ENGLISH

Choosing to Speak, Learning to Hear:

Disclosure of Gender-Based Violence in Humanitarian Crisis Settings

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Contents

Executive Summary

With nearly 90 million people on the planet forcibly displaced from their homes and homelands, and with growing acknowledgment that gender-based violence can be both a driver and consequence of this flight, the challenge of ensuring survivors' access to protection and support has never been more urgent. The humanitarian community has made tremendous strides in detecting and responding to gender-based violence in these crisis settings. And yet, too many survivors are still unable to access the care they need.

This study focuses on the concept of the "disclosure" of gender-based violence (GBV) - specifically to a service provider in a humanitarian crisis setting. "Disclosure" is related to, but distinct from, more systematic, organization-driven "identification" efforts in these contexts. Instead, it focuses on the experiences, perspectives, and needs of a *survivor* that may influence their decision or ability to come forward. It is critical to understand facilitators and inhibitors of GBV disclosure in order to create safe opportunities for survivors to express need for - and ultimately access - support and protection.

This research draws from a total of 63 in-depth interviews, including with 54 service providers working with forcibly displaced populations in Mexico, Greece, and Kenya in 2021 and an additional 9 interviews from foundational research conducted in Mexico in 2017. Findings focus on several critical barriers to GBV disclosure from across the three countries. These include individual-level barriers, such as shame; fears of retribution or social rejection; mental health impacts of GBV; lack of awareness of rights or available support; and simply having other urgent priorities in the chaos of displacement. Study participants also noted social or community-level barriers, such as stigma; social norms around gender, violence, and even family; and a general "normalization of violence" based on home country and displacement experiences. GBV disclosure can also be inhibited by systemic, structural barriers as well, including insufficient availability of GBV-relevant services; rushed or insensitive support and protection processes; and lack of basic operational requirements including adequate interpretation and space for private conversation. In addition to addressing challenges faced by women and girls generally, study participants also noted barriers associated with specific survivor profiles, including children, victims of trafficking, LGBTIQ+ individuals, and cis-gender straight males.

Study participants reported several individual and institutional strategies to overcome these diverse barriers. Key among them were the intentional creation of "safe spaces" to enable GBV disclosure, survivor-centered and trauma-informed interviewing approaches, preparatory work with interpreters, and deeper outreach to and liaising with communities of concern.

The study offers several insights. First, findings suggest that GBV disclosure can be described as "self-motivated", "enabled", "elicited", or "third-party" – triggering specific responsibilities for relevant service providers. Second, GBV disclosure occurs at different depths, for different

reasons – with eligibility for most GBV-related services requiring minimal disclosure, at most. Third, efforts to support safe disclosure of GBV requires understanding and addressing survivors' diverse motivations, opportunities, and capabilities to come forward. Fourth, providers should think of "safe space" as more than the four corners of their office, but also the way they personally embody "safety" – intentionally and explicitly demonstrating empathy, confidentiality, and respect. Finally, findings emphasize the importance of taking an all-of-team approach to GBV disclosure. It is impossible to predict whom a survivor may feel comfortable approaching on a team. Similarly, a survivor's decision to disclose (or not) is downstream of countless earlier interactions with staff that day. Everyone – from the security guard to the cook to the psychologist - must be trained on GBV and how to respond appropriately to its disclosure.

This research provides the foundation for the accompanying *GBV Disclosure Toolkit: Responding to Gender-based Violence Disclosure in Humanitarian Crisis Settings.* It is our hope that together, they help service providers across diverse contexts develop ethical, effective approaches to GBV disclosure and, ultimately, increase survivors' access to the care they seek.

Introduction

Why, when, how and to whom do some survivors decide to reveal their experiences of gender-based violence (GBV), and the impacts and needs that follow?

Are there specific barriers to GBV disclosure for those displaced by armed conflict, natural disaster, and other humanitarian emergencies?

What, if anything, can service providers do in these contexts to make it easier for those GBV survivors who do wish to disclose?

Project Background

This study is part of a broader project aimed at answering these questions through primarily qualitative research and producing evidence-based, practical guidance for service providers in humanitarian crisis settings. This work began with exploratory research in Mexico and Guatemala in 2018, resulting in a report entitled, *The Silence I Carry: Disclosing gender-based violence in forced displacement – Mexico, Guatemala.*[1] From these preliminary findings and at the request of study participants, the research team then developed a conceptual toolkit for use in the Mexican context. In 2020, with support from the United States Department of State Bureau of Population, Refugees and Migration, the research team was able to work with the Office of the UN High Commissioner for Refugees, Mexico Country Office to pilot and refine this initial toolkit in several areas of Mexico.[2] Researchers were also able to expand research on GBV disclosure to humanitarian contexts in Greece and Kenya. Finally, the team conducted an online survey of humanitarian practitioners focused on GBV in other countries and focus group discussion with women refugees and asylum-seekers in Athens, facilitated by local partner, Melissa Network.

> In the context of this research, "disclosure" specifically refers to an individual revealing their experience of GBV to a service provider in a humanitarian crisis setting. It can range from the general expression of a need for shelter from an abuser or access to a pregnancy test, to speaking in more specific detail about the acts of violence or its impacts.

"Disclosure" is related to, but distinguishable from, the more familiar matter of "identification." In the context of this study, "identification" refers to affirmative, often systematic, efforts made by state actors, UN entities, and others providing support services in humanitarian crisis settings to detect GBV survivors among populations of concern. In a way, "identification" is the *seeking* of this information whereas "disclosure" is the *offering*.

Most importantly, "disclosure" focuses on the experience, perspective, and needs of GBV survivors whose decision to speak may be influenced by myriad personal, social, and structural or contextual forces. It is critical to understand facilitators and inhibitors of disclosure in order to create safe opportunities for survivors to express need for - and ultimately access - support and protection.

Methods and limitations

This report focuses on the desk and interview research conducted in Mexico, Greece, and Kenya, primarily between May and December 2021. Interviews were conducted remotely due to the COVID-19 pandemic. A detailed study protocol was followed to ensure quality control, data security, and ethical treatment of study participants. Ethical approval was secured at Washington University in St. Louis, as well as through appropriate ethical review processes Kenya, Mexico, and Greece.

After preparatory research and consultation with UNHCR country offices in each case study country, locally-based and CHRGM-affiliated researchers conducted interviews with service providers working with forcibly displaced communities in Mexico, Greece, and Kenya – including potential and known GBV survivors. Interviews were conducted in English, Spanish, and Greek, with all transcripts ultimately translated into English as relevant. In total, researchers completed interviews with (63) service providers working across humanitarian support sectors as well as in urban, camp, and rural settings. This includes (11) interviews in Mexico (Mexico City, Monterrey, Ciudad Juárez, Saltillo, Tijuana, Matamoros, Mexicali, Piedras Negras), (26) in Greece (Athens and Lesvos), and (17) in Kenya (Nairobi and Kakuma camp), plus (9) existing interviews from foundational research in Mexico in 2017 (Mexico City, Palenque, Tenosique, Villahermosa).

A comprehensive qualitative coding framework was developed to allow for analysis of multiple disclosure-related themes raised by study participants, using a grounded theory approach. To limit researcher bias, coding was reviewed by senior members of the project team prior to moving to the thematic analysis and writing stages.

The study faced various limitations. First, due to the COVID-19 pandemic, researchers were unable to personally observe study locations and operational contexts. Second, all interviewees were representatives or members of service providing organizations, state agencies, international agencies, national organizations, or community-based organizations. Refugees, asylum-seekers, and other forcibly displaced individuals were not recruited for this research, so their valuable insights and perspectives regarding GBV disclosure were unavailable as data for the study portion of this project. Fortunately, several refugee and asylum-seeking women in Greece later advised on development of the accompanying toolkit.

Report and toolkit

This report focuses on a subset of data gathered by the project team about GBV disclosure in humanitarian crisis settings in Mexico, Greece, and Kenya. This interview data, combined with responses to an online survey of humanitarian practitioners working with GBV survivors globally, as well as inputs from a group of refugee and asylum-seeking women in Greece and other project advisors, produce the basis for an accompanying practice guide, "*GBV Disclosure Toolkit: Responding to Gender-based Violence Disclosure in Humanitarian Crisis Settings.*"[3] The report and toolkit are mutually illuminating and should be read as complementary resources.

Overview: GBV and displacement in Mexico, Greece, Kenya

This research focused on diverse settings in Greece, Kenya, and Mexico – urban areas, border towns, and camps in deserts and on islands. The sites were selected due to the diversity of displaced populations served, the political context of the host country, as well as the humanitarian response environment.

México

Mexico is a country of origin, transit, and destination for migrants, refugees, asylum-seekers, and other displaced persons. The number of displaced individuals in Mexico has continued to increase through 2021,[4] with the Mexican Commission for Refugee Assistance (*Comisión Mexicana de Ayuda a Refugiados, COMAR*) reporting a record 131,448 asylum applications in 2021.[5] Most are from countries in Central America. Since 2019, however, an increasing number are arriving from Africa, the Caribbean, and Asia,[6] specifically Cuba, Haiti, and Venezuela.[7] This has challenged Mexico's asylum and migration institutions, requiring adaptation to new linguistic and cultural groups.[8] Populations on the move in Mexico have also met higher levels of apprehension and expulsion by the administration of President López Obrador. Moreover, the administration has restricted access to humanitarian visas, deployed the National Guard for immigration enforcement along both its borders, and aimed to contain asylum-seekers in southern Mexico despite the area's dire conditions.[9]

Historically, most people on the move through Mexico were single men. Since around 2012, however, the number of women and children, both accompanied and unaccompanied, has been on the rise. The number of women apprehended at the Mexico-U.S. border more than tripled between 2018 and 2019 to nearly 300,000, and the ratio of women to men increased from 32% to 54%.[10] The U.S. Border Patrol also reported "encounters" with nearly 145,000 unaccompanied children (UACs) in 2021, up from around 40,000 "apprehensions" of UACs in 2014.[11]

Gender-based violence (GBV) is both a cause of displacement and a common experience for refugees and migrants in transit through Mexico. While few reliable statistics exist on violence experienced during transit through Mexico, some estimates suggest that rates of sexual violence hover around 24% for women, 5% for men, and 50% for gay and transgender migrants and refugees.[12] Diverse forms of GBV are reported, including rape, transactional sex, sexual assault, forced prostitution, intimate partner violence, and sex trafficking,[13] with traffickers commonly exploiting recently arrived migrants at Mexico's southern border.[14] Aware of GBV-related risks en route, many women take precautions. They may travel with a male counterpart for protection, although this comes with risk of abuse as part of the travel agreement.[15] Many women also take an injectable contraceptive prior to beginning their journey to prevent ovulation – what they call the "anti-Mexico shot."[16] For some, sexual violence in transit may be seen simply as the "price to pay" for travel through Mexico.[17] Specific groups of refugees and migrants face additional vulnerabilities in Mexico. Key informants reported that Haitian migrants are at particular experience of racial discrimination, in addition to GBV.[18] Rates of sexual assault, violence, and discrimination are particularly high for LGBTIQ+ refugees and migrants,[19] especially for trans women in Mexico.[20]

Greece

Historically a country of transit, Greece has recently become a destination country for populations on the move arriving via Turkey, at the islands of the Aegean, and at the Evros land border. In 2016, the EU-Turkey Statement[21] was signed, aiming to limit arrivals to Europe and facilitate readmissions to Turkey. Reception and Identification Centers (RICs) were set up on islands, where asylum seekers are subject to a "geographical restriction" until their case is processed. Exceptional fast-track procedures with short deadlines and limited guarantees were introduced, as well.[22] This resulted in thousands being stranded in sub-standard reception conditions and at risk of violence.[23] Authorities have been criticized for unlawfully restricting access to asylum, performing push backs, establishing "closed" facilities, and criminalizing search and rescue operations.[24] Further, COVID-19 brought further restrictions to camps and RICs. These have been consistently extended, despite the nationwide lifting of the lockdown.

Asylum-seekers in Greece have often experienced GBV in their countries of origin or en route, particularly in Turkey.[25] Also, pervasive GBV in the RICs has been well-documented.[26] Study participants stressed the continuity of violence and co-occurrence of different forms, highlighting that victimization often takes place before, during and after flight. Domestic and sexual violence were identified as the most commonly encountered forms of GBV. The former was described as more common in populations from Afghanistan, Syria and Iraq. Most cases concern female survivors suffering multiple types of abuse by husbands and partners.[27] Sexual violence was more commonly encountered by service providers in populations from African states, and occurred particularly before and during flight, but also after arrival; for instance, participants stressed the extremely high rape rates in male and female survivors from DRC and Cameroon. In women, incidents of rape reportedly co-occurred with trafficking or with selling/ exchanging sex, while men had often suffered sexual violence in the context of torture before arrival.[28] In Moria, the former RIC on the island of Lesvos, sexual violence incidents were perpetrated against people of various profiles, including UACs and LGBTIQ+ individuals. In Athens, homelessness and precarity expose survivors to further violence.[29] Trafficking was discussed as more commonly encountered in African populations, even though there is limited disclosure.[30] Transactional and survival sex was also highlighted as common among UAMs, while GBV against children also included child marriage in home countries and other harmful traditional practices, such as female genital mutilation (FGM).[31] Participants also noted that LGBTIQ+ individuals had often experienced violence including GBV before arrival in Greece, though it often continued - especially on the islands.[32]

Kenya

Kenya experiences widespread and complex migration impacted by several factors including, amongst others, violent conflict which leads to mass displacement in most of its neighbouring states. As such, Kenya hosts a large population of asylum-seekers and refugees. By the end of January 2021, the total population of refugees and asylum seekers was 508,033.[33] The majority of the refugee population originates from Somalia (53%). Other nationalities include South Sudanese (25%), Congolese (10%), and Ethiopians (5.6%). Sudan, Rwanda, Eritrea, Burundi, Uganda and other nationalities made up 6.9% of the total population (approximately 550,817 as of April 2022).[34] About half of the refugees in Kenya (43%) reside in Dadaab, 41% in Kakuma while 16% reside in urban areas, mainly Nairobi, alongside an approximate 18,500 stateless persons.[35]

Several segments of the refugee population have experienced and are exposed to GBV. These include women, young girls and boys, elderly women, and persons living with disabilities. One respondent observed that, in terms of gender, women and children mainly from the same families seem to be targeted.[36] The common forms of GBV reported among the refugee population include rape, sodomy, intimate partner violence, and forced marriages.[37] Although FGM is practiced among some refugee communities, it is hardly reported because it is culturally sanctioned. Most of the cases that are reported at one GBV clinic are domestic and intimate partner violence, rape, defilement, sodomy, physical assault as well as emotional or psychological abuse. While there are cases of early and forced marriages, no cases of FGM have been reported.[38]

Findings

Research findings highlighted several aspects about the disclosure of gender-based violence in humanitarian crisis settings and other contexts of forced displacement.

When GBV disclosure happens

Findings highlight five service provision-related scenarios in which refugees, asylum-seekers, and migrants often disclose GBV in Greece, Mexico, and Kenya.

- **Seeking healthcare / medical services,** including reproductive and sexual healthcare as well as emergency services (including post-rape care);
- **In emergency situations,** as to police officers, doctors or nurses in medical facilities;
- **Seeking psychosocial support,** primarily to psychologists, counselors, and other social service providers in governmental bodies and NGOs;
- **Engaging legal services or legal processes,** primarily to lawyers, legal assistants and/or officers of relevant state agencies, including asylum and migration authorities;
- **In community contexts or in social media,** to trusted members of the community or women's rights, children's and LGBTIQ+ advocates, who may refer them to support services.

Who receives GBV disclosure

Across service provision contexts, GBV survivors disclose to many different people, for different reasons. Findings suggest a few key characteristics or patterns.

Trust

Not surprisingly, survivors disclose GBV to people they trust. Trust depends either on how well they know the person themselves or the reputation that a person has in the survivors' communities. Through word of mouth, survivors learn about professionals who have helped other victims or who are sensitive to gender issues. Study participants noted that, to build trust, it is important to create a climate of mutual respect, clarify and ensure how confidentiality will be maintained, and consistently help survivors resolve their challenges. As one key informant from Kenya put it: *"I think that's a real key factor, is constantly being there for them, really for them not trying to kind of tell them what to do or try and figure out what the problem is. But just simply being there day in, day out and listening, I've noticed it's a key factor in them opening up."*[39]

Gender

Study participants observed that survivors often prefer to disclose to persons of the same gender. This may not always be true for certain survivors, including some male survivors. Study participants noted that more important than the actual gender of the individual

provider is that person's gender sensitivity and ability to establish trust.

Different professional roles

When with professional service providers, some survivors prefer to disclose to individuals in specific roles - mostly psychologists and social workers - who traditionally have expertise and experience in dealing with GBV cases. On occasions, however, survivors may expect to disclose to other professionals. For example, one participant in Greece felt that newly arriving Afghan women often disclose to doctors (irrespective of gender) more readily than to social workers or psychologists, because in Afghanistan, it is doctors who most frequently manage GBV cases. Notably, some survivors may feel comfortable sharing their experiences with others in a service provision context – for example, the shelter cook with whom they prepare meals, a kind and elderly security guard, or other participants in a weekly group activity. It can be difficult to predict who may make a survivor feel comfortable or safe.

Interpreters

Participants noted how interpreters can help or hinder GBV disclosure. A warm, trusted interpreter can help a service provider earn a survivor's trust; alternatively, an insensitive or judgmental interpreter may undermine a survivor's willingness to speak to an otherwise trustworthy service provider. Interpreters are key to the exchange. So, apart from technical language skills, they must also be acceptable to the survivor before GBV disclosure can feel safe.

Others outside service provision

Beyond the service provision context, survivors may of course to disclose to people they trust – often those who have their own GBV experiences or people who can support and protect them. This includes friends, family members, neighbors, religious leaders, or other community members. These individuals may provide a critical link by guiding survivors to available services. They also occasionally disclose *for* a survivor – though this is usually only appropriate with the survivor's consent.

Reasons for disclosing GBV

Often, survivors see no good reason to speak about their past GBV experiences. Stigma and other barriers are discussed below. However, study findings highlight a few key motivations that still drive many GBV survivors to disclose what happened to them.

Psychological relief

Many survivors speak about GBV experiences as part of their psychological healing process. One Mexican study participant described individuals who had undergone many severe hardships both at home and on the road: *"Trauma. They bring a backpack very heavy with emotions. When they arrive in Tijuana, they reach a point where they are finally releasing and getting all of this trauma off their chests."*[40] Another service provider in Mexico City routinely greeted clients with a signal that they can unload any anxieties they wish when stepping into her office. She would ask, *"How are you today? And how is your heart?"* Often, this helped survivors feel safe sharing GBV-related concerns – either immediately or in time.

Study participants suggest that GBV disclosure may be easier when survivors have access to specialized services for legal, social and psychological support and counselling. Survivors in state or NGO-run shelters or apartments may have greater awareness of and access to such programs than those living in overcrowded and unsafe camps. Nevertheless, even in camps, there are opportunities to disclose GBV when safe spaces and structures for protection are in place.

Community support and solidarity

Study participants noted that many survivors seek community and solidarity with others who understand their experiences – but it is not always clear where to find this. As one study participant noted, being able to share GBV experiences with other survivors can be a very powerful motivating experience: *"…They begin to have contact with … other migrant women who have been victims and who … are already in an advanced process in their case and they share their experience with them and they begin to tell them that they are much better off now."*[41] Refugee and immigrant communities as well as women's rights and LGBTIQ+ organizations play an important role in creating spaces where survivors can find and support each other or simply engage in activities together. Disclosure often happens in these spaces.

Access to safety or limited benefits

Survivors may disclose past GBV experiences because in order to access protection or limited or expedited benefits related to asylum or refugee resettlement, better housing, social support, or sexual and reproductive healthcare. For example, in Greece, identification as a GBV survivor triggers special reception processing on the islands. Moreover, demonstrating that one suffered GBV in Turkey can help show Turkey is not a safe country for return. Similarly, in Kenya, GBV survivors may be permitted to move from refugee camps into the urban areas or resettle in a third country. Or, as one study participant observed of survivors in seeking asylum at the US-Mexico border:

> *"They can't take it anymore and they are terrified. They are on the point of being able to enter US and they can't. So, they are revealing everything about their case so that we take their case seriously. And it's hard for them to understand why they can't enter if they tell everything? So, it's very common that they send us photos of their wounds, text messages, audios they've received, photos of reports, articles that came out in the press about their cases, etc.; anything to demonstrate that they're victims."*[42]

GBV disclosure barriers for survivors

Survivors face multi-faceted obstacles to disclosure of GBV, including from distinct but connected barriers at individual and social levels, as well as at the structural level. Specific survivor groups such as victims of trafficking, children, and LGBTIQ+ individuals may also face unique barriers.

• Individual-level barriers

At the level of the individual survivor, a number of factors can affect GBV disclosure. These factors may be different for different survivors, and they may vary at different points in time.

Safety risks, fear of further violence

Survivors may fear further harm from a perpetrator if they report the violence, especially when the perpetrator is a romantic partner, relative, someone living in the same community, someone with more money or power, or an armed actor. For example, a provider in Greece observed,

> *"(…) there is too much brainwashing: 'If you report it to anybody, I'm going to find out and you're going to get arrested too. You won't get asylum because you were part of what happened.' There is a long path before people get to us - that is important for us to know, too. If there is a person who has been tortured and then a victim of human trafficking, … by the time they get to Greece they have been told by everyone: 'Don't tell anyone because then this country or the military in the country of origin will know because governments work together,' that discourages disclosure as well."* [43]

In addition, survivors may fear backlash and reprisal from their own families or communities if their disclosure is seen to bring shame or disruption to the social network.

Higher priorities

Participants across the three contexts highlighted that GBV disclosure is simply not a priority for many survivors. There are often more urgent needs in displacement, like ensuring access to shelter and safety. For survivors facing insecurity and struggling to re-gain security, speaking about past violence can be further destabilizing, as one participant working with survivors in Greece shared:

> *"Talking about a refugee population, a population that has no fixed point of reference, that has all these known problems that we know … in terms of their life, their status recognition, their existence, and what happens next, where they end up; they will not open such an issue because this issue is difficult to manage. It is like having to climb a mountain and saying that then you will climb another and another. It is not convenient for them; it is not what they seek."* [44]

Other participants emphasized that some survivors prioritize their onward movement, particularly in transit contexts such as Mexico, where GBV disclosure could be seen as delaying or complicating one's journey north.

> *"The main urgency is that I want to cross – nothing else is as important… Even if there is a medical or sexual and reproductive need and high-risk pregnancies, or … maybe recent rapes, it was not something … they give importance to. Because the priority is to cross, it is to be able to obtain asylum."*[45]

Study participants also noted that female survivors often tend to prioritize their children's needs over their own. Depending on circumstances, this may motivate or impede GBV disclosure.

Shame, guilt, self-blame

Survivors' feelings of shame, guilt, and self-blame were often noted as challenges to GBV disclosure. Some study participants felt this barrier was more pronounced in certain communities than others. For example, a provider in Greece felt that Arabic-speaking female survivors were less likely to disclose GBV than others due to feelings of shame. A study participant in Mexico noted that trans women survivors of GBV may experience feelings of self-blame due to wider cultural and gender norms:

> *"Culturally, it's hard for trans women to accept because they as biologically men they think they have some strength that should have given them ability to resist GBV. This is especially the case for survivors from Salvador, who report a lot of gang violence [maras]. And the discourse from gangs is that you have to make yourself a man, so they [survivors] have this feeling of guilt of not having responded biologically as men when experiencing this violence."*[46]

Lack of trust

A major disclosure barrier noted across contexts was survivors' lack of trust in service providers or authorities. On one level, a basic level of trust is essential in order to speak about GBV-related experiences or needs to another person. As noted earlier, it may take a considerable amount of time to establish this– perhaps more time than an individual service provider will have with someone. In Kenya, study participants felt that some survivors fear that staff would doubt or judge them if they disclose GBV, or violate their rights to privacy or confidentiality. On another level, many GBV survivors lack trust in systems or institutions themselves – possibly due to past experiences or lack of protection from authorities in their home countries. For instance, urban refugees in Nairobi were reportedly unwilling to disclose GBV to authorities because of fear of police hostility. In Greece, survivors reportedly feared police and asylum procedures. On the Mexican borders, GBV disclosure was linked to survivors' generalized insecurity and fear of state authorities, but also gangs, cartels, and traffickers.

Mental health, trauma and fear of re-traumatization

Service providers in the three countries noted the mental health impacts of past traumatic events, including GBV, as affecting survivors' willingness and ability to speak about these

experiences. For example, a participant in Mexico noted that depression can make it difficult for survivors to feel motivated to seek help at all, much less speak about GBV. Another stated that some survivors, particularly adolescents, try to avoid pain and discomfort that comes with recollecting such experiences. Trauma-related impacts on memory itself can also make it disclosure difficult.

Language barriers

Across contexts, study participants noted that GBV disclosure suffers where a survivor and service provider do not speak the same language(s). For example, language barriers have been a major challenge among Afghans and French-speaking Africans in Greece, as well as among Mam Mayans and Haitians crossing through Mexico. Interpretation is not always available. Even where it is, it may be inadequate or survivors may be inhibited by the presence of a third party – particularly if the interpreter does not seem to be a safe intermediary. One study participant working in Kakuma camp in Kenya explained,

> *"… You see if I am from this community and the person who's supposed to interpret for me is from another community or from the same community, I would not want them to hear my complaints or my cries. So I'll tend not to speak out because I don't want a third party knowing what I went through."*[47]

Provider (and interpreter) gender

The gender of the service provider (and interpreter) may inhibit GBV disclosure for some survivors. Study participants felt that women may be reluctant to share their GBV experiences with male practitioners, preferring to open up to another woman instead. This preference was less clear-cut for male survivors, suggesting the need for further study. Ultimately, though, sensitivity about GBV and the ability to earn trust may be more important to a survivor than a service provider's gender.

Cultural or religious norms

Cultural or religious norms around sex, gender, violence, and even family privacy may influence whether, how, and to what extent a survivor discloses GBV. For example, in Greece, Afghan female survivors were mentioned as less likely to disclose because of norms around speaking about gender or family matters. Similarly, another study participant noted how conservative religious norms may limit the language and extent of disclosure:

> *"Or girls who might be more religious will say it in a way that you might not understand that was violence... I remember a Somali girl, raised in Djibouti, who was travelling alone and in Turkey she was subjected to violence and a kind of forced marriage with a trafficker so that she could continue her journey. She kept saying, 'He made me his wife but I didn't want to.' And she didn't want to say anything else. After posing questions, I remember that again she couldn't say the words, 'He raped me.' And she was a very educated girl. She disclosed immediately but the words she chose were very carefully worded."* [48]

Feared impact on access to shelter, benefits, or legal status

Across the three case studies, participants highlighted how survivors may hesitate to disclose GBV out of fear that doing so will affect their access to basic necessities or humanitarian assistance. In Mexico, for example, many survivors of domestic violence are financially dependent on abusive partners, who, as heads of household, may be the family members eligible for cash-based support. In Kenya, survivors may fear that disclosing GBV could cost them their shelter or access to basic necessities; this was also true for separated minors suffering GBV at the hands of relatives hosting them. In Kakuma camp, one participant said,

> *"(…) Some are scared that if I report then … will I lose my house? Will I go to the streets? And yeah, so they're scared. And also there's a [humanitarian] system, you have an allocation for the house, in that household, there's the allocation for your food, your allocation for basics like soap and so on and so forth. So there's that fear that when I report then I lose the comfort of my home, I lose my access to food, … to basic needs."*[49]

Survivors may also fear impacts on their chances for international protection or legal status. Study participants in Greece observed that survivors often do not disclose GBV while their asylum procedure is ongoing, out of fear of creating complication and delays. In Mexico, survivors recognized as refugees through a family application for protection may decline to disclose intimate partner violence out of fear of losing their refugee status, where an abusive partner was the primary applicant for the family unit.

(Perceived) lack of support or undesired consequences

Across contexts, GBV disclosure can be obstructed where survivors do not believe support services exist or are effective. This includes lack of confidence that the police can protect, as well as the fear that organizations will not be useful. Word of mouth can be powerful in this regard. As one study participant put it: *"You hear in the community, 'The woman left and then came back, why should I talk about it? There was nothing. She was taken there, she was on her own, she had no support.'"*[50] Survivors may develop their own protection measures in fear that disclosing GBV to an official entity will trigger a series of unwanted or destabilizing interventions, such as shelter placements, over which they will have limited control. For example, in Mexico, survivors were described as reluctant to seek HIV testing in public health centers because they assumed that they would be asked about GBV, which could set undesired reporting processes into motion.

Lack of information or awareness

Survivors' lack of knowledge about their rights and on how to address GBV, as well as lack of information about available services can impede GBV disclosure. In Greece, lack of awareness or negative perceptions of professionals, such as psychologists and social workers, surfaced as further barriers.

- Social / community barriers

In addition to individual-level barriers, survivors' disclosure of GBV is heavily influenced by societal or community-level forces such as stigma, gender norms, normalization of violence, and community reconciliation and mediation practices.

Stigma, social judgment

Fears of being stigmatized, doubted, judged or blamed by family or community were identified as major social factors inhibiting disclosure. In Lesvos as well as in Kakuma and Nairobi, some participants noted that people are afraid to even be seen approaching medical services that might associate them with GBV. One study participant in Kenya explained,

> *"You find that the women ostracize the survivors also. So they will not invite you to social events, they will not sit with you at functions. So most of the women, you talk to them, they say, 'I was raped, but I didn't report anywhere. I couldn't tell the community, the chairman of our camp or the chairman of Rongai Banyamulenge group or the Oromo community, I wouldn't say it because once people find out then the women are not going to be with me anywhere or I'll be seated somewhere and people will be talking and laughing at me.'"*[51]

In Greece and Kenya alike, fears of stigmatization could be exacerbated by reliance on interpreters, who often come from refugee communities themselves.

> *"There, too many times, women who were my cases, they would say, 'I dare not say it, because he (the interpreter) was my husband's friend' or 'my rapist's friend' or 'he was there when I was raped.' That's what I saw too in a great extent: cultural mediation performed by people within the camp who are experiencing the same situations, who know the whole community."*[52]

Male survivors, LGBTIQ+ persons and women from the Middle East were perceived as extremely concerned with post-disclosure stigma in Greece, while in Kenya some participants felt that male and LGBTIQ+ survivors were the most often dissuaded from disclosing GBV due to survivor blaming and severe community reprisal or exclusion.

Gender and cultural norms

Study participants across the three countries identified variations in disclosure patterns tied to gender and cultural norms, including taboos, homophobia / transphobia and tolerance of intimate partner violence (IPV). For instance, service providers in Kenya explained how GBV disclosure can be inhibited by a "culture of not sharing" within the communities or the perception that sexuality is private and should not be openly discussed. In Mexico, cultural and gender norms impeding disclosure were particularly relevant for Mayan populations, who were reportedly less likely to identify themselves as GBV survivors, and for Haitian women, who were seen as less likely to approach service providers on their own. Similarly in Greece, female survivors from Syria, Afghanistan or Somalia were described as less willing to disclose, particularly in cases of intimate partner violence, where resulting shelter placements

might shame survivors' families and result in social exclusion. Further, gender norms can inhibit GBV disclosure for male survivors:

> *"And again in the side of men, the community or the society believe men are the head of the family, now that somebody has perhaps raped you, they fear to come out because we believe that men are the heads of the family, they should provide the security. Now that they are weak, who will go to them?"*[53]

"Normalization of violence"

Across study contexts, the collective acceptance or normalization of GBV was highlighted as a common reason female survivors do not disclose GBV. Study participants frequently noted that survivors who experienced or observed high levels of gendered violence in their home countries often considered GBV "normal" or "not worth mentioning". In Greece, this could include intimate partner violence, as well as marital rape, forced marriage and female genital mutilation – which are often perceived as normal family matters. A study participant described something similar in Mexico:

> *"I believe that the other great challenge we face is that people, in this case women, especially Central Americans and Mexicans from the South, come from a life of daily violence, which is something they know and they know that they will have to live with it throughout their lives . … They see it as something so typical like my other friends, my other companions, my family experience it, they normalize it and they feel that for the simple fact she is not being severely beaten or left in a hospital, she is not being abused."*[54]

For some survivors in Mexico, there was an "assumption of risk": GBV was even understood as a price one must pay for migrating north.

Community / family conflict resolution mechanisms

Interestingly, community conflict-resolution practices can impede survivors' willingness to share their GBV-related experiences or needs. For example, in Kakuma camp, survivor families often opt to solve complaints of domestic or sexual violence internally or with local leaders, often resulting in agreements, out-of-court settlements or forced marriages as reparations. A study participant explained:

> *"I would give, maybe, an example of a school-going girl who has been violated. They tend to talk to their parents and due to the culture, the parent will not even speak it out anywhere else and if at all they are pushed to do it, they will talk to the elders in that community because they're trying to protect their culture and they don't want this woman to go out of their cultural beliefs and their cultural norms. They will tend to sort it out in those local barazas to the point that they would say since you violated this lady, you will have to marry her, again, they will end up being married, being a minor married to a very old man (mzee)."*[55]

• Structural / systemic barriers

Layered onto individual barriers, study participants noted numerous structural and systemic challenges impeding the disclosure of GBV in these settings.

Insufficient GBV-related services

Systemic gaps in GBV response were identified as significant barriers affecting disclosure in all three settings. In Greece, lack of long-term interventions and the inflexibility of the institutional response reinforce fears of post-disclosure uncertainty and ultimately hinder disclosure, especially for intimate partner violence survivors and unaccompanied minors. For instance, inadequate systemic responses and delays were highlighted as challenges by a participant working with youth in Athens:

> *"But when I don't have anything more to offer you because the competent authority or the prosecutor's office or I don't know who, will take a week for them to react, what can I do? Take you to my home? I mean, we kind of have to take a look at the broader context in all this, as well. Are the facilities okay, so to speak? Is the referral pathway okay? Is it in place? Do we know what we're going to do?"*[56]

Further, lack of safe shelters was highlighted as a major disincentive to disclosure of GBV. There may simply be nowhere else to live. A study participant explained the situation in the Greek islands:

> *"A woman who is being abused, either by her husband or someone else, knows that at this point there is no way to move to safer living conditions. It is a gap. Now the new camp has been operating for a year and that gap has not been filled. In my opinion this is the biggest disincentive when it comes to disclosing such incidents."*[57]

In Kenya, participants argued that disclosure is hindered by the complicated GBV response system, poor handling of cases, including long waiting times and lack of feedback or holistic approaches for referred cases, all exacerbating lack of trust to institutions. Similarly in Greece, lack of or insufficient referral mechanisms and protocols additional barriers, particularly with regard to the public sector.

Notably, participants in Greece and Mexico highlighted that most GBV-related services are geared toward women, often leaving other survivors without services or opportunities to disclose:

> *"I think of the way that sexual violence is described in the law in Mexico. The law itself erases sexual violence against men and boys. Everything is "Centro de Justicia para Mujeres", "INMUJERES", "CONAVIM" – it has "women" [mujeres] all over it. So male LGBTI folks, non-binary folks, and straight*

> *cisgender men – they may be reluctant to disclose for gender / cultural reasons, but then if they do want to disclose, who do they disclose to? Even the NGOs – they are for women. There is in general massive invisibilization of violence that happens to men, boys, non-binary folks. I dread to think – I know it's difficult for Mexican trans men to get a gynecological appt, and I can't imagine what that's like for an immigrant / refugee. Those are invisible survivors."*[58]

Insufficient sensitization or cultural competency

In Greece and Mexico, lack of GBV-related sensitization and competency especially within the public sector were singled out as contributing to non-disclosure or re-traumatization of survivors. For example, in Greece, a participant stressed the importance of staff sensitization to different forms and levels of GBV:

> *"[M]aybe it's said in other ways and the person across them can't understand … that this is violence. So we're talking about training the people who are dealing with these issues. Violence is also on many levels, it's not just coming in beaten up."*[59]

Study participants also noted lack of cultural competency and discrimination on the part of service provider staff and authorities as a barrier to disclosure across the three countries. For instance, in Mexico, widespread discrimination against Haitians by local communities as well as hospital staff and other service providers was seen as hindering access to services and exacerbating lack of trust. Further, participants expressed concern that some religious shelters may be blind to, or even block, disclosure due to their non-acceptance of LGBTIQ+ individuals or those seeking contraception or abortion. In Greece, several participants mentioned lack of sensitivity or belief in GBV survivors' disclosure, particularly in public actors. Both in Greece and Kenya, participants noted survivor-blaming, discrimination, cultural biases, and general insensitivity towards potential re-traumatization within police, who reportedly actively discourage survivors from reporting.

> *"That is the fact that they know that even when they report, I think nothing much is going to happen, you know, for example, if they report to the police you know, that they are faced some form of violence, they are even likely going to receive them even more violent from law enforcement. So that's another thing that prevents, you know, victims coming out and saying this is what has happened to me. (…) I think even for women generally, you know, the general public or even the law enforcement system and even the criminal justice system does not take issue of GBV seriously. I mean, you see, you go to the police station, for example, to your point and say you have been sexually assaulted. The police tell you, you know, that you have to go and solve that issue with that person. You know, that's a personal issue, but it's not an issue that you can bring to the police station. So I think it's those two issues."*[60]

Time

The extremely limited time survivors are given to tell their histories during vulnerability and refugee status determination procedures can also inhibit disclosure.

> *"When someone is interviewed when they arrive on the islands, having just been rescued from a shipwreck or from a difficult situation, and they have just arrived in a country, they usually don't have the possibility to process exactly what has happened, what is substantial and what is insignificant. So I think that the interviews that take place on the islands and the border are very problematic because there people usually do not have the time to process and understand where they are and what has happened to them exactly (…)"*[61]

Time emerged as a critical factor in cases of trafficking. Confinement and prolonged violence associated with trafficking can also block survivors' disclosure, which requires significant recovery and trust to overcome. Disclosure cannot and should not be expected to happen immediately. It might never happen for some. As one participant in Mexico noted:

> *"Time is the factor for women who are victims of trafficking that is not exactly the same as with other women, that is more of a barrier for disclosure. They bring so many things, so much harm, physical as well as emotional, and trying to break this harm so she can talk about it, requires much more time. In addition to trust and everything else we've discussed, but especially time. And also to disconnect them from the situation / trafficking network they're in. Sometimes they are victims for many years, can be complicated to break the connection to this harm. So I think it is time, more than anything else."*[62]

Lack of privacy

In multiple countries, participants noted that lack of privacy during service provision or likely blocked disclosure for many, due to the stigmatizing nature of GBV. Similarly, lack of privacy during RSD procedures in Greek islands surfaced as a structural barrier. Further, in Mexico, certain service providers' requirements such as registration prior to service provision may reinforce fears about privacy and confidentiality in the absence of clear assurances about confidentiality and data security.

Legal procedures, law and immigration enforcement

In all three countries, participants mentioned how lack of investigation, cultures of impunity, and inaccessible or hostile legal procedures impede disclosure of GBV. They also raised concerns about whether certain legal procedures and law enforcement practices may actually cause psychological harm due to lack of a survivor-centered approach. In Greece, for example, asylum legislation and processes can hinder disclosure to asylum service and legal aid providers due to abrupt fast-track and admissibility screening procedures. Procedures also posed disclosure barriers, such as remote interviewing, survivors' children being present during the interview, and difficulty separating a domestic violence survivor's file from that of

an abusive spouse.

Similarly, participants in Kenya described how survivors are exposed to and potentially re-traumatized by long legal procedures which often still do not bring them a sense of justice or safety. More specifically, police inaction and corruption were highlighted as discouraging survivors who believe that even if they file a complaint, officers will request bribes to take their cases forward, or that without a bribe, the perpetrator will be set free. There may be other challenging consequences to reporting to the police, as well:

> *"So when we talked to the policemen, the police said that once they arrest these individuals back in Dadaab, the onus of feeding the perpetrator is on the complainant. So if the complainant does not bring in food once or twice, they will be forced to release the perpetrator. And the other issue was that the court system there was mobile. It could come in every two months. They come in for one or two weeks to sit. So arresting a person for a whole month, waiting for the courts to come and sit, depending on the complainant to feed that person was not sustainable. So you find that the perpetrators would easily be released and they would continue doing whatever they were doing."*[63]

Risk of further harm by law enforcement was also raised by some participants in Kenya and Mexico:

> *"[The] National Institute for Migration, government, police, is a threat to them. Instead of protecting migrants, it's the opposite. So there is a very specific violence, and many times clients don't want to talk about their cases when they get to us. (…) We have seen women who were subjected to sexual slavery. In the last month, I've seen some who were enslaved by federal police and narcos. They have them kidnapped and locked in their houses for their own 'use'.*[64]

Finally, negative disclosure experiences with law enforcement may inhibit a GBV survivor from further disclosure to other actors. A study participant in Mexico noted,

> *"… Most natural points of disclosure are unworkable. If they can access the health system, it's hostile. If they disclose to authorities, they are going to go through hostile process which will inhibit further disclosures or not go anywhere. They may be so revictimized that they will stop seeking assistance."*[65]

Lack of / insufficient interpretation support

Lack of interpreters surfaced as a major structural barrier across the three contexts. In Greece, where people from over a dozen countries have been arriving for years, this is a longstanding challenge. Study participants noted it as particularly relevant in police and public services, where interpretation support was rarely available. Survivors there could often not access services unless they had accompaniment or intervention from NGOs. In Mexico,

where a historically Spanish-speaking mixed movement has now seen the arrival of thousands of Haitians as well, participants discussed how general lack of Kreyol interpretation at state institutions meant that recently-arrived Haitian refugees had no meaningful opportunity to speak about their experiences to the public prosecutor's office or healthcare providers. This was particularly true in the south of Mexico, where even civil society organizations struggle with a lack of Kreyol interpreters when attempting to communicate rights and obligations to Haitians.

Logistical and administrative issues

In addition to previously mentioned concerns about access to services, more specific structural barriers were also identified as limiting disclosure. For instance, in Kenya, persons without IDs are not able to access some public services or face discrimination and in some cases survivors need to pay fees in order to receive medical attention. In Kakuma camp, distance to service providers and inaccessibility during the rainy season an important structural challenge; similarly, distance to police station was mentioned as a barrier in Lesvos.

- ## COVID-19 related barriers

The COVID-19 pandemic reportedly exacerbated both individual and structural barriers to disclosure. Overall, study participants felt access to support services declined. Some noted that the switch to remote service provision seemed to impact opportunities for disclosure for those living in precarity or survivors of domestic violence, perhaps due to lack of access to technology or a diminished sense of privacy over virtual communications. In Kenya, lack of income during the pandemic meant that some survivors could not call service providers due to lack of cellular "airtime"; others could not access emergency shelters due to Covid-19 restrictions on mobility or social distancing measures. In Mexico, remote service provision seemed to inhibit disclosure, while COVID-19 exacerbated discrimination and lack of access in public health system for Haitians, who struggled to be seen. Similarly, in Greece, COVID-19 served as an excuse to de-prioritize refugees' access to public services and limit their access to the asylum service. Survivors in camps were placed under prolonged lockdown, which further obstructed disclosure opportunities. This affected people in Lesvos in particular.

- ## Survivor groups with specific barriers

Study participants noted the diversity of survivors and considered how certain groups or profiles of survivor may face specific barriers to GBV disclosure. This section shares findings related to profiles such as children, survivors of intimate partner violence, victims of trafficking, and LGBTIQ+ individuals.

Children, including unaccompanied and separated minors

Study participants across the three contexts discussed how disclosure can be challenging for children with diverse profiles. For instance, young children or children with developmental disabilities may have extreme difficulty expressing their GBV-related experiences or fears. Further, unaccompanied minors might not approach service providers due to lack of trust, avoidance of answering difficult questions about personal challenges, or fear of certain consequences of indicating protection needs, such as placement in "protective" programs that would hinder their mobility or access to others. In Greece, some unaccompanied

children find themselves in extremely vulnerable situations, such as living in small apartments with dozens of adult men from their home countries, unable to cover basic needs and often without access to asylum. In Kenya, as well, a participant noted that unaccompanied or separated minors' disclosure of GBV could be inhibited by reliance on their perpetrators:

> *"(…) It is an uncle who is defiling a girl or maybe an aunt defiling a boy, and this uncle or this aunt is the one who is the head of this family because at times you find that we have the refugee children being hosted by an aunt or an uncle. So you find that this girl or the boy might not be in a position to disclose because they are fearing if they disclose it, they are going to be chased away from that home and they don't have any other place to go and live."*[66]

Some children remain completely invisible, suffering labor exploitation in the agricultural sector. Others are hidden due to substance use. Since GBV remains a taboo in many children's home communities, abused children often do not confide even in friends, much less service providers –unless the violence the suffer reaches a peak.

Survivors of intimate partner violence

Some participants in Greece and Mexico felt survivors of intimate partner violence face multiple barriers due to perpetrators' control over them, including coercion, intimidation, control of finances, mobility and communication, and fears about post-disclosure impact on their livelihood or, potentially, asylum case. Participants in Greece observed that women who are single or alone often tend to disclose more easily, while married women, particularly those coming from the Middle East or other socially conservative regions, are less likely to speak of their GBV experiences due fear of reactions from husbands or communities. Similarly, in Mexico, women accompanied or "spoken for" by husbands or other relatives can be less visible to service providers. This means fewer chances to speak independently about past harm. In situations of intimate partner violence where the abusive partner controls interactions with service providers and others, it can be nearly impossible for an abused partner to communicate about the situation of violence.

Urban refugees and those living outside camps

Urban refugees and others residing outside a camp context may be less visible to service providers and thus have fewer opportunities to explain their GBV-related needs. They were perceived as more isolated and with less access to services. Even in cities where GBV-related services exist, it can be difficult to understand where to go for help or how to navigate an unfamiliar urban environment. Where individuals in large urban areas are in irregular or undocumented status, they may be at greater risk of violence and exploitation. This, too, can greatly impede their ability to speak about GBV in safety. For instance, in Greece, many urban refugees are unregistered, have had their asylum cases rejected, or are present in violation of the geographical restrictions requiring them to remain on the islands. Participants noted that this vulnerable legal status inhibits willingness to come forward to seek help or protection. Similarly, in Nairobi, refugees who have left the camps without authorization fear that reporting violence will lead to trouble with state authorities, especially if they are involved in sex work:

> *"… Refugees themselves are afraid of reporting because they know what they're doing is illegal. But even more fundamentally is because they are in Kenya. Let me say, because Kenya has an encampment policy where refugees are supposed to stay in camp. Especially law enforcement, they're usually very hostile to … to urban refugees, you know, they think that all refugees should be in the camp. Because those refugees are afraid of being taken back to the camp, so they just decide to stay underground and just endure the kind of violence that they face, both sexual and physical violence."*[67]

Victims of trafficking

Victims of trafficking were seen as extremely unlikely to disclose GBV or other harms. The danger is simply too great. In cases of ongoing exploitation, most cannot even move freely so chances of encountering a person or organization offering assistance is extremely low. A participant in Greece noted that, even when they may have access to services, many trafficking victims may have been misled by traffickers' false promises of future legal documents elsewhere in Europe, so they are reluctant to derail those plans. In Mexico, trafficking victims were described as having strong feelings of shame when invited to speak about their experiences, even when doing so would help them secure protective immigration status.

Further, a service provider in Greece reflected on how connected trafficking rings are to communities, as well as the extent to which traffickers' proximity can limit their victims' opportunities to seek help. For instance, she explained that traffickers at times accompany their victims when they apply for asylum, as it is in traffickers' interest that they have legal documents which can facilitate onward movement. Another concern raised in Greece related to the fact that even if victims reveal what has happened to them, their applications for protection may be rejected for lack of specificity as to circumstances and traffickers' names. They may not be legally recognized as victims of trafficking and, without legal status, they may again become vulnerable.

Even if they are able to break free from exploitation, victims of trafficking frequently lack options for security, medical care, mental health support, social re-integration, and livelihood support. This can make it harder for them to re-build stable lives for themselves after leaving a trafficking situation. In addition to facing significant stigma associated with trafficking, this protracted precarity can keep GBV disclosure from being a priority for survivors – and make them vulnerable to re-trafficking.

LGBTIQ+ survivors

Study participants spoke frequently of the violence and discrimination experienced by LGBTIQ+ individuals in their host countries. For instance, participants noted violence against these individuals in Greek camps, while in Kenya, they can be abused by members of both home and host communities, who see them as "demonic". Participants had varying views on how easily LGBTIQ+ persons disclose GBV experiences. For instance, some service providers in Greece felt that social barriers such as fear, religious mores, and stigmatization are intense for this group of survivors and so impede GBV disclosure, while others felt that LGBTIQ+ people did not encounter significant additional barriers in disclosure, as compared to other survivors. Others noted that they seem less likely to disclose GBV while in camps and

surrounded by members of their home community – disclosing GBV to external providers may feel safer.

LGBTIQ+ survivors were perceived as having particular challenges disclosing GBV when working through an interpreter. For example, a study participant in Greece explained how they may try to avoid working through an interpreter:

> *"To which interpreter [am I] going to say it? And if the interpreter understands and reveals it? … Usually, the incidents that have been disclosed to me and we have discussed about homosexuality are those who at least could somehow speak English. So, they would say to me, 'Can we talk the two of us, please?'"*[68]

In Kenya, even though some noted that LGBTIQ+ persons may disclose GBV experiences, they are often reluctant to seek justice for the violence they suffered. Trans survivors are particularly unlikely to come forward, facing additional layers of discrimination and stigma-related barriers. In Kenya, non-acceptance was observed to be particularly acute in the public sector - including in law enforcement and at public health facilities. For example, in Mexico, a participant noted:

> *"We have nil disclosure of LGBTI identity among Haitian population. Not because there aren't LGBTI Haitians, but because of completely embedded cultural homophobia, transphobia. I have refined training so that colleagues don't directly ask someone's gender identity. But when COMAR sometimes asked that question before, we saw instances of Haitians being offended that they could be LGBTI. This is invisible to us right now. It is a type of violence we assume is there but we aren't seeing it. There is no option for disclosure … for LGBTI Haitians."*[69]

Cis straight male survivors

Across three countries, participants noted that Cis straight male survivors do not readily disclose experiences of GBV. For instance, in Kenya, male survivors may fear they will be labeled as "weak" if they disclose, due to prevailing norms around masculinity. However, male survivors may also be invisible due to lack of available services for them, which limits their opportunities to speak with someone. Further, in Greece and Mexico, single men in mixed movement are overlooked by GBV-related programs and, worse, may sometimes be feared to be dangerous.

Other "invisible" survivors

Participants raised several additional survivor profiles that seemed to have particular challenges in seeking help and finding opportunities to speak to service providers about GBV. For example, some participants mentioned that persons with mental health issues or disabilities have specific vulnerabilities to GBV and at the same time can be more invisible and less able to access services. In addition, survivors without a support system, those

unfamiliar with technology, those of low literacy levels can all have heightened difficulty in access services and seeking help.

Service provider strategies

Over the course of interviews, study participants all reflected on strategies they had engaged to help mitigate the GBV disclosure challenges they encountered.

Safe spaces

Perhaps the most fundamental condition to enable safe, survivor-centered disclosure is the creation of a safe space. Rooms that are calm, quiet, and undisturbed by external stimuli give a sense of protection. Intimate and familiar objects, smells and sounds that create a feeling of "home" can bring comfort to survivors who have been on the move for long periods of time. One organization run by migrant women in Athens provides an excellent example – it is located in a sunny apartment with mostly open layout and free access to coffee, tea, biscuits for visitors; there is community members' art on the wall and easy access to childcare while visiting women participate in classes, workshops, or individual support sessions. Staff find that this environment provides comfort and a sense of normalcy to the women who come seeking support.

Not all offices can be made to look and feel like a home, of course. And yet, even in the most limited or difficult circumstances, a space for private conversation is essential.

Study participants added that, even in a typical office space, measures can be taken to reduce apprehension or feelings of anxiety. For example, actions or features that may provoke feelings of imprisonment, constraint, or interrogation should be minimized (e.g., abruptly closed doors or either dim or overly harsh lighting). One participant reminded to pay attention to body language and body position, suggesting that, *"no one is sitting in positions of authority behind a desk; chairs are placed in the space in a circle; and the person - the victim – feels calm and under control coming in and going out of the room freely.*[70]

Study participants' responses suggested that the concept of a safe, enabling space can mean many things. It is not simply about a physical room. It may also mean being able to speak privately, away from children, strangers, or an abusive partner. Or it may mean making space and time for informal solidarity- and community-building activities, where the focus is on support and trust-building that may in time help survivors feel safe speaking about their experiences. For example, some service providers in Greece met survivors in women's health and psychology classes, jewelry or beauty care workshops. After working with them in such informal contexts, they were able to build relationships that made disclosure possible. Female, LGBTIQ+, or child friendly spaces and discussion groups in camps or refugees' communities may also help build a sense of comfort that can support later GBV disclosure.

Giving survivors time

Most study participants agreed that, ideally, service providers would allow for GBV disclosure to happen in time, without expecting it to happen in a first or second meeting. This requires first having time to clearly explain to survivors their rights and build a relationship of trust and inclusiveness is an important strategy to elicit disclosure. A survivor's decision to disclose often grows slowly and in response to many factors, including the degree of trust they develop with specific individuals in an organization. To allow for this time, single

appointments should not be rushed and follow-up visits are important to offer where possible. Ideally, there are a number of ways to engage a survivor apart from individual appointments – as noted above, their participation in regular group activities in a safe space can lay the groundwork for GBV disclosure later, if they choose.

Creating opportunities for interaction with other survivors

On a related note, some study participants noted that it can be helpful for survivors to have safe encounters with others who have similar experiences and have been able to move on with their lives. When survivors meet victims of violence – particularly those who are also refugees, asylum-seekers, or otherwise displaced, it is an opportunity to see that they are not alone. Seeing that others like them have overcome their painful experiences and gone on to an independent life, can strengthen survivors' recovery and provide hope. Such encounters are not only a source of psychosocial support, but also give survivors the opportunity to learn more about their rights and options should they choose to disclose their GBV experiences. This can inform their decision about whether to do so.

Avoiding victim-blaming and judgment

To enable disclosure, many study participants felt that service providers must be well-trained to avoid victim-blaming, which can exacerbate survivors' feelings of guilt and shame. Creating a sense of trust and safety involves "listening" without judging. Moreover, to foster trust, service providers must be aware of their own biases and ensure they do not interfere with their ability to listen openly to the individuals they seek to serve, even when their world views may differ dramatically. For example, in Greece, a psychologist stressed that when some trafficking survivors talk about being forced by Voodoo or sorcery to obey their traffickers, she always shows understanding even though this is not part of her own belief system.

> *"Women actually disclose to people when they will somehow feel that they do not doubt them. To me that's very important and it is our team's culture. We accept what she says as if it's real, without judging her. We just hear it; we affirm that this is violence. To me it's very important to say it so they can hear it."*[71]

Non-verbal or side communication

Moreover, some service providers have found that non-verbal tools, including drama and art therapy techniques, can help survivors open up – even through their children.

> *"You can inspire trust without saying much, build a framework of safety without talking. Now I have a family, we have not decided with the victim how to proceed, she is not ready to make the decision to separate the case and file for divorce. I remember, her toddler was there at the first session. We were talking generally about Afghanistan, in general conversation about what was going on there, etc. I had given the little girl paper to draw on, and*

> *she drew the mom, the interpreter, herself and the brother, and me, very tall, standing next to them. The father was nowhere to be found. I asked her to tell me who they all were and thanked her for including me and the interpreter. At that moment I catch the mother smiling and I said "oh, so there can only be a family with women huh?" and the mother smiled again, and I said to the little girl I'm so glad I'm in. I kept the drawing and we had it there for the next few meetings. I don't know if it worked, but while before that we had a more process-oriented relationship, afterwards it was different."*[72]

In addition to use of actual non-verbal tools, study participants noted some training and differences in approach among practitioners from different disciplines. For example, they noted that psychologists and social workers often learn to "listen" to physical, silent signs of violence and abuse, especially when survivors are accompanied by adult male relatives or partners. They further noted that non-verbal techniques do not seem to be widely used by legal professionals, who often lack the training to express empathy or engage in survivor-centered interviewing.

Focusing on the strength and resilience of survivors

Some service providers adopt practices that focus not only on offering basic protection and support, but also on encouraging survivors to have hope and recover a sense of agency.

> *"We try to focus on their strengths, resilience, their own desires - what do you want, where do you want to go, how do you see yourself in three years? Some things we would do with our own daughters. By bringing in this element of 'desire' into the overall discourse, it opens up a bigger door. It's like when you ask this one thing, a little window of light comes in and we can see some more things that we can then start building from, working with. Some people think of it as a pandora's box with only ugly things coming out, but it can also be the opposite."*[73]

This study participant suggested a developing a process in which one helps a GBV survivor to gradually take the lead in different aspects of their lives, ranging from decisions about whether they should have tea or coffee to decisions about when and to whom they share their fears and hopes. These are choices that are not often afforded in other institutional contexts.

Explaining and ensuring confidentiality

Study participants recognized that many survivors hesitate to share their GBV experiences out of fear that perpetrators will learn of their disclosure - especially when survivors live in small, isolated communities or in camps in which news travel fast. For this reason, several interviewees in all three case studies stressed the importance of explaining what privacy and confidentiality can be assured to survivors, then enforcing these promises through clear and consistent procedures. This is critical when members of the survivor's community are employed as interpreters or cultural mediators.

Working through interpreters

In cases where a potential survivor and a service provider do not speak the same language, study participants emphasized how crucial high quality, survivor-centered interpretation support is if survivors are to have a chance to share their GBV-related experiences. For example, in Kenya, providing translation in other languages than English or Swahili which are the official languages, has proven to be a key factor in enabling disclosure for survivors from the Turkana and Congolese communities. However, interpretation is complicated and demands careful preparation of the intended interpreter (e.g., sensitivity to GBV issues, familiarity with colloquial terms relating to sex, body parts, slurs; understanding of and adherence to expectations around confidentiality), as well as ensuring that they are not of a gender, or political, ethnic, religious, or other background that might cause the potential survivor discomfort or apprehension. It should also be noted that, interpreters may be affected by the heavy stories they are asked to relay.

Community liaisons

Community-based partners and liaisons can be critical in facilitating contact with GBV survivors who seek assistance. For example, service providers in Kenya mentioned that some survivors are more likely to disclose GBV to fellow community members because they share the same linguistic and cultural codes and trust them more than NGO staff and government officials. In these cases, community leaders or representatives can act as liaisons between service providers and survivors, facilitating efforts to introduce survivors to helpful trusted providers, even accompanying them to offices when needed. This community-based support can also assist with follow-up visits or accompaniment through an onward referral process. It is, of course, paramount that confidentiality be understood and respected by all parties.

Community outreach and information dissemination

Acknowledging that the vast majority of people on the move – including GBV survivors – might never come to their offices, study participants raised the importance of at least putting information about GBV and available services out into the community in case it reached persons in need of it. Information offered would target the specific questions relevant to survivors and their surrounding community members. For example, what is GBV? What kinds of help are available and how can they be accessed? What are survivors' rights to protection, support, and even legal status?

Methods of dissemination are varied and should, ideally, be diverse enough to cater to community members of different genders, literacy levels, and degrees of access to cell phones and social media. This can include emergency hotlines, pamphlets about GBV and nearby organizations, secure chat groups on social media, or even signage in commonly traveled areas like train stations or parks where persons of concern gather. In addition, some service providers have found it useful to organize information sessions on GBV to facilitate disclosure especially amongst women, children, and LGBTIQ+ persons, who may feel constrained by their communities and families. Finally, for some study participants, outreach is combined with more individualized approaches. For example, some NGOs in Greece use community outreach activities (e.g., "GBV days" and or community presentations in different languages) to engage survivors in a community setting on certain days, while also seeing them at the office in separate, individual visits. These parallel exchanges can reinforce feelings of trust as well as create multiple opportunities to disclose GBV.

Considerations for elicited disclosure

It was generally recognized that disclosure of GBV is fully a survivor's decision and it should never be forced or even actively pursued. However, service providers acknowledged that in some rare cases, it may be helpful for certain actors to learn about GBV-related experiences in order to provide the benefit a survivor is seeking. This situation most commonly referred to those representing asylum-seekers or trafficking victims, or those adjudicating their claims. While it should not be necessary to ask for great levels of detail, many service providers acknowledged that those involved with preparing or assessing GBV survivors' applications do need to understand the general contours of the claim in order to build the strongest possible case for eligibility. Further, those assisting GBV survivors with these processes often want to make sure that they will be credible if interviewed, so asking clarifying questions may be necessary. As one lawyer from Greece put it:

> *"Credibility in cases of GBV is one of the most difficult issues. If we don't have the proper training, it's a one-way street to traumatize the person. We have indicators and we follow them so that we don't re-traumatize in both domestic violence and human trafficking cases."*[74]

In these rare cases, the provider must be well-trained to ask open questions and conduct a survivor-centered, trauma-informed conversation to gather basic information about the kinds of harm a person has experienced or fears in the future. Strong referrals must also be in place to provide necessary care and follow-up after GBV disclosure in this context.

Study participants also noted that state authorities adjudicating family petitions for protection (e.g., asylum) may find that when the husband is the primary applicant but there is reason to suspect violence within the family, it can be important to speak with the wife separately. However, an officer's ability to then split a family case without also causing risk of retaliation to the vulnerable spouse posed another administrative challenge.

Finally, some study participants suggested taking a holistic approach to elicited disclosure in particular. This means more than having a strong referral pathway across service providers. It means taking a collaborative approach in direct work with GBV survivors, with teams consisting of lawyers, psychologists, and social workers. Some participants felt that such an approach can help promote survivor-centered interviews, since psychologists or social workers can help lawyers work in more trauma-informed ways during an interview or can provide immediate intervention and accompaniment to survivors during or after these meetings. As one study participant in Mexico explained,

> *"… We try to collaborate at all times with our colleagues … so that if we detect any type of violation or case in specialized care which has legal implications, we can refer or even if they are carrying it out and detect it, we can also work as a team and reach a point where the person, the beneficiary, feels more comfortable and we affect them as little as possible."*[75]

Others, however, felt that certain collaborative approaches can force psychologists and social workers to compromise their therapeutic mandates of ensuring a survivor's psychological safety and recovery, in favor of simply assisting their legal colleagues with case-building.

In general, though, study participants felt that a holistic response is most critical so that, upon GBV disclosure, a team can provide a survivor with support – directly or through referral – for psychological and socioeconomic recovery and physical protection when needed. From this perspective, holistic approach involving close cooperation between professionals with legal, psychosocial, and case management expertise can greatly assist GBV survivors together after disclosure.

Discussion

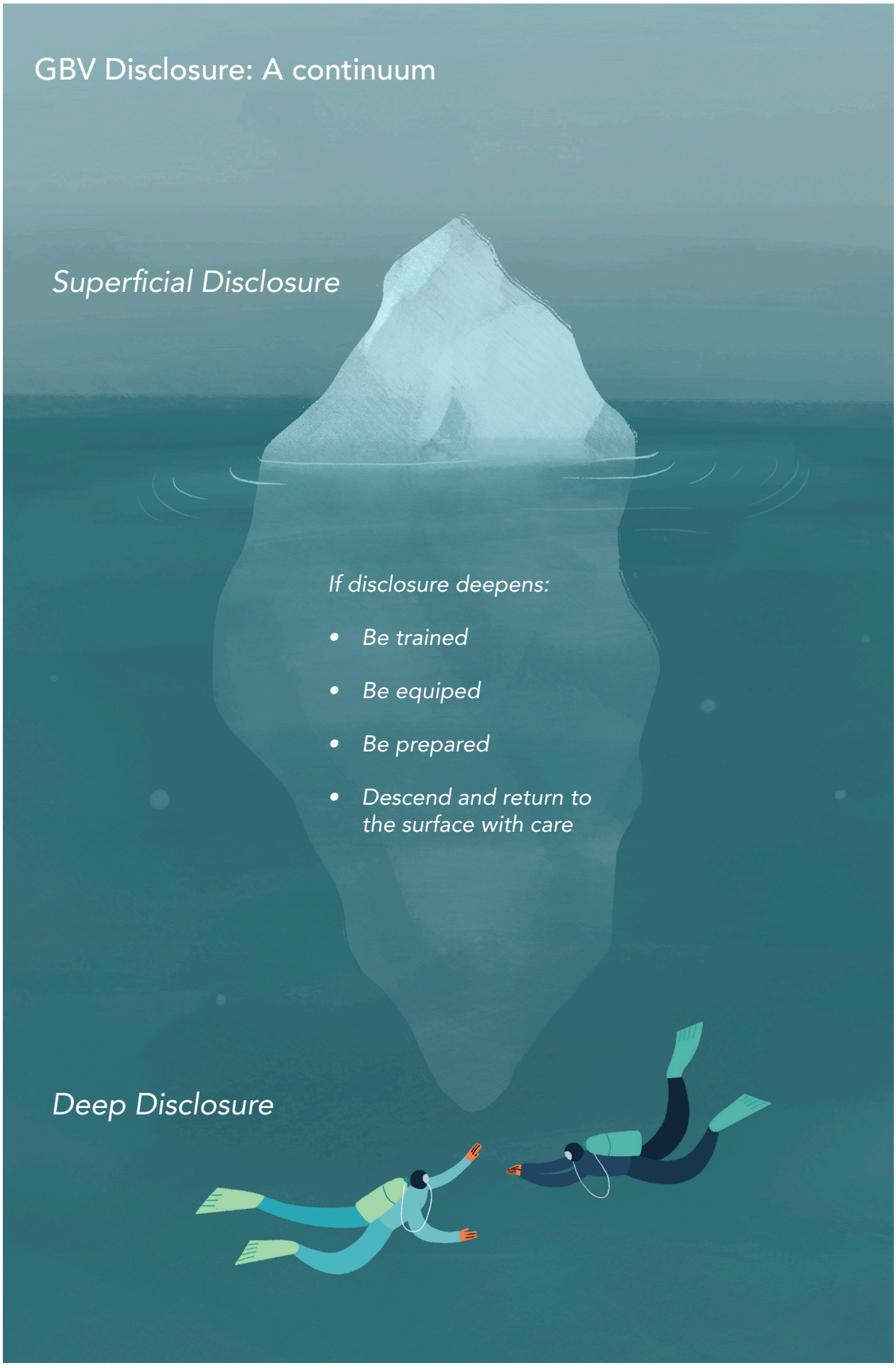
The study was based on the premise that disclosure of GBV is key to an individual's ability to access all the support and protection they might need. However, the survivor holds this key. Disclosure depends on whether they are willing or able to come forward to share their GBV-related experiences or concerns. Findings from this study illuminate barriers and strategies related to GBV disclosure to service providers in humanitarian crisis settings, which can help improve providers' approach and response – and survivors' access to care.

Types of GBV disclosure

First, the specific type of disclosure that arises in these contexts can be described as falling into a rough typology of (4) distinct, but related, forms. They can be loosely categorized as "self-motivated", "enabled", "elicited", and "third party" disclosure. The accompanying table provides elaboration. Helpful takeaways from this conceptualization of disclosure "types" include that while "self-motivated" and "elicited" disclosure are or, in the case of the latter, *should* be quite rare, "enabled" disclosure is everyone's business. Everything from how office furniture is arranged to how warmly a security guard or receptionist greets a survivor upon arrival can either enable or inhibit disclosure of GBV – the staff specialists, no matter how well-trained, are downstream of countless earlier interactions and environmental influences that can affect whether a GBV survivor feels safe or comfortable speaking about past harm in a meeting. For this reason, a survivor-centered, all-of-team approach is essential from the very first interaction and impression.

GBV DISCLOSURE IN SERVICE PROVISION CONTEXTS: A TYPOLOGY

Types of disclosure		Sample scenarios	Commonly implicated service providers	Approaches and considerations
Self-motivated disclosure	Survivor has independent reason or intent to disclose GBV, regardless of environment or provider action.	Survivor wants a pregnancy test at a medical clinic after rape experience. Survivor requests referral to a safe house due to experience or fear of GBV.	Healthcare providers (medical, psychosocial support). Law enforcement officers. Shelter staff. *Note: All providers should be prepared for self-initiated disclosure of GBV, however rare it may be.*	• Capacity to provide psychological first aid. • GBV sensitization of entire staff, including survivor-centred and rights-based approaches. • Confidential interview space. • Confidential and updated referral, information management, and case management systems. • Diversity of gender, ethnicity, age, language, and sexual orientation / identity on staff, to extent possible.
Enabled disclosure	Survivor is encouraged to disclose GBV due to the existence of a supportive environment or general showing of receptivity on the part of a provider.	Survivor who feels welcome at migrant shelter confides in kitchen staff. Survivor engaged in general group therapy activities eventually feels comfortable revealing GBV experience.	Healthcare providers (medical, psychosocial support). Law enforcement officers. Shelter staff. *Note: All providers should aim to create a safe, enablingenvironment for those wishing to discuss GBV experiences or concerns.*	All of the "self-motivated disclosure" approaches, plus: • Creation of safe, welcoming facility. • Engagement of migrants and refugees in routine activities, chores, etc. to create rapport and predictable opportunities to speak freely. • Provision of diverse interaction opportunities, including group activities (know-your-rights trainings, group therapy sessions, etc.) • Display of posters and other materials about GBV and available support services. • Availability of "GBV officer," "women's officer," etc.
Elicited disclosure	Survivor discloses GBV in response to direct questioning about past or future harm.	Survivor responds to question about harms fled in home country, asked to determine asylum eligibility. Police are contacted about GBV and must question survivor-witnesses.	*Actors who must understand past harm in order to provide benefit sought (e.g., asylum or crime response.)*	• Generally speaking, service providers should NOT ask about GBV directly. • Trained specialists mandated to learn about harm should use trauma-informed techniques to pose follow-up questions if survivor mentions GBV. • The need for this information and how it will be used and kept confidential must be explained to the survivor.
Third party disclosure	A third party mentions the GBV-related experience of a survivor, with or without the survivor's knowledge or consent.	Parent informs service provider about sexual abuse of a child, in order to secure medical care or protection for the child. Community member mentions intimate partner violence occurring to neighbour in refugee camp to protection staff. Survivor of conflict-related sexual violence identifies other individuals who were attacked during her ordeal.	Healthcare providers (medical, psychosocial support) Law enforcement officers Legal aid attorneys Community leaders or outreach workers	All of the "self-motivated disclosure" approaches, plus: • Clear information about available services for GBV survivors to share with survivor. • Strict data security protocols re: GBV and survivor identity. • Reminders about confidentiality, especially among community members. • Access to experts trained in interviewing/ disclosure of GBV by survivors under 18 years of age.


GBV Disclosure: A continuum
Superficial Disclosure
If disclosure deepens:
• Be trained
• Be equiped
• Be prepared
• Descend and return to the surface with care
Deep Disclosure

Disclosure continuum

Second, findings illuminate how disclosure of GBV can happen to different degrees. In this way, disclosure may be thought of as an ongoing and potentially deepening process. First, at the most superficial level of disclosure, one might generally express a need for protection or desire to access support services– the rough equivalent of saying, "I am afraid of staying in that shelter" or "Something bad happened and I need a pregnancy test", without much more. This degree of disclosure should in most cases be sufficient to secure access to the services sought, possibly with modest follow-up inquiry. Second, at a slightly deeper level of disclosure, an individual might reveal the basic contours of their GBV experience – for example, brief reference to their age at the time, basic description of circumstances or perpetrators, or mention of having sought medical care of police assistance. Third, at deeper level, a survivor might offer substantial detail about the nature, severity, motives, and impacts of past GBV – including specific stigmatized acts, perpetrators words, and any past or ongoing physical or psychological impacts of the harm.

This continuum has at least three major implications. First, it is critical that service providers have clarity about what they actually need to know about a person's GBV experience in order to assist them. For the vast majority of situations, there is no need – nor is it appropriate – to seek more than the most superficial level of signaling about GBV-related needs. Second, deep disclosure may bring the greatest risk of re-traumatization and most service providers have no business encouraging or leading a GBV survivor to that depth. And yet all must be prepared for it, in case a survivor unexpectedly ventures there. This includes specialists as well as any staff members to whom a survivor might develop trust and approach on their own; it also means interpreters must be prepared – and cared for – when they accompany at depth. Third, deepening disclosure may take time. A survivor may nominally disclose GBV one day and never wish to speak of it again. Or they may want to add more at a later time, as trust or healing progress. To the extent possible, service providers should "leave the door open," inviting survivors to always feel free to speak more in the future, should they choose.

Motivation, opportunity, capability

As with other actions and behaviors, a decision to disclose GBV depends to large degree on whether a survivor possesses sufficient motivation, capability, and opportunity.[76] And, if they do not, what are the barriers? What kinds of interventions can help reduce these barriers?

First, findings suggest multiple motivations for GBV disclosure, which can be categorized into three broad categories. First, there are **psychological motivations.** Survivors may disclose GBV as part of their healing from traumatic events, re-asserting a sense of agency, or seeking connection to other survivors or community members. Second, there are **protection motivations,** as when a survivor seeks immediate police response or claims for asylum. Third, there are **support motivations,** as when GBV disclosure can provide the basis of eligibility for shelter, cash assistance, or health services, particularly sexual and reproductive services. These motivations are important. The latter two can be enhanced by access to information – what rights does one have? Where can one find help? Community outreach and establishment of trusted, consistent sources of information are crucial to motivation.

Once there is *motivation* to disclose, a survivor also needs *opportunity and capability*. Findings noted several key opportunities for GBV disclosure arising in a service provision context. While disclosure can certainly arise in the context of one-on-one conversation or interview with a psychologist or lawyer, it can just as – if not more – easily arise in more informal spaces and moments, as in a weekly art or sewing circle, or while preparing dinner with the ancient cook in the shelter canteen. Ideally, a survivor would have multiple modes of engagement with a service providing team – they may develop more trust in the team while also having multiple, diverse opportunities to interact with staff and share their histories. Capability is separate. It is also sometimes something service providers can affect – e.g., do we have quality interpreters to overcome the language barrier? Do we offer accommodation or remote options for support for those who suffer from limited mobility or lack funds or time to travel to us? Can we connect this person with psychological support so their well-being is restored before trying to understand their past? In order to help lower a particular survivor's barriers to opportunity and capability to disclose, service providers need to understand what those barriers are. This takes time and care to learn. Taking that time can build critical trust along the way.

Re-conceptualizing safe space

There is much talk about "creating a safe space" as part of survivor-centered and trauma-informed care. Most providers understand that their physical, built environment can contribute to or detract from a sense of safety – are there posters signaling welcome to LGBTIQ+ individuals? Is there ample light? Are seats arranged so that a survivor can see the door, or her children? Are coffee, tea, and biscuits lain out for the taking, without requiring a survivor to ask permission? These aspects of space are all important. And yet, study participants' responses illuminated ways in which they, themselves, strove to embody safe space – independently of the four walls of their office. For the social worker in Mexico City, asking, "How are you? And how is your heart?" means "I am here to listen." It is powerful to realize that, whether working in a sunlit apartment or a public health clinic or under a tree in a desert camp, an empathetic service provider can create all the space a survivor might need.

All-of-team approach

One final take-away from the study findings is that GBV disclosure requires an all-of-team approach. First, while great effort can (and should) be invested in creating an enabling environment for disclosure, it is impossible to predict when and to whom a survivor may wish to share their experiences. Within a service provision ecosystem, it might be the healthcare providers who receive more disclosure than the police. Within a single organization, it might be the friendly trilingual receptionist or the grandfatherly security guard more frequently than the well-trained GBV focal point or psychologist. It is hard to know. For this reason, everyone working at an organization that serves refugees, asylum seekers, and other displaced individuals must have basic familiarity with GBV and what to do if someone raises it. This could be a soft referral to another, specialized colleague on the team, or it could mean knowing where to call in an emergency. Within a network of providers, clear and effective referrals for care are key, as is clarity regarding consent and confidentiality across organizations. Second, the ability to make effective, reliable referrals to diverse forms of care is important to ensure survivors benefit from holistic support in the event of disclosure. Psychological care is important even short of outright re-traumatization. Information about legal options and possible status might be appreciated, even if a survivor is unsure they want to proceed at that moment. It is simply important to know one's options. Finally, this work is difficult and it can take a toll on service providers. To have longevity in it and to come to work every day feeling replenished and supported means feeling one has back-up, that one is part of a team. Building up intra-organizational support and mutual-care practices is essential for service providers themselves, as well as for the sustenance and quality of care survivors receive.

Endnotes

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