to call in cases of emergency, then they scramble in the moment to find informal stop-gap solutions. The president of Angels, in Kampala, is the go-to point of contact for LGBTI refugees throughout the city.

A handful of LGBTI refugees shared that they had received, or were receiving, emergency cash assistance from a UNHCR partner organization – and that these funds had been essential to their survival. Mindful that such funds for cash-based interventions are scarce, it bears noting how important these emergency funds have been to individual LGBTI recipients. The current lack of shelters for LGBTI individuals (the WRC identified no LGBTI-friendly shelters in any target city), combined with discrimination faced in employment and housing, and estrangement from traditional networks of support (including familial), leaves high-risk LGBTI refugees with few options. “It’s how I get by,” one gay Syrian woman told us, speaking of emergency cash assistance she was receiving from UNHCR; since moving to Beirut, she had been disowned by her family for being gay.

In some locations, UNHCR partners are providing housing assistance to LGBTI refu-

gees, but this happens in an ad hoc and inconsistent manner. Little to no guidelines or referral protocols exist for assisting LGBTI refugees in procuring shelter, either in the first instance or in emergency situations, and little to no vetting of options is done in advance of a problem arising. In addition, all service providers, including UNHCR, noted a severe lack of funds for addressing the emergency needs of LGBTI refugees.

“There is no place to host us. I was like a stray dog on the street.”

– Transwoman in Kampala, speaking about having been abruptly kicked out of her apartment and not having anyplace safe to go, even temporarily

Lack of activities and programs considered safe, inclusive, and responsive to the needs of LGBTI refugees. LGBTI refugees reported not feeling safe or welcome attending job training sessions, language skills classes, or other programming for refugees. Participation risks discrimination and violence from service providers as well as other refugee participants. Moreover, because job placement and other activities do not account for the particular discrimination LGBTI refugees face, these initiatives are often largely irrelevant for them.

While there are some LGBTI-specific activities hosted by service providers, refugees reported feeling these activities are being organized more for the service provider’s benefit – so the provider can “tick the LGBTI box” and report that back to UNHCR – than for their own benefit. More specifically, in certain locations, refugees reported that despite their hosting LGBTI activities, service provider staff remained outwardly homophobic and/or transphobic. Refugees feel that efforts to tailor activities toward their needs have been superficial and perfunctory, where “filling the room” or meeting a donor’s quota is prioritized over hosting something meaningful. LGBTI refugees in two locations, for instance, reported feeling “taken advantage of,” as though humanitarian partners had little genuine interest in serving them: “They get paid because we exist but they don’t work for us.” “They are taking money from funders for our cause but do nothing.”

Such frustration and anger arises, in part, where LGBTI programs or activities are designed from without: refugees are not asked to provide input, so resulting interactions fail to address the needs and concerns most important to them. In addition, programming is rarely hosted in a place LGBTI refugees feel is safe and easy to get to; nor is it always run by staff whom refugees consider trustworthy or committed. And in some cases, although organizations have voiced their willingness to have LGBTI-friendly programs, they clearly lack the capacity to implement them.



Syrian transwomen refugees in Beirut participate in an art therapy project.

© MOSAIC

Ultimately, these sentiments underscore the critical importance of meaningfully engaging LGBTI refugees in designing, implementing, and monitoring interventions for LGBTI refugees. Humanitarian actors must use a participatory approach whereby LGBTI refugees contribute ideas and help set the conditions – the who, the why, and the where – of programming designed to empower their community.

Good Practices⁵⁵

Contributions host community LGBTI organizations are making to refugees' protection. Host community organizations in various cities have become an important part of LGBTI refugees' protection environment; often this happens organically, without engagement by humanitarian actors.

Angels Refugee Support Group Association in Kampala

Members of Angels Refugee Support Group Association in Kampala (Angels) called the group “essential to our survival.” It was also described as having its own “internal security protection system,” in reference to the informal protection trainings members do for each other, for instance, on what streets of the city are safer than others, how to dress for interviews, who it is safe in the city to “come out to,” and what types of work are safe. “The only family we have is [this group], the biological family is not there,” one member said. “It’s like a place where you find others and you can make unity which helps to you face problems,” said another.

Angels is open to all L, G, B, T, and I refugees and has an official headquarters in the city – an “office” that ends up housing upwards of ten LGBTI refugees at a time who would otherwise have nowhere to sleep. The group has had to change the location of its office/shelter three times in the past four years due to police raids. It currently sleeps eight people, in a room built to fit two people, and many more than that are desperate for shelter.

Leaders of Angels proactively reach out to LGBTI refugees who have recently arrived in the city, whom they learn about mostly through word of mouth, to let them know about the organization and offer them emergency food or housing. (Refugee service providers also know about Angels and refer LGBTI refugees there, and many refugees come to the group after learning of it through word of mouth.) In cases of emergency, members of the group contact each other and come to each other’s aid, whether that means accompanying a GBV survivor to a hospital, or raising funds to pay their medical bills. In addition, the organization provides peer counseling, limited medical services, including HIV testing, as well as its own internal cyber café so that members can stay in touch with friends and family in their countries of origin without having to use public cafes, where they face GBV risks.

Angels was begun by refugees themselves, and while it initially had only two to three members, it now has 109, most of whom are in their early twenties. It is still led by refugees, but they receive various kinds of in-kind support from the Refugee Law Project. This support includes access to a meeting space where they can hold workshops or trainings, guidance in navigating legal or administrative requirements, and fundraising assistance. Nonetheless, Angels struggles to stay afloat, to afford its office/shelter in the city, to provide food rations for those going hungry, and to pay members’ emergency hospital bills. The group has had partial success securing small grants from international and bilateral donors, but gets no financial support from UNHCR.

Angels’ leaders envision that with additional funds they could engage in more livelihood activities for members, since many currently do sex work and would like alternative or supplementary options for generating income, not least because of the GBV risks encountered doing sex work (see section on Refugees Engaged in Sex Work). Among the livelihood activities they would like to start are opening a unisex hair salon and producing specialty goods like soaps and candles. “If our members face issues of insecurity,” Bibé, the president, said, “it’s because they need money for food and shelters. So this would reduce those risks.”

Helem, for instance, is well known by LGBTI Syrians and has a strong online presence and outreach network. “We only exist because Helem exists,” one transwoman from Syria said, speaking of the role Helem plays in facilitating risk mitigation and enabling a protection environment for trans refugees. Helem provides informal peer support to refugees, helps them connect with each other and with Lebanese LGBTI people, and provides assistance to LGBTI refugees looking for housing and guidance in accessing services. Sometimes staff at Helem, who are Lebanese, accompany transwomen, at their request, to the offices of refugee service providers, including registration centers and case management partners. This staff person waits in the waiting room during a refugee’s interview, serving as a combination moral supporter, system navigator, and potential witness or deterrent to discrimination or violence.

Also in Beirut, an organization called MOSAIC is mapping ways to improve LGBTI refugees’ access to employment and vocational training, for instance by making calls to investigate potential job placement opportunities for transwomen. This is an example of the type of targeted, specialized role that host community LGBTI organizations can play in filling protection gaps.

Strengthening linkages between humanitarian actors and LGBTI organizations. Humanitarian actors in every target city expressed a commitment to strengthening relationships between the humanitarian sector and local LGBTI organizations. In all locations, however, uncertainty about how to achieve this, or about whose responsibility it is to build these relationships, exists and impedes progress. Steps are being taken in some locations to build these linkages. In the fall of 2015, UNHCR Lebanon, for instance, hosted a roundtable with all LGBTI NGOs in Beirut.

Strengthening and sharing resources with LGBTI refugees’ peer support groups. LGBTI refugees find peer support through formal and informal channels. Transwomen refugees in San Lorenzo, Ecuador, for instance, form a tightly knit group of friends, confidants, and coworkers. They do not belong to any organization, although they expressed a desire for a safe space, somewhere they could hold activities not only for themselves, but also for Ecuadorian LGBTI and other city residents. They ventured that such a place could help “legitimize” their presence in the community.

Elsewhere, more formal peer support groups exist, and after consulting with their members it is difficult to understate the positive impact that belonging to such a group can have on an individual LGBTI refugee’s psychosocial well-being and physical protection. (See box, page 84.)

Public awareness raising. A handful of refugee service providers consulted proactively signal that their office is open and welcoming to refugees, for instance by

making a rainbow flag or brochure visible in their waiting rooms. This not only signals to LGBTI refugees that they are in a safe space, but also communicates a message of respect for LGBTI rights among the broader refugee population.

It bears mentioning, however, that this was not true of all service providers or UNHCR partners, and even in cases where a rainbow flag or brochure was visible, it often stood alone. Given that the rainbow flag is not a universal symbol all LGBTI people recognize – especially those who are older, younger, less educated, or from rural areas – inclusion and safe space signaling requires more nuanced and multi-faceted efforts. Recent IOM/UNHCR training materials include various ideas for disseminating messages that can reach a diversity of LGBTI populations, including those who cannot read or are differently abled.^{xvii}

Recommendations for Mitigating GBV Risks Faced by Urban LGBTI Refugees

The WRC recommends that humanitarian actors actively pursue a twin-track approach to addressing the GBV risks and protection gaps affecting LGBTI refugees in urban settings, one that supports both long-term LGBTI mainstreaming and immediate risk reduction. Doing so will ensure that humanitarian actors continue building their knowledge, skills, and programming to better serve LGBTI refugees, while also ensuring that urgent risks are addressed – even as service providers' capacities and competencies to work with LGBTI refugees are strengthened over time.^{xviii}

Short-term risk reduction

- **Investigate and evaluate a range of potential safe shelter and livelihood options for LGBTI refugees.** Field staff should be tasked with compiling a range of potential safe housing alternatives, be they LGBTI-friendly neighborhoods, apartment buildings, landlords, or possible shared housing. The same should be done with potential formal or informal employment options. LGBTI refugees and local LGBTI groups should be consulted in this process, with the needs and potential risks facing L, G, B, T, and I refugees considered separately. The result of this process will be an ever-evolving menu of potential referral options or suggestions, updated regularly.⁵⁶

xvii. The recent IOM and UNHCR manual contains a unit on creating safe spaces. See IOM/UNHCR (2015); Module 1 Participant Workbook, note xi, p. 70.

xviii. The WRC is currently piloting Urban GBV Risk Assessment Guidance that includes breakout sections for assessing the heightened GBV risks faced by L, G, B, T, and I individuals in urban settings. This guidance is intended to supplement existing all-purpose GBV assessment tools, such as UNHCR's Heightened Risk Identification Tool, 2010.

- **Map local LGBTI organizations as well as all LGBTI-friendly service providers (those with particular expertise, training, or experience) in urban areas.**^{xix}

Learn what engagement they currently have, if any, with LGBTI refugees living in their community, and what role they may be willing or able to play going forward. Some organizations or service providers may only have the capacity to share information related to LGBTI protection (e.g., safe neighborhoods, landlords, or job placements for LGBTI refugees), whereas others may be willing to serve as referrals or provide services to LGBTI refugees.

Depending upon their capacity, interest, and contextual feasibility, humanitarian actors should work to facilitate and enable connections between host community LGBTI and LGBTI refugees, for instance through joint activities or mentorship-type programs that encourage LGBTI host community members to share information about LGBTI living in a particular city (safe places to go, preferred neighborhoods, etc.). As part of the mapping exercise, humanitarian actors should also inquire about what types of resources (e.g., information, training, and cost-sharing) local LGBTI organizations and LGBTI-friendly service providers may need in order to include refugees in their work.

- **Bring local LGBTI organizations or LGBTI-friendly service providers into urban humanitarian response in a way that works for them.** Not all local organizations will be familiar with humanitarian response, let alone “cluster systems,” and not all of them will have the program capacity to meet the administrative burdens normally required of UNHCR partner organizations. Finding accommodations wherever possible and removing unnecessary obstacles to local organizations’ participation in urban response will ensure that their potential contribution to LGBTI refugees’ protection is given space to grow and is not stymied from the start.
- **Convene meaningful dialogues between local LGBTI organizations and humanitarian actors,** including UNHCR and its partners, through roundtables or other in-person meetings. If these dialogues are initiated through existing humanitarian infrastructure, for instance, through the cluster system or as part of a task force initiative, note that local LGBTI organizations may not be familiar with these structures and/or may need additional support (such as information, translation services, or preliminary meetings at their own headquarters) in order to engage meaningfully and participate equally alongside experienced humanitarian actors.

These dialogues should prioritize (1) *referral pathways* for LGBTI refugees, both

xix. The WRC is currently piloting an Urban Mapping Tool that includes guidance on mapping local LGBTI actors.

formal and informal, and mechanisms for ensuring that referral pathways are two way, so that humanitarian actors can refer LGBTI refugees to local organizations and vice versa; (2) *entry points for accessing services*, including LGBTI-friendly counseling and medical services; (3) *outreach strategies* for LGBTI refugees, including through social media and local LGBTI networks, and through outreach volunteers who are selected in consultation with LGBTI refugees.

- **Design comprehensive referral pathways that give LGBTI refugees options in accessing services.** This includes options to: access a particular service at an implementing partner's office or in an alternative safe space; access psychosocial counseling from staff at an implementing partner or from/co-led by a trusted LGBTI-friendly service provider. This will put LGBTI individuals at the center of their own protection, enabling them to rely upon their own knowledge, experience, and self-assessment of risk to protect themselves from stigmatization and violence when accessing services they need. Consistent with a rights-based approach, LGBTI refugees should be consulted in the development of these referral pathways.

Since many LGBTI refugees, especially transwomen, face risks every time they leave their home, consider ways of bringing activities and services to them, rather than requiring them to travel to implementing partners' offices. This will also mitigate risks LGBTI experience from other refugees or from staff persons at partners' offices.

- **Develop safe and anonymous feedback mechanisms for LGBTI refugees, so they can communicate protection gaps to UNHCR and its partners in ways that foster accountability while preserving refugees' confidentiality.** Although mechanisms like LGBTI focus groups already exist in some cities, including one of the four assessment cities for this project, LGBTI refugees shared that because these focus groups were hosted by one of UNHCR's implementing partners, they did not feel they could speak openly about service gaps they experienced or discrimination they faced at the point of service. To avoid such conflicts of interest and to encourage participation, feedback opportunities should be developed in consultation with LGBTI refugees and held in locations they feel to be safe spaces.
- **Conduct a preliminary assessment of LGBTI refugees' preferences regarding whether they are comfortable being grouped together or whether separate activities for lesbians, gay men, bisexual, transgender, and intersex persons would be more appropriate.** Sexism and transphobia exist within LGBTI communities, and where they do, organizing activities for all LGBTI people together may not be appropriate. In extreme cases, it could put some individuals at risk.
- **Where possible, conduct assessments through group discussions with gay**

men, lesbians, bisexual, intersex, and trans persons separately, in locations they have identified as being safe and comfortable for them, with facilitators from the LGBTI community. Holding group discussions separately will also encourage gay, lesbian, and trans refugees to express needs and concerns they may not be comfortable sharing with all LGBTI refugees, including risks of violence or discrimination they face from other LGBTI refugees.

- **Conduct a preliminary assessment to learn whether LGBTI refugees are currently part of formal or informal peer support groups, and how humanitarian actors can support LGBTI refugees in strengthening their protective peer networks.**

In some cities, LGBTI refugees may find that it makes sense for them, or is desirable, to have their own support group, made up solely of refugees. In other cities, like Beirut, LGBTI refugees may find support in host community LGBTI organizations, such that they feel no need to create a stand-alone group. In still other cities, like Quito or Delhi, where there are currently no linkages between LGBTI refugees and host community LGBTI organizations, and LGBTI refugees reported⁵⁷ feeling alone and doubtful there is “anybody else like them” in their community, the first step toward establishing peer support networks may be asking LGBTI refugees if they are interested in meeting each other.

Whatever form an LGBTI peer support network takes, experience suggests that to survive and be effective, it will need various types of institutional support from humanitarians. Depending upon the needs and interests of the group, types of support they may need include funds to assist members in emergencies (e.g., with food or hospital bills) or to set up an informal shelter for members facing violence or homelessness, funds to engage in their own livelihood support activities, or a meeting place or another safe space.

- **Whenever convening feedback sessions or group discussions with LGBTI refugees, maximize the benefits to their participating by also offering them services, information, activities, and peer support opportunities.** Since many LGBTI refugees encounter GBV risks whenever they leave their home or take public transportation, providing multiple services at once is another way to mitigate their overall GBV risk.
- **Develop protocols for urgent cases and emergency situations, for instance when an LGBTI refugee is arrested or evicted or faces an immediate threat; set aside funds for this purpose.** Given LGBTI refugees’ heightened risk of being arrested in some cities, and of being evicted and targeted for violence in

many cities, special guidance for engaging LGBTI refugees in emergencies is needed. This is all the more true because LGBTI refugees are often unable to access protective resources available to other refugees in emergency situations, such as the police, churches, or women's shelters.

- **Ensure that existing referral pathways are safe and LGBTI-friendly.** In more than one city, LGBTI refugees were referred to service providers where they were made to feel not only unwelcome, but also at risk of physical and/or verbal abuse because of their diverse sexual orientation or gender identity.^{xx} None of these service providers had expertise or training in serving LGBTI individuals, or had visible signs in their waiting rooms that they were LGBTI-friendly.

Longer-term LGBTI mainstreaming

As was recognized by all UNHCR field office staff consulted during these assessments, much remains to be done to ensure that all individuals working in urban response have the appropriate training and guidance to serve LGBTI refugees. Just as homophobia, transphobia, and rigid gender norms persist in many urban communities that are also hosting LGBTI refugees, these biases can exist among staff at refugee service providers. The WRC stands with UNHCR's commitment to mainstream the needs and participation of LGBTI refugees in urban protection,⁵⁸ and offers the following recommendations for carrying those efforts forward.⁵⁹

- **Expand discourse and programming for LGBTI refugees outside the GBV context.** To the extent that LGBTI issues are currently being addressed in urban response, it is typically within a GBV frame and, in some locations, considered or even expressly deemed the purview of GBV working groups. This is too narrow. It short-circuits important conversations and specialized services that must be taken up across protection and urban response writ large, as part of a holistic approach to reducing LGBTI refugees' GBV risks.
- **Ensure that the recent UNHCR/IOM training materials are used globally and the learning is implemented.**
- **Develop a short, practical guidance note for field missions on operationalizing various aspects of LGBTI protection.** The protection-specific content in the recent

xx. All of these referrals were to faith-based organizations, but by no means does this suggest that faith-based organizations, as a rule, discriminate against LGBTI individuals. However, humanitarian actors should be on notice that many faith-based organizations are not grounded in cultures of tolerance toward persons of diverse sexual orientation and gender identity, so name-checking organizations with host community LGBTI organizations can help illuminate which local service providers may be known within the community to be LGBTI-friendly or unfriendly.

UNHCR/IOM training package offers a useful starting point for a directive that can be circulated quickly and widely. Appropriate responses to protection concerns will of course depend upon local contexts, but a broad blueprint of what steps to take – such as mapping and reaching out to LGBTI-friendly host community organizations, adapting sample interventions, and vetting shelter options – is needed.

- **UNHCR should dedicate a staff person or consultant to spearhead efforts around strengthening LGBTI protection at the field level.** This person can be deployed to urban and non-urban missions to ensure programs, services, and working group dialogues are LGBTI inclusive. They can make recommendations about pursuing targeted actions for LGBTI refugees (disaggregated for the L, G, B, T, and I) and developing tailored protocols that account for local contexts. This should be a subject matter expert who can also conduct sensitivity and operational trainings for field staff using a “training of trainers” model.
- **LGBTI sensitivity and operational training should be compulsory for all gender, protection, and GBV focal points.**
- **It is time for humanitarian actors, including UNHCR, to participate more in high-level, inter-agency policy conversations about interventions and programming that engage at-risk populations.**⁶⁰ This includes recent conversations among WHO, UNDP, UNAIDS, UNFPA, and civil society around the development and implementation of the Trans Implementation Tool (TRANSIT)^{xxi} and the Sex Workers Implementation Tool (SWIT),^{xxii} which offer guidance for engaging transpersons and sex workers, respectively.
- **Continue efforts to disseminate practical tools, pool good practices, and share sample interventions among humanitarian field staff.** Operational trainings are essential here. Sensitivity trainings alone will be inadequate, especially where staff are working in settings where legal and social norms discriminate against diverse sexual orientations or gender identities. Conversations with staff who have participated in LGBTI trainings suggest that trainings will be most effective where they emphasize practical guidance and communicate clear standards of conduct and professionalism, rather than focus on changing people’s minds or uprooting personal biases.

Moreover, it is not enough for one or two staff members to attend an LGBTI training session – all staff members of all assisting organizations, from case managers to administrative personnel to security guards – should be required to receive LGBTI

xxi. See note iv, p. 10, for an explanation of the TRANSIT.

xxii. See note v, p. 10, for a discussion of the SWIT.

training. Another service provider suggested “not just a training, but a forum where [staff] can clarify their doubts...not everyone is a social worker, and a lot in the organization are ignorant” about what it means to be LGBTI. Operational training sessions should be delivered by trainers with expertise in LGBTI cultural competency and LGBTI issues in the context of forced displacement, and refreshers should be held annually.

- **Where possible, consult with local LGBTI organizations in developing sensitivity and capacity-building trainings for humanitarian actors,** to ensure they are locally relevant and include city or community-specific information that national or international LGBTI organizations may not know. Some local LGBTI organizations may already have experience doing capacity-building, but even those that do not may have knowledge or materials that can be folded into trainings, or be interested in collaborating to adapt global materials for local contexts.
- **Map and consult host community LGBTI organizations at the onset of a crisis, during the earliest stages of establishing any sort of urban humanitarian infrastructure.** Do not wait until there has been a visible influx of LGBTI refugees.

Bringing these groups into the early stages of response, along with their expertise and social capital, can not only help mitigate GBV risks faced by LGBTI refugees, but also help build trust and relationships of reciprocity between local LGBTI organizations and humanitarian actors. Waiting months or years to establish these dialogues, by contrast, can make it much more difficult for them to take hold.

- **Develop qualifications and criteria for hiring service providers, including GBV case managers, and ensure they receive proper operational training around engaging LGBTI refugees before engaging any refugees.** Since any refugee that walks through the doors of a UNHCR partner could be LGBTI, it is imperative that every single case manager be prepared to provide at least basic response and assistance to LGBTI refugees. Some can then be trained to provide more comprehensive or specific support, including GBV case management or guidance around a range of referral options or options for accessing friendly services. In addition to promoting an open and tolerant office culture, UNHCR partners must be held accountable for ensuring that UNHCR’s non-discrimination and Age, Gender, and Diversity policies are taken up and enforced at the field level. This means all partner staff understand that discrimination against LGBTI beneficiaries expressly violates UNHCR policy, as do all verbal and physical displays of homophobia and transphobia.
- **Invite local LGBTI organizations with capacity and interest to participate not**

only in conversations around LGBTI protection, but also in implementation. This will enable urban response to leverage not only LGBTI organizations' expertise, but also their LGBTI community networks, social capital, and technical skills around LGBTI protection.

- **Consult with LGBTI refugees and local LGBTI organizations to identify alternative safe spaces for LGBTI refugees to receive support and case management, where usual locations are not suitable.** In Beirut and Kampala, for instance, LGBTI refugees reported feeling at risk of GBV when visiting the offices of UNHCR's main implementing partners and/or community centers where GBV case management takes place.
- **Maintain open dialogues with local LGBTI organizations to facilitate information sharing,** to ensure that humanitarian actors stay informed of developments in the host community that may affect LGBTI refugees, as well as gaps in service provision being observed by host community LGBTI organizations.
- **Where desired by local LGBTI organizations or LGBTI-friendly service providers, convene a training to support them in understanding and participating in the mechanisms of humanitarian response,** such as working group and cluster systems.
- **Mainstream LGBTI protection issues into all urban response programming and discourse, including within the cluster system,** rather than housing them in one particular working group, such as the GBV or gender working group. Not all LGBTI refugees may identify as GBV survivors or be interested in GBV case management, and not all gender programming is appropriate or useful for LGBTI refugees, but all LGBTI refugees face protection issues. Similarly, because protection and health sectors are often siloed, gaps in information sharing exist between protection and health actors. In Beirut, for instance, the WRC consulted with staff at Marsa, a sexual health clinic with expertise in trans health. Marsa staff reported that while they often attend health sector working groups overseen by UNFPA, they had never participated in any other working groups even though, given the populations they serve, they have knowledge, ideas, and expertise relevant to LGBTI protection more broadly.
- **Implement inclusive workplace policies, strengthen existing workplace diversity policies, support LGBTI staff members, and regularly communicate the organization's commitment to an office environment free of discrimination. Wherever possible, hire people who are openly LGBTI to be on staff at UNHCR field offices and partner organizations.** Signal that a service provider is LGBTI friendly by displaying symbols such as rainbow flags and other safe

space indicators, such as posters, videos, and literature, in waiting rooms and in counselors' and case managers' offices.⁶¹ As noted above, however, given that the rainbow flag is not a universal symbol all LGBTI people recognize – especially those who are older, younger, less educated, or from rural areas – inclusive messaging requires nuanced, multi-faceted efforts tailored to reach diverse LGBTI populations.^{xxiii}

During field visits, the WRC spoke with a wide range of institutional actors on the topic of mitigating GBV risks and bridging service gaps affecting LGBTI refugees. A common theme across these conversations was the expression of heartfelt interest in doing more to protect LGBTI refugees. There was also wide acknowledgment that greater dialogue and collaboration between humanitarian actors and host community LGBTI organizations and LGBTI-friendly organizations will be essential to these efforts.

Enhancing the protection space for urban LGBTI refugees is a problem as urgent as it is important, both because of the gravity of the risks and rights violations they experience daily, and because humanitarian principles demand a proactive response.

xxiii. See IOM and UNHCR (2015); note xi, page 70, Module 1 Participant Guide

Refugees Engaged in Sex Work^{xxiv}

“Everybody knows it is happening, we just don’t know what to do about it....What can we be mindful of? How can we approach it? How should we talk about it? This we don’t really know.”

– Refugee service provider in Delhi

“It’s an unknown world.”

– UNHCR staff in an urban field office, speaking about refugees engaged in sex work

“We really don’t know what types of services should be given to them. We have no answer.”

– UNHCR staffer in urban field office

“I tried to get a job, but I could not. When I started sex work, nobody was on my side to give me counseling to tell me ‘you have to protect yourself against HIV, STIs’....You leave your house with 5,000 shillings [USD 1.40] and that has to cover your drink at a bar and transport, and you might not even get a client....Sometimes you have to go with five men because you need the money. And sometimes they don’t even pay you and you can’t report it because

xxiv. This report adopts the definition of ‘sex work’ and ‘sex worker’ used by the WHO, UNFPA, UNAIDS, the Global Network of Sex Work Projects and the World Bank in *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions* (also known as the *SWIT*) (2013). As set forth there, ‘sex workers’ are “female, male, and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally.” Ibid. at xiii (internal citation omitted). The authors go on to clarify that “sex work may vary in the degree to which it is ‘formal’ or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities.”

Neither that publication nor this report addresses the sexual exploitation of minors. During consultations with adult and adolescent refugees, however, the WRC did hear first and secondhand accounts of refugees under 18 years of age selling sex. Reasons proffered for doing so ranged from wanting to be able to afford school fees to supporting their families. A refugee woman in Delhi, for instance, shared that “Many under 18 are doing sex work because they don’t get education and need to support their family. Their family doesn’t have enough money to support their education, so they see a wall. They see their friends doing it, and their friends are getting clothes and an education, and they want this also. So they do sex work and get money.” While this report contains recommendations for humanitarian actors on how to approach engaging adult refugee sex workers (18 years and over), some of these recommendations may also be relevant for serving youth and adolescents. A fuller dialogue on how to address the issue of adolescent refugees engaged in the sex industry is much needed, and it should be one grounded in evidence as well

you'll be arrested. It's so sad."

– Female refugee sex worker

"It's really a desire of everyone to have a job....But the fact is that few of us have a job. So we find ourselves engaging in sex [work], which is very dangerous for us. We find we are not happy with what we are doing, but we are doing it to survive."

– Female youth refugee sex worker

"If I don't sleep with people I cannot get money to feed myself."

– Female refugee sex worker who identified as a transwoman^{xxv}

"We do it to get money because without that we cannot live. We need to make sure we feed our family and feed ourselves. Being a sex worker, we also do it to see if we can start a small business."

– Female refugee sex worker

Many urban refugees are sex workers. This was a common theme that emerged in all four urban assessments, across adults from every subgroup, and across every faith, gender, and country of origin. That urban refugees sell sex to earn money is well known among humanitarian organizations. Yet, very little research about this subpopulation has been conducted: their numbers; their GBV risks and protection concerns; their access to services, including sexual and reproductive health services; how they are received by service providers; and their peer support networks. There is also very little practical guidance for field staff on how to appropriately address this issue from a protection standpoint, using a rights-based framework, and little knowledge about how to engage with these refugees or present them with the specialized information,

as consultative, participatory processes that involve a range of experts, including adolescents themselves. In the interim, the WRC sounds a note of caution to practitioners whose existing SOPs call for them to immediately contact the police and/or child welfare services whenever they hear that an adolescent is selling sex. Without more information about the circumstances surrounding these adolescents' activities (for instance, whether or not they are being coerced by another person to trade sex or coerced by parents, or doing it in secret), taking such steps may put an adolescent at even greater risk of GBV, as in some cases where adolescents are immediately removed from their families and placed in foster care or juvenile detention facilities. Assuming that every adolescent involved in the sex industry is being coerced by another party does not reflect the diverse realities of these young people, and does a disservice to those who could benefit from a range of services or programs.

xxv. Throughout this section, we distinguish between cisgender and transgender females by noting where an individual self-identified as trans.

services, and referral options they need.^{xxvi}

Refugees from nearly all subgroups engage in sex work, including women, men, youth (ages 18-24), LGBTI persons, and persons with disabilities. They do this in cities where sex work is legal and in places where it is against the law. Engaging in sex work increases refugees' risks of GBV, as discussed in greater depth below; however, in cities where it is criminalized, refugee sex workers reported facing even higher risks of violence and exposure to HIV/STIs at the hands of both clients and police.

Refugees reported engaging in sex work for a variety of reasons: they cannot find other work, or compared to other work they are able to find, the pay selling sex is better, more reliable, and requires less grueling hours. They reported that although sex work can be very dangerous in its own right; it is not always less safe than other informal sector jobs open to them, where employers are known to sexually assault, harass, and even rape refugee workers. They also reported that wage theft with sex work can be less, or as common as it is in other jobs, and that sex work offers more autonomy over work hours. Working mothers especially cited this as being beneficial to them, because it allows them to watch their children at home during the day. Working conditions also vary greatly and are correlated with GBV risks: refugees who work the streets reported being more exposed to certain types of violence than those able to work in nightclubs or hotels.

A number of refugees reported that despite having completed their education in their countries of origin and/or having specialized skills, sex work remains the only job available to them for a number of reasons: as a refugee, they are not legally permitted to work; language barriers; a lack of proper paperwork evidencing high school graduation or other job requirements (a number of refugees reported that their diplomas and other documentation had been irrevocably lost, so despite meeting educational requirements they were rejected from employment); and a lack of childcare during the day. "Even people who are highly educated in their home country are doing sex work," a service provider in Delhi noted, because so few alternatives are available to them.

xxvi. While this report focuses on urban refugees, the WRC also heard from refugees and service providers that sex work is common in camps and settlements. Just as there is little research and guidance for serving urban refugee sex workers, there is a limited knowledge base around serving those in camps, and in this vacuum those who do sex work are exposed to high levels of stigmatization and violence; they are also without critical health services like regular HIV/STI testing, peer support and counseling, and ready access to condoms: "There's no safe work environment...many sex workers in the camps didn't even know how to put on a condom." Sex workers in camps have nowhere to report incidence of violence or receive condoms. A partner in Kampala shared that sex workers in camps are known to meet with clients in the bushes for lack of a better setting, and are unfamiliar with health information because sex work is so heavily stigmatized there, including among service providers.

The following quotes from refugee sex workers in different cities illustrate their diverse perspectives:

"I find myself in a situation of sex work because of life, because of poverty, because of war. It's not [because] I enjoy what I'm doing. I do it because of life. How to survive. How to be someone. And I put my life at risk. You sleep with someone, you don't know from where."

– Female sex worker who identified along the LGBTI spectrum

"Most of them are single mothers and they don't get enough food to eat, so sometimes they go to malls and busy places and they sell their body to feed their children."

– Female sex worker

"UNHCR pays SA [subsistence allowance] every month. It's not much money, less and less...it's not a solution. The people are living in the capital city, so they need everything the Indians have. That's why the mother cannot sit in the house and see everything the Indians have. That's why she's selling her body. To get enough food for her and her children. The SA is too small."

– Refugee in Delhi, explaining that subsistence allowance to single mothers covers rent but is not enough to cover food expenses

"I do it because I feel I like it, I love it."

– Female sex worker who identified as a transwoman

"For me, I am taking care of my grandma so I don't have a job and we have no one to support us at all. Without me doing sex work, I cannot get money for us to live."

– Female sex worker

"I'm doing this job to take care of my daughter...to make her happy, that's why I am doing sex work. I don't have any other jobs."

– Female sex worker

"Because we are living in Kampala and everything is expensive. You have to pay rent, you also need to dress yourself and feed yourself."

Also as an LGBTI, who will accept you or give you another job? Automatically you can be judged so it's hard to find a job."

– Female sex worker who identified as a transwoman

"We always keep [the fact that we are doing sex work] silent to service providers because they don't understand us. They don't believe us. Some of us prefer to keep quiet and not even go get health services. But for me, I don't care because this is the job I'm doing and I respect my job."

– Female sex worker

"Some are doing it because life is so bad. It's so hard to care for children. Others are doing it as a job because they like it."

– Female sex worker

"How we live, we're very poor...so the main problem is just to survive. Just to have one meal, we have to exploit our lives. We are hand-to-mouth refugees. Our life is also gone."

– Female refugee on sex work in her community

Some sex workers viewed sex work as a job like any other, whereas others saw it as a gritty means of survival. Nearly all of them spoke about having few alternatives for earning money, at least in the near future, and of the common GBV risks they faced in doing sex work, as well as stigmatization and service gaps they experienced.

As the quotes above demonstrate, refugees who do sex work have different perspectives and attitudes towards it. Where some regard it as shameful, others personally feel no shame but feel stigmatized by other refugees, family members, and service providers. All of them, however, were unapologetic about earning a livelihood in what they felt was the best of limited options, or even the only option, available to them. And all of them expressed a desire for more information about sexual health and friendly health providers, as well as access to peer support and trainings on how to do sex work more safely within the city.

GBV Risks Associated with Sex Work

Public health and social science literature establishes the magnitude and diversity of GBV risks sex workers experience, as well as the link between GBV risks and sex workers' increased vulnerability to HIV/STIs.⁶² There is, fortunately, an ever-broad-

ening evidence base around protection strategies for sex workers, including evaluations of community-based interventions for mitigating GBV risks. In 2013, the World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work Projects, and the World Bank jointly authored a report pulling together much of this research into a resource manual for practitioners. The manual, *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions*, includes separate chapters on promoting community empowerment, addressing violence against sex workers, community-led services, and good practices.⁶³ (Colloquially, this manual is known as the *Sex Worker Implementation Tool*, or *SWIT*.)

Refugee sex workers consulted during the field assessments reported experiencing all of the GBV risks catalogued in the *SWIT*, including physical, sexual, and emotional or psychological violence. They experience this violence in diverse contexts, including the workplace, from intimate partners and family members, in public spaces, and from state and non-state actors.⁶⁴

Yet refugee sex workers feel strongly that they experience more frequent and more severe risks of violence than host community sex workers. As refugees, they experience additional layers of discrimination, stigmatization, isolation, and risk because of where they are from, the language they speak, and the color of their skin. Many refugees also fear that if anyone – from police officers, to refugee service providers, to neighbors – finds out they are selling sex it could compromise their asylum claim



Refugee sex workers in Kampala.

and potentially get them deported. Refugee sex workers feel especially vulnerable to violence from clients, police, and others because of their refugee status: everyone knows they bear the double stigma of being both sex workers and refugees, so it is unlikely that they will “make trouble” or draw attention to themselves by reporting violence. They are without leverage to protect themselves or hold attackers accountable, and this vulnerability is understood and exploited.

In places where sex work is illegal, refugee sex workers reported that this is a key factor in increasing their risk of GBV, since perpetrators of violence know sex workers cannot officially report violence without fear of being arrested themselves, and refugee sex workers not only risk arrest, but also their right to stay in the country. Where refugees do not speak the language of the host community, they are even more fearful of police, since if arrested they would be unable to assert their rights or understand what is happening, which would create even more space for abuse to occur while in detention.

By contrast, in places where sex work is decriminalized, refugee sex workers reported enjoying a degree of protection from GBV risks. They shared that they are often still at risk of GBV from clients and from law enforcement and still experience stigma, but they have more access to sex worker-friendly services; can officially report incidents of violence; and also benefit from the social and legal advocacy being done by host community sex worker organizations, as well as their membership networks. In Ecuador, for instance, sex worker CBOs exist in several large cities, including at least four in Quito with which the WRC consulted. Members of these CBOs often work together, as a protection strategy, and provide each other with emotional and psychological support, including peer counseling. They also share information related to work safety, GBV prevention strategies, health concerns, and friendly health providers. Some CBOs have working relationships with police departments; they have built these over time to improve interactions between law enforcement and sex workers. All four Quito-based organizations work with refugees on a regular basis and/or have refugee members. These refugees come to them either through word of mouth or proactive outreach (several organizations conduct outreach at night, in neighborhoods where sex work is common). Prior to the WRC’s assessment, none of these organizations had ever had contact with a humanitarian actor.

Refugees engaged in sex work reported experiencing physical violence mainly from three sources: clients who beat and rape them; host community sex workers; and police officers. They also reported heightened risks of GBV due to stigmatization and isolation on account of working in the sex industry.

“Clients know they can exploit you because you’re a refugee.”

– Female refugee sex worker

GBV risks from clients. Refugee sex workers told many stories of being raped and beaten by clients who had lied to them about what service they were seeking. Some clients refuse to pay what has been agreed, or refuse after the fact to pay anything at all. Refugees shared instances of being sexually tortured by clients, for instance, clients using chloroform to render them unconscious or chili powder to inflict pain, and of being lured to a place only to find multiple people waiting there to rape them at gunpoint. In cities where sex work is illegal, refugees feel they cannot report such incidents to police for fear of being arrested. As a refugee service provider in Kampala stated, “If they [the police] come across a sex worker reporting a violation or violence, they will first arrest her... This is why it’s imperative that a refugee sex worker [attempting to make a police report] has a lawyer with them – literally, with them.”

“You have to bribe them, they will take everything you have.”

– Female refugee sex worker

“Remember if the police catch you, you cannot tell them to use a condom. They don’t want to use protection and that is dangerous for us.”

– Female refugee sex worker

Refugees said that clients often pressure them to have unprotected sex: “Because of the conditions you’re living in, you don’t have a choice but to have sex without a condom.” They also often feel they have no choice but to take clients back to their homes, even if their children or other family members are there, because they cannot afford to pay for hotel rooms and have no leverage to insist that clients pay for a room.

GBV risks from police. Refugees engaged in sex work shared experiencing violence at the hands of police, and often being forced to bribe officers – to hand over their money or personal items (e.g., jewelry or mobile phones), or have sex with officers – in exchange for not being arrested. Refugees reported being beaten and raped by officers, sometimes at gunpoint. They reported that police working street beats “exchange” sex for protection on the street and that being arrested for sex work puts them at a high risk of being raped while in detention. Reports in Uganda included police officers exchanging food for sex with refugees who were spending the night at the station waiting for legal services.

“I’m requesting NGOs dealing with refugees to think on... respecting the rights of sex workers.”

– Female refugee sex worker

GBV risks from host community sex workers. Refugee sex workers reported that

host community sex workers view them as a business threat, which creates tension between host community and refugee sex workers that frequently escalates into violence. Refugee sex workers in Kampala reported being “jumped” on the street by women armed with razor blades and chili powder. They also noted that host community sex workers are much safer than refugees for a number of reasons: their relationships with police are better; they speak the language and can negotiate better with clients for safe sex; and “they know there are many places they can go, even to share parts of the road [with each other].” Refugees, in contrast, reported being forced to work in the most isolated, least-lit areas of the city, and being forbidden to enter nightclubs: “Since we are not [nationals] they always kick us out of places in clubs and on the street. They say we are not supposed to stand there.”

“You need to include in your advocacy that we need more centers for health. For LGBTI sex workers... There aren’t many places we can go.”

– Female refugee sex worker who identified as a transwoman

Stigmatization and discrimination compromise protection. Refugees doing sex work reported experiencing high levels of stigmatization and discrimination, both from other refugees and service providers. Some had internalized stigma, and shared experiencing feelings of worthlessness, depression, and shame. Refugees are constantly negotiating their comings and goings to hide what they do from their landlord, family members, and neighbors. They shared that the vast majority of the time they hide what they do from service providers, even though they desire psychosocial support, sexual and reproductive health information, or health services. “We always keep it silent to service providers because they don’t understand us. They don’t believe us.”

“We are calling upon NGOs and service providers to expand services and have trainings on how to avoid the risks of doing sex work.”

– Female refugee sex worker

A number of refugees consulted, including those who are not selling sex, expressed appreciation that this topic was being raised as an issue for discussion, in many cases for their first time, and not for the purpose of chastising refugees who sell sex but rather to draw attention to their rights and concerns, and the GBV risks and service gaps affecting them.

Sex Work Survey Responses*

	Answered Yes to Sex Work: “Have you, or any other refugee you know, ever engaged in sex work (selling sexual services) as a source of income?”
Quito	43% (of 35 respondents)
Beirut	30% (of 33 respondents)
Delhi	47% (of 32 respondents)
Kampala	53% (of 91 respondents)

Survey respondents were also invited to write in responses to the following question: “What services might be most helpful for refugees who sell sex as a form of income?” Below is a sampling of the diverse responses received.

“[Service providers] need most to be trained how to respond to sex workers’ needs and concerns. They need most to be trained how to treat sex workers with respect and dignity.”

“We do this job of sex work because we don’t have another one. We are suffering from several diseases so that we beg any assistance from you....If there is another job, we can do it. Sex work has many risks and it is dangerous.”

“Training on how to treat or serve sex workers by listening to them and on discrimination and supporting them.”

“This is informative and helpful.”

“How to interact with refugees doing sex work. How to respond to sex workers’ needs and concerns.”

“For this [issue] we all need to make more awareness, a session worldwide, but no one wants to listen to us as they [have] feelings [about] the profession.”

* In addition to asking about refugees selling sex as a form of income, the survey asked about sexual coercion in the form of refugees being pressured to exchange sex for rent, employment, safety, or goods. As noted earlier in this report, more than 50 percent of respondents in all four cities reported having been coerced, or knowing someone who had been coerced, in this way.

Service Gaps

As noted above, the stigma associated with selling sex is a barrier to refugees accessing services they need – everything from GBV case management to sexual and reproductive health care to psychosocial counseling. A number of refugee sex workers also expressed a desire for vocational trainings and assistance in starting small businesses, either to enable them to exit sex work or as a supplemental source of income, a backstop in case they do not have clients for a period of time.

“We need trainings for sex workers to get skills on how to do other things. Sex work is a job, a business. But at least to have some kind of alternative business you are doing.”

– Female refugee sex worker

“This job we’re doing it’s not a permanent job. At a certain age you can no longer do it...It’s better to have some skills you know.”

– Female refugee sex worker

“Because they are foreigners, [host community] men know they can treat them any way and they have no protection. So they make them do things they wouldn’t make a [local sex worker] do...then they threaten with reporting them to the police because homosexuality is illegal. Because you’re a refugee, and he’s a national, it’s your word against his.”

– Refugee service provider, describing some of the additional risks LGBTI refugee sex workers face

Refugees emphasized their need for greater access to sensitive health care providers and to safe sex materials like condoms and lubricant. Many refugees shared that they either do not know where to go to procure these items or are too embarrassed to ask for them at health clinics, especially given the quantity they need.

In several cities, the WRC consulted with host community sexual health centers with expertise in serving sex workers, conducting outreach to them (e.g., through mobile clinics), and ensuring they have sufficient access to condoms and other safe sex resources. Although these centers reported serving refugees regularly, on account of being open to serving any sex worker who walks through their doors, each reported having little to no contact with any humanitarian actor. For instance, RedTrabSex in Ecuador has a team of health promoters and community workers who conduct outreach and distribute “preventative packs” containing condoms, lubricants, leaf-

lets informing sex workers of their legal rights, and contacts for health centers. Yet no refugee service provider with whom the WRC consulted had ever heard of RedTrabSex or its sister organizations. Similarly, in Kampala, a local organization named Reproductive Health Uganda runs a free health clinic and peer education program specifically for sex workers, but these initiatives are largely unknown to humanitarian actors and refugees.

Sex worker-led CBOs have also developed protection strategies and host safety trainings about which refugees have little information. In Quito, for instance, a local CBO called *Marcha de las Putas* has a “legal patrol” that pools information related to safety and maintains an open dialogue with different police departments in the city. Sex worker organizations in Delhi and Kampala engage in similar information sharing with peers, as well as advocacy with local law enforcement and public health officials.

Good Practices

Referrals to knowledgeable and friendly health clinics. In Beirut and Kampala, some refugee sex workers reported knowing at least one sex worker-friendly sexual and reproductive health care provider. They learned of these providers through word of mouth, local LGBTI organizations, and, in rare instances, from a refugee service provider.

Protection trainings. In one target city, a local organization that works with sex workers had conducted a one-off sexual and reproductive health training for LGBTI refugees in the office of a refugee service provider. This training, which was organized by a refugee-led LGBTI support group, included a module on protection strategies for sex workers. Attendees said it was helpful and recommended additional trainings in the future for non-LGBTI sex workers.

Strong expressions of interest in training humanitarian field staff and developing policies to serve this population. Refugee service providers across all four cities acknowledged a need for training, research, policies, and protocols on how to *talk about, engage, and conduct outreach* to refugees involved in transactional sex, using a rights-based framework. UNHCR field offices expressed strong interest in increasing staff knowledge and capacity on these themes through a combination of trainings, engaging local CBOs with expertise, and soliciting the participation of refugees to develop referral pathways and guidelines.

Refugee-led sex worker CBO. Around the world, sex workers have formed their own CBOs to support their members in a variety of ways. They provide health services and information, peer support, and safe spaces for their members; they also conduct

advocacy and community outreach. The WRC consulted host community sex worker-led organizations in each target city to learn about what they do, who their members are, and what GBV risk mitigation strategies they endorse.

“As a refugee sex worker, we found we were really left behind. So OGERA was started to identify our needs and address our specific issues.”

– OGERA Executive Director

In Kampala, the WRC also met with a local CBO led by, and for, refugee sex workers. The Organization for Gender Empowerment and Rights Advocacy (OGERA) was started in 2013 in response to barriers refugee sex workers were facing in trying to participate in activities organized by Ugandan sex worker organizations. In addition to some of the social tensions between refugee and host community sex workers outlined above, the refugees were encountering language barriers that made it difficult for them to participate in grassroots organizing and which rendered their immediate objectives slightly different from those of Ugandan sex workers. (OGERA does collaborate with Ugandan sex worker organizations and refers to them as “sisters.”) Among OGERA’s goals are to “build and sustain partnerships with key stakeholders,” including humanitarian actors, and to “provide free and legal health services to OGERA members.” Their activities, which are far-ranging and premised on a holistic approach to self-empowerment, include promoting adult literacy and English language skills for members; supporting HIV-positive members; distributing condoms, health, and legal information; and planning alternative livelihood projects, including a catering and party equipment rental business. OGERA is also starting a “memory project” that will train members to provide each other with structured psychosocial support in response to trauma.

“Sometimes you don’t know if you will have a client, but at least you’ll have income coming in from somewhere else. At least you know that if I am not doing sex work, I am not going to be evicted.”

– OGERA member, discussing the benefits of members starting their own small catering or beading business

Recommendations for Mitigating GBV Risks Faced by Refugees Engaged in Sex Work

The WRC is developing, in consultation with sex workers, a guidance note for humanitarian actors, including UNHCR field offices, on the subject of engaging refugee sex workers and mitigating their GBV risks. As a precursor, the WRC would like to

emphasize the prevalence of this issue in urban contexts and the need for additional consultations, research, information sharing, capacity building, and rights-based dialoguing around it.

- **Integrate into urban humanitarian response the practices, learning, guidance, and evidence-based programming set forth by the WHO, UNDP, UNAIDS, Global Network of Sex Work Projects (NSWP), and the World Bank in the *Sex Worker Implementation Tool*.** Adopt the human rights-based approach and community empowerment models promoted therein.
- **Counter attitudes and behaviors that stigmatize and discriminate against refugee sex workers.** Make sure all service providers, including health practitioners, GBV case managers, and legal support staff, have the skills and capacities to provide refugees engaged in sex work with the information they need and treat them respectfully.
- **Provide refugees engaged in sex work with the trainings they seek on issues related to sex workers' legal rights, sex worker safety, and sexual and reproductive health issues.**
- **Map and engage host community sex worker-led organizations; they have expertise on issues ranging from GBV risk mitigation strategies to local sexual health clinics.** Map sex worker-friendly service providers, especially health providers who provide free STI/HIV testing through mobile clinics and who distribute condoms and other safe sex resources.
- **Develop referral pathways and options for refugees engaged in sex work, using a participatory approach** where refugees and sex worker-led organizations are invited at the outset to share their perspectives, concerns, and capacities.
- **In referring refugees engaged in sex work to service providers, use a rights-based framework responsive to individual refugees' needs and concerns,** whether they are wanting to exit sex work and looking for an alternative livelihood option, or are looking to obtain information and resources that will help them do sex work more safely. A primary consideration must be respecting the choices of individual refugees and providing them with information on the full range of services, supports, and referral options that are available.
- **Offer support and technical assistance to refugee sex workers interested in forming their own CBOs and peer networks,** for instance, by helping them to identify safe spaces and opportunities for peer education trainings.

Persons with Disabilities

“In Kampala I have shifted over [moved to new housing] more than ten times because when I reach somewhere all the people who are renting nearby, they start to complain and they go to the landlord and say that if I remain here with my daughter who is like a monster, maybe the pregnant ladies nearby are going to give birth to babies who are also monsters, like my daughter... Where can I go again?”

– Mother of a girl with a physical disability, discussing the difficulty of finding stable and safe housing in the city

Previous Research on GBV among Refugees with Disabilities

This project seeks to expand on previous research conducted by the WRC on GBV against refugees with disabilities, addressing the ongoing gaps in evidence around effective strategies for GBV risk mitigation in urban settings.

Persons with disabilities, as defined by the Convention on the Rights of Persons with Disabilities, “include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”⁶⁵ Persons with disabilities are a heterogeneous group in terms of both impairment type and functional capacity. This diversity, overlaid onto other intersecting identities, like those related to age and gender, means that depending on their disability, individuals will encounter different GBV risks and barriers to inclusion in humanitarian response, including in GBV programming.

In 2008, the WRC embarked on cross-sectional research that examined the protection concerns of persons with disabilities in humanitarian settings, and released a report and a toolkit for practitioners. In Nepal, Thailand, and Ecuador, the field studies cited sexual violence, domestic abuse, and physical assault as protection risks facing refugee women with disabilities.⁶⁶

More recent assessments conducted by the WRC with refugees and displaced persons in Bangladesh, Ethiopia, India (Delhi), Lebanon, Nepal, Philippines (Mindanao), Thailand, and Uganda found that violence was reported by both men and women with disabilities in all contexts. Women and girls with disabilities were most likely to report concerns about sexual violence, with concrete examples suggesting that those with intellectual and mental disabilities may be most at risk. Isolation, lack of contact with community networks, and few independent living options also exposed both men and women with disabilities to different forms of violence inside the home.

Further, adolescents and young persons with disabilities were excluded from peer activities that could facilitate the development of vital social networks and enhance their protection from various forms of violence, including GBV.⁶⁷

From 2012 to 2014, the WRC conducted a study into the sexual and reproductive health needs, risks, and capacities of refugees with disabilities living in Kenya, Nepal, and Uganda. This study identified that refugees with disabilities who are isolated in their homes, and those with intellectual disabilities, had reduced access to information about family planning, violence, and other sexual and reproductive health issues. Risks of sexual violence were highlighted across all three sites, with caregivers expressing concern about sexual violence against those with intellectual disabilities.⁶⁸

In a separate project, the WRC and the International Rescue Committee conducted participatory action research on disability inclusion in GBV programming in humanitarian settings in Ethiopia, Burundi, Jordan, and Northern Caucasus in the Russian Federation. Findings identified that women with physical disabilities who are isolated in their homes in urban settings were being raped on a repeated and regular basis, often involving multiple perpetrators; and that women, men, girls, and boys with intellectual disabilities were particularly vulnerable to all forms of sexual violence, as well as emotional and physical abuse in these contexts.⁶⁹

Methodology for Engaging Persons with Disabilities

Building on findings from previous research, this project sought to document in more detail the factors that make persons with disabilities more vulnerable to GBV in urban settings; the gaps in services that are linked to GBV prevention and risk mitigation; and recommendations for humanitarian actors operating in urban settings to reduce risk of violence, abuse, and exploitation of refugees with disabilities.

In Beirut, the WRC conducted group discussions with refugees with intellectual disabilities and their caregivers. They were identified through the UNHCR ProGres database and community center partners, and invited to participate in the consultation process. Caregivers participated in group discussions and interviews. A concurrent activity was conducted with individuals with intellectual disabilities, using participatory methodologies, to collect information about their own concerns and perspectives.

In Kampala, the WRC targeted a fledgling association of refugees with disabilities for group discussions. This group was established in 2011, supported by the Refugee Law Project, and provides support to roughly 120 families in Kampala. The Association identifies new arrivals and shares information about available services and assistance, including agencies that have dedicated disability officers and focal points. Represen-

tatives have further been identified for the various national origins and languages that are used by the diverse refugee community.⁷⁰ Most of the individuals consulted in these group discussions had physical disabilities or were caregivers of persons with intellectual and hearing disabilities.

In Quito, the WRC was unable to locate refugees with disabilities to engage in the project through our partners, highlighting a significant gap in inclusion in refugee programs in this context. We did, however, interview service providers and other key informants in all three sites to identify gaps and opportunities to strengthen disability inclusion for the purposes of GBV prevention and risk mitigation.

In addition to drawing from the experiences of refugees consulted in Beirut and Kampala during this project, this section of the report is also informed by consultations undertaken with women, men, adolescent girls, and adolescent boys with disabilities and their caregivers from other WRC projects, including research conducted in Bujumbura, Burundi; Kampala, Uganda; and Ramtha, Mafrq, and Irbid, Jordan.

The discussion below expands on this previous research, highlighting the following key GBV-related risks faced by urban refugees with disabilities and their caregivers. The section also explores good practices, notably around strengthening protective peer networks for refugees with disabilities and their caregivers, both through support groups and through building linkages with host community representative organizations of persons with disabilities (DPOs).

Key GBV Risks

Risks related to stigma and discrimination

Refugees with disabilities are stigmatized and discriminated against on the basis of their disability. This intersects with other types of discrimination they face due to their refugee status, nationality, ethnicity, religion, and, of course, gender.

The discrimination that women and girls with disabilities face gives rise to a host of GBV risks, including significant risks of emotional violence and sexual violence, both inside and outside their homes. Women with disabilities who are isolated in their homes are particularly at risk of sexual violence and rape, as are girls with intellectual disabilities. The stigma associated with being raped makes many woman and girls reluctant to report such violence, and many are also unable to report it because they have little interaction with people outside their immediate family or immediate environment.

“People don’t want to share their experiences because they think it’s shameful or degrading, so they keep it all inside... The majority of the women [in the group] who have become disabled, they... were raped. Because they are considered a taboo, they feel shame in talking. They keep having those problems. We find it very really hard for them to get services.”

– Male participant in a group discussion with the Association of Refugees with Disabilities in Kampala

Although we know that globally, women and girls are generally more at risk of sexual violence than men and boys, consultations with urban refugees with disabilities and their caregivers suggest that boys and men with intellectual disabilities are also targeted for sexual violence.

Adult men with disabilities, on the other hand, most often reported experiencing emotional violence and being denied employment as a result of their disability. This perpetuates a cycle of emotional violence at home and within their community, since they are unable to fulfill their assigned roles as “men” and are targeted for emotional violence as a result.

“We have a lot of challenges in getting jobs. When they see physical appearance it’s very difficult to get a job. But he could be the father of children or a grandfather. So it affects the entire family.”

– Man with a physical disability in Kampala

The rejection from employment on the basis of disability, combined with the added costs that households of persons with disabilities face due to frequent health visits and transportation needs, creates a ripple effect on the lives of their families. They struggle to find alternative sources of income necessary to survive in a city, and rely on income-generating activities that are often fraught with GBV risks of their own, from putting their children to work to engaging in sex work. Women with disabilities in a variety of urban contexts have also reported that poverty and a lack of income-generating opportunities increases the likelihood that they may engage in sex work and/or exploitative relationships.⁷¹

“They are discriminated against in all activities – you don’t have any value. When men propose sex to her, she accepts because she needs money to provide food for to her children.”

– Participant in group discussion with women survivors with disabilities and female caregivers in Bujumbura⁷²

Boys and young men with disabilities are subject to emotional violence along the same lines. They are often not able to marry, or work, which is perceived by families and community members as an indictment on their masculinity, which is communicated through verbal and physical abuse. If you are a young man with a disability, “there’s no way you can be acceptable.”⁷³

“Because a boy is disabled...he cannot really contribute anything to the family. That’s how they are judging him...And then in the family you find that this one is living without any hope.”

– Man with a disability in Kampala

GBV risks related to a lack of stable and safe housing

In an urban context, where refugees are largely responsible for finding their own housing, persons with disabilities encounter unique barriers to finding adequate shelter. Landlords refuse to rent to them, or evict them abruptly not only on grounds of stigma and discrimination, but also, in some locations, stigmatizing superstitions around disability. In Kampala, for instance, where many Ugandans believe that disability is contagious, or a bad omen, landlords refuse to rent to refugees with disabilities, or to refugees who have a family members with a disability. These families are also forced to move continually, as neighbors agitate and mobilize for their eviction.

“My kid has epilepsy...people think it’s contagious. Others run away when he’s having an episode....Even the landlord is against me, thinks it’s a bad sickness, wants to kick us out because of it.”

– Father in Kampala

In Lebanon, persons with disabilities and their caregivers have spoken of similar risks related to their housing, which instead stem from tension with their neighbors and landlords over noise that individuals with disabilities sometimes make while in their home. In these settings, multiple families may be sharing a single apartment or even a room in close proximity to neighbors. This factor, combined with the stress of displacement, can affect the behaviors of some individuals with disabilities.⁷⁴

“In custom here they say if a woman who is pregnant sees someone who [has a physical disability], then she’ll give birth to someone like that. So when her mom wants a place to rent they say that can’t give her a place to rent. Even neighbors don’t want her to live nearby.”

– Refugee woman in Kampala discussing housing discrimination for persons with disabilities



An adolescent girl with intellectual disabilities from Syria shares her concerns and ideas through pictures at a consultation in Beirut. © Emma Pearce/WRC

Similarly in Lebanon, rented accommodation is largely inaccessible to persons with physical disabilities, increasing their isolation and reducing their access to services and programs. Caregivers also reported that the lack of space and overcrowding of apartments present risks for the safety and dignity of individuals with disabilities, particularly women and girls with disabilities.

"They can't move, they are always locked up and can't even do basic hygiene."

– Caregiver of a young woman with intellectual disabilities, Beirut

Ultimately, in urban contexts, persons with disabilities and their families have less control over where they live, and in what conditions, and their families have fewer opportunities to build relationships with neighbors and develop the social networks that are central to community-based protection.

GBV risks related to isolation

The lack of stable housing contributes to isolation, since families are unable to establish social ties with neighbors or CBOs near where they live.

Persons with disabilities and their families experience isolation within their communities and within their homes in urban contexts – this disproportionately affects women, as families perceive them to be at greater risk of violence, abuse, and exploitation in the community. Group discussions with caregivers, particularly with mothers, highlighted that there is a fear of sexual violence and exploitation against girls and women with intellectual disabilities living in Beirut. They perceive that all locations outside the home pose a risk to women and girls with intellectual disabilities, and as such stay “locked up in the house.” They described how women and girls with disabilities need to be accompanied at all times, and that they are very cautious about which organizations and activities they allow them to attend. As a result, women and girls with intellectual disabilities spend most of the day inside their home, assisting with housework or watching television and listening to music. As one caregiver described it: “When there is minimal social communication, there is minimal chance of violence.”⁷⁵

“I am afraid of sending her alone and that someone will sexually exploit her. Maybe someone will hurt her or kidnap her...”

– Mother of a girl with an intellectual disability, Beirut

While caregivers were less concerned about GBV against boys and men with intellectual disabilities, who reported more freedom of movement in the Lebanese community, they acknowledged that they are equally isolated from age-appropriate peer networks, and as such spend most of their day interacting with children.

Transportation challenges unique to urban contexts also contribute to this isolation, preventing persons with disabilities from accessing services, programs, and activities. Refugees with physical disabilities, for instance, report having great difficulty taking even the most ubiquitous and affordable means of public transportation; getting to a bus stop can be extremely difficult, and can put a service or participation in a peer activity out of reach. Added costs and logistical challenges relating to transportation have been documented to reduce access for GBV survivors with disabilities to case management and medical care in other urban settings, such as Bujumbura.⁷⁶

“There is no transport, so even if you know where services are, you still can’t get there.”

– Participant in group discussion with women with disabilities and female caregivers, Bujumbura⁷⁷

Female caregivers in Beirut also reported that time constraints and other responsibilities in the home reduced their capacity to assist persons with disabilities to attend activities outside the home, including refugee programs being run in the community centers. This reduced their access to information about programs and services, including information about GBV services.

When someone with a disability requires full-time care inside the home, it can also be difficult if not impossible for their caregiver, often a female family member, to attend services or peer support meetings. Hence, isolation not only affects the individual with a disability, but also other women and girls in the family who may also be excluded from activities, reducing their access to information and structured support.

GBV risks related to the loss of protective networks

Refugees with disabilities face unique risks resulting from the breakdown of protective networks that happens with displacement; these networks are often harder to rebuild in an urban context. Caregivers in Beirut described how displacement has disrupted vital community networks – they no longer know their neighbors, and as such don't feel that is safe to let persons with intellectual disabilities, particularly women and girls, move around the community on their own. The loss of protective networks not only increases risk of violence outside the home, but also inside the home for persons with intellectual disabilities, as families have less support for caregiving: "Parents are over-exceeded in capacity and stressed – they need NGOs to take them out. Behaviors at home between family members are not good (because of the stress)." ⁷⁸

Caregivers in Kampala also reported a lack of adequate emotional and technical support for the work they do. This increases persons with disabilities' perceived – and actual – risk of abandonment and institutionalization. As one mother in Kampala expressed, she simply does not have the physical strength to care for her son, who requires assistance going to the toilet. She resorted to institutionalization: "I went to beg for help to take care of him" – even though she recognizes that, psychologically, this is harmful to him, "but he doesn't know that I can't take care of him at home."

GBV risks related to service provision

Discrimination in GBV service provision – both prevention and response. Refugees with disabilities in Kampala encounter discrimination, emotional violence, and verbal abuse when trying to access services. In consultations, they shared that they do not feel they are treated with dignity and respect when they go in for basic assistance, such as healthcare referrals, or when they go in for case management services, including to report incidents of rape and other forms of GBV.

“This recommendation is just to tell those officers [NGO staff] not to take away the little hope they have. If I tell you, ‘I’ve been raped’, don’t tell me ‘So what, you’ve been raped!’”

– Women representative from the Association of Refugees with Disabilities in Kampala

Access to good quality survivor-centered case management in health facilities may be a challenge for all GBV survivors, with one key informant expressing: “[The health clinic] is very crowded. I’m wondering how a raped, stigmatized woman with a disability walks in there. Maybe the man who raped her is there. Then she’s supposed to sit in a chair and wait in line all day? With the same people coming in for malaria care? For education?”

Humanitarian actors, families, and communities across all countries tend to prioritize the disability-related needs of persons with disabilities, often failing to respond to other factors that may have a greater impact on GBV risk and protection. These factors might include a lack of peer support networks, children being out of school, living in substandard shelter, caregivers needing added assistance, or maybe just being a single woman with disabilities, which require a more comprehensive and holistic protection assessment and referral to a variety of other non-health-related services.

“Service providers neglect persons with disabilities, they assume they cannot go [to activities]. They assume that a physical disability also means [our] brain is not working.”

– Man with a physical disability, Beirut

Refugee service providers in nearly all locations reported that they lack the skills and capacities to better serve and engage persons with disabilities. They assumed that acquiring these skills and capacities would require many resources, including additional manpower and financial resources, so as to provide adequate health-related care to persons with disabilities.

Wider WRC research, however, has highlighted that attitudes of staff and partners can be both the most significant barrier and the most significant facilitator to inclusion in GBV programs, with small, inexpensive changes making the biggest difference to participation of persons with disabilities.⁷⁹

Children with disabilities are often excluded from youth programming generally. A father of a seven-year old girl with a disability in Kampala said that his daughter had never been invited to participate in International Children’s Day celebrations at a local refugee service provider, or similar activities.

Limited linkages to host country DPOs. Mainstream humanitarian partner organizations do not have regular contact with host country DPOs with which they could share information, or to which they refer refugees with disabilities for peer support. Many of the linkages that do exist between humanitarian actors and organizations with expertise around disabilities are focused solely on the medical and health response, such as the procurement of aids and devices for persons with disabilities. Indeed, in one city, a refugee service provider shared that its main priority for serving persons with disabilities is to help them obtain a special identification card that affirms their eligibility to receive a public subsidy for persons with disabilities; beyond that, they do not have disability inclusion or protection strategies in place.

There are, however, some positive examples of host country DPOs reaching out to refugees with disabilities, albeit on a small scale, and in turn strengthening their protective peer networks in urban contexts. (See section below on Good Practices.) It is important to note that host country DPOs may not be familiar with humanitarian principles and protection mainstreaming. One key informant from a DPO said that community members expressed dissatisfaction when they tried to deliver materials only to refugees with disabilities, perhaps demonstrating a lack of community engagement in planning, which could in turn expose individuals with disabilities to added risks in their community. Host country DPOs consulted throughout this project also acknowledged that they need further capacity development to fully recognize and respond to age and gender issues across their activities.

Gaps in community-based protection approaches. In most urban locations there is a gap in both community outreach and support. This has particular implications for persons with disabilities who are isolated in their homes and/or those who do not feel safe to leave their homes. This increases the risk of GBV both within and outside of the home; as individuals with disabilities and their caregivers do not have the same access to information about available services, they are more likely to be targeted by perpetrators and less likely to get adequate support. Home visits are essential, as they are often the only occasions where individuals with severe physical disabilities whose mobility is restricted and individuals with intellectual disabilities have direct contact with service providers.

A lack of family-based care and support for individuals with more severe disability and a lack of respite for caregivers increase the likelihood of institutionalization, either through “boarding schools” and “mental hospitals,” separating them from their families and communities. Another primary motivator for sending family members with disabilities to institutions may be linking them up with a particular service, such as enabling their access to a specialized health or education facility for persons with disabilities. This is the case in Kampala, for instance, where parents of children with disabilities reported

sending their children to state-sponsored boarding schools for the sole purpose of ensuring their children have access to an education, as inclusive education was not available. Global research on violence against persons with disabilities, however, has demonstrated that individuals who are institutionalized are at a higher risk of sexual abuse than those living in the community,⁸⁰ making the link between caregiver support, protective networks, and GBV a critical risk factor for refugees in urban settings.

Good Practices

Support group for refugees with disabilities and caregivers. Support groups that are run by, and for, persons with disabilities can become an integral part of their protective peer networks. Refugees with disabilities and caregivers in Kampala, for instance, have formed a support group that serves a variety of functions that they themselves prioritize. The group is called the Association of Refugees with Disabilities in Kampala. They started the group on their own, but now get referrals and support, such as a safe space to hold their meetings, from refugee service providers. One provider in particular, the Refugee Law Project, has been and continues to be their main supporter.

“A reason we formed this association of people living with disabilities is it’s a way of comforting one another: giving support and sharing experiences.”

– Member of Kampala support group, Association of Refugees with Disabilities

“In the association we are a family, we are not really a group. I’d like to tell you that here we have different tribes, different nationalities. We came from different places: Congolese, Rwandese, Burundian, Sudanese.”

– Member of Kampala support group, Association of Refugees with Disabilities

Identifying home visits as a foundational piece of their peer support and protection, members of the group spoke of their desire to be able to conduct these visits themselves, to check in on each other and those who are isolated in their homes. It is also an important part of affirmative outreach to persons with disabilities and their caregivers who feel too stigmatized to ask for support from service providers, or seek out peers. Yet the group was only able to conduct home visits once, during a one-week period, with the help of a small grant they received from a refugee service provider to hire a vehicle and a driver that enabled them to make the visits. They lack the financial resources to do it again, let alone to make it a regular activity.

Linkages with host community organizations of persons with disabilities. While humanitarian actors have limited contact with host community DPOs, there are some positive examples of these organizations reaching out to refugees with disabilities, albeit on a small scale, and in turn strengthening their protective peer networks in urban contexts. This has proven effective in reaching particularly marginalized groups within the disability community, such as albinos, women and girls with disabilities, and those with intellectual disabilities.

The Lebanese Association for Self-Advocacy was established to ensure the voices of persons with intellectual disabilities are heard and all their rights respected. They have recently started self-advocacy training for refugees with intellectual disabilities in Lebanon, working with these individuals and their caregivers to explore topics such as expressing emotions and making decisions. These sessions bring together refugees with intellectual disabilities and Lebanese with intellectual disabilities and their caregivers, highlighting the things that they have in common and strengthening peer support through this shared identity.

In Kampala, the National Union of Women with Disabilities of Uganda (NUWODU) reached out to refugee women and girls with disabilities to identify their concerns and recommendations, and used this information to advocate for inclusion with other DPOs, humanitarian agencies, and donors at national, regional, and global levels.⁸¹ They conduct “afternoon teas” each month at a different member’s home, inviting refugee women and girls with disabilities, so they can meet new people and get to know the safe places in Kampala.

“I went and testified in church about this miracle that happened to make us meet with other women with disabilities in Africa and other visitors and how we were treated during the workshop. This has been my achievement in 2015, and it will always be [part of] my story. I want to thank NUWODU for searching for refugee women with disabilities.”

– Refugee woman with disabilities living in Kampala⁸²

Inclusive community-based protection. UNHCR and its partners in Lebanon have continued to expand community-based protection mechanisms across the country. Networks of volunteers, local community representatives, and partners help link individuals with protection concerns to relevant service providers, and community and social development centers act as base for information and support to refugees. Some 329 community self-managed structures have now been established in collective sites and community centers.⁸³ Persons with disabilities are being recruited as



refugee outreach volunteers and are represented in these management structures. Refugee outreach volunteers have demonstrated that with appropriate support and capacity development, they can be a valuable resource to vulnerable and isolated individuals and families in urban and non-camp contexts.

“They will feel like they don’t have one disability, but rather many disabilities....I can provide support, communicate and encourage them. I can sensitize the family, but I understand that in some cases, when there is violence, I must refer....The community should not isolate persons with disabilities – they all have a role.”

– Refugee Outreach Volunteer with a disability from Tripoli⁸⁴

Recommendations for Mitigating GBV Risks Faced by Refugees with Disabilities

- **Address discrimination by service providers.** Stigma and discrimination relating to disability – and fear of interacting with someone who is “different” – is ingrained in society, and will inevitably affect the work of humanitarian actors. Mentoring staff to reflect on their own attitudes relating to disability,⁸⁵ as well as to highlight successes in their interactions with persons with disabilities,⁸⁶ can have a greater impact on practice and preventing discrimination.
- **Support in finding safe, long-term shelter.** Recognizing the prevalence of housing discrimination on the basis of disability and heightened GBV risks associated with a lack of stable housing, humanitarian response must include targeted, proactive support for refugees with disabilities and their families in finding adequate long-term housing. This needs to consider the specific needs of individuals who require more space because they are lying down most of the day, or because they may become agitated and distressed from too much noise.
- **Strengthen family-based care support and inclusive education.** Given growing evidence of the risk of violence faced by persons with disabilities in institutions around the world, it is critical that humanitarian actors strengthen community-based programs and the inclusion of persons with disabilities, wherever possible avoiding separation from their families and communities. To the extent that humanitarian actors provide referrals or support – including financial subsidies – for refugees to attend these institutions, protection monitoring mechanisms are crucial to ensuring that these institutions are safe places, and that sending persons there does not increase their exposure to GBV risks.

- **Support host community DPOs to expand and include refugees with disabilities.** Host community DPOs, particularly those focused on marginalized groups, which are often fledgling associations, cannot expand to include refugees without both financial and technical support. They should remain aligned with their wider mission, which is most commonly advocating to their governments on legislation, policies, and programs, but can also advocate for refugees with disabilities to have the same access to local services. DPOs may need training and mentoring on both gender and protection mainstreaming, which can be conducted by mainstream humanitarian actors.
- **Strengthen the representation of refugees with disabilities in community-based protection mechanisms.** Support refugees with disabilities and their caregivers in creating and maintaining their own support groups and pursuing the activities they identify as most likely to mitigate their GBV risks and strengthen their protective networks (e.g., trainings, workshops with DPOs, livelihood initiatives, home visits). Encourage them to reflect on the gender balance in these groups, and how persons with different types of disabilities are going to be reached and included in activities. Provide a budget for transportation or link this group to a livelihoods project.

As demonstrated in Kampala, these groups can also be a valuable resource to humanitarian actors, with information about the concerns of persons with disabilities and suggestions for change. Establish a regular meeting with these groups – this will help them to better understand the opportunities, as well as the limitations, and shape their recommendations accordingly.

“Advocate for at least one meeting per year of the representatives of UNHCR with a group of refugees [with disabilities]”

– Association of Refugees with Disabilities in Kampala

Lastly, set targets for the proportion of volunteers, refugee staff and committee members who will be persons with disabilities and their caregivers. A representative target would be 15 percent. This will encourage staff and partner to reach out, identify, and invite persons with disabilities.

Men and Boys^{xxvii}

In contrast to other refugee subpopulations, men were the least forthcoming about GBV risks they and their sons face as urban refugees. Some men were unfamiliar with the concept of GBV, or unfamiliar with the idea that it could affect men and boys, not just women and girls. For others, the term GBV (or its local equivalent) itself triggered frustration, because they had heard it so often from refugee service providers: they were starting to feel its deployment had become accusatory, and that service providers were prioritizing GBV over their families' more immediate needs like access to safe shelter, food, and jobs.

Even among service providers, not much is known about the magnitude and type of GBV risks faced by refugee men. This is true in both camp and urban contexts, although evidence suggests that men and boys are more at risk in urban environments than in camps, because of the risks associated with livelihoods and discrimination by the host community. Anecdotal evidence further suggests that refugee male survivors of sexual violence are likely to migrate to urban centers where possible, preferring them to camps where confidentiality is hard to maintain and stigma around male rape runs high. In cities, they have more hope of accessing medical care and maintaining anonymity, although they often continue to suffer in silence.

Among both refugees and service providers, discussions of men and boys' GBV vulnerabilities tended to focus on sexual violence, rather than other forms of GBV, such as emotional violence. Undoubtedly this reflects contemporary assumptions, norms, and bounded awareness around GBV, rather than an empirical absence of other forms of GBV.

Most of what is known about men and boys' GBV risks in cities comes from anecdotal evidence, mostly second-hand reports of sexual violence experienced by adolescent boys and young men who work in certain types of jobs – usually a type of informal work common among refugee male youth in a particular city. In Delhi, for instance, young men often work “night parties” as catering staff, where they are exposed to GBV both while they are working and traveling home late at night. Rag-picking (Delhi), working at hookah bars (Beirut), and begging (multiple cities) are also common jobs for young male refugees where sexual harassment and violence is known to occur.

Consultations in these assessments reaffirmed previous findings that forced displacement can upend traditional gender roles, undermining norms and established behav-

xxvii. This section focuses on the GBV-related risks and service provision for heterosexual, cisgendered, able-bodied male refugees.

iors premised on ideas of hegemonic masculinity.⁸⁷ What this means in practice is that displaced men, as well as boys, are vulnerable to physical and emotional GBV in their communities, including within their homes, because they are unable to meet expectations around being the family “protector” or “breadwinner.” This vulnerability is heightened in situations where male refugees are unable to work, or discriminated against in employment opportunities due to disability or their refugee status. They may be earning less income than they used to, or even, for the first time, making less than what women in their family are able to earn.

Men and boys are also targeted for sexual violence by those who presume that, as refugees, they have fewer ties to the community and are already living on the margins of society, and are therefore less likely to report violence than host community men – or to be believed even if they do report it. Police and members of the military may be especially emboldened to target refugee men and boys for rape, as was reported by survivors of such attacks in Kampala. For these men, it was a source of profound emotional distress that although they had been able to escape war in their home country (usually the DRC) without becoming a victim of sexual violence, they had not been able to avoid it as refugees living in Kampala. Hence risks of sexual violence, often stemming from encounters with police, soldiers, and other armed forces, can follow men and boys from conflict into their cities of refuge.

Some men and boys may face added risks of GBV due to intersecting identities, such as race, ethnicity, and disability. In Uganda, mothers of persons with disabilities (children and adults) perceived that men and boys with disabilities may be targeted for rape and sexual violence at the same time as women and girls. This is aligned with findings from other WRC research, which identified men and boys with intellectual disabilities as vulnerable to rape and sexual exploitation. In fact, analysis of GBV Information Management System data from refugee settings in Ethiopia and Burundi suggest that approximately 17 percent of survivors with disabilities reporting to GBV service providers are male.⁸⁸

“As you see this boy, my son, has been raped even living with disabilities. And after that, they raped the younger sister of him.”

– Mother of child with disabilities, Kampala

Recommendations for Mitigating GBV Risks Faced by Refugee Men and Boys

- **Additional, targeted research is needed on the particular GBV risks men and boys face in urban humanitarian contexts**, including the emotional and physical violence they experience as a result of not being able to meet established

norms and expectations around masculinity.

- **Map host community organizations with experience engaging men and boys around issues of gender equality and GBV prevention.** Partner with them to conduct outreach and awareness raising around GBV risks faced by men and boys, to tailor and make case management accessible to them, and to identify particular areas of vulnerability they face, both within and outside the home.

A good practice here is humanitarian actors' partnership in Beirut with ABAAD Resource Center for Gender Equality, which runs a Men's Center that provides services such as support groups, discussion groups, and individual psychological counseling, from a gender perspective. It is open to all men residing in Lebanon, including refugees; cost-sharing from UNHCR has been instrumental to this inclusion.

- Given that a lot of risk and exploitation boys face is around child labor, ensuring safer livelihoods for them and stronger, more appropriate livelihood options for their family is essential to enhancing their protection. **Concurrently with exploring alternative livelihood options, refugee service providers – including but not limited to GBV practitioners – should engage men and boys to identify particular jobs, businesses, and industries that are sites of GBV for them.** Appropriate responses will be context-dependent, but may involve direct advocacy and/or engaging a range of local actors, from merchants' associations to law enforcement.

Male Survivors of Sexual and Gender-Based Violence

Male survivors of sexual and gender-based violence⁸⁹ were not one of the target subpopulations of the WRC's urban assessments. Yet the invisibility of this group was made plain during each field assessment, through consultations with service providers and other refugees. Only in Kampala, however, where we collaborated with the Refugee Law Project – a UNHCR partner and leading voice in raising awareness around the rights of male survivors and their invisibility in humanitarian response – did the WRC consult with male survivors directly.⁹⁰ The Refugee Law Project's systematic screening of refugees approaching their offices for services, as well as in refugee settlements, indicates that between one in four and one in three male refugees in Uganda have been victims of sexual violence in their lifetime.

We take as our starting point for this discussion previous research done by both the Refugee Law Project⁹¹ and the Hebrew Immigrant Aid Society (HIAS).⁹² Their findings establish a profound and widespread gap in knowledge, discourse, and services for male survivors, both in Kampala and in other contexts.

In particular, male survivors encounter significant barriers in accessing basic needs, from medical care – including life-saving reparative surgery to treat rectal trauma – to safe shelter, to jobs. They endure stigma and shame that keeps them from disclosing incidents of violence and their physical and emotional consequences. Even those who do seek medical care or counseling are often met with discrimination, emotional violence, and even physical violence.

Lack of access to trained and sensitive service providers exposes male survivors to greater GBV and health risks. It can also have profound consequences for their family members, who are forced to endure secondary violence – emotional, physical, and economic – arising from the silent suffering of their fathers, brothers, and husbands. Gaps in discourse and service provision for male survivors also perpetuate stigma around male rape, while reinforcing outdated notions of gender as binary. These notions are dangerous for women and girls as well, since they anchor the same social norms that prescribe fixed and limited roles for women and girls in all aspects of life.

The WRC's consultations with stakeholders in all four cities, and with male survivors in Kampala, reinforce these findings. There needs to be much greater awareness of GBV against men, as well as boys, in conflicts and crises. And to meet its obligations to all survivors, the humanitarian community must develop comprehensive guidance and programming that affirms the rights, needs, and dignity of male survivors and is integrated into inter-agency standards and humanitarian action at every stage of response.

Stigma and Discrimination

Male GBV survivors remain highly invisible within refugee communities, largely due to cultural stigma, misperceptions, and entrenched stereotypes around masculinity. In many refugee and host communities, sexual violence against men and boys is conflated with homosexuality. Hence, this is a misperception male survivors confront not only within themselves, but also from others, including their family members, service providers, and even medical practitioners. Many choose to remain silent about incidents of violence, lest they be “marked” as lesser men and, as such, targeted even further for emotional and physical abuse. This silence comes with serious emotional and psychological costs, as survivors experience recurring trauma, feelings of depression and isolation, and post-traumatic stress disorder – all without receiving any structured counseling or psychosocial support. In Kampala, focus groups with adolescent males stressed that reporting sexual abuse is rare and informal; reports tend to be confidential between survivors and group leaders unless they are brought up to Refugee Law Project officials.

“You survive, then you die into the trauma.”

– Male survivor in Kampala

“Other male survivors are in hiding, they won’t access services and they will die in shame and fear.”

– Male survivor in Kampala

Lack of Services, Referrals, SOPs, and Sensitive and Trained Service Providers

In some cities, refugee service providers who provide GBV case management had no information, referrals, or protocols in place relating to male survivors. The same was true of host community GBV organizations: while many maintain an “open door” policy for treating men, they have no protocols, focal points, or programming in place – such as targeted outreach or a hotline – for men and boy survivors. In some cases, policies and referral pathways have been adopted based on assumptions, without any evidentiary basis, and have ultimately proven harmful to male survivors. For instance, male survivors suffering rectal trauma have been referred to local hospitals, where they are humiliated, and their already painful wounds exacerbated, by doctors and nurses with no expertise in treating male survivors. Male survivors who have been referred to the police to report incidents of violence are met with disgust, stigmatized, and told they are “homosexuals” because men cannot be raped.

Having tailored policies and protocols in place is essential because men and boys

face significant barriers to accessing information about GBV-related services. They also encounter stigma when accessing services that are commonly understood to be for women. In one city, for instance, GBV case management is conducted at community centers that are collectively understood to be, and are commonly referred to as, “women’s centers.” In this context, “there are no services for male survivors of SGBV,” one protection coordinator put it bluntly.

Good Practices

Expanding upon the positive practices identified in previous research by the Refugee Law Project and HIAS, the following positive attitudes and practices were identified by the WRC in its field assessments.

Interest in expanding GBV protection and response for male refugee survivors. UNHCR Headquarters, UNHCR partners, GBV practitioners, university researchers, and a number of NGOs have been vocal about their interest in building the knowledge base around GBV against men and boys, and in bridging the service gaps that deny them care and perpetuate stigma and misinformation. Technical trainings and sensitivity workshops are still few and far between, but momentum is building toward structural changes that will meaningfully integrate male survivors into larger humanitarian GBV architecture. In September 2015, for instance, UNHCR in the Middle East and North Africa (MENA) region held its first workshop on working with men and boy survivors of GBV. Participants were largely field-office staff from UNHCR and implementing partners in various countries, and the modules developed for that course will be used in future workshops.

Identification of skilled and sensitive health care providers. In select cities, including Kampala, UNHCR partners have identified and vetted referral points for male survivors, including medical practitioners who can provide adequate post-sexual violence care. Having this small yet trusted referral network has proven essential to ensuring male survivors are not exposed to additional physical and emotional violence when they go for treatment. Even in Kampala, however, where service providers have made proactive efforts to build linkages with good medical providers, there are not enough doctors or surgical facilities to provide sustained care. Moreover, even where adequate providers do exist, there is often insufficient funding to pay for individual care – whether that is a reparative surgery necessary for them to be able to use the toilet again (and restore their dignity), or even smaller basic goods many survivors need, like diapers and soft foods.^{xxviii}

xxviii. According to Chris Dolan, Executive Director of the Refugee Law Project, “to date, the only governmental funder that has proactively sought to support projects for male survivors is the U.S.” (private

Support groups for male refugee survivors. In Kampala, the WRC consulted members of a support group for male survivors of sexual violence called Men of Hope. Many members were raped in their countries of origin, others were raped as refugees living in Kampala, and some had been raped in both countries. Members spoke with conviction and gratitude for the role Men of Hope plays in their lives. They spoke of a “before” and “after”: before joining Men of Hope they felt despair and isolation; after joining their emotional well-being improved dramatically and, by extension, so did that of their family. Being able to share their experiences with each other has been critical to their emotional survival.

Men of Hope does outreach within the refugee community to encourage male survivors who are “in hiding” to come forward and to encourage those who are too ashamed to seek medical services, psychological counseling, or peer support to do so. They also engage in wider advocacy, including in popular media, to dislodge assumptions and misperceptions around male rape and promote additional funding and learning that will enhance male survivors’ access to rights-respecting GBV response. “We have two purposes,” one member said, “breaking the silence by raising our voices and enabling people to come forward and access services.”

Training of duty-bearers. In Kampala, the Refugee Law Project has provided extensive training to police, both in police stations servicing communities with high concentrations of urban refugees, and also through the Police Training School, where it has been able to enrich the curriculum to include GBV issues affecting men and boys, as well as women and girls. This has also led to revisions in the forms used by plastic surgeons to document medical examinations in cases where survivors report cases to police.

Recommendations for Mitigating GBV Risks Faced by Male Survivors of Sexual and Gender-based Violence

- **Humanitarian actors, including UNHCR Headquarters, must continue to support training and awareness raising around the GBV risks that men face – both during conflict and as refugees in their host communities – as well as around how to respect the rights and dignity of male survivors while ensuring they have access to quality services that respond to their medical and emotional needs.**
- **Where host community medical providers lack sufficient training and sensitivity to provide adequate post-rape care to male survivors, humanitarian actors should support their capacity-building, to ensure adequate referral pathways exist for both refugee and host community male survivors.**

- **More resources, including financial and human resources, are needed so that trainings and programming can be replicated and scaled.** Humanitarian actors should support training and awareness raising among relevant medical and legal actors, as well as police. Programs should consider expanding counseling to families of survivors as well.
- **Existing guidance and tools tailored to serving male survivors should be disseminated widely, and adapted for local contexts.** The Refugee Law Project, for instance, has developed a screening tool for male survivors that has potential application not only outside Kampala, but also across sectors, so it can be used by those who provide various types of support, from psychosocial counseling to legal assistance.
- **Additional funding for male survivors' post-rape care is needed,** both to cover the costs of medical interventions like reparative surgeries, as well as goods intrinsic to their basic dignity (e.g., soft foods).
- **Humanitarian actors should support and enable groups like Men of Hope, providing them with financial and in-kind support** – for example, technical assistance, a safe space – so they can develop a protective peer network for each other, and engage in other activities they deem desirable and appropriate, such as advocacy and outreach.



Male survivors of sexual and gender-based violence encounter significant barriers in accessing basic needs, from medical care, to safe shelters, to jobs.

Conclusion

Today, an overwhelming majority of people fleeing crisis and conflict are turning to cities for refuge. This new era of urban migration requires a monumental shift in humanitarian response, including protection. As UNHCR recognizes, meeting its protection mandate in cities will require a complete rethink of operational priorities, approaches and partners, as well as how donor funds are spent. Similarly, among humanitarian GBV actors, there is a consensus that GBV programming must be rethought and adapted for cities, to respond to the particular GBV risks faced by urban refugees and their unique service needs.

Research conducted by the WRC across four very different urban settings sheds light on how established principles of protection can be operationalized in practice. It also explored the complex ways in which urban GBV prevention and response can be situated within – and potentially draw from – a diverse network of actors, including city actors and institutions, non-humanitarian agencies, and non-state actors.

Among the key research findings is the need for urban humanitarian practitioners to *systematize* and *broaden* their engagement with local actors. Who these local actors should be will likely vary from city to city, along with their respective capacities and commitment to serving refugees. But the importance of leveraging their skills, expertise, and social or political capital in urban protection is universal. Another key finding is the extent to which refugees, in all cities, linked their GBV risks back to shelter and livelihoods: the two greatest areas of vulnerability for urban refugees. Addressing these sources of risk will require *proactive, targeted strategies* that are responsive to local contexts, and which ultimately offer refugees a range of options and information about what kinds of shelter and jobs are safest and within their reach.

Some urban refugees encounter heightened risks of GBV due to their intersecting identities as refugees and members of another at-risk group, such as women, adolescent girls, LGBTI individuals, persons with disabilities, sex workers, or male survivors of sexual violence. Providing protection to these refugees, including GBV prevention and response, will require holistic yet tailored approaches, driven by *targeted actions, proactive outreach, and direct consultations with at-risk refugees*. A great deal more effort and resources are needed to support such approaches – much more than is currently being allocated, prioritized, or funded in urban operations.

Refugees from these particularly vulnerable risk groups also experience GBV when attempting to access mainstream refugee services and programs, including those provided by UNHCR and its partners. This underscores a need for *non-discrimination principles to be more meaningfully enforced, promoted, and adhered to at the field*

level, along with survivor-centered standards of care for all GBV-related services. This is especially true in cities where legal, social, or cultural norms sanction prejudice against certain groups, which renders refugees from these groups especially vulnerable to GBV in their day-to-day lives.

This report highlights the need for protection strategies that are informed by, and responsive to, the unique contextual challenges and opportunities that exist in urban settings. It calls for more urban-specific funding and operational guidance, as well as capacity-building for field staff, bolstered by more formal opportunities to share good practices and information about what works, or is showing promise, in different cities worldwide.



Refugees in cities often live in conditions that are not conducive to protection from GBV. Here, Rohingya refugees, Delhi.

Notes

1. UNHCR, Policy on Alternatives to Camps (2014), <http://www.unhcr.org/5422b8f09.html>
2. UNHCR, Policy on Refugee Protection and Solutions in Urban Areas (“Urban Policy”) (2009), <http://www.unhcr.org/4ab356ab6.html>
3. Ibid.
4. See, e.g. UNHCR, *The Implementation of UNHCR’s Policy on Refugee Protection and Solutions in Urban Areas Global Survey* (2012), <http://www.unhcr.org/516d658c9.pdf>
5. This definition comes from the updated Inter-Agency Standing Committee’s *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (2015) (hereinafter IASC Guidelines), <http://gbvguidelines.org/>
This report uses the term “gender-based violence” and its acronym, GBV, rather than “sexual and gender-based violence” and SGBV. We do this to comport with current humanitarian discourse and guidelines, but also see the former as being inclusive of the latter: few if any instances of sexual violence lack a gendered component.
6. As a companion piece to this report, the WRC is releasing a literature review pulling together existing research base on urban refugees’ GBV risks and related humanitarian programming.
7. Sustainable Development Goals, <https://sustainabledevelopment.un.org/?menu=1300>
8. These different “policy environments” include variations in, for example, policies around refugees’ right to work and right to access public services.
9. As discussed further in the subsection on LGBTI refugees, current UNHCR guidance on serving LGBTI individuals, while a significant step forward in mainstreaming their needs and concerns, does not offer operational directives or sample interventions currently sought by urban protection staff in the field. See, e.g., UNHCR, *Need to Know Guidance 2: Working with Lesbian, Gay, Bisexual, Transgender & Intersex Persons in Forced Displacement* (2011), <http://www.refworld.org/pdfid/4e6073972.pdf>. A similar gap exists for urban protection staff seeking to operationalize global guidance on serving persons with disabilities. See, e.g., UNHCR, *Need to Know Guidance 1: Working with Persons with Disabilities in Forced Displacement* (2011), <http://www.unhcr.org/4ec3c81c9.pdf>
10. For more information about a “survivor-centered approach,” see the IASC Guidelines, Part 2: Background.
11. In Ecuador, the WRC visited and met with urban refugees living in Quito, as well as in two smaller cities along the Ecuadorian-Colombian border: Esmeraldas and San Lorenzo.
12. Despite efforts, the WRC was unable to access intersex and transmen refugees.
13. Sex workers are “female, male, and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally,” the World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work Projects and the World Bank, *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions* (2013) at xiii (internal citation omitted). The authors go on to clarify that “sex work may vary in the degree to which it is ‘formal’ or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities.” Ibid. Neither that publication nor this report addresses the sexual exploitation of minors.
14. July 2014 numbers. UNHCR Statistical Snapshot, <http://www.unhcr.org/pages/49e492b66.html>
15. UNHCR Global Appeal 2014-15 Ecuador, <http://www.unhcr.org/pages/49e492b66.html>
16. Ibid.
17. UNHCR Statistical Snapshot, numbers as of December 2014. <http://www.unhcr.org/pages/49e4876d6.html>
18. UNHCR India (personal communication).
19. UNHCR, Lebanon Crisis Response Plan 2015-2016.
20. Ibid.
21. UNHCR, Lebanon Crisis Response Plan 2015-2016.
22. Michela Macchiavello, *Forced migrants as an under-utilized asset: refugee skills, livelihoods and achievements in Kampala, Uganda*, UNHCR Evaluation and Policy Analysis Unit, no. 95 (October 2003).
23. For guidance on developing urban livelihood interventions that take into account GBV risks, see WRC’s *Guidance for Achieving Self-Reliance for Urban Refugees*, which presents a framework for urban refugee self reliance and recommendations, and related guidance on Integrating Protection/GBV Mitigation in Livelihoods Programs.
24. For a profile of these groups, see the Refugee Law Project, <http://www.refugeelawproject.org/files/others/>

[RLP support groups_profile.pdf](#)

25. UNHCR, Policy on Alternatives to Camps at 9 (2014), <http://www.unhcr.org/5422b8f09.html>
26. Karen Jacobsen "Refugees and Asylum Seekers in Urban Areas," *Journal of Refugee Studies*, Vol 19, Issue 3 (2006): pp. 273 – 286.
27. UNHCR, *The Implementation of UNHCR's Policy on Refugee Protection and Solutions in Urban Areas: Global Survey – 2012* at 5-6, <http://www.unhcr.org/516d658c9.pdf>.
28. Examples of such refugee-led organizations are Angels Refugee Support Group Association in Kampala and the Refugee Community Development Project in Delhi; both are profiled herein.
29. See UNHCR, "Community-based Protection," (2013), <http://www.unhcr.org/51d19cb79.html>
30. Ibid.
31. See, e.g., Internews, "Lost: Syrian Refugees and the Information Gap" (Nov. 2013), https://www.internews.org/sites/default/files/resources/Internews_Lost_SyriaReport_Nov2013_web.pdf
32. UNHCR, *World at War: UNHCR Global Trends: Forced Displacement in 2014* (Geneva: 2014), p. 2.
33. UNHCR. *Age, Gender, and Diversity Mainstreaming Forward Plan, 2011-2016*, <http://www.unhcr.org/4e7762f19.html>
34. For more information about what a "survivor-centered approach" entails, see the *IASC Guidelines*, Part 2: Background. <http://gbvguidelines.org/>.
35. For examples of home-based enterprises, see those being run by Jordanian and Iraqi refugee women in Zarqa, Jordan; they include food and dairy production, as well as the trade and re-sale of clothes and blankets. Near East Foundation et al., *Enhancing the Economic Resilience of Displaced Iraqis and Poor Jordanians: Economic Assessment: Opportunities and Constraints for Vulnerable Women and Youth in Zarqa, Jordan* (March 2014), <http://reliefweb.int/sites/reliefweb.int/files/resources/Zarqa%20Economic%20Assessment%20-%20Full%20Report.pdf>
36. Information in this section on children's GBV risks has been triangulated from consultations with parents, siblings (adolescents), and service providers. The WRC did not directly consult with children (ages 15 or younger) during its field visits. In Beirut, mothers attended group discussions with adolescent girls (ages 15-18).
37. We have included a separate subsection here on adolescent girls, given the heightened risks they face as well as the fact they have traditionally been overlooked in humanitarian response, and their particular needs and concerns lost in broader discussions about children and youth. Adolescent boys also face particular risks of GBV; however, since these are often linked to gender norms and social expectations around masculinity, which are disrupted in contexts of forced displacement, they are addressed in the subsequent section on Men and Boys.
38. On a conceptual level, it can be difficult to parse whether, and when, certain types of violence constitute gender-based violence. Where that line gets drawn can be arbitrary, a question of interpretation. School bullying poses such challenges, but we include it here as a GBV risk faced by children because it often has a gendered component.
39. WRC, forthcoming report on findings from implementing the *I'm Here Approach* (2016), <https://women-refugeecommission.org/resources/document/1078-i-m-here-report-final-pdf>
40. Ibid.
41. Of the 42 girls consulted in Beirut (ages 15-18), only two were attending school.
42. For more information on how conflict and displacement affect early and forced marriage for girls, see CARE, *"To Protect Her Honor": Child marriage in emergencies – the fatal confusion between protecting girls and sexual violence* (2015); Gayle Lemmon, *Fragile States, Fragile Lives: Child Marriage Amid Disaster and Conflict*, Council on Foreign Relations Working Paper (2014); UNICEF, *A Study on Early Marriage in Jordan* (2014); Jennifer Schlecht et al., "Early relationships and marriage in conflict and post-conflict settings: vulnerability of youth in Uganda," *Reproductive Health Matters*, Vol. 21, Issue 41 (May 2013).
43. Child Protection Working Group (2012), *Minimum Standards for Child Protection in Humanitarian Action*, <http://cpwg.net/minimum-standards/>
44. http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-child-protection-08_26_2015.pdf
45. For more information on addressing livelihood-related GBV risks encountered by children and adolescent refugees, see Global Protection Cluster, Child Protection. 2010. *Responding to the Worst Forms of Child Labor in Emergencies* (including urban case studies), http://cpwg.net/wp-content/uploads/sites/2/2014/12/Review_Responding_to-WFCL_in_Emergencies_final.pdf. See also IASC GBV Guidelines 2015, Livelihoods (http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-livelihood-08_26_2015.pdf) and Child Protection (http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-child-protection-08_26_2015.pdf) sections.



46. Retrak, for instance, conducts outreach to vulnerable children and adolescents to provide food, medicine, clothing, hygiene, and shelter. Their resources present methodologically reliable and accurate approaches to counting children on the street and evidence and theory-based approaches to training and conducting outreach work with street children. See, e.g., Retrak, *Enumerating Street Children* (2014), <https://www.retrak.org/content/uploads/2015/06/Retrak-Enumerating-Street-Children-Oct2014.pdf>; Retrak, *Standard Operating Procedures: Conducting Outreach* (2015), <https://www.retrak.org/content/uploads/2015/11/Retrak-Outreach-SOPs-Oct2015.pdf>
47. See, e.g. Malhotra, A., Warner, A., McGonagle, A., & Lee-Rife, S. (2011). *Solutions to End Child Marriage*. Washington, DC: International Center for Research on Women, <http://www.icrw.org/files/publications/Solutions-to-End-Child-Marriage.pdf>. See also Population Council, "New Research from the Population Council Shows Child Marriage Can be Delayed," (Press Release, 12 Aug 2015), <http://www.popcouncil.org/news/new-research-from-the-population-council-shows-child-marriage-can-be-delaye>
48. For a breakdown of the tools and information about field testing of the *I'm Here* Approach, see <https://womensrefugeecommission.org/resources/document/1078-i-m-here-report-final-pdf>
49. See, e.g. UNHCR, *Guidelines on International Protection No. 9: Claims to Refugee Status based on Sexual Orientation and/or Gender Identity within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees* (2012), <http://www.unhcr.org/50ae466f9.html>
50. HIAS, ORAM, and Heartland International are among a handful of organizations leading the way in researching and advocating around the protection gaps affecting LGBTI refugees. See, e.g., ORAM, *Blind Alleys: The Unseen Struggles of Lesbian, Gay, Bisexual, Transgender and Intersex Urban Refugees in Mexico, Uganda, and South Africa* (2013); HIAS, *Triple Jeopardy: Protecting At-Risk Refugee Survivors of Sexual and Gender-Based Violence* (2014); HIAS, *Invisible in the City: Protection Gaps Facing Sexual Minority Refugees and Asylum Seekers in Urban Ecuador, Ghana, Israel, and Kenya* (Yiftach Millo for HIAS) (2013); Heartland Alliance International, "No Place for People Like You" (2014).
51. UNHCR, *Need to Know Guidance 2: Working with Lesbian, Gay, Bisexual, Transgender & Intersex Persons in Forced Displacement* (2011), <http://www.refworld.org/pdfid/4e6073972.pdf/>
52. Some calculations put this number at 76, others at 79. See *Erasing 76 Crimes*, <http://76crimes.com/76-countries-where-homosexuality-is-illegal/>
53. Although the Lebanese Penal Code does not explicitly criminalize homosexuality, Section 534, which prohibits "sexual intercourse contrary to the order of nature," is often used as a basis for arresting and prosecuting LGBTI individuals. See Amnesty International, Country Report: Lebanon, <https://www.amnesty.org/en/countries/middle-east-and-north-africa/lebanon/report-lebanon/>
54. In Quito, a refugee service provider reported referring LGBTI refugees to a faith-based organization because that organization specializes in serving "vulnerable populations."
55. Given the rarity, on a global level, of targeted interventions to enhance LGBTI refugees' protection and reduce GBV risk, the "good practices" profiled herein may be more suitably cast as minimum standards for all field operations. Similarly, once the "best practices" profiled in UNHCR's recent report have been proven effective, they may be incorporated into an evolving suite of minimum standards or operating procedures for promoting LGBTI refugees' protection. UNHCR 2015 Protecting Persons, note ix, page 69.
56. UNHCR does not, as a matter of practice, rent premises for housing refugees.
57. LGBTI refugees in Quito and Delhi reported this either to the WRC during an individual interview, or to a refugee service provider, who then communicated it to the WRC.
58. See UNHCR, *Age, Gender and Diversity Policy* (2011) and *Age, Gender and Diversity Mainstreaming Forward Plan 2011-2016* (2011).
59. These recommendations are made alongside, and are intended to be complementary to, those recently put forward by IOM/UNHCR in their comprehensive training package, see note xi, p. 70, as well as those put forward by Heartland Alliance, HIAS, and ORAM. See, e.g., Heartland Alliance International, *No Place for People Like You: An Analysis of the Needs, Vulnerabilities, and Experiences of LGBTI Syrian Refugees in Lebanon* (2014); HIAS, *Triple Jeopardy: Protecting At-Risk Refugee Survivors of Sexual and Gender-Based Violence* (2014); and ORAM, *Blind Alleys: The Unseen Struggles of Lesbian, Gay, Bisexual, Transgender and Intersex Urban Refugees in Mexico, Uganda and South Africa* (2013).
60. Recently, UNHCR joined with 11 other UN entities to call on states to act urgently to end violence and discrimination against LGBTI adults, adolescents, and children. *Ending Violence and Discrimination Against Lesbian, Gay, Bisexual, Transgender and Intersex People* (September 2015), http://www.unicef.org/media/files/Joint_LGBTI_Statement_ENG.pdf
61. ORAM recently published a toolkit for actors providing services to LGBTI refugees and/or processing their asylum claims; the kit including posters and other products for creating a safe, LGBTI-friendly space.

- ORAM, *Credibility and Assessment and Protection Suite – SOGI* (2015), http://oraminternational.org/en/?option=com_content&view=article&id=382
62. See, e.g., K Shannon and J Csete. *Violence, condom negotiation and HIV/STI risk among sex workers. Journal of the American Medical Association* 2010; 304(5):573-74; UNAIDS Advisory Group on HIV and Sex Work. *Report of the UNAIDS Advisory Group on HIV and Sex Work*. Geneva, 2011, available at <http://www.nswp.org/news/the-report-the-unaid-advisory-group-hiv-and-sex-work>.; Deering, K.N., Amin, A., Shoveller, J., Nesbitt, et al., 2014. "A systematic review of the correlates of violence against sex workers." *American journal of public health*, 104(5), pp. e42-e54; World Health Organization, *Violence against Sex Workers and HIV Prevention*, Information Bulletin Series, No. 3 (2005), pp. 1-2 (citing L. Cler-Cunningham and C. Christerson, "Studying Violence to Stop It," *Research for Sex Work*, vol. 4 (2001), pp. 25-26. See also World Health Organization et al., *Implementing Comprehensive HIV/STI Programs with Sex Workers: Practical Approaches from Collaborative Interventions* (also known as the 'Sex Worker Implementation Tool' or 'SWIT') (2013), Chapter 2, "Addressing violence against sex workers" (citing sources), http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/
 63. World Health Organization et al., *Implementing Comprehensive HIV/STI Programs with Sex Workers: Practical Approaches from Collaborative Interventions* (also known as the 'Sex Worker Implementation Tool' or 'SWIT') (2013), Chapter 2, "Addressing violence against sex workers" (citing sources), http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/
 64. Ibid. at Chapter 2, "Addressing violence against sex workers."
 65. Convention on the Rights of Persons with Disabilities, Art. 1, <http://www.un.org/disabilities/convention/conventionfull.shtml>
 66. WRC, *Disabilities among Refugees and Conflict-affected Populations* (2008).
 67. WRC, *Disability inclusion: Translating policy into practice in humanitarian action* (2014)
 68. WRC, *Sexual and reproductive health and disability: Examining the needs, risks and capacities of refugees with disabilities in Kenya, Nepal and Uganda* (2015).
 69. WRC and IRC, *"I see that it is possible": Building capacity for disability inclusion in gender-based violence programming in humanitarian settings* (2015).
 70. WRC, *"We have a right to love": The intersection of sexual and reproductive health and disability for urban refugees in Kampala, Uganda* (2014).
 71. See note 69.
 72. Ibid.
 73. Father whose son has a disability, Kampala.
 74. WRC field visit report, *Disability inclusion in the Syrian refugee response in Lebanon. October 2015 – Consultations with children and youth with disabilities and their caregivers* (2015).
 75. Mother of a girl with intellectual disabilities, Beirut.
 76. See note 69.
 77. Ibid.
 78. Caregiver of a child with an intellectual disability, Beirut.
 79. Ibid.
 80. WHO, *World Report on Disability* (2011).
 81. <http://nuwodu.org/index.php/blog/109-humanitarian-acts-on-inclusion-of-refugee-women-with-disabilities>; <https://womensrefugeecommission.org/resources/document/1131>
 82. Commission on the Status of Women 59th Session Report (NAWWD, 2015).
 83. <http://data.unhcr.org/syrianrefugees/download.php?id=9236>
 84. WRC, *Positive practices in disability inclusion. "We all have a role": The valuable contributions of persons with disabilities in community outreach* (2014).
 85. See "Activity 1: Where do we stand?" in the Training Module for GBV Practitioners in Humanitarian Settings. This can be adapted for different groups and different topics, and is also available in Arabic. <https://womensrefugeecommission.org/component/zdocs/document/download/1166>
 86. See the Reflection Tool for GBV Practitioners. This can be adapted for different groups and topics, and is also available in Arabic. <https://womensrefugeecommission.org/component/zdocs/document/download/1159>
 87. See, e.g., Kerstin Rosenow-Williams and Katharina Behmer, "A Gendered Human Security Perspective on Humanitarian Action in IDP and Refugee Protection," *Refugee Survey Quarterly* 34.3 (2015): 1-23; Marta Y. Young, and K. Jacky Chan, "The Psychological Experience of Refugees: A Gender and Cultural Analysis," *Psychology of Gender Through the Lens of Culture* (Springer International Publishing, 2015): pp. 17-36.
 88. See note 69.

89. Certain aspects of this discussion, including around access to adequate medical care, also have particular relevance for gay men and transwomen refugees.
90. See UNHCR and Refugee Law Project, *Need to Know Guidance No. 4: Working with Men and Boy Survivors of Sexual Violence in Forced Displacement* (2012), <http://www.refworld.org/pdfid/5006aa262.pdf>
91. See, e.g. Refugee Law Project, *Men Can be Raped Too* (film) (2015), <http://refugeelawproject.org/rfp-resumes-direct-support-to-refugees/348-film-men-can-be-raped-too.html>; Refugee Law Project, *Promoting Accountability for Conflict-Related Sexual Violence Against Men: A Comparative Legal Analysis of International and Domestic Laws Relating to IDP and Refugee Men in Uganda* (2013). See also Chris Dolan, ICRC No. 894 *Letting go of the gender binary: Charting new pathways for humanitarian interventions on gender-based violence* (Sept 2015) <https://www.icrc.org/en/international-review/article/letting-go-genderbinary-charting-new-pathways-humanitarian>
92. HIAS, *Triple Jeopardy: Protecting At-Risk Refugee Survivors of Sexual and Gender-Based Violence* (section on male survivors) (2014) at 27-32.

Appendix

Four Urban Contexts

Quito, Ecuador

More than 133,000 persons of concern currently reside in Ecuador; over 120,000 are refugees, constituting the largest refugee population found in any Latin American country.¹ Roughly 98 percent of refugees in Ecuador have fled from Colombia as a result of the conflict between the Colombian Army and the FARC and other armed groups.² The remaining 2 percent have come from countries as various and faraway as Sri Lanka, Cameroon, and Syria. Nearly two-thirds of refugees and asylum-seekers in Ecuador have sought safety and security in urban areas, including Quito and Guayaquil; the rest live in less densely populated regions throughout the country, including in towns like San Lorenzo and Esmeraldas along the northern border with Colombia.³

Ecuador is a party to the 1951 Convention on the Status of Refugees and has ratified its 1967 Protocol. A Presidential Decree passed in May 2012 (No. 1182) instituted restrictions on asylum claims that have subsequently raised the rate at which asylum applications are rejected. This has created additional barriers to refugees' right to work in Ecuador, as well as access to health and other services. The Decree has been challenged in court for, inter alia, narrowing the definition of refugee in a way that constricts refugees' rights while contravening Ecuador's obligations under international law and its state constitution.⁴

UNHCR has identified the priority of refugees in Ecuador as interested in pursuing local integration, while resettlement to a third country is an alternate preference.⁵ The UNHCR operational budget for providing services to refugees in Ecuador increased by over USD 1 million between 2014 and 2015, with the entire budget prioritized for refugees and asylum-seekers as opposed to services for stateless individuals or internally displaced persons. Although USD 1.5 million is allocated specifically toward prevention and response to sexual and gender-based violence,⁶ resource constraints continue to limit the ability of these and other programs to meet the needs of growing refugee and asylum seeker populations. According to the 2014-2015 UNHCR Global Appeal, this budget will include support for access to education, health services, increased child protection mechanisms, financial management, employment, and additional government assistance.⁷ Further, UNHCR has committed to the reduction of sexual and gender-based violence risks among refugees, notably through risk reduction, the provision of legal services, psychological care and services, and access to safe houses for survivors, as well as resettlement of women at risk and survivors of violence and torture related to GBV.

Delhi, India

Currently more than 200,000 refugees and asylum seekers from various countries live in India.⁸ On a national level, India does not have existing legal frameworks or institutions that provide specific services or protections for refugee populations. India is not signatory to the 1951 Convention on the Status of Refugees, nor the 1967 Optional Protocol. As such, refugees fall under India's Registration of Foreigners Act of 1939, the Foreigners Act of 1946, and the Foreigners Order of 1948. These laws do not distinguish between undocumented migrants and refugees and, subsequently, India has few procedural mechanisms in place to protect refugees living within its borders. UNHCR has no formal agreement with the Government of India, but instead operates under the agreement of the United Nations Development Programme.

More than 33,000 refugees and asylum-seekers are registered with UNHCR as residing in Delhi.⁹ This population has grown significantly over the past few years and is at its highest number since the exodus of refugees from Afghanistan during the 1990s. The largest groups among the persons of concern are Afghan (Hindu Sikh Afghans and "ethnic Afghans" who are Muslim) and Burmese, primarily Burmese Chin. These three groups constitute more or less stand-alone refugee communities in Delhi; while they can hardly be considered unified or as speaking with one voice, they do loosely cohere: they tend to have their own leadership structures and substructures, social factions and community representatives, and often live in clusters. There are also much smaller populations of Somalis, Iraqis, Eritreans, Ethiopians, Congolese, Sudanese, Iranians, Pakistanis, and Palestinians. There is also a newer community of Rohingya refugees from Myanmar. Approximately 700 of them, Muslim and Christian, currently live in Delhi.¹⁰

Refugees' residence permits must be renewed every two years, which can be an expensive process (costing approximately 1,395 rupees (USD 31)) fraught with delays. The Government of India has a restrictive policy on the issuance of work permits for foreigners, including refugees. As a result, it is very unlikely that refugees will receive work permits from the government, even if they possess residence permits. Refugees are, however, allowed or tolerated to work in the informal economy. Refugees in Delhi reside largely in impoverished areas of West Delhi (Burmese Chin and Hindu Sikh Afghans) and in the less well-to-do neighborhoods of more affluent South Delhi (ethnic Afghans and Somalis).

Beirut, Lebanon

Since 2011, an estimated 1.5 million families and individuals fleeing the Syrian crisis have taken refuge in Lebanon.¹¹ Refugees are concentrated in the north, around Tripoli and its outskirts; in the Bekaa Valley in the east; and in Beirut and its surrounding areas.¹²

Four years on, with little end to the violence in sight, communities and resources in Lebanon have reached a critical point. The mass influx of people, in a country whose population is just 4.3 million, has strained resources that were already spread thin across Lebanese poor, including land, schools, water resources, and health centers. Political and popular will to host refugees has also faltered under the weight of the influx,¹³ and as of May 2015, per instructions from the Government of Lebanon, UNHCR Lebanon has temporarily suspended registering new refugees.¹⁴

Acknowledging these tensions and the need to support Lebanon during this time, the Lebanon Crisis Response Plan (LCRP) lays out a framework for channeling international financing to strengthen national services and infrastructure in ways that will benefit not just displaced Syrians, but also poor Lebanese and Palestinians living in Lebanon. At the same time, enhancing national capacities is meant to address social tensions and long-term poverty, while reinforcing Lebanon's political, economic, social, and institutional stability.¹⁵ Implementing the LCRP will require an estimated USD 2.14 billion, of which only USD 210 million has been secured thus far, through multiyear donor commitments.¹⁶ Similarly, Lebanon's appeal of USD 1.85 billion for 2015 is currently funded at only 45 percent.¹⁷

Lebanon is not a signatory to the 1951 Refugee Convention, and national legal protection for refugees in the country is extremely limited. Refugees are not allowed to work, which forces them to find jobs in the informal sector, often in agriculture or construction for a few days each month, earning approximately USD 15 for a 12-hour work day. Women and children working in agriculture earn as little as USD 4 a day.¹⁸ An estimated 70 percent of all refugees in Lebanon are living below the national poverty line of USD 3.84 per day. Furthermore, nearly 40 percent of refugees are in debt to their landlords, usually more than two months behind on their rent.¹⁹ Of the 1.2 million Syrians who are registered with UNHCR, an estimated one-third lack legal documentation for residing in the country, which under national law must be renewed every six months.²⁰ This further constrains refugees' mobility and, with it, their ability to access services and provide for their well-being.



Kampala, Uganda

In Uganda, policies and procedures governing refugee protection and assistance have been ad hoc, limited, and limiting. The 2006 Ugandan Refugee Law allows refugees to settle in Kampala or other non-camp areas, but refugees who do so forego access to the bulk of humanitarian services, which are restricted to camps, known as “settlements” in Uganda. As a result, refugee protection is limited in urban areas. In Uganda, a commonly cited figure for the total number of refugees living in Kampala is 80,000, with the majority having fled conflict in the Democratic Republic of Congo (DRC). Some have been in the city for decades, while others are arriving from more recent conflicts in Rwanda, Burundi, DRC, Sudan, Somalia, Ethiopia, and Eritrea.

Within Kampala, refugees are scattered across the city’s slums, with Somalis concentrated in the central neighborhood of Kisenyi and the Congolese in Katwe, Makindye, and Masajja. Urban refugees face many of the same barriers as the Ugandan poor in accessing services, finding employment, and staying safe. However, they also face additional constraints, such as language barriers, discrimination, lack of legal documentation, and limited access to credit and formal sector employment.

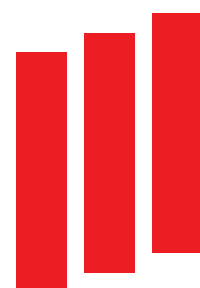
Uganda is a signatory to the 1951 Refugee Convention, the 1976 Protocol, and the 1969 Organization of African Unity Convention Governing the Specific Aspects of the Refugee Problem in Africa – agreements that detail the rights of refugees. Historically, the Ugandan Control of Alien Refugees Act required all refugees to reside in settlements. With the newer 2006 Refugee Law, refugees have freedom of movement within Uganda and may choose to settle in Kampala, or elsewhere.

Despite refugees’ legal rights, Ugandan attitudes towards refugees are generally negative. Refugees are viewed as an economic burden and looked upon with suspicion as collaborators with foreign governments that have in the past been hostile to Uganda. UNHCR and its implementing partners provide refugees with legal aid, health care support, language classes, psychosocial counseling and minimal livelihood interventions, such as micro-credit and vocational training.^{21, 22}

Notes (Appendix)

1. July 2014 numbers. UNHCR Statistical Snapshot, <http://www.unhcr.org/pages/49e492b66.html>
2. In addition to those who have fled the country, there are 5,840,590 internally displaced in Colombia. Ibid.
3. UNHCR Global Appeal 2014-15 Ecuador, <http://www.unhcr.org/pages/49e492b66.html>
4. Human Rights Watch. Amicus Brief on Refugee Rights in Ecuador. <https://www.hrw.org/news/2014/06/16/amicus-brief-refugeerights-ecuador>
5. 2015, UNHCR, 2015 Subregional operations profile–Latin America. www.unhcr.org/pages/49e492b66.html
6. Ibid.
7. UNHCR Global Appeal 2014-15 Ecuador, <http://www.unhcr.org/pages/49e492b66.html>
8. UNHCR Statistical Snapshot, numbers as of December 2014. <http://www.unhcr.org/pages/49e4876d6.html>
9. UNHCR India (personal communication).
10. Greater numbers of Rohingya are living outside of Delhi, in Hyderabad and Jammu.
11. UNHCR, Lebanon Crisis Response Plan 2015-2016.
12. <http://data.unhcr.org/syrianrefugees/country.php?id=122>
13. Ibid.
14. Ibid.
15. Ibid.
16. <http://www.arabstates.undp.org/content/rbas/en/home/library/CPR/3RPLebanon.html>
17. UNHCR. *Vulnerability Assessment of Syrian Refugees* (November 2015), <http://www.unhcr.org/564ef96f6.html>
18. Ibid.
19. Ibid.
20. UNHCR, Lebanon Crisis Response Plan 2015-2016.
21. Michela Macchiavello, *Forced migrants as an under-utilized asset: refugee skills, livelihoods and achievements in Kampala, Uganda*, UNHCR Evaluation and Policy Analysis Unit, no. 95 (October 2003).





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