Final Report

Accessibility and barriers to Gender-Based Violence Services for refugee and migrant girls, boys, women and men in Greece.

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List of Abbreviations

ACCMR	Athens Coordination Centre for Migrant and Refugee issues
AMIF	Asylum Migration and Integration Fund
ASB	Arbeiter – Samariter - Bund
AS	Asylum Service
BIA	Best Interest Assessment
CP	Child Protection
CRWI DIOTIMA	Center for Research on Women's Issues DIOTIMA
DRC	Danish Refugee Council
EC	European Commission
ECHO	European Civil Protection and Humanitarian Aid Operations
EI	Exit Interviews
EIGE	European Institute for Gender Equality
EKKA	National Center for Social Solidarity
EKEPY	National Center for Health Operations
ERCI	Emergency Response Centre International
EU	European Union
FGD	Focus Group Discussion
FGD CM	Focus Group Discussion with Community Members
FGD SP	Focus Group Discussion with Service Providers
FGM	Female Genital Mutilation
FRA	European Union Agency for Fundamental Rights
GBV	Gender Based Violence
GBVIMS	Gender-Based Violence Information Management System
GCR	Greek Council for Refugees
GSGE	General Secretarial for Gender Equality
KEELPNO	Hellenic Center for Disease Control and Prevention
KEM	Migrant Integration Center
KETHI	Research Centre for Gender Equality
KII	Key Informant Interview
(I)NGO	(International) Non-Governmental Organization

IOM	International Organization for Migration
IRC	International Rescue Committee
LGBTQI	Lesbian Gay Bisexual Transgender Queer Intersex
MdM	Médecins du Monde
Med.in	Medical Intervention
MoMP	Ministry of Migration Policy
MSF	Médecins Sans Frontiers
OAED	Manpower Employment Organization
PD	Presidential Decree
PEP	Post Exposure Prophylaxis
PoC	Person(s) of Concern
RIC	Reception and Identification Center
RIS	Reception and Identification Service
SGBV	Sexual and Gender Based Violence
SMA	Association for the Care of Minors
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
TdH	Terre des Hommes
UAC	Unaccompanied Children
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
WAHA	Women and Health Alliance International
WHO	World Health Organization
WRC	Women's Refugee Committee

1. INTRODUCTION

1.1. Background

In the period from 2015 to 2016, Greece experienced an unprecedented influx[1] of migrants and refugees fleeing war and deprivation in their home countries in the Middle East, Africa, and South Asia, or in search of a better and safer life in the EU. The closure of the border between the Republic of North Macedonia and Greece in early March 2016 left thousands of refugees[2] and migrants stranded in Greece. Their arrival and, consequently, their emerging needs put the existing national refugee/migrant protection and safety system under strain.

Several international and local actors stated from the beginning the need to safeguard human rights and to secure the protection and safety of the affected population, particularly the most vulnerable i.e. unaccompanied children, Gender-Based Violence (GBV) survivors and/or persons at risk of GBV, aged people, LGBTQI people, pregnant women, single-headed families, people with serious medical needs. In face of an extremely challenging situation, the international humanitarian community provided important international aid (both in kind and financial), as well as other resources (knowledge, know-how, human resources).

Respectively, state actors, such as the Gender Secretariat for Gender Equality[3], having recognised that the protection of the human rights of women is an aspect of equality and in an effort to better respond to the arising needs of female refugee GBV survivors, underlined the need to fight against the social exclusion of the aforementioned target group in the "National Plan for Gender Equality 2016-2020''. The GSGE had previously initiated the establishment of a multi-stakeholder Steering Committee, consisting of state[4] and civil society actors, whose work culminated in the adoption of the "Protocol on Cooperation" in December 2017[5], which set down a common framework of procedures for the identification, referral, accommodation, and provision of services to migrant and refugee women. The National Network of Struc-

[1] Nearly 857.000 refugees and migrants arrived in Greece in 2015. Over 173.000 came to Greece in 2016 by sea and 30.000 in 2017. Over 45.000 are estimated to be stranded in the country, https://ec.europa.eu/echo/where/europe/greece_en

[2] The term refugee in the current research is used more descriptively rather than analytically. Its use does not coincide with the refugee's legal classification as expressed by the Geneva Convention of 1951, but includes all people who migrate - necessarily or by choice - as in most cases "selection" takes place within a context of violence, political repression or economic coercion. Thus, the term refugee is used as a general category that includes people who migrate for political, economic, social, environmental, religious or other reasons (for a critical review of definitions of refugee concept see Malkki, L., Refugees and Exile: From "Refugee Studies" to the National Order of Things, *in Annual Review of Anthropology*, vol. 24 pp. 495-523, October 1995*).*

[3] The General Secretariat for Gender Equality is the governmental agency competent to plan, implement, and monitor the implementation of policies on gender equality and particularly on GBV.

[4] 1) The General Secretariat for Gender Equality (Ministry of Interior), 2) the General Secretariat of Reception (Ministry of Migration Policy), 3) the General Secretariat of Public Health (Ministry of Health), 4) the Ministry of National Defense, 5) the Research Centre for Gender Equality, 6) the Association of Greek Regions, 7) the Central Union of Greek Municipalities, 8) the National Centre for Social Solidarity, and 9) the Hellenic Agency for Local Development and Local Government.

[5] Available at https://bit.ly/2P1D955

tures for the Prevention and Combating of Violence against Women and its **services,** provided through Counselling Centres, shelters and SOS line (24/7), became thereby officially available to refugee/migrant women and their children. Adding to that, KETHI (the scientific and technical assistance state agent of the National GBV protection system) responded with the capacity building of the staff members, conducted a study on the needs of the female refugees who reside in the temporary accommodation facilities and signed further agreements with local Bar Associations for the provision of free legal aid to GBV survivors[6], including documented female refugee and migrants.

At the same time, in accordance with the interagency cooperation principles, a spectrum of specialised services started being provided to GBV survivors and/or to persons at risk, through partnerships between international actors and a number of national NGOs. This included the provision of accommodation/shelter, GBV case management, psychosocial support, legal aid, awareness raising programmes and women-friendly spaces, initially in camp settings and, more recently, also in urban areas.

1.2. The scope of the research

The structural changes in Greece's refugee protection system, in particular the GBV response system, and its transition from a mainly NGO-led response during an emergency situation to one in which the public sector takes the lead role, has raised the need to account for the progress made so far, to identify existing but also new needs and to evaluate the sustainability of current policy approaches. In addition to that, given that **the national system of GBV protection is currently exclusively focused on female survivors**, there is a pressing need to investigate its response capacity, not only with regard to (cultural) diversification aspects, but also the needs of other groups experiencing GBV, such as adult men and children. Children survivors of sexual abuse, currently benefiting from the broader child protection framework, have been **left outside** the scope of specialised care and protection services, procedures and arrangements, which are foreseen by the national GBV protection framework.

In light of all the above, the present research, building on existing knowledge, takes a step forward towards assessing in a comprehensive manner the availability, accessibility and quality of GBV services, addressing the needs of **refugee and migrant women, men, girls and boys,** and makes proactive findings and recommendations on the national GBV response capacity in light of the current transitional phase in Greece. To this purpose, the present research covers the services provided by both state and non-state actors and analyses the challenges that the evolving protection regime has generated. It thereby takes into consideration the need to fill persistent gaps and constantly growing needs in the

[6] For 2018, the local Bar Associations which have signed the agreement with KETHI are those of Rhodes, Serres, Piraeus, Ioannina, Patras, Alexandroupoli, Herakleion, Hleia, Larissa, Thiva, and Kalamata.

provision of integrated GBV support **in view of state's increasing role and involvement.** By following a qualitative approach and by bringing together the reflections and lessons learned from all relevant stakeholders, including for the first time the beneficiaries themselves, the research also attempts to shed light into the variant barriers to the accessibility of existing services, the quality of the services provided and their capacity to meet the needs of the users. Drawing from data and evidence-based insights from the field, the research identifies good practices and ongoing gaps, summarises key action points related to policy making and programme development, and makes recommendations on the effective allocation of resources to sustain and advance Greece's response capacity towards GBV.

The present report adopts the **definition of GBV agreed by the IASC and also used by UNICEF[7],** according to which Gender-Based Violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. With regard to violence against children, the present research focuses on child survivors of sexual abuse[8]. To address geographical variations, the research focuses on **selected regions of the mainland and the islands** and investigates the services provided **in both camps and urban settings** by: a) the state/public sector and b) INGOs and NGOs, as well as the interrelation between these sectors. The geographical scope of the research encompasses the regions of Greece where the majority of the refugee population resides in order to ensure a nationwide overview: **Attica, Central Macedonia (Thessaloniki), Eastern Macedonia** and **Thrace (Evros),** and **Northern Aegean (Lesvos island)**.

The specific objectives of the research are:

1. To better understand **the legal, policy, and procedural frameworks** regulating GBV prevention and response services in Greece, the ways in which they pertain to refugee and migrant women, men, boys and girls, as well as identify unattended needs.
2. To **map the existing GBV prevention and response services** for survivors provided by public and (I)NGO actors in Greece across a range of sectors and regions and to capture regional variations, such as in Attica, Central Macedonia (Thessaloniki), Eastern Macedonia and Thrace (Evros), and Northern Aegean (Lesvos island)**.**

[7] UNICEF refers to the definition provided in the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, available at https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf, pp.5

[8] Child sexual abuse is defined as any form of sexual activity with a child by an adult or by another child who has power over the child. By this definition, it is possible for a child to be sexually abused by another child. Child sexual abuse often involves body contact. This could include sexual kissing, touching, and oral, anal or vaginal sex. Not all sexual abuse involves body contact, however. Forcing a child to witness rape and/or other acts of sexual violence, forcing children to watch pornography or show their private parts, showing a child private parts ("flashing"), verbally pressuring a child for sex, and exploiting children as prostitutes or for pornography are also acts of sexual abuse. Definition provided by UNICEF and IRC in Caring for Child Survivors of Sexual Abuse, Guidelines for health and Psychosocial Service Providers in Humanitarian Settings, 2012, available at https://www.unicef.org/pacificislands/IRC_CCSGuide_FullGuide_lowres.pdf

3. To clarify existing **GBV referral pathways** and analyse the ways in which they are used in practice by the actors involved, identify strengths and challenges, impediments and omissions.
4. To assess the capacity and quality of **health, psychosocial, and safety services** throughout the procedure of identifying, referring and managing **a GBV case**.
5. To **identify** good and/or **promising practices.**
6. To assess stakeholders' understanding of obstacles and accessibility barriers to services and positively **influence policy changes and administrative practices through evidence-based policy recommendations**.

To reach its objectives, the present study attempts to answer a number of questions. **Key research questions include** (see Annex 8.1. for more details)**:**

1. What is the **overall system of support for GBV survivors** and how do the actors involved relate to each other?
2. How **available** and **accessible** are the services provided to GBV survivors?
3. What is **the services' quality** and efficiency?
4. What **types of GBV prevention policies/programmes** are available?
5. What are the **specific barriers** that refugees and migrants face or might face in accessing appropriate services?
6. How do the **policies** under planning take into consideration the gaps in the service provision (including the barriers in accessing the existing services)?

2. METHODOLOGICAL APPROACH

Data on the GBV service provision and/or on ways to improve the existing response capacity were collected through field research. Two qualitative methods were applied to best examine the accessibility, the availability and the quality of the GBV services for refugee and migrant women, men, girls and boys: **Focus Group Discussions (FGD)** with Service Providers and Community Members, and **Semi Structured Interviews** with Key Informants and with Former Service Users. In addition to that, the method of Participant Observation was employed in the camp settings where DIOTIMA has been present (see Annex 8.2. for more details). Research concerns and ethical considerations were discussed and considered prior to the commencement of interviews with volunteer participants (see Annex 8.3.). **The methodological approach adopted** aimed at giving the space to all participants to provide data and details they consider important and to describe their experiences through the lens of their own perception, free from any research's hypotheses and researchers' pre-fixed ideas (for the axes of questions see Annex 8.2). Consequently, the different experiences of the actors and beneficiaries of the GBV response system were gathered in an inclusive, yet diverse manner. The information collected through the different methods was then analysed[9] to shed light and provide insights into the key research questions.

The field research took place **between the 7th of May and the 26th of July 2018,** reaching out to **146 participants** in total. **33 Key Informant Interviews** were conducted (16 in Athens, 4 in Thessaloniki, 9 in Evros and 4 in Lesvos), as well as **4 FGDs with Service Providers** (one in each of the above-mentioned locations) reaching out to a total of **78 professionals** with different areas of specialisations[10]. Moreover, **10 Exit Interviews with Former Service Users** (6 in Athens and 4 in Thessaloniki) and **7 FGDs with Community Members** (3 in Athens, 1 in Thessaloniki, and 3 in Lesvos) were conducted, reaching out to **68 individuals,** out of whom 53 were women and 15 men. **Key Informant Interviews** with policy makers, programme coordinators and high-ranking civil servants (see Annex 8.4 for detailed list and profiling of participants), provided information regarding policy- and programme-making in relation to GBV among refugee population, as reflected in service provision. **FGDs with service providers and front-line workers** (see Annex 8.4) brought to the foreground their experience in relation to gaps and obstacles in service provision. **FGDs with community members**, based on selection criteria such as gender, age (over 18), ethnicity (representation of major ethnic groups i.e. Syrians, Iraqis, Afghans, sub-Saharan Africans), explored perceptions of the community regarding GBV, as well as

[9] This minimizes the effect of bias on behalf of the researchers, and therefore offers an alternative (to the positivist paradigm) kind of objectivity. One that places the research participants at the centre of research, as the subjects of knowledge, being closer and directly involved with the matter under question. Indeed, as feminist scholars Donna Haraway (1991) and Helen Longino (1999) have argued, knowledge (and truth) grows out of the lived social experience, unique perspective, standpoint, and one's situated location.

[10] Among them, Social Workers, Doctors, Psychologists, Police Officers, Managers, Public Officers and Administrators. Many of the 78 professionals are holding key positions in a wide range of Non-Governmental Organizations, International and Public Institutions.

knowledge/familiarity with the available services for survivors[11]. **Interviews with former service users** unraveled accessibility factors, coping mechanisms and levels of satisfaction by the actual assistance provided by services. Regarding the sample of volunteers among former service users, the following criteria were considered: age (over 18), gender and nationality (see Annex 8.2. for more details). Out of a total of 10 interviews with former service users, 9 were conducted with female services users and 1 with a male service user. The interviews did not deal with the GBV incidents *per se* that the former service users had experienced[12].

2.1. Limitations/Challenges

The present research provides an analysis of the GBV response capacity and the existing needs of GBV survivors as those occurring within the context of the refugee and migrant population in Greece in 2018. Within this volatile environment, the research results can refer only to the period of its conduct. In the absence of a harmonising approach towards gathering, analysing, and sharing information on GBV cases, the collection of such information from service providers became particularly challenging. Data from secondary sources have also been included as needed.

When setting up the FGDs with Community Members, the main challenge lay in ensuring adequate ethnic representation through the composition of each group, whilst overcoming language barriers. Due to the restricted time of the FGD on the one hand and the time needed for interpreting in different languages on the other, the research team limited the number of languages per FGD to one. Only in three of the FGDs (Skaramagas, Melissa and Thessaloniki) did interpretation in two languages take place. Another challenge was the difficulties participants in the FGD experienced to directly share information on GBV related issues. The same limitation was not observed in those FGDs that were organised in settings where beneficiaries felt empowered, for instance community centres. It is important to mention that the aforementioned challenge was particularly evident during the FGDs with male participants. Unsurprisingly, male participants were reluctant to speak on GBV, often adopting a dismissive attitude – in large attributable to wider socio-cultural determinants formulating gender relations, gender understandings and gender rights issues. As regards former service users, the voluntary participation of male former service users (initially planned to be 3) proved to be a particular challenging task; male GBV survivors remain in large invisible and have fewer opportunities to reach services compared to female ones. As a result, only one interview with a male survivor was conducted in the end.

[11] Case workers and/or psychologists were available and ready to provide prompt support if needed to participants in the FGDs with community members.
[12] Case workers and/or psychologists were anyhow available and ready to provide prompt support if needed to former service users.

3. LITERATURE REVIEW

During the preparatory phase and prior to the field research, a literature review was conducted for the purposes of laying down the necessary background framework. The literature review covered the current humanitarian context in Greece, GBV in Greece in particular towards Greece's refugee population, key trends of GBV, the legal framework including the transposition of EU directives into national legislation as well as the major actors in the response. Moreover, qualitative and quantitative data presented in reports by (I)NGOs, International/European Institutions as well as academic papers in journals were reviewed and integrated as needed.

Electronic resources by the following organisations and institutions were among the **key sources of the desk review:** Amnesty International, Human Rights Watch, IRC, WHO, Reliefweb/Refworld, ACAPS – Global Emergency Overview, FRA, EIGE, General Secretariat for Gender Equality (GSGE), EKKA, Ministry of Migration Policy/Asylum Service/Reception and Identification Service, UNICEF, UNHCR, IOM, UNFPA. In addition to the above, a series of academic journals such as *Gender & Development, Feminist Review, Feminist Studies, Signs, Women's Studies International Forum, Forced Migration and Journal of Refugee Studies* were also consulted. Furthermore, the literature review included a wide range of material shared by UNICEF, especially guidelines, codes and standards, focusing on aspects relevant to research with GBV survivors and children.

Due to ongoing developments on the ground, the research team consulted on a systematic basis and throughout the different research phases periodic publications by various (I)NGOs and/or Public Institutions. This included assessment reports (e.g. UNHCR), reports by local and/or international NGOs (e.g. GCR, IRC, Network for Children's Rights), newsletters disseminated by Public Institutions (e.g. Ministry for Migration Policy), as well as articles published in various sites and newspapers, describing and/or reflecting the current situation on the ground (see Annex 8.5. Bibliography).

3.1. Recent research on GBV among the refugee population in Greece

I**nternational research has shown**[13] that GBV is quite prevalent in humanitarian emergency situations. Apart from an alarming lack of GBV data, the available data, such as reports from police, healthcare providers, legal services or other sources, represnts only a very small fraction of the actual number of incidents of GBV. Even then, they mainly deal with

[13] Gender-Based-Violence in Emergencies, Commissioned and published by the Humanitarian Practice Network at ODI Number 60 February 2014, available at https://odihpn.org/wp-content/uploads/2014/02/HE_60_web_1.pdf

female survivors. **In Greece** in particular, a recent UNHCR briefing note[14] highlighted the heightened risk of sexual violence refugee women and children face amid tensions and overcrowding in reception facilities on the Greek islands.

In 2016, in an effort to account for the GBV phenomenon in the female refugee population, the Research Centre for Gender Equality (KETHI) assigned to CRWI Diotima the implementation of a 3-month study[15]. The objective of that study was to identify and map existing gaps and related needs in the infrastructure, services, human resources and know-how in the areas of prevention, protection and safety, and assistance to vulnerable groups, especially female single parent families, pregnant women, single women and survivors of GBV. Some of the key issues addressed in that research included the low number of identified GBV cases (disclosure); shortcomings and gaps in the scope of existing programmes; the small number of GBV actors, programmes or specialised and experienced professionals; the limited availability of (female) interpretation/cultural mediation in the camps but also in public shelters; the scarce provision of specialised legal aid services (in particular court representation); the lack of clear and established referral pathways as well as delays in the referral process and incidents of breach of confidentiality at different stages of the procedures; the limited number of prevention programmes and community engagement activities.

With regard to GBV incidents affecting children, a report by the Harvard FXB Center for Health and Human Rights, in April 2017[16], focusing on the situation of refugee and migrant children in Greece, documented an alarming pattern of exploitation and abuse, including physical violence and sexual abuse.

3.2 Available data on GBV in Greece

In Greece, the General Secretariat for Gender Equality (GSGE) is the only state actor collecting and disseminating data related to GBV. The most recent and publicly available database on **calls to the 15900 helpline** covers the period from 19/11/2016 to 19/11/2017[17]. During that period a total of 5,154 communications (5,041 telephone calls, and 113 mails) were recorded. Out of 4,266 (the ones with available data) telephone calls, 85% concerned cases of GBV; out of those, 71% were reported by survivors themselves, and 29% by third parties. In connection to the forms of violence reported, 80% concerned domestic violence, 2% sexual assault and the rest other unspecified forms of GBV. None of the calls were related to trafficking. As regards the types of specialised services requested through the helpline, 40% were for psychosocial support, 26% for legal counseling, 5% for legal aid and 7% for sheltering. In terms of nationality representation,

[14] UNHCR Briefing Note**:** Refugee women and children face heightened risk of sexual violence amid tensions and overcrowding at reception facilities on Greek islands, 09 February, 2018, available at https://bit.ly/2nVKxTF

[15] DIOTIMA and KETHI, Study on the he needs of the female refugees who reside in the temporary accommodation facilities all over Greece, 2016, available at https://bit.ly/2wM0ccC

[16] Emergency within an Emergency: The Growing Epidemic of Sexual Exploitation and Abuse of Migrant Children in Greece, Jacqueline Bhabha and VasileiaDigidiki, for the Harvard FXB Center for Health and Human Rights, April 2017, available at https://cdn2.sph.harvard.edu/wp-content/uploads/sites/114/2017/12/Emergency-Within-an-Emergency-FXB.pdf

[17] Statistical Data by the 15900 SOS Helpline and GSGE Network of Structures, available at https://bit.ly/2p8uOCh

82% were Greek citizens, while 7% were non-Greek survivors. No particular information however has been publicised about the nationalities of non-Greek survivors contacting the helpline.

As far as **service provision is concerned**, over the period 1/11/2016-31/10/2017, 5,210 women reached the public system, out of whom 4,849 were assisted by the Counselling Centres and 361 were hosted in public shelters. Again, the vast majority (71%) were victims of domestic violence. In terms of services: 43% received PSS, 21% received legal counselling and 16% information. Out of all GBV survivors reaching the public GBV support system, 78% of the service users were of Greek citizenship and 22% were non-Greek nationals. No further information has been provided regarding the nationalities of non-Greek survivors.

Previous research[18] undertaken by KETHI[19] reveals that over the period 04/2016-10/2016 based on data drawn from 20 shelters out of 21 in total, 155 refugee women requested to be sheltered, out of whom 134 were hosted with their children in Athens, Thessaloniki, Ioannina, Larisa and Rhodes, whereas 21 requests were not satisfied due to lack of available space.

Additional relevant yet, incomplete data have been provided by UNHCR, which in 2017 received 622 reports about SGBV among migrant and refugee persons residing on the Aegean islands. Notably, at least 174 cases experienced SGBV after their arrival to Greece, a finding which raises serious protection matters. The above-mentioned figures represent only female survivors and cover inappropriate behaviour, sexual harassment and attempted sexual attacks. In addition, the information provided by UNHCR is not broken down any further (e.g. age of victims) to allow a more in-depth analysis of the figures. Although data on incidents of GBV among the refugee population are not being systematically collected and the figures mentioned earlier do not provide a complete picture of the situation on the ground, service providers and refugee and migrant community members commonly report that women, men, girls and boys experience various forms of GBV and are in need of effective GBV support services[20].

[18] DIOTIMA and KETHI, Study on the he needs of the female refugees who reside in the temporary accommodation facilities all over Greece, 2016, available at https://bit.ly/2wM0ccC.
[19] In Greece, the Research Centre for Gender Equality (KETHI) studies issues of gender equality. KETHI uses its knowledge to propose and implement specific policies, practices, and actions to promote gender equality.
[20] DIOTIMA and IMC, A Summary of Assessment Findings and Recommendations: The Situation of Refugee and Migrant Women in Greece, spring 2016, available at http://data2.unhcr.org/fr/documents/download/52747, spring 2016.

4. MAPPING OF GBV PROTECTION AND RESPONSE SYSTEM

4.1. Regulatory framework

4.1.1. The Greek Legal Framework on Gender Based Violence

Law 3500/2006, which addresses domestic violence[21], and articles 322-353 of the Penal Code[22], which prohibit crimes against sexual freedom and crimes involving financial exploitation of sexual life, are the main regulatory framework on GBV related issues in Greece. Law 3500/2006 classifies spousal rape as a felony (including rape in a non-marital union), prohibits the corporal punishment of children, provides for the prosecution of all domestic violence cases and foresees the provision of support to the victims through placement in safe shelters[23]. Additionally, the law provides for the mandatory reporting by professionals in the field of education, whenever they receive information or identify that a student has been subjected to domestic violence.

Gender-Based Violence as a term, along with references to gender as a social construction and gender equality as an objective, are used for the first **time in Law 4351/2018[24], which transposes the Istanbul Convention into national law[25].** This transposition is expected – together with other provisions – to provide a more comprehensive legal framework towards combating GBV, by broadening the scope of the definition and strengthening the legal tools to address it. According to the Istanbul Convention, the Member States are obliged to provide three types of services that are considered crucial to the support and protection of **female victims of violence:** general victim support services (such as shelters, phone helplines, financial assistance, housing, education, training, and assistance in finding employment), health care services (including psychological counseling), and legal aid[26]. In addition to that, the services should be available to female victims of all forms of violence covered by the Convention and should be ensured for all women in need and their children[27]. A very important provision of Law 4351/2018 with regard to refugee and migrant women survivors or at risk of GBV is that **it enables them to report the violence perpetrated against them, even if they are with an irregular status and do not possess the necessary documents to reside legally in Greece.** In cases of undocumented GBV survivors, deportation is not allowed. With regard to male GBV survivors, the relevant regulatory framework for GBV applies. More specifically, the law on domestic violence applies to all family members. Accordingly, the Penal Code provisions

[21] Law 3500/2006, "For combating domestic violence and other provisions''.
[22] Greek Penal Code, 1951, articles 322-353
[23] For a more detailed overview of the Greek migration and asylum legislation as well as legislation for domestic violence (prior to the ratification of the Istanbul Convention), see KETHI research carried out by Parsanoglou, D., ''BUILDING SAFETY NET FOR MIGRANT AND REFUGEE WOMEN, Situation analysis and mapping of the existing legal and policy framework in Greece'', 2017.
[24] Law 4351/2018 on combating violence against women and domestic violence
[25] Istanbul Convention, drafted 12 April 2011, available at https://www.coe.int/en/web/istanbul-convention/home
[26] Ibid, p.28-32
[27] Ibid, p.29

protect both men and women. However, **male survivors of GBV** are not covered by the provisions of the Istanbul Convention (and consequently by its transposition to the Greek legislation).

As regards **trafficking in human beings,** the main legislative acts[28] criminalise trafficking for both sexual and labour exploitation and guarantee basic protection and assistance to the victims, such as health and medical support, security, access to education for specific age groups, psychological and legal support. Law 3875/2010[29] ensures that the domestic legal system guarantees to victims of trafficking the right to seek compensation for the damage suffered"[30]. Despite legal developments in the field of human trafficking, it is only victims of sex trafficking who fall under the definition and within the scope of domestic violence, as described in the Law 3500/2006. This narrow definition neglects other forms of gender-based violence, such as forced and early marriage, female genital mutilation, survival prostitution or transactional sex, which remain in large marginalized at both the legal and policy level. Regarding **the trafficking of children,** Laws 3625/2007[31] and 3727/2008[32] foresee heavy sentences and fines, but also provide for assistance to the victims, such as accommodation in safe shelters and psychosocial support. In the field of asylum and migration, according to Laws 3386/2005[33], 3907/2011[34] and 4251/2014[35], victims of human trafficking that collaborate with the juridical and police authorities for the arrest and prosecution of the traffickers are entitled to one-year residence permit without fees. Law 4198/2013 provides that the reports of specialists such as psychologists, psychiatrists (as well as child psychologists) are treated as juridical evidence and that the victim has the right to testify in camera or remotely. Finally, Law 4236/2014 provides that interpretation services should be available to all non-Greek citizens during penal procedures[36].

Although the Greek regulatory framework on GBV is quite advanced, its actual implementation remains poor due to a number of documented factors. First, there is often limited awareness amongst public officers and in particular police staff, of the specific legal provisions and/or legal developments in relation to migrant and refugee GBV survivors' rights and duties of aid. Cases, where female survivors of GBV were arrested by police officers while filing a complaint on account of their irregular status, along with cases where female survivors of GBV were discouraged by the Police to file a

[28] a) Law 3064/2002 (transposition of the Council Framework Decision2002/629/JHA of 19 July 2002 on ''combating trafficking in human beings''), b) Presidential Decree 233/2003.
[29] Law 3875/2010 on "Ratification and Implementation of the United Nations Convention against Transnational Organized Crime and related provisions''.
[30] Article 6, paragraph 6.
[31] Law 3625/2007 incorporating the Optional protocol for the Protection of the Rights of the Child.
[32] Law 3727/2008 on the ''Ratification and implementation of the Council of Europe Convention on the protection of children against sexual exploitation and abuse, measures to improve living conditions and decongesting detention facilities'' and other provisions
[33] Law 3386/2005, ''Codification of Legislation on the Entry, Residence and Social Integration of Third Country Nationals on Greek Territory''.
[34] Law 3907/2011 on the ''Establishment of an Asylum Service and a First Reception Service'', transposition into Greek legislation of Directive 2008/115/EC "on common standards and procedures in Member States for returning illegally staying third country nationals" and other provisions
[35] Law 4251/2014 enacting the ''Code of Immigration and Social Integration'' and other provisions.
[36] Law 4236/2014

complaint, have been registered by the Legal Department of DIOTIMA. In many cases the victims did not wish to continue the procedure due to the fact that reporting **a GBV incident requires an administrative fee of 50 euro** (with the exception of cases of domestic violence). Moreover, even though survivors of GBV and victims of trafficking (VoT) are entitled to free legal aid, they rarely exercise it in practice as there is no pathway between the police and the courts or the different Bar Associations. Evidently, the lack of proper information to GBV and VoT often also leads to inaction towards their nominal legal rights. Finally, the absence of long-term support and re-integration services, including financial support to both survivors of GBV and VoT, is a further deterrent factor that discourages victims.

4.1.2. The Greek Legal framework for children

Alongside the above-mentioned laws on domestic violence and trafficking against children**, the Greek Civil Code**[37] (articles 337, 339, 349, 351, 589, 1350, and 1665) defines and punishes sexual harassment against children, sexual intercourse, early marriage, child prostitution and provides for legal guardianship. Other protective measures, such as health care, psychosocial support, legal aid, safe shelter and education for child GBV survivors (both Greek and refugee/migrant children), are provided by the general regulatory framework described earlier. With regard to unaccompanied refugee/migrant children, **Law 4375/2016**[38] defines an unaccompanied child as *a person below the age of 18 who arrives in the Greek territory not accompanied by an adult responsible for him/her according to the Greek legislation and for as long as he/she is not effectively taken into the care of such a person, or a child who is left unaccompanied after he/she has entered Greece.* Provisions for education, health care and shelter are also made. More specialised provisions are included in the latest legislative amendment, **Law 4554/2018**[39]**,** which is expected to provide a more comprehensive regulatory framework for the safety and protection of unaccompanied children, including child GBV survivors, mainly through the establishment of a body of professional guardians mandated to effectively assume the legal guardianship of UAC[40].

4.2. GBV response system: actors and related services

The GBV response system comprises different policies and a series of services provided by both state and non-state actors such as safety and security, health, accommodation, legal protection, livelihoods and integration. In Greece, the

[37] Greek Civil Code, 1946
[38] Law 4375/2016 on the ''Organization and operation of the Asylum Service, the Appeals Authority, the Reception and Identification Service, the establishment of the General Secretariat for Reception'', (transposition into Greek legislation of the provisions of Directive 2013/32/EC).
[39] Law 4554/2018 on the ''Commission 'Guardianship of unaccompanied Children'' and other provisions.
[40] a) the establishment and appointment of a Supervisory Board Committee for Unaccompanied Children, b) the establishment of a Directorate for the Protection of Unaccompanied Children at the National Center for Social Solidarity (EKKA), c) the establishment of a Register of Reception Centers for Unaccompanied Children, d) the registration in the Register of Guardians- professionals with appropriate formal and substantive qualifications, such as vocational training and expertise, language skills.

main stakeholders are: **a)** the state through its various public services[41], i.e. the Ministries (especially Ministry of Migration Policy, Ministry of Interior and Ministry of Justice), the General Secretariats (especially the General Secretariat for Gender Equality), the Asylum Service, the Reception and Identification Service, the Hellenic Police, the Hellenic Centre for Disease Control and Prevention (KEELPNO)[42], the National Centre for Social Solidarity (EKKA) and public hospitals, **b)** the local governance i.e. Municipalities[43], **c)** International Organisations, **d)**International Non-Governmental Organisations, and **e)** national NGOs.

In connection to **state/public services (a) as well as those at local level (b),** the main document that is currently guiding the participation and roles of the different state key actors involved is the **"Protocol on Cooperation"** initiated by the GSGE which, after a period of consultations, was finally signed in the beginning of 2017**.** The Protocol was designed and agreed to fill the gap caused by the absence of a common framework of procedures for the identification, referral, accommodation and provision of counseling services and support activities to refugee female survivors of violence and their children, as well as women who are single mother, heads of households.

In order to effectively respond to the aforementioned need, the different state actors involved have been assigned with specific roles and responsibilities. In the context of the GBV response as described in the Protocol Document, **the GSGE** holds a coordinating role and is accountable for actions such as informing the different actors with regard to their role, updating the rules and procedures of the shelters, cooperating with (I)NGOs to best address the needs of the refugee population, as well as overseeing the distribution of multilingual information material to the target group. **The Research Center for Gender Equality (KETHI)** has a supervising role of the provided services, is accountable for the recruitment and the capacity building of the staff, including interpreters, and for the referrals of beneficiaries to the Shelters through the Counseling Centers. **The General Secretariat of Reception (MoMP) and the Ministry of National Defense** ensure the identification and referral of women of the target group through the distribution of material and by informing them

[41] **Reception and Identification Service (RIS)** is an independent agency under the Deputy Ministry of Migration Policy General Secretariat of Reception. Mission of the Reception and Identification Service is the effective management of third country nationals who cross the Hellenic borders without legal documents and/or procedures, by placing them in first reception procedures. A**sylum Service**is an autonomous body reporting directly to the **Minister of Migration Policy** and is in charge of the examination of international protection claims. **KEELPNO** is the state competent actor to offer medical and psychological evaluation and support in RICs and camp settings. The **General Secretariat for Gender Equality (GSGE)** is the governmental agency competent to plan, implement, and monitor the implementation of policies on gender equality and particularly on GBV. **National Centre for Social Solidarity (EKKA**) is responsible for managing the referral mechanisms for placement to shelters of unaccompanied children. It also provides accommodation for female survivors of GBV**. Ministry of Migrant Protection** is responsible for the overall planning and implementation of migration and refugee related policies. **Ministry of Justice** is entrusted with the management of the judicial function and with the development of legislative initiative in basic justice sectors, in which is included the harmonization of internal law with the rules of international law. **Public Prosecutor's** office is a judicial authority independent from courts and executive authority and has as a mission the maintenance of legitimacy, the defense of the citizens and the preservation of the rules of public order.

[42] KEELPNO drafted the Clinical Management of Rape Protocol, a very important tool for the medical sector.

[43] Municipalities as signing parties to the Cooperation Protocol are tasked with referring, through their Social Services and the Municipality Counseling Centres, women survivors of GBV and their children to the public shelters. They are also responsible for undertaking the transference of the beneficiaries by vehicles owned both by local and regional authorities to (and from) the accommodation structures.

about the opportunity to be assisted by the Counseling Centers and be accommodated in the Shelters. **The General Secretariat of Public Health** has undertaken tasks such as the identification and the facilitation of the referral procedure of refugee women especially to the public health structures, but also contributes to and facilitates their medical assessment. **The Central Union of Greek Municipalities and the Association of Greek Regions** are responsible for referring through their Social Services and the Municipality Counselling Centres the women of the target group and their children to the shelters, as well as arranging for their transportation from and to the accommodation structures or as otherwise necessary. **The National Center for Social Solidarity (EKKA)** contributes to the overall monitoring of the project, refers women and their children to the shelters and undertakes transportation when necessary. **The Hellenic Agency for Local Development and Local Government (EETAA)** is responsible for monitoring on a weekly basis the accommodation availability, for keeping data and providing -under the approval of the GSGE- information based on those data. **In the overall,** the Protocol on Cooperation by GSGE has contributed towards overcoming the important coordination gap of GBV case management services among the different state actors and, more importantly, ensuring the inclusion of refugee women in the 62 anti-violence Structures.

In total, 21 **public shelters for female GBV survivors** under the auspices of GSGE, with a total of 350 places, are operating throughout the country in various cities and run by Municipalities (19) as well as EKKA (2), distributed as follows: in Northern Greece, at Thessaloniki (2), Kordelio, Komotini, Kozani and Ioannina; in Central Greece, at Volos, Larisa, Agrinio and Lamia; in Southern Greece, in Athens urban area (3, Acharnon, EKKA, Municipality of Athens), Piraeus, Patra, Tripoli; on the islands, Rhodes, Lesvos, Kerkira, and Heraklion and Chania on Crete. Although the 21 public shelters are in principle available also to refugee GBV survivors, there has been identified a variety of reasons to limit their accessibility. That is the overall capacity of these shelters, their scattered location and the scarcity of interpretation services that create practical barriers in either accessing them or in effectively corresponding to refugee survivors' needs. Safe Houses, where GBV survivors may be accommodated in emergency cases, are also offered by 4 NGOs in Athens (Mother Teressa, Mosaic, Orange House, Jafra Foundation) and one (1) shelter exclusively for Victims of Trafficking (Damaris). There is no safe accommodation and/or shelters available to host male GBV survivors. In addition, accommodation programmes (HESTIA) run by UNHCR and NGO partners provide for a number of places to accommodate females and males GBV survivors in emergencies. Still, it is quite common for female and male GBV survivors to return to the harsh environment of overcrowded camps, until their transfer and accommodation in the mainland has been arranged by UNHCR and partners. With regard to unaccompanied minors[44] they are accommodated at NGO-run shelters (such as ARSIS, Praksis, METAdrasi, Med.in, Iliaktida, SMA, Melissa Network, Apostoli, Hellenic Red Cross), as well as in hotels for emergency accommodation run by IOM (and partners), under the supervision of EKKA,

[44] http://www.ekka.org.gr/images/PDF_ARXEIA/%CE%A0%CE%91%CE%A1%CE%95%CE%9C%CE%92%CE%91%CE%A3%CE%95%CE%A9%CE%9D/GR%20EKKA%20dashboard%2031-7-2018.pdf

according to the latest legislative amendment, **Law 4554/2018**[45]. In addition, accommodation for unaccompanied minors is provided at: RICs, safe zones, in open temporary accommodation facilities, in informal housing arrangements and SIL (supported independent living) apartments, protective custody.

With regard to medical services for GBV survivors, significant progress has been made in the general medical sector, through the recent drafting of **the Clinical Management of Rape Protocol,** introduced and widely disseminated by KEELPNO. It is noteworthy that PEP treatment must be available in all hospitals in Greece. In case a hospital does not have this treatment available, it is under the obligation to acquire it immediately when such need arises, without referring the survivor to another hospital. The wide dissemination of PEP among the various state medical actors has been secured with the assistance of UNFPA and UNHCR at earlier stages. The enhancement of the skills and the know-how of NGO and state/local actors in the provision of medical services during GBV case management, initiated by various actors (e.g. IRC, UNHCR, UNFPA, IOM, DIOTIMA) has strengthened the response capacity of staff members . An important step forward has been the increasing involvement of KEELPNO in the GBV case management services on the sites and RICs. However, there are still serious gaps in its response capacity, in terms of a high turnover of the staff due to short-term contracts, resulting in staff being without specialised training on GBV issues or incapable of undertaking all aspects of the GBV case management, i.e. provision of proper PSS and legal aid, and therefore usually operating as focal points to refer to other actors present at the sites or to public services such as the Counselling Centres.

Legal services and, especially, legal aid and the possibility for having legal representation at court (penal, civil and administrative) play a significant role during the GBV case management process. It has been reported[46] that since 2015 legal aid services (including the costs for legal fees) have been remarkably absent in the GBV response. The majority of international organisations as well as the anti-violence public structures provide legal assistance/counseling but not representation. Although the Free Legal Aid System (Law 3226/2004) offers in theory a legal/institutional option, in practice most of GBV survivors have no easy access due to the lack of interpretation services, the scarcity and/or lack of availability of GBV-sensitised lawyers and lawyers capable of interacting effectively with culturally diverse clients. Moreover, as mentioned earlier, there is currently no referral pathway between police and bar associations to provide support to survivors who wish to take the first step of legal action i.e. filing a complaint. Consequently, the majority of refugee GBV survivors is left without means to fully exercise their rights and is deprived of the necessary support to take legal action and have equal access to justice.

[45] Law 4554/2018 on the ''Commission 'Guardianship of unaccompanied Children'' and other provisions.
[46] Evidenced by Key Informant Interviews and reports of the Legal Working Group of UNHCR

Accessibility to existing GBV response services is greatly dependent on the ability to overcome language barriers. Even though the number of interpreters/cultural mediators remains insufficient to this day, negatively impacting on actual servicing, some progress has been made through the PHILOS programme of KEELPNO, which has provided interpreters to camps and RICs, still without being possible to have any concrete data about the number of cases serviced due to lack of any records being systematically collected and shared with relevant actors or researchers and due to the fact that they usually refer the cases after the first intake. KETHI has also equipped the services of the Counselling Centres and the shelters with seven (7) interpreters. In addition, some of the Municipalities (Athens, Thessaloniki) have staffed their services with a number of interpreters (6), mainly in the context of the accommodation programmes they operate e.g. REACT in Thessaloniki. It is also important to underline that during 2017 and 2018 various actors (e.g. DRC, Spanish Red Cross) have started offering free interpretation services to other NGOs, as well as to the State (including escorting to Public Hospitals). The same applies to the NGO METAdrasi, which has the largest pool of interpreters in Greece and provides interpretation services to Public Hospitals[47] and other public services or NGOs upon request; through contracts with the state and/or private funds. Overall, the problem with interpretation persists, especially in relation to rare languages, creating real barriers in accessing the available GBV services.

With regard to livelihood, cash assistance to refugees is provided mainly through UNHCR partnerships, while UNHCR has the responsibility of validating the data. In the case of GBV survivors and, particularly in the context of domestic violence, cash distribution has reportedly become a real challenge, where the perpetrator is the family member (head of household) eligible for the cash; efforts to separate the cash cards have been proven to be in practice quite complex. A positive measure which contributes to the support of GBV survivor's economic independence has recently been adopted by OAED[48]. According to that measure, many beneficiaries without permanent address (e.g. homeless, asylum seekers/refugees residing in squats/informal accommodation, GBV survivors in shelters) could apply for registration at OAED. Such a development is crucial, since it offers access to various services (e.g. free transportation, possibility to apply for social benefits) and solves a number of subsistence issues faced by GBV survivors.

On a different note, **specialised GBV services for male survivors and child survivors of GBV** are scarce and unevenly distributed. DIOTIMA (Athens, Thessaloniki, Larissa, Lesvos) and GCR (Athens, Thessaloniki) offer case management to male survivors in urban areas and through referrals from camp settings. DIOTIMA has also a male engagement component in its intervention to strengthen protection and prevention. MSF treat male survivors psychosocially and medically in Athens, with a special focus on victims of torture. Babel in Athens offers similar services. In the overall, support to male survivors is still work in progress within the Greek GBV response system regarding a number of aspects i.e. specialized

[47] For the list of Hospitals where METAdrasi offers its interpretation services, please see here:https://bit.ly/2IETfCX
[48] http://www.oaed.gr/documents/10195/1214556/DELTIO+TYPOY+ASTEGOI+28+02+2018.pdf/8b5ebd83-9ece-4efc-9163-dbbe359fde42

professionals and know-how, safe accommodation and shelter options as well as referral pathways. Minors that are survivors of GBV are offered the general protection services by Child Protection actors (state's and NGO's), despite of the fact that many experts have raised concerns about the lack of a separate component in Greece's child protection system to address sexual abuse. There is still the need to include specific GBV aspects in the child protection system, indicatively through tailor-made pathways and procedures for children GBV survivors, provision of PSS services by specialised professionals, unanimously endorsement of Child Safe Guarding rules in UAC accommodation settings.

A constituent element of GBV response is **integration**, especially the empowerment of survivors and the strengthening of their prospects for a better life. In this direction, the employment counselling offered by the national GBV system as well as the facilitated accessibility to OAED mentioned previously hold vital possibilities, but the majority of refugee and migrant survivors are ultimately excluded due to language barriers. The absence of integration programmes is partially covered by initiatives undertaken by NGOs and civil society organisations, which operate various community centers in the urban areas and provide women with safe spaces but also offer the refugee population as a whole integration-oriented support, mainly through recreational and educational activities and female empowerment activities. Although their approach and ways of operation differ significantly, it is important to mention a few of these organisations; Melissa Network and Chora Community Center (in Athens), Blue Dot Centers and Social Solidarity Centers running by Solidarity Now (in Athens and Thessaloniki), Mosaic and Tapuat in Lesvos.

All the above-mentioned developments, policies and procedures are important steps towards a rights-based and survivor-centered approach in the sector of GBV. However, there are still gaps in GBV case management services on specific sites, there is only partial coverage in urban settings (Athens and Thessaloniki), whereas in Lesvos the existing actors cannot cover all needs. It is worth mentioning that the number of GBV cases reaching support services has been steadily increasing[49] not only as a result of the development of service provision but also as a result of information, prevention and empowerment activities which encourage self-referrals and disclosures, as corroborated by international knowledge on the GBV phenomenon, known as the iceberg phenomenon, which explains that by its acknowledgment as a social phenomenon it gains public visibility and allows its emergence.

The section below maps the support services in the four (4) regions under research, focusing on key GBV support services provided by state and non-state actors in open accommodation centres and urban settings. The aim is to offer an overview of the situation and identify and evaluate regionally-specific gaps and unattended needs.

[49] https://mail.google.com/mail/u/0/#inbox/KtbxLvhRZfSBKSFZbnWgvJJPVpGMtZjHBV?projector=1&messagePartId=0.1

4.2.1. Attica Region

In the Athens city area, 14,700 asylum seekers and refugees are currently accommodated under UNHCR funded accommodation (ESTIA scheme)[50]. Moreover, a significant number of refugees sustain themselves under different living arrangements. Several specialized GBV case management actors, such as DIOTIMA, Solidarity Now, GCR and Melissa, are currently assisting through partial or holistic GBV case management, namely by providing the whole series of services needed to properly managing each GBV case. In all the five (5) camp settings located in the Attica region (Schisto, Skaramagas, Eleonas, Malakasa, Lavrio), KEELPNO is the major focal point actor, attending to the needs of a fluctuating refugee population of about 6,323 people[51].

With regard to *medical services:* In the urban setting of the greater Athens area, medical care is provided by the public hospitals assisted by (I)NGOs, such as MSF, MdM, and PRAKSIS, which offer medical services and/or run medical clinics for refugees[52]. KEELPNO, the state appointed actor, also provides medical care in the five (5) above-mentioned open accommodation facilities (camps) through the PHILOS programme (Emergency Health Response to Refugee Crisis). Moreover, a navy or military doctor is present in some of the Attika camps, such as Skaramagas, Lavrio and Eleonas. It is important to mention that there is no formal requirement for these professionals to have been trained on GBV medical issues, even though they receive and treat GBV cases. Last but not least, PEP is available on a regular basis in all hospitals in the area as well as at the MSF polyclinic[53].

With regard to *emergency accommodation services/shelters*: state actors such as EKKA are managing the referral mechanisms for the placement of unaccompanied children in shelters and two emergency shelters for female survivors of GBV. Four (4) state- and municipality-run[54] shelters are available to adult female survivors (about 80 places). In case a woman is accompanied by her children, the age limit is 12 for boys and 18 for girls to be allowed into a public shelter. These often act as a barrier and are a source of frustration, in particular when emergency accommodation is being sought for a substantial number of refugee survivors by GBV actors in the field. UNHCR's Implementing Partners (such as SN, ADDMA, PRAKSIS, ARSIS) also provide emergency accommodation to GBV survivors under the HESTIA Accommodation Scheme. Despite the efforts made, the accommodation offered through partners does not effectively respond to demand and it often takes quite some time (occasionally up to 1-3 months) before a formal answer is

[50] UNHCR Greece: Accommodation Update, July 2018, available at https://reliefweb.int/sites/reliefweb.int/files/resources/65060.pdf
[51] UNHCR, Greece: Site Profiles, July 2018, https://reliefweb.int/sites/reliefweb.int/files/resources/65334.pdf
[52] It needs to be noted that staff offering care are rarely specialized on GBV and any relevant training they have received has been incidental.
[53] As of February 2018, according to KEELPNO there are currently 93 hospitals in Greece (with the addition of MSF Clinic) that offer PEP, either under the services of Departments of Infectious Diseases or Outpatients Departments for HIV+ patients, on a regular basis at the mainland and the islands. Next to these hospitals, all public Greek hospitals are instructed to keep and renew sufficient supplies of antiretroviral treatment to cover emergency cases for HIV exposure. Focal points for PEP are appointed all over the country.
[54] One run by the municipality of Athens, two run by EKKA and one by GSGE.

provided. During this intermediate period pending a formal reply, temporary accommodation is usually provided by hosting survivors in hotels, a solution with significant security risks. The UNHCR-funded accommodation scheme is open for male survivors of GBV[55], as there is no such provision by the existing national system. The same type of barriers outlined immediately above prevent however easy and timely access.

With regard to *legal aid services*[56]: NGOs, such as GCR, DIOTIMA and Solidarity Now, provide legal aid (including representation at court) in urban settings to women and men survivors of GBV. Free legal aid by the state is available through the Athens Bar Association. However, as will be analysed in more detail in the next chapter, the state free legal aid system is barely accessible to refugee/migrant survivors due to the small number of available lawyers and the lack of interpretation services. NGOs -such as ARSIS, PRAKSIS and Solidarity Now- provide legal aid to child survivors of GBV, even though very few cases are in practice identified and referred.

With regard to *psychosocial services*: Specialised GBV case management actors, such as DIOTIMA, GCR, Solidarity Now but also other actors, such as Melissa, Babel, Hestia Hellas, and INGOs MSF and MdM, provide psychosocial support in the urban area to women and men survivors of GBV. Few of these actors, such as Solidarity Now and Babel, are also providing psychosocial support to child survivors of GBV, mostly in the context of family support. Psychological support to female survivors of GBV in the urban settings is also provided in the seven (7) state-run Counselling Centres and the four (4) Shelters, under a specific scheme of a limited number of sessions. KEELPNO offers psychological services in the open accommodation facilities to women and men survivors, often however with the aid of professionals with no or little previous GBV-specific training.

With regard to *interpretation services*: In the urban area interpretation services are provided by state actors, such as KETHI (in the Counselling Centres and Shelters) and by municipality interpreters available at the Migrant Integration Centres of Athens and Piraeus. Interpretation services in the urban area are also provided by local and (I)NGOs, such as METAdrasi. KEELPNO and (I)NGOs' interpreters are available in the camp settings. However, the lack of 24/7 interpretation services and, especially, lack of female interpreters is observed in all settings, in particular among public services, such as public hospitals and police departments. The lack of or limited access to interpretation is often responsible for a survivor's inability to seek legal remedies. It is also linked to the reduced quality of medical care or the limited access to a doctor and access to other public services in general. These can in their turn result in the low reporting of cases and, thereby, disrupt the whole referral process.

[55] Including apartments accommodating LGBT people.

[56] By legal aid services we mean the assistance and not only counseling on legal matters. Legal aid may include or not representation in court. A reference to whether the legal aid actors provide also representation in court is made in the current section.

With regard to *referral pathways:* In most of the camp settings, KEELPNO has appointed GBV focal points and referral pathways among the actors get updated during the various meetings (e.g. Protection Meetings, Child Protection Meetings). In all camp settings, except Elefsina, GBV referral pathways are in place[57].

With regard to *prevention programmes*: UNICEF, through its partners, runs prevention programmes, such as information sessions on GBV, female friendly spaces in camp and urban settings (Solidarity Now, Melissa). Moreover, UNICEF helps provide life skills and empowerment to women as well as to adolescent boys and girls. Further on, NGOs such as Faros, Chora, DIOTIMA and Solidarity Now, provide recreational and educational activities either to the general refugee population or empowerment activities to women refugees only.

For the urban area of Athens specifically, information on who does what is provided through the ACCMR[58]. Additionally, relevant information is also included in the national updates of the SGBV Working Group, initiated and coordinated by UNHCR. However, due to the scattering of service providers and the high numbers of the refugee population, the use of available services is often confusing for the beneficiaries, as reflected in the thoughts shared during the FGDs as well as during the interviews with former service users. In addition to that, the dissemination of information on the available services, the referral pathways among the complementary services provided by NGOs as well as among NGOs and the public sector, not to mention among site and urban actors, further complicate the situation on the ground. Therefore, the attempt made by the Municipality of Athens to bring together through the ACCMR platform all actors working with the refugee population, in order to share information through the establishment of thematic working groups (including GBV), and discuss the prospect of joint action, establish synergies and exchange of know-how, might be considered as a good practice of a coordination model that needs to be further developed and may be utilized at governmental level.

For more detailed information on the available services for the Attica Region, see the table below. Marked in orange colour, are the actors who also provide services to male survivors; marked in blue, are the actors that provide services to unaccompanied children; marked in green are the actors who provide services to women, men, girls and boys survivors of GBV.

[57] Ibid, No[42]

[58] Athens Coordination Center for Refugee and Migrant issues is a Digital Coordination Platform which aims to support the effective mapping of services and activities concerning migrants and refugees in the City of Athens and thus to facilitate the exchange of information and resources between the different stakeholder groups involved in the provision of services/organization of activities and between their professional staff, funded by Stavros Niarchos Foundation https://www.accmr.gr/en/digital-platform.html

Table 1. Actors and type of services provided to GBV survivors in Attica Region

LOCATION	GBV case management	Medical services	Psychosocial Counseling (+Mental Health)	Legal assistance/aid for GBV survivors	Emergency accommodation within a reasonable distance	Interpretation services
Urban Athens	DIOTIMA, Solidarity Now, GCR,PRAKSIS, Melissa, Faros, GSGE Counseling Centres and shelters, EKKA	MSF,MdM, PRAKSIS,Public Hospitals	MdM,DIOTIMA, PRAKSIS, MSF, Solidarity Now,Melissa,GCR, Faros, Babel(especially mental health), METAdrasiGuardianship network for minors	DIOTIMA,SolidarityNow,GCR, ARSIS	GSGE Shelters, EKKA Shelters, Solidarity NOW, ARSIS,PRAKSIS, public hospitals	KETHI, Municipality Interpreters, METAdrasi,Interpreters of NGOs
Eleonas	GBV focal point by KEELPNO and RIS	KEELPNO/Military doctor (in the weekends)- interpretation is not always guaranteed	European Expression (only for women)/ UNHCR undertakes the cases of male survivors and LGBTI as there is no specialized GBV actor for these cases at present	Referrals to externals in urban Athens	GSGE Shelters, EKKA Shelters, Solidarity Now, ARSIS,PRAKSIS,safe zone in the camp, public hospitals	Interpreters ofNGOs, KEELPNO
Skaramangas	GBV focal point by KEELPNO	KEELPNO/Navy Doctor	KEELPNO	Referrals to externals in urban Athens	GSGE Shelters, EKKA Shelters, Solidarity Now, ARSIS, PRAKSIS, safe zone in the camp, public hospitals	Interpreters of NGOs, KEELPNO

Lavrio	GBV focal point by Solidarity Now	Navy Doctor	Municipality workers, Solidarity Now	Referrals to externals in urban Athens	Public hospitals	Interpreters of NGOs
Malakasa	GBV focal point by KEELPNO,referrals to externals in urban Athens	KEELPNO	KEELPNO/IOM/Municipality workers	Referrals to externals in urban Athens	Safe zone in the camp, public hospitals	Interpreters of NGOs,KEELPNO
Schisto	GBV focal point by KEELPNO,referrals to externals in urban Athens	KEELPNO / Air Force Doctors	KEELPNO	Referrals to externals in urban Athens	GSGE Shelters, EKKA Shelters,Solidarity Now, ARSIS, PRAKSIS, safe zone in the camp, public hospitals	Interpreters of NGOs, KEELPNO
Elefsina	GBV focal point by KEELPNO,referrals to externals inurban Athens	KEELPNO/Military doctor	None, referrals to externals in urban Athens	None, referrals to externals in urban Athens	GSGE Shelters, EKKA Shelters, Solidarity Now, ARSIS, PRAKSIS, public hospitals	Interpreters of IOM, KEELPNO

In the overall, although a range of services and actors involved in the GBV response system are in place in the Attica region, the interconnection between the services provided in the urban area of Athens and the population residing in camp settings is hampered by several obstacles. These include the lack of easy access i.e. public transportation, to and from, the (public and NGO) services located in Athens urban area, from remote camps such as Ritsona, Malakasa, Lavrion, etc. Moreover, lack of easy transfer in emergent cases whereas there is the need to urgently remove from perpetrator and/or transfer and escort a survivor to public services such as hospitals, police stations, forensic,

counselling centers and shelters etc; the lack of means of transfer from counselling center to a shelter; the lack of clarity, updating and/or efficiency of the referral pathways and mechanisms in the urban area to reach qualified agents being public or NGOs; the lack of efficient coordination especially in emergency cases and the need for collaboration among the different actors in the camps and in the urban that leads to either gaps or overlaps, in addition to the uneven capacity levels (staff) to respond to the needs among existing actors due to funding restraints.

In conclusion, the greatest challenge within the Attica region remains the operational coordination that will ensure monitoring of previously established distinctive roles and responsibilities, as well as, the referral pathways among the GBV actors in the camps and the urban setting, as well as among NGO and state GBV service providers. To this direction the SGBV WG broadened by the participation of all relevant state actors, based on the experience gained so far and with the use of existing tools i.e. mapping of service provision, Activity Info etc, constitutes a promising prospect.

4.2.2. Central Macedonia (Thessaloniki)

In Thessaloniki, 3,797[59] officially registered asylum seekers are accommodated in UNHCR-funded accommodation places. It is estimated that a significant number of refugees and migrants also resides in other types of accommodation, but the exact number is not known. This population can receive GBV related services through various actors, such as DIOTIMA, Solidarity Now, GCR, PRAKSIS, coupled by one (1) Counselling Centre and three (3) Shelters run by public actors, including GSGE and EKKA.

With regard to *medical services*: Public hospitals, MSF and MdM offer medical care in urban settings. KEELPNO and WAHA provide medical care in the two camps of Diavata and Lagkadikia (1,888 residents)[60]. It should be noted that the staff offering care are rarely specialised on GBV and any relevant training that they have received is often incidental. Medical services are available to girls, boys, women and men survivors of GBV by all actors. PEP is available at all hospitals, while two hospitals also have HIV/AIDS care units.

With regard to *emergency accommodation services*: Three (3) in total public shelters are available to female GBV survivors and their children providing 40 places, with the limitation of age eligibility criterion mentioned earlier i.e. male children over 12 years of age. EKKA manages the referrals of unaccompanied children to the UAC shelters in the region. No specialised emergency accommodation is provided to male as well as to child survivors of GBV.

With regard to *legal aid services*: GCR, DIOTIMA, Solidarity Now provide legal aid to male and female survivors of GBV. Solidarity Now also provides legal aid to child survivors. NGOs ARSIS and PRAKSIS, as CP actors, provide legal counselling

[59] UNHCR Greece: Accommodation Update, July 2018, available at https://reliefweb.int/sites/reliefweb.int/files/resources/65060.pdf
[60] UNHCR, Greece: Site Profiles, July 2018, https://reliefweb.int/sites/reliefweb.int/files/resources/65334.pdf

with no specialisation however in child survivors of GBV. Free legal aid by the state is available through the local Bar Association, although as in the case of Athens, this is in practice hardly accessible to female survivors.

With regard to *psychosocial services*: MdM, DIOTIMA, Solidarity Now, A21, REACT, PRAKSIS, ARSIS, Intersos, TdH provide psychological counselling. However, not all organisations employ professionals specialised in GBV. In addition to that, one Counselling Centre run under the supervision of GSGE provides PSS to female users, with the same limitations however in the number of sessions as described earlier i.e. up to 12 sessions per beneficiary.

With regard to *interpretation services*: Interpretation services are provided by state actors such as KETHI (in the Counselling Centre and Shelter) and by municipality interpreters available at the two Migrant Integration Centres. METAdrasi provides interpretation upon request (although there is a scarcity of services for particularly rare languages and for female interpreters). NGO actors usually employ their own interpreters, as in all other regions. KEELPNO and NGO actors intervening in the two camp settings (Lagadikia and Diavata) employ their own interpreters. Similar to the Attica region, interpretation is not available 24/7 in the public services and female interpreters are overall rare.

With regard to *referral pathways:* In the camp settings, KEELPNO has appointed GBV focal points and the referral pathways among the actors get regularly updated. In the urban area, updated information on the actors providing services to GBV survivors is provided through the regional SGBV WG (coordinated by UNHCR). However, due to the diversity of services provided, the dissemination of information on the available services is problematic and the referral pathways are therefore not always clear, even though efforts to overcome this issue are also made by the SGBV WG among all actors in Thessaloniki. Referrals between camps and urban based GBV services, when the need arises, demonstrate that accessibility remains limited due to lack of regular transport means and the absence of appropriate escort to the services, which is rarely covered by camp SMS actors.

With regard to *prevention programmes*: As in Attica, it is NGOs (Solidarity Now, Caritas) and volunteer/grass root organisations (Irida) which operate community centres and organise a spectrum of recreational and educational activities (i.e. language lessons) addressing the general refugee population and occasionally also women-empowering activities.

For more detailed information on the available services and the referral pathways for Central Macedonia (Thessaloniki) see the table below. Marked in orange colour, are the actors who also provide services to male survivors; marked in blue, are the actors that provide services to unaccompanied children; marked in green, are the actors who offer services to women, men, girls and boys survivors of GBV.

Table 2. Actors and type of services provided to GBV survivors in Central Macedonia (Thessaloniki)

LOCATION	GBV case management	Medical services	Psychosocial Counseling (+ Mental Health)	Legal assistance/aid for GBV survivors	Emergency accommodation within a reasonable distance	Interpretation services
Urban Thessaloniki	DIOTIMA, Solidarity Now, GCR, PRAKSIS, GSGE and EKKA Counseling Centre and Shelters	Public hospitals/ MdM Polyclinic (partially - certain services)	MdM, DIOTIMA, Solidarity Now, REACT, PRAKSIS, ARSIS, Intersos, TdH	GCR, DIOTIMA, Solidarity Now, ARSIS, PRAKSIS (no representation)	GSGE Shelters, EKKA Shelters, public hospitals	KETHI, Municipality Interpreters, METAdrasi, Interpreters of NGOs
Diavata	None, referrals to externals in urban Thessaloniki	WAHA, KEELPNO	ANTIGONE, ARSIS ASB	ARSIS ASB for children and referrals to externals in urban Thessaloniki	GSGE Shelters, EKKA Shelters, safe zone in the camp, public hospitals	Interpreters of NGOs, KEELPNO
Lagadikia	None, referrals to externals in urban Thessaloniki	WAHA, KEELPNO	KEELPNO	GCR, referrals to externals in urban Thessaloniki	GSGE Shelters, EKKA Shelters, public hospitals	Interpreters of NGOs, KEELPNO

To sum up, in Thessaloniki a number of actors are involved in the GBV response system in the urban area. However, it seems that the services are not enough to cover all the existing needs, especially towards all PoC, men, women, boys and girls survivors of GBV. This is the given situation, not only and mostly in terms of numbers of cases arising, but also in terms of complementarity of services needed and/or of the accessibility to the existing ones (when for instance interpretation is missing, transfer from sites to urban is lacking, places in shelters may be not currently or not at all available e.g. in cases of male survivors). Moreover, the lack of effective dissemination of the referral pathways to public actors, in particular among the Counselling Centres and shelters which do not participate in the UNHCR SGBV Working Group, results in limited interaction between public and NGO sector. In conclusion, in Thessaloniki there is a lack of adequate and well-coordinated GBV related services that can respond effectively to all the diverse needs. The situation becomes even

more challenging in accessing services available in the city area, when the (SMS) actors in the camps receive new populations transferred from Evros without proper referrals, as there is no GBV focal point there to facilitate the procedure.

4.2.3. Eastern Macedonia and Thrace (Evros)

In the region of Evros (Fylakio), there is a Reception and Identification Centre (RIC), where about 258 people are currently residing[61] and a Pre-Removal Centre. Evros is characterised as a transit spot, due to the short term stay of the majority of PoC who go through the first screening/identification and asylum procedures there and are usually released within 20-25 days[62].

With regard to *medical services*: The Health Centre of Orestiada and the hospitals of Didymoteiho and Alexandroupoli (PEP is available at Alexandroupoli's hospital) provide medical care to all residents of the RIC in Fylakio, while the transfers are facilitated by the police who has allocated one police van to this purpose. In the RIC in Fylakio, two nurses (appointed by OAED for a short period of time) are also present. One doctor is available in the Pre-Removal Centre in Fylakio. Medical services in the public hospitals and health centre of the region are supposedly available to girls, boys, women and men survivors of GBV; nonetheless, the referral of GBV cases depends on the sole focal point of RIC. In addition, there is also a reported lack of training on GBV among the staff in the Evros region.

With regard to *emergency accommodation services*: The NGO ARSIS provides accommodation to unaccompanied children in the two shelters that the organisation runs in Alexandroupoli. Emergency accommodation provided by the public shelter is only aimed at female adult survivors and is not easily accessible due to its distance from Fylakio. No accommodation for male survivors is available in the region.

With regard to *legal aid services*: ARSIS offers legal aid services to the unaccompanied children in the two shelters in Alexandroupoli and through a mobile unit in the RIC in Fylakio. Free legal aid by the state is available through the local Bar Association, although similar to the situation in Athens and Thessaloniki, it is not easily accessible.

With regard to *psychosocial services*: In the Pre – Removal Centre in Fylakio one psychologist and one social worker are available through the Health Units SA contracted by KEELPNO. These two professionals are however expected to cover the needs of all residents in Fylakio and are not specialised in GBV case management. The Counselling Centres also provide PSS where referrals should be made by the focal point of RIC in Fylakio, in order to overcome access barriers. Children, when needed, are referred to the Child Psychiatric clinic of Alexandroupoli hospital by CP actors, such as ARSIS.

[61] UNHCR, Greece: Site Profiles, July 2018, https://reliefweb.int/sites/reliefweb.int/files/resources/65334.pdf
[62] The Evros region does not fall under the E.U. – Turkey Statement and thus the admissibility procedure followed on the islands' RICs' does not apply there. PoC are therefore released earlier.

With regard to *interpretation services*: In RIC in Fylakio, METAdrasi provides interpretation services, including female interpreters. METAdrasi provides interpretation services to the public hospitals of the region and the police upon availability; however they do not suffice to cover the constantly arising needs. KETHI provides interpretation to the Counselling Centre, mainly over the phone.

With regard to *referral pathways:* Referral mechanisms are in place only with regard to medical services for the general refugee population and in the context of child protection services. GBV referral mechanisms are not in place.

For more detailed information on the available services and the referral pathways for the Evros region see the table below:

Table 3. Actors and type of services provided to GBV survivors in the Evros region

LOCATION	GBV case management	Medical services	Psychosocial Counseling (+Mental Health)	Legal assistance/ aid for GBV survivors	Emergency accommodation	Interpretation services
Fylakio RIC	GBV focal point by RIS	Public Hospitals of Alexandroupoli and Didymotiho, Health Centre Orestiada, RIC (2 nurses	ARSIS for children,METAdrasi Guardianship network for minors	ARSIS for children	Public hospitals	METAdrasi, Interpreters of NGOs
Alexandrou-Poli	None	Public hospital	ARSIS for children,METAdrasi Guardianship network for minors, public hospitals	ARSIS for children	Public hospital	KETHI, METAdrasi, Interpreters of NGOs
Fylakio Pre-Removal Centre	None	Public Hospitals of Alexandroupoli and Didymotiho, Health Centre Orestiada, Doctor by Health Units S.A.	ARSIS for children, public hospitals	ARSIS for children	Public hospitals	Health Units S.A. (not covered)

In the Evros region there are many gaps due to lack of available services. Specialised teams for the provision of medical and psychological support are completely absent in the RIC. The current infrastructures are not adequate and often result **in women and men GBV survivors residing in the same section and in close distance with the perpetrators.** Referrals and transfer from the RIC to the public services, such as public hospitals and Counselling Centre, are hardly provided, due to lack of resources to assure the availability of a van and driver(s). Beneficiaries departing from the RIC are not referred to specific accommodation sites and have no clear information on where they will reside next (apartments, open accommodation facilities). In conclusion, there is a general lack of specialised GBV services, whereas the few existing ones are difficult to access.

4.2.3. Northern Aegean (Lesvos island)

On the island of Lesvos, about 10,000[63] refugees (unfortunately age/gender breakdown is not currently available) reside in the two sites of Moria and Kara Tepe, where a further 681 are hosted under the ESTIA programme in the city[64]. GBV focal points have been appointed by KEELPNO and recently by RIS in Moria (2 staff members). UNHCR administers protection and monitoring on the sites and in the urban setting of Mytilene. UNHCR also undertakes GBV case management tasks and arranges referrals to external GBV and CP actors in Mytilene, such as DIOTIMA and MSF respectively.

With regard to *medical services*: KEELPNO, MSF, Boat Refugee Foundation, ERCI provide medical care in Moria (more than 8000 residents). MdM provide medical care in Kara Tepe (1,188 residents[65]). Vostaneio public hospital provides medical care for residents of Moria, Kara Tepe and Mytilene. Medical services are available for girls, boys, women and men survivors of GBV. PEP is available at the only public hospital of the island, Vostaneio.

With regards to *emergency accommodation services*: NGO Iliaktida, through UNHCR's Accommodation Scheme, and the Municipality run shelter are available on the island. The latter though provides emergency accommodation to refugee female survivors of GBV (only in cases of high emergency and only for 2 days). In addition, a specific section for single women heads of families is for the time being available within the camp of Moria, where survivors may be hosted if the perpetrator is not present in the camp. For male survivors, UNHCR reserves accommodation places for male and LGBTQI survivors and arranges for their placement.

[63] https://refugeeobservatory.aegean.gr/en/over-10000-refugees-lesvos-first-time-2015-16
[64] UNHCR Greece: Accommodation Update, July 2018, available at https://reliefweb.int/sites/reliefweb.int/files/resources/65060.pdf
[65] UNHCR, Greece: Site Profiles, July 2018, https://reliefweb.int/sites/reliefweb.int/files/resources/65334.pdf

With regard to *legal aid services*: NGO actors, such as DIOTIMA, provide legal aid services to female and male survivors of GBV. The Counselling Centre (GSGE) provides legal counseling, although with limited capacity due to lack of regular (only one interpreter) interpretation services. PRAKSIS provides case management and legal assistance for children at risk in Moria and Mytilene (but no court representation).

With regard to *psychosocial services*: In Moria, KEELPNO offers psychosocial services to GBV survivors. KEELPNO is also responsible for GBV case management and for referral to other actors, in case of need. RIS has appointed a GBV focal point that coordinates GBV referrals together with KEELPNO and UNHCR. UNHCR provides case management services to women and men and refers to other actors after a case-by-case assessment. MdM provide psychosocial services in Kara Tepe to women and men. IRC provides MHPSS services in Mytilene to girls, boys, women and men survivors. DIOTIMA offers psychosocial support to women and men survivors of GBV and PRAKSIS to child survivors, both in Moria and Mytilene. One Counselling Centre and one shelter are available for psychosocial support to female service users, with limited capacity, due to the availability of phone interpretation only.

With regard to *interpretation services*: In Mytilene, state actors such as KETHI provide interpretation services to the Counselling Centre and the shelter over the phone. METAdrasi offers interpretation services to the Vostaneio public hospital and the police upon availability. All (I)NGOs have interpretation services in the area of operation (camp settings and urban). However, a lack of female interpreters is observed in all settings especially in public services sector, such as public hospital and police stations.

With regard to *referral pathways:* In the RIC of Moria, KEELPNO and RIS have appointed GBV focal points and referral pathways among the actors are regularly updated. In Kara Tepe, referral mechanisms for GBV are in place. In the urban area, updated information on who does what is provided through the regional SGBV WG coordinated by UNHCR.

With regard to *prevention programmes*: Community centres such ‘’Together for better days’’ run by Iliaktida, Tapuat Centre (funded by UNICEF) and Mosaic (funded by Lesvos Solidarity) offer language lessons and recreational activities to the general refugee population as well as female-empowering activities.

For more detailed information on the available services and the referral pathways for Lesvos island see the table below. Marked in orange, are the actors who also provide services to male survivors; marked in blue, are the actors that provide services to unaccompanied children; marked in green, are the actors who provide services to women, men, girls and boys survivors of GBV.

Table 4. Actors and type of services provided to GBV survivors in Lesvos island

LOCATION	GBV case management	Medical services	Psychosocial Counseling (+Mental Health)	Legal assistance/ aid for GBV survivors	Emergency accommodation within a reasonable distance	Interpretation services
Kara Tepe	Referrals to externals in Mytilene	MdM	MdM, referrals to DIOTIMA, IRC (mental health),Caritas, METAdrasi Guardianship network for minors	UNHCR/GCR (expected), referrals to DIOTIMA in Mytilene	GSGE shelter, Iliaktida, PRAKSIS,public hospital	Interpreters of NGOs
Moria	GBV focal point by KEELPNO and RIS, UNHCR, referrals to externals in Mytilene	KEELPNO/MSF (only for cases that survived violence in the last 72 hours – PEP treatment)/Boat Refugee Foundation/ERCI	KEELPNO/MSF (cases in the last 72h – PEP treatment) /PRAKSIS only for children at risk, referrals to DIOTIMA, UNHCR,METAdrasi Guardianship network for minors	UNHCR (only Counseling)/ on a case by cases basis/ PRAKSIS only for children at risk, referrals to DIOTIMA	GSGE shelter, Iliaktida, PRAKSIS,safe zone in the camp, public hospital	Interpreters of NGOs, KEELPNO
Mytilene	DIOTIMA, MSF GSGE Counseling centre and shelter	Public hospital, MdM	Iliaktida, DIOTIMA, PRAKSIS (only for children at risk), MdM,IRC (mental health), Caritas, METAdrasi Guardianship network for minors	DIOTIMA,PRAKSIS (only for children at risk)	GSGE shelter, Iliaktida, PRAKSIS, public hospital	KETHI, METAdrasi, Interpreters of NGOs

Over the past months, the humanitarian situation in Mytilene has deteriorated severely due to overcrowding, especially at the RIC of Moria. Notably, the extremely high level of insecurity inside Moria limits the effectiveness of the available services, including the effectiveness of the GBV services (i.e. the GBV focal points assigned at RIC). Consequently, although a spectrum of services are already in place, they are far from covering the constantly arising needs. The

medical and psychological screening procedures are rendered dysfunctional due to the lack of adequate human resources having received the necessary induction or specific GBV training to become competent in servicing GBV survivors. Moreover, the referral pathways from non-state actors to the local Counselling Centre and shelter are closed; referrals are acceptable only through KEELPNO. GBV actors have thus limited sheltering options, as efforts are concentrated towards prioritising emergency cases. The GBV actors' capacity to offer holistic case management – i.e. provide not only PSS but also legal aid to female and male GBV survivors is far from being adequate to respond to needs (only one actor is currently present on the island - DIOTIMA). Efforts made by the local office of UNHCR to monitor the response to demand has resulted in a backlog of cases and in the adoption of prioritisation criteria such as the incident to have occurred in the last 3 months and the presence of the perpetrator on the island. It is noteworthy that GBV case management in Lesvos, as on other islands, becomes more complex once geographical restrictions are lifted and a case is characterised as vulnerable, as additional time consuming procedures need to be followed; often to the detriment of the whole case management process especially with regard to safe accommodation. Last but not least, children survivors of GBV in this context are supported by one GBV actor (MSF) and, partially, by PRAKSIS which become however occasionally unavailable due to having reached their maximum capacity of new cases.

4.3. Referral pathways and their functionality

Throughout the field research, it was quite evident that formal referral pathways do exist in every region both in camp and urban settings. Most of the participants working in the field (state and non-state actors) agreed that the current referral mechanisms are clearer than in the beginning of the "refugee crisis", when each side had to figure out the *modus operandi* of the other one.

Even though updates of the referral pathways are regularly conducted by the SGBV WG, one of the biggest future challenges is which actor will be responsible for the updating of the referral mechanisms when UNHCR will no longer be undertaking this task. Responding to the need for open and clear referral pathways, the state actors have taken specific actions such as the Protocol of GSGE mentioned earlier, to make the public support services accessible. However, a number of additional measures should be taken, if full accessibility to public services is to be ensured, such as a more reliable transfer system, amendment of the entrance criteria to public shelters, especially by raising the age limit of male children, dissemination and consensus on the Protocol's provisions to every actor involved in the GBV response system and implementation of suggested amendments[66]. The appointment of GBV focal points in most of the camp settings and RICs by KEELPNO, as well as the decision of the MoMP to appoint focal points of GBV in the RIS, despite existing

[66] As reported by several Key Informants interviewed in Athens

challenges with regard to the clarity of their role, their mandate and their competency to respond to GBV cases, are certainly important steps in the right direction.

As far as the service providers are concerned, the research shows that informal networks and personal contacts often play a crucial role among field professionals when they try to navigate through the referral processes. Although the referral pathways seem clear when drafted in paper, the reality on the ground reveals a hidden and much more complex process which is challenging both for service providers and beneficiaries who attempt to access the needed services.

> *"One of the main problems we face in the field is the complexity of referral pathways. If an organisation does not have its own referral pathways* (meaning providing all services, our comment), *the situation could be very complicated"*, a participant argued (Key Informant Interview with Service Provider, Thessaloniki).

From the perspective of the beneficiaries, the main challenge lies in that they are expected to navigate their way through a system of services constantly changing in terms of 4Ws. In addition to that, the existence of different entry points into the protection system and of different actors that may first identify and handle or refer a GBV case, could have a further disorienting effect on the survivor. Navigating through the maze of referrals and taking a long (path)way in order to finally reach the GBV services, is not the exception, but a common experience among most of the interviewees. There have been cases where even after a GBV incident was disclosed to professionals on the field, neither service provision nor referral to a GBV actor followed, resulting in a great delay in the provision of services and discouraging the beneficiary[67].

For GBV survivors, apart from the established entry points through service providers (e.g. hospitals, NGOs providing services, police), friends, neighbours and relatives may also act as referring persons ("word-of-mouth" approach). Among former service users a considerable number entered the support system through informal access points such as "a lady at the bus station" or "a co-patriot on the street", whereas in two cases, it was through the beneficiary's own initiative and persistence to finding the GBV services that access was achieved (self-referral). Extensive re-routing (i.e. referring the case from one organization to another), apart from disorientating survivors, also obliges them to present their demands and needs in a repetitive manner in front of various actors, which is not only a waste of resources for the service providers but also detrimental to the survivors' own sense of helplessness. Repetition of a painful story to a number of actors, next to triggering feelings of helplessness, also violates the "do no harm'' principle as it can generate

[67] As reported by two former service users during the interviews conducted in Athens

false expectations and may result in retaliation risks and re-traumatisation of the person seeking help. In one of the interviewees' own words:

> *"And sometimes, like, for other… you will go there, they will show you appointment… sometimes they don't talk to you, you will be shouting and you will move from here, go to the side… the other time…I said "I want to ask you a question", I came here, you know. This process here we don't know. Most of the things, we don't know, because if you go here, they will tell you "go here", if you go here, they will tell you "go here", if you go here, "go here", like…"* (participant in Focus Group Discussion with Community Members in Moria)

A promising practice in order to encourage self-referrals and facilitate and standardise referrals to existing actors that was shared during the field research is the implementation of regular meetings/info sessions (run by NGOs) on GBV and women's rights among the refugee women in the camps. Next to serving as a GBV prevention activity, it constitutes a successful GBV response practice: it creates a platform that facilitates self-referrals as entry points to the services.

4.4. Additional remarks

By way of concluding this chapter, reflecting upon some critical points and formulating relevant recommendations can be of great value to address the remaining. **Long-term funding for GBV related services** has not always been available and accessible to all actors, especially national NGOs, despite the fact that are highly dependent on it. Short-term funding (e.g. 3 to 6-month project's duration) and time lapses between funding, apart from creating service gaps, do not facilitate strategic planning regarding further development of their response capacity. Indeed, GBV actors are often deprived of motivated, well trained, specialised and experienced staff, precisely due to the lack of employment security.

It is important to add that in the course of 2018 several (I)NGOs withdrew their GBV-related services from the camps, mainly because of lack of funding. At the same time, when KEELPNO was appointed as the GBV focal point, the handover by previous GBV actors proved challenging as the new procedures to be followed had not been proactively ensured. For a certain period of time, this added to the perplexity of the referral pathways among both state and non-state actors; a situation which has not been fully resolved to this day. Another major concern raised by all field professionals and Key Informants (KI), relates to the **coordination gap** among GBV state and non-state actors, once UNHCR no longer carries out this role. It was also observed that several agencies and state entities are gradually less involved and less engaged in

coordination groups and forums, such as the SGBV Working Groups initiated by UNHCR[68] that are set up at the national or regional level. This makes it difficult to systematise and promote the coordination and collaboration of all actors as well as ensure a smooth transition with regard to GBV response. This challenge needs to be addressed as a matter of high priority, given also that no (state) actor has yet been identified to take the lead and that relevant discussions/consultations on this critical matter have not taken place yet either.

Furthermore, there is an urgent need for the joint development with the involvement of all actors, of a robust long-term plan and a broader GBV strategy for all populations in Greece, so as to reach an inclusive response and ensure the sustainability of the progress succeeded. Such a strategic plan should reinforce and complement existing efforts by filling the existing gaps in services, by making best usage of the capacity of both state agents and NGOs, by securing at the same time the optimum allocation of resources (financial and human) as discussed by KI and other field professionals.

Another concern raised was about the lack of reliable data about GBV cases, (e.g. GBVIMS), as there is no agreement yet among the various actors on common data collection system and every GBV actor uses its own. Moreover, there is no system in place that would allow an overview of the GBV cases occurring and reported throughout the country, as no agent/institution is charged with this type of data collection. Some primary data from the public GBV services i.e. SOS line, Counselling Centres and Shelters are collected by EETAA, yet these do not include crucial parameters such as nationality. In addition, they do not record cases serviced by NGOs. Common GBV case management tools such as consent forms and intake forms are endorsed and included in the national GBV SOPs. The interagency referral forms are regularly updated in order to reflect emerging needs and are subsequently endorsed through the Protection Working Group of UNHCR. However, all the above-mentioned tools are not practically applied and consistently used by all relevant actors in the field. Overall, the absence of reliable data about GBV cases leads to limited ability of evidence-based programming, hinders policy design and assessment of the effectiveness of specific policy measures, including the possibility of reliable evaluations based on measurable outcomes.

Finally, despite the fact that respect for confidentiality is paramount, both within the organisations' own Code of Conduct and within the relevant European legislation, there is a strong **need for a Sharing Information Protocol that will be binding for all GBV actors.** This Procotol would provide clear guidance on when confidential information may be shared e.g. in cases of emergency and life-threatening situations or in cases where reporting is obligatory by law (as in the case of children survivors of GBV).

[68] UNHCR co-chairs the SGBV Working Group with the General Secretariat on Gender Equality to coordinate the prevention and response to SGBV in Greece. The SGBV WG has developed Standard Operating Procedures, while in Thessaloniki and Lesvos, regional SGBV sub-WGs coordinate on specific issues in the field where the risk of SGBV is even higher.

> *"We had to deal with issues of collection and storage of sensitive personal data. We realized that each NGO had laptops in every camp where they collected and stored personal data. Of course, they had no such permission from the Hellenic Data Protection Authority"* (Key Informant Interview with Policy Maker, Athens).

Given the fact that the national support system is addressing female GBV survivors only, the response to male survivors was considered a main challenge by the participants. Services to cover their needs have to be well thought out according to Standard Operating Procedures (SOPs), which are however missing in large. Although a spectrum of services is seemingly available in all regions where field research has been conducted, there are still significant gaps, especially with regard to integrated GBV case management. This hampers the ability to respond to the diverse needs a refugee GBV survivor faces. The fragmented provision of GBV services creates additional challenges in coordination and prolongs the referral of the beneficiaries from one service to another to the detriment of addressing their needs. In addition to that, long-standing barriers hinder accessibility to services. The most important gaps in the provision of services and the barriers impeding access to existing services are summarised below and analysed in more detail in the next chapter.

5. KEY FINDINGS: AVAILABILITY, ACCESSIBILITY AND QUALITY OF SERVICES

In the following chapter, the key findings from the field research are presented and crucial information and insights are highlighted and synthesised into an evidence-based assessment regarding the availability, accessibility and quality of GBV services. The availability of the services is examined through a regional perspective and within the context of the current transition process. The assessment of availability seeks to highlight existing as well as upcoming gaps and shortages in relation to actors, services and needs of PoC. The accessibility of the available services (both public and NGO led services) is discussed on the basis of identified and existing barriers created by service providers and the constraints experienced by the beneficiaries themselves. Finally, the quality of the services provided by both state and non-state actors is analysed through the lens of a survivor–centered approach, capable of serving users with diverse needs and socio-cultural backgrounds.

5.1. Availability of GBV related services

Availability, barriers and impediments in Lesvos and Evros

In the context of Lesvos, where the majority of refugees reside in the overcrowded RIC of Moria (three times over its capacity), a great number of demands regarding GBV cases/disclosures are in practice impeded due to the lack of adequate human resources. In order to cope with the problem, it has been decided by all actors (based on what they shared during the FGD conducted in Mytilene) that specific priority and selection criteria will be put in place, before beneficiaries can be characterised as eligible for GBV services: i) the incident has occurred in Greece, ii) the perpetrator is close to Moria/there is an immediate risk, iii) the incident has occurred during the last 3 months. Although this system of prioritisation seeks to facilitate response within a context of the severely limited resources, it is far from being ideal since it excludes specific GBV cases and may further marginalize the affected persons, for instance survivors who experienced GBV in the country of origin and/or during their journey to Greece. The capacity of the available human resources is further reduced by the multitude of often unrelated tasks professionals are expected to perform. Front-line professionals, such as psychologists and social workers, often have to carry out administrative work (FGD SP, Lesvos) becoming thereby unable to provide proper GBV case management to all incidents reported. **This results in survivors feeling even more helpless,** as mentioned during the FGD in Moria, in the case of a GBV survivor who had asked for psychological support:

> *"If you don't fall on the ground and start screaming they will pay no attention to you" and "they told me if I need a psychologist now, I should go to a private one and pay myself"* (Focus Group Discussion with Community Members, Moria).

In the Evros region, as mentioned by almost all Key Informants and during the FGD with service providers, a) there is a lack of psychosocial support in the RIC, and b) the distance between the RIC (Fylakio) and urban areas where the public sector services (hospital and the local Counseling Centre) are based (Alexandroupoli), together with the scarcity of available means of transportation to refer cases, hampers accessibility and leaves the majority of the needs uncared for.

The child protection system leaves unattended the needs of children GBV survivors

Little attention has been paid to this day to children survivors of GBV, a major gap in the service provision that is related to the lack of Child Protection actors (both state and non-state) specialised in child GBV programmes, as mentioned by several Key Informants. This gap in available services is even more evident when child victims of trafficking are concerned, for whom specialised infrastructure and staff are needed to raise the response capacity of the Child Protection system in Greece[69]. Another significant gap is the lack of any type of specialised/protected accommodation, which would also provide the relevant GBV support services to GBV child survivors that are referred and hosted. As a result, there is a resort to *ad hoc* and often inappropriate solutions for identified survivors such as staying longer than needed in hospitals before any accommodation placement is secured, which also creates the risk of being identified and/or threatened by the perpetrator(s) (KII 22, Athens). This gap was also raised by field staff in the hospital:

> *"…we take care of the children, the truth is, it's taking too long, some children, healthy children, might stay for 3 months or 6 months and also the investigation […] is not easy"* (Focus Group Discussion with Service Providers, Athens).

The lack of this type of infrastructure/specialised service, together with the challenges of providing accommodation in UAC shelters, leaves the children for long time **in precarious living conditions[70]** (informal accommodation/homelessness), exposes them to safety risks and limits the overall capacity for effective protection. Despite the recent development of a database (operated by EKKA and funded by UNICEF), which has accelerated the whole procedure for placement of UAC in accommodation , the situation remains challenging, especially due to shortcomings in available places. Furthermore, in the absence of a formal procedure that would ensure that children are placed in accordance with their age, for instance in order to avoid hosting 17-year-old boys together with 11-year-old ones, creates additional risks of GBV[71]. In addition, diminishing GBV risks and in particular risks of child-on-child abuse, is strongly linked with the lack of consistent existence of Child Safeguarding policy and procedures, that will be formally endorsed but also operationally adopted by the management of shelters and respected by all professionals.

[69] As stated during Key Informant Interview with service provider in Thessaloniki
[70] Approximately 2.351 UAC remain in a waiting list to be accommodated of whom 477 are homeless, 253 in informal housing arrangements, 135 under protective custody and 289 have no specific location registered, Situation Updated provided by EKKA, July 2018.
[71] As stated during Key Informant Interview with child expert in Athens

Another relevant concern that was raised in the course of the field research was the low rate of GBV incidents reported among children populations accommodated in shelters. This may be related to the well-documented low reporting rates among male GBV survivors, given that the majority of UAC hosted in such shelters are boys. Moreover, the small number of disclosures is presumably related to the absence of a supportive and trustful environment that would encourage disclosures or prevent in a proactive manner the occurrence of GBV incidents prevailing in the majority of UAC Shelters, rather than the actual absence of GBV incidents as such[72]. Further on, the small number of disclosures is related to a lack of gender mainstreaming approach, in the context of which, both boys and shelter staff would be more sensitized to address abuse and sexual violence occurring among adolescents.

> *"The shelter staff reported tragically low rates [of GBV incidents], the history of sexual victimization of the reference population, i.e. the UAC, which is consistent with the low rates of official recognition of SGBV survivors, which in turn tells us not that none of these children have been sexually abused, but rather that* ***the system is set so that they do not tell us, we never learn****"* (Key Informant Interview with Child Expert, bold ours).

Limitations in the management of cases where both mother and children have experienced or witnessed GBV in the context of domestic violence were also observed. **Coordination or inter-agency approaches among Child Protection actors and GBV case management services is hardly in place** to ensure the provision of integrated and complementary protection and support. To effective respond to such cases, the need for training in the complexity of those cases in order to enhance the capacity of front-line professionals was raised on various occasions[73].

In conclusion, although the allocation of UAC to shelters in urban areas is a positive step within the Child Protection system, major weaknesses, such as the lack of acknowledgement of the need for specialised GBV services, capable of identifying and responding to sexual violence within the already established context of Child Protection, remain.

Major gaps in specialised services for male GBV survivors

There is a considerable lack of specialised services for adult male GBV survivors. Although some NGOs have recently started providing services to male survivors of GBV, mostly in the urban areas, in camp settings there is still a great need for actors and focal points, competent to make referrals. The lack of relevant data makes the number of male GBV disclosures almost anecdotal. Drawing from DIOTIMA's data and on the basis of the cases received, the estimated ratio is approximately six (6) male survivors for every hundred (100) female ones. The KIIs and FGDs with the service providers revealed great barriers that male survivors experience in disclosing GBV, partially attributable to the feelings of shame

[72] As shared by two Key Informants, a child expert in Athens and a child care service provider in Alexandroupoli
[73] As stated during Key Informant Interview with child expert in Athens

and guilt caused by individually and/or collectively shared social norms, especially when faced with male professionals and co-ethnic interpreters. In the context of accommodation in apartments in urban settings, potential entry points and referral to GBV services are the staff i.e. social workers/psychologists and the accommodation managers, who have however a high number of residents under their responsibility (1 carer/60 apartments). In addition to that, many have only received induction trainings which are often not adequate and they usually lack the necessary sensitisation to build trust and encourage GBV disclosure. This deficiency, coupled by dominant gender perceptions and stereotypes, leaves the real number of male GBV cases hidden.

The interviews with former service users revealed that compared to female former service users, male survivors face additional difficulties. Access to services is limited due to a number of persistent obstacles, which include lack of awareness/training of field professionals on male GBV as well as absence of processes and tools to identify male survivors. Consequently, male vulnerability related to GBV often fails to be identified and properly assessed by all relevant actors. The male former service user who was interviewed for the purposes of this research, reported that he reached the services only after having approached the actors himself and having sought support in a persistent manner. However, self-referrals are not the norm and it is safe to assume that male GBV survivors have to go on a long "journey" in order to gain access to the appropriate services and nonetheless still run the risk that their vulnerability remains unidentified[74].

A further observation that was shared by the male former service user during the interview, was that even though he had been recognized as being in a bad mental condition, he did not ask to talk with a psychologist. This might be linked to the stigma a GBV disclosure bears, especially when it comes to male survivors. As one participant in the focus group with service providers in Athens underlined, rape and sexual assault against men are often perceived as signifying a threat to their masculinity and undermine their self-esteem. The conclusion that can be drawn is that, next to the inadequate existing services for male survivors, self-stigmatization is on the other side of the coin. These two parameters together compose a large part of the picture of the poor male GBV response system. In practice, this means that single men that are GBV survivors may end up living in the same place, especially in the camps, with the perpetrator(s). In a few cases of male GBV survivors on Lesvos island, the absence of specialised services failed to prevent further traumatisation, such as incontinence among men traceable to repeated rape back in their country of origin, as reported by MSF[75].

[74] As expressed during an interview with a former service user in Athens

[75] https://blogs.msf.org/bloggers/liz/%E2%80%9Cit-difficult-believe-europe%E2%80%9D-mental-health-crisis-moria-camp

Absence of adequate protection services for Victims of Trafficking

Throughout the field research, it became evident that there is **a gap in existing data and data collection mechanisms** to account for the trafficking phenomenon in Greece and, more specifically, in the context of the recent refugee crisis. NGO A21 is the major referral actor that has established cooperation with the majority of the relevant actors, due to its specialisation and unique presence in specific regions (i.e. on the islands and in Northern Greece). As it comes out of the following quotation the interconnection between trafficking and recent refugee influx, is stated:

> *"[In terms of] Ethnicity of VoT survivors is predominantly of African origin... Now that I was at Samos, the people there reported a new wave from Africa, from Central Africa mainly: Cameroon, Nigeria, Ghana, Gabon, DRC[...] We had many ... in early '17, people from Dominican Republic, but now it starts again, and they aim for Spain, because they are Hispanic. And as of the other…, we see from Afghanistan and Pakistan, especially young boys, there is a very big issue there, it has ... it has grown a lot and there is probably interconnection between Athens, Thessaloniki and Lesvos. [...]"* (Key Informant Interview with Trafficking Expert, Thessaloniki).

Even though Greece is considered to be primary a transit country, it is also a destination for many Victims of Trafficking (VoT). The provision of services to survivors of trafficking is a complex and highly demanding process which requires a multi-dimensional approach, including dealing with high levels of protection and serious safety risk for both beneficiaries and field professionals; expertise in the identification and screening of the case in terms of risk assessment; an immediate operational safety plan including protected accommodation/shelters, as well as good levels of cooperation and coordination among different state actors, e.g. police, non-state actors and service providers (KII 20, Thessaloniki).

In terms of response, apart from A21, KEELPNO has prepared a set of tools[76] to help identify VoT (including children). Notwithstanding the contribution of this initiative to the identification of VoT, dysfunctions in identification and screening procedures (e.g. overcrowding in the reception conditions and lack of human resources) continue to be observed in the RICs, hampering the provision of the relevant services. Moreover, public actors in urban areas that can be related to trafficking are mainly limited to services, such as hospitals and police.

It is noteworthy that to this day there is still a great lack of specialised services for trafficked children, especially boys. In the words of a Key Informant Interview on the situation of children among refugee populations:

[76] https://philosgreece.eu/images/MyMedia/pdfs/informative/trainingGR/Trafficking_and_smuggling-Apo_ton_orismo_stin_praxi.pdf, http://www.southeastsafenet.eu/publications(through Southeast SafeNet Project).

> *"There, the biggest problem is **that the number of boys that are suffering sexual exploitation is constantly higher and higher,** especially because they want to pay off the expenses of their journey, a fact that places them in the position of the possible victims. And for this issue there are neither enough services nor specialised staff* (Key Informant Interview with NGO Service Provider, Thessaloniki)

Last but not least, there are **no specialized services offering support to adult male victims of (sex) trafficking**. Although male victims of trafficking do exist, there are huge gaps in Greece's male trafficking response; an area which is heavily under-explored. Further research is needed in this field and special services are still waiting to be designed. An important step in this direction is the SOPs for male VoT that have been developed by A21 in Central Macedonia.

The critical absence and the urgent need of Rehabilitation and Integration programmes in the GBV response system

Rehabilitation and integration services, a critical stage of the so called Tertiary prevention of violence, which includes interventions to prevent relapse and to ensure socio-economic re-integration of GBV survivors, have only recently become available by state actors such as the GSGE and EKKA shelters, mainly through the form of employment counselling. However, refugee GBV survivors face a number of obstacles to accessing these programmes/services, which are in principle aimed at GBV survivors within Greece's entire population. Such obstacles include the limited time a beneficiary is usually allowed to stay in the shelter, as well as language barriers, since no interpretation is provided. Female refugees are often deprived of the opportunity to get knowledge about how to secure their livelihood on their own means and, in the absence of other financial support or social network resources, they often end up returning to an abusive environment.

Integration programmes, specifically tailored to support the capacity for autonomous living among refugee GBV survivors, are in large non-existent. One alternative is currently being offered by the communal Day Centres run by NGOs and civil society organisations in the big cities (Melissa, Diotima and Chora in Athens, Blue Dots and Social Solidarity Centres by Solidarity Now in Athens and Thessaloniki), as well as in the city of Mytilene on Lesvos (Tapuat, Mosaic, Bashira). These Day Centers offer a range of activities and learning opportunities to the refugee population. Operating with the "one-stop-shop" model, meaning providing a multiplicity of socializing occasions, language learning courses, cultural and recreational activities e.g. music, dance, handicrafts etc encourage involvement, not to mention creating a trustful environment in which GBV survivors are empowered to disclose (as witnessed by the DIOTIMA's field teams). In this sense, they are considered an example of a good practice and a valuable social experiment/initiative that could also be adopted or utilised by state planned integration policies and programmes to ensure greater substance. To this day, however, the National Integration Strategy (MoMP) is still in the process of internal consultation prior to its

public declaration and the opening of the relevant calls for proposals, amidst widespread acknowledged by many other actors of the urgent need to proceed with its actual implementation.

The safety and security of survivors is undermined by lack of police intervention on the sites

Since the beginning of the 'refugee crisis', significant progress has been made in order to ensure safe living conditions for women and girls in RICs and open accommodation sites. Security issues, such as locks on doors, working lights, sex segregated toilets and showers, safe spaces fall under the competence of the site management (and/or site management support). The conditions of security are improved in some camps in the mainland, but remain inadequate at border locations, with Moria being a particularly notorious example, and tend to be overlooked within any accommodation facility that becomes overcrowded.

Safety and security issues (including reports on incidents of violence in general and GBV in particular, possible removal and/or arrest of the perpetrators, referral of the survivor to forensic services) in camps, RICs and urban settings are handled by the police, with the exception of the Skaramagas camp were a private security company has been subcontracted. The mandate of the police includes intervention in cases of incidents of violence. In the camp settings, however, police remains outside the gates, usually with two police officers on duty and one police car per shift. In the RICs the police remains within the premises of the centre. However, the police do not always intervene due to lack of available police staff members but also lack of training and senisitisation on GBV related issues. It should be noted that the inactivity of police officers in cases of GBV is a commonly observed weakness of the response across the country and might affect any GBV survivor independent of ethnicity or background. Consequently, although there are spaces reserved for vulnerable populations (children and women) in many camp settings ("Safe Spaces for UAC", "Female Friendly Spaces", designated wards), the level of security achieved within these spaces varies significantly and cannot be easily sustained, while overcrowding (i.e. in Moria) and limited supervision render such spaces often accessible to perpetrators of GBV and/or traffickers.

With regard to the reporting of GBV incidents, it was mentioned quite often by the community members that the **police officers are not sensitive enough when handling a GBV report.** Whether a GBV survivor (or a person at risk) reports the incident to the police by herself/himself or is accompanied by an actor, cases where their claims were not even written down in the police incident book (as provided for by the relevant legal procedures) have come to the attention of the research team. Moreover, accountability procedures are not always initiated on time contrary to existing legal provisions (e.g. *ex officio* prosecution), resulting in the perpetrators being able to continue to threaten the victim of GBV and effectively leaving the survivor unsafe and unprotected. Unsurprisingly, survivors end up often seeing no point in reporting a GBV incident. As mentioned by a female GBV survivor in Moria:

"*I told them [to the police] I was attempted to be raped and they did not believe me*" (Focus Group Discussion with Community Members, Moria).

Emergency situations putting the protection system under strain

Emergency GBV services during weekends and after working hours **are rarely available,** especially in camp settings, as most actors are out of office. Although GSGE and EKKA have an SOS helpline, referrals are not possible without a facilitating actor who would identify the GBV emergency incident and make the referral during the non-working hours and days.

"There was an emergency GBV incident, Friday afternoon at 6 o'clock. And there was nothing we could do. Because all structures, and the entire system, do not work on the weekend" (Key Informant Interview with Service Provider, Athens)

This gap is filled in *ad hoc* manner by NGOs which seek to alleviate the situation by providing emergency accommodation services (e.g. DIOTIMA, Solidarity Now). Nonetheless, this solution is not itself sufficient in relation to the magnitude of the needs.

5.2. Accessibility of existing GBV related services

Psychological Support and Mental Health issues

GBV survivors, as discussed by former service users, identify psychological support as one of their most significant needs. The need to talk and be listened to is more than a therapeutic process and a way to deal with trauma, but an ultimate means for survival:

"I must be able to speak, because if I don't, I will die" (Interview with Former Service User, Thessaloniki).

Nevertheless, access to PSS services is often overtaken by the need to first ensure safe accommodation, food, cash, and documents of legal residence etc., which have to be covered before a person may feel ready to open up and tell his or her "story". Consequently, the availability of psychological support to GBV survivors may be proven in practice ineffective or may have a limited impact for as long as major concerns regarding the survivors' future livelihood remain in limbo.

Notably, in cases of camps and/or RICs where basic human needs are poorly met and living conditions are substandard, (e.g. Moria), the unsuitability of the environment often acts as an aggravating factor to the further deterioration of the psychological well-being of many survivors. As a participant in the FGD with service providers in Lesvos remarked:

> "*But I think, the main thing is the lack of psychological support for survivors of SGBV who **continue to be re-traumatised daily** in the conditions that they live in, without any support".* (Focus Group Discussion with Service Providers, Lesvos).

Although, psychological support is offered by various state and non-state actors in both urban and camp settings, there **is a lack of long-term psychological support.** Public shelters for female beneficiaries, for instance, only allow up to 12 sessions per person, which even then might not always be possible due to the scarcity of available interpretation services.

Actors that do provide long term psychological and mental health support, such as the NGO Babel, have witnessed a growing demand for MHPSS (in general, not only among GBV survivors) that exceeds their resource capacity. To maintain the quality of the services and prevent field professionals from work overload and burnout, there is currently a long waiting list of beneficiaries and prospective beneficiaries. As a result, the mental health needs of refugees might remain unmet for a considerable period of time. It may take up to several months for a GBV survivor to access the service, which is a vital shortcoming in effectively attending to their needs.

KEELPNO's recent involvement in GBV case management in the camps is mainly related to health issues i.e. medical case management, as it is considered to be better equipped to undertake such a responsibility. This approach has resulted in a rather medicalised approach towards GBV cases, instead of an integrated approach which would take care of all different needs and traumatic experiences survivors have to cope with including restoration and legal aid support to protect their rights. This is partly explained by KEELPNO's medical-rather than GBV-oriented organisational mandate. Moreover, not all NGOs or state actors have available psychiatrists. In the camps where KEELPNO is present there are huge delays in the provision of mental health services (up to three (3) months for an appointment) due to limited number of specialised staff (psychiatrists) to proceed with diagnosis and pharmaceutical therapy.

> *"I go to them and they tell me come back other time. We don't have appointment. And I go every day and nothing"* (Focus Group Discussion with Community Members, Moria).

Mental health assessment has also proven a barrier for some GBV survivors to accessing GSGE shelters, which on account of their regulatory framework/mandate cannot accept female residents with mental health problems, even if the survivor has been under medical treatment for a long time. The whole matter becomes even more difficult to be handled properly during GBV case management, as it may take months to get an appointment for an assessment by a public hospital psychiatrist. Practically, this means that GBV survivors who face psychiatric problems have no access to safe accommodation – a major gap in the GBV response system.

Transfer of GBV survivors to services creates additional accessibility barriers

According to the GSGE Protocol, the actor which recommends the referral of a GBV case (state official or certified NGO) is responsible for escorting the beneficiaries and their children from the sites either to the Network of GSGE structures or to the Municipality's Social Services, as well as to EKKA. Transfer to, from and among the public services in both urban settings and sites remains however highly problematic and often renders the available services inaccessible. The GSGE Protocol, for instance, does not contain provision regarding the availability of means of transport by the Municipalities. Gaps also exist in connection to facilitating the transfer from the Counselling Centres to the shelters as well as between camps and Counselling Centres. Underlying the persistence of this gap is the intersection of various factors, such as lack of either human (staff) or material resources (gas/cars), lack of interpretation, as well as deeper-running parameters, such as lack of funding and possible lack of prioritisation of this kind of service provision.

It is mainly the NGOs that often fill this gap, albeit with limited resources and only if they have authority to transfer GBV survivors. Transfer is thus a very critical issue as it directly impacts on the management of severe GBV cases which require emergency medical evaluation in hospitals/health care services and/or transfer to the police or judicial services (prosecutor/forensic). The **lack of available means of transport and/or escort services** to the different agencies creates a *de facto* accessibility barrier to reaching public shelters mostly from the camps, even when such referral has been made by a public service, as described by hospital/medical staff participating in this research (FGD SP, Thessaloniki). In the words of one state actor:

> *"I have spoken to my coordinators in the camps how to transport the victims. We do not have any way to transport the GBV survivors!"* (Key Informant Interview with Public Officer, Athens).

Finally, it is important to mention that despite the existence of some programmes, such as the UNHCR-funded project of METAdrasi that provides escort services to GBV survivors from their place of residence to the EKKA shelter upon a referral made by EKKA, this type of short-term projects, do not guarantee any sustainable solutions in the long run. In view of all the above, there is a clear need to amend the Protocol in order to better regulate issues related to the transfer of GBV survivors[77].

Interpretation: a critical component in the GBV response system affecting the available services

Since 2015, there has been a significant increase in the availability of interpretation services among state-led services, while NGOs have been covering most of the needs during the initial response as well as during the current transition stage.

[77] As shared during a Key Informant Interview with a service provider in Athens

GSGE's response to refugee women GBV survivors, in particular by securing their eligibility to be serviced by the National GBV Support Network, was supported by KETHI which provided the Counselling Centres and Shelters with interpretation services through eight (8) interpreters (primarily female), based in Athens, Thessaloniki and on Kos island. In addition to that, interpreters were provided to cover the needs of other public services, such as hospitals and EKKA. In response to regional needs, such remote Counselling Centres/Shelters lacking access to locally based interpreters, interpretation over the phone or via Skype was also made available. Support to cover the interpretation needs of Counselling Centres and Shelters has also been provided by the Migrant Integration Centres operated by Municipalities e.g. in Thessaloniki. However, only eleven (11) Municipalities have established such centres to this day. These centres are designed to function as information points for migrants and refugees, including for survivors of GBV with regard to the available services. The availability of interpreters through the ''PHILOS'' programme run by the public actor KEELPNO has contributed towards addressing the constantly growing needs, especially in camps and on the islands. The major provider of interpretation services continues to be the national NGO METAdrasi, which has been providing (upon request) its services to hospitals and other actors, both state and non-state ones, reaching its full capacity to meet demand.

Acknowledging the need to cover these gaps and also ensure the quality of interpretation services, the MoMP is planning to regulate the working status of interpreters –in their majority, third country nationals. Nonetheless, the lack of interpreters for less common languages creates barriers for specific ethno-linguistic groups to gain access to GBV services.

A common concern among NGO practitioners, state service providers and service users, is the **limited number of female interpreters**. Especially for female service users, such a gap acts as a deterrent to seeking psychological support (PSS) or medical examination in public hospitals. Moreover, the partial availability of a female interpreter during the asylum interview (and other important procedures) does not reportedly lead to disclosure and ensuing identification of a GBV case by the asylum service officers and appeal committees, a fact that might prove detrimental for the survivor's claim (EI 5, Athens).

From the perspective of **former service users, the interpreter is not perceived as a neutral mediator between her/him and the actor:** the presence/non-presence of the interpreter, the gender, the ethno-linguistic background, her/his behavior and professionalism or lack of it, are of paramount importance to the beneficiary and may facilitate or block entrance to the service itself. For instance, the scarce availability of interpreters at police stations and public hospitals has led to repetitive visits by the beneficiaries seeking access, due to the fact that the survivor has to return when the interpreter will be available. This can discourage and demotivate the survivor, who may feel exhausted and disappointed

after continuous appointments. Indeed, in one case, the lack of interpretation at the police station restricted a woman from filling a complaint and opening a legal case against her abusive husband[78]. In other cases, the medical results could not be delivered to the beneficiary due to lack of interpretation[79]or the medical examinations were conducted with the use of body language[80]. Even in situations of emergency, interpretation has reportedly become available only after several days[81].

In view of the scarcity of interpreters and in order to respond to the existing needs, it is not uncommon for some NGOs and for the police to use **members of the community as interpreters,** who often lack however proper training on interpretation, let alone GBV related principles. The mere presence of an interpreter with strong ties to the community may deter survivors from testify in front of the police and/or court out of fear of being stigmatized and facing retaliation from the community:

> "S*he left in the night… she did not report it finally… even though our prosecutors begged her almost, she said NO you will not be able to protect me from my community*" (Key Informant Interview with Public Officer, Athens).

According to one interviewee, another cultural and gender related-barrier, related to the above, which bars access to services (e.g. hospitals, police, NGOs) is the reported attitude of **gatekeeping** among certain (male) interpreters. There is a tendency to discourage female GBV survivors from proceeding with reporting their case, due to prevalent cultural norms that the interpreter abides with[82].

Persons acting as interpreters/cultural mediators but not following the relevant Code of Conduct or not respecting the principle of confidentiality, in large due to oversights in their training on GBV issues, were also mentioned by service providers and users of services as one of the deterrents. Incident of sexual harassment against a GBV survivor by a male interpreter was also shared with researchers in the context of an interview with a former service user. The survivor subsequently left the organization without reporting the incident, out of fear of the interpreter's reaction.

Moreover, a considerable number of interpreters/cultural mediators lack knowledge of the Greek language and interpretation takes place to and from English; a fact that complicates communication in particular when they provide their services to public officers, whose knowledge of the English language is often elementary.

[78] As shared by a former service user in Athens
[79] As shared by a former service user in Thessaloniki
[80] As shared by a former service user and by a Key Informant service provider in Athens
[81] As shared by aformer service user in Athens
[82] As shared by a former service user in Athens

In sum, there is ample evidence not only of the scarcity and/or low quality of the available interpretation services in the various public service sectors (police, courts, hospitals, GBV specialised services), but also in the context of penal procedures interpretation is only scarcely available to GBV survivors, notwithstanding the existence of legal right to have access to interpretation during any legal procedure (through lists of accredited interpreters). To make matters worse, the low quality of some interpretation services risks jeopardizing the whole GBV case management procedure.

The criterion of vulnerability may leave the needs of GBV survivors unattended

According to Article 14(8) Law 4375/2016 on **reception and identification** procedures applicable principally to **newcomers,** the following groups are considered to be vulnerable: unaccompanied children; persons who have a disability or suffer from an incurable or serious illness; the elderly; women in pregnancy or having recently given birth; single parents with children; victims of torture, rape or other serious forms of psychological, physical or sexual violence or exploitation; persons with a post-traumatic disorder, in particularly survivors and relatives of victims of ship-wrecks; victims of human trafficking. The vulnerability assessment, which is first applied during the reception and identification procedures, may also take place during other stages of the asylum procedure. In mid-2017, the responsibility for health services in RICs and camp settings was transferred to state actors, such as the Ministry of Health and KEELPNO.

The recognition of vulnerability is critical towards ensuring the rights of GBV survivors or of those being at risk of GBV. Apart from giving access to a series of rights (asylum/international protection, relocation, lift of geographical restriction on the islands), the characterisation of an individual as vulnerable may also secure easier access to accommodation and GBV support services.

In RICs however, the long delays, the shortage in human resources and the dysfunctional identification processes, as well as other gaps in the provision of the relevant services described earlier, reduce significantly the capacity to conduct a proper vulnerability screening in the reception and identification procedures, as a result of which many cases of GBV survivors remain unidentified.

In the course of the field research, an updated vulnerability assessment form was drafted and shared by KEELPNO. Nonetheless, the identification of vulnerable individuals remains a challenge. On the one hand, it requires the involvement of a range of professionals from different fields (medical, administrative, psychosocial) who have to be able to work with the same evaluation system while having different priorities and approaches. On the other hand, it is not unheard of for PoC to try to utilise the vulnerability assessment channel as a way to escape the abhorrent conditions of living they are exposed to, by placing claims that often bring discomfort to field professionals.

> *"That is, they press a doctor, give me a paper! He/she might have an old bone break since 5 years, it will be remembered now that it hurts. And cannot be treated in Mytilene, but in Athens. Or during another period, we had [problem] with the neurologist, that all suffered by epilepsies… someone told them that if you get the vulnerability paper, you will go faster… it is logical"* (Key Informant Interview with Public Officer, Lesvos)

also

> *"they all ask for a psychologist for vulnerability"* (Key Informant Interview with Service Provider, Lesvos).

There is a shared perception among field professionals/protection officers, particularly on the islands (e.g. Moria), that female refugees may report incidents of rape or threat of rape to "gain" the vulnerability status in order to ensure access to better treatment and/or in order to lift the geographical restrictions; a behaviour that risks being used as a pretext for overlooking the refugees' actual needs. GBV actors in Moria, both state and non-state ones (UNHCR, KEELPNO, RIC, Asylum Service, DIOTIMA) have been aware of that risk and make efforts for better screening and identifying GBV cases and properly referring them to local service providers.

The vulnerability assessment has been criticised also from the point of view of **who is conducting the assessment** (currently it is the obligation of the camp manager), with what knowledge and what capacity especially inside RICs, after the PHILOS programme comes to an end. In relation to the law of 2016, one participant critically observed the following[83]:

> *"Well yes! I disagree with that law because you put a man who has not the background to declare vulnerability. Practically, vulnerability is not the responsibility of the medical and psychosocial team [of KEELPNO]. According to the law it is the obligation of the camp manager. And does he know to just whether a person has a chronic disease or is a victim of GBV? But he has not the background for this[…]. It is at his disposition to accept it or not"* (Key Informant Interview with Policy Maker, Athens).

[83] Law 4375/2016

Asylum and judicial procedures hinder access to GBV services and fail to safeguard equal access to justice

Difficulties in accessing the asylum procedure (due to the requirement of Skype preregistration for those in the mainland and long waiting lists) leave **many GBV survivors in a stressful situation with regard to their legal residence**, which in its turn negatively influences the decision to disclose a GBV incident. In the majority of the exit interviews with former service users, it became evident that before legal residence has been attained and the ability to cover one's basic needs has been achieved, in other words some autonomy has been established, GBV survivors are reluctant to seek help with the experience of abuse (most referring to domestic violence) and ask for more specialized services.

Access to justice is undermined by several barriers in the context of public procedures, such as the lack of a confidential environment during the trial to ensure that the survivors can testify without the presence of the perpetrator. These canals undermine the scope of free legal aid and representation in court and turn the proceedings into a traumatic experience. In addition to that, the long delays in the judicial procedures undermine the survivors' sense of trust into the judicial system and into accountability procedures. The complexities of other regulatory procedures, such as getting divorce from an abusive husband when the cooperation of two judicial systems (Greek and that of the country of origin) is needed, reporting a GBV incident when the legal fee of 50 euros to the police is a prerequisite (apart from cases of domestic violence), and practicalities, such as the lack of interpretation services, raise additional obstacles. Issues as the ones described act as deterrents to the decision to take legal action, as a result of which many GBV survivors never have the opportunity to move forward and find closure. One former service user, who wanted to report an incident, described how she paid the fee but in the end was never able to file the complaint, as there was no interpreter available at any times that she visited the police department:

> "*I had gone by myself in the police. They told me that I should give 50 euros for a paper. I paid and then when I got them the paper they told me that they had no interpretation. I went everyday and there was no interpreter"* (Interview with Former Service User, Athens).

The failure to disseminate timely information to the Greek police about the special provisions applicable to migrant and refugee GBV survivors has also been documented. As mentioned earlier, cases where police officers arrested female refugee GBV survivors for being undocumented (without any documents or with expired Police Notes) have been reported. Moreover, the state-run free legal aid scheme is not sufficient in practice, since there is reluctance among lawyers to respond, creating thus long waiting lists of beneficiaries, which limit its overall effectiveness (DIOTIMA's Legal Department observations).In light of all above-mentioned barriers and shortcomings, GBV survivors are often unable to access the legal and judicial protection they are entitled to.

5.3. Quality of the available services

Great need for capacity building to ensure better quality of services and sustainability of the system

It is undisputed that during the last three (3) years important progress has been made with regard to the capacity building of front-line workers. Trainings on GBV related issues, such as GBV case management, on gender and violence organised by International Organisations as well as by local NGOs (indicatively DIOTIMA, IRC, UNICEF, A21, IOM, UNHCR, and UNFPA) have taken place. In several cases, based on pre- and post- training questionnaires, the knowledge of professionals that participated has been advanced. The trainings have targeted state and non-state professionals from a wide spectrum of specialties, including police officers, social workers, psychologists, case managers, health professionals, UAC shelter staff, teachers and non-formal educators, as well as GBV specialised professionals. It is indicative that several of this research's FGD participants shared that they have received capacity building on GBV. However, **significant gaps in knowledge and/or in skills required for applying this knowledge have been noted**. These gaps concern practical aspects, such as procedures (SOPs), protocols (GSGE Protocol on Cooperation), referral pathways, as well as matters of cultural and gender sensitivity regarding GBV survivors. For example, public hospital staff were not aware of the Protocol on Cooperation (FGD SP, Thessaloniki & Athens), showcasing that it has not been disseminated at the hospitals in such a manner as to reach all staff members. Furthermore, there is still much room for improvement for police staff in order to be competent to handle GBV cases properly and safeguard the rights of vulnerable people (children, GBV survivors, refugees). Moreover, as mentioned earlier, **breaches of the Code of Conduct** by interpreters have been documented, as mentioned in two former service users' interviews, a fact that demonstrates –among other issues – the need to further train and guide this group of professionals[84].

It is important to underline that, despite the fact that capacity building on GBV related issues has been available, **the impact of the acquired knowledge with regard to GBV is not yet distinctively evident on the field**. It is imperative that more focused trainings are designed, based on identification of gaps and assessment of needs. Last, apart from tailor-made capacity building curricula, there is a strong need for the formulation and implementation of specialised trainings that will help strengthen the response capacity towards less attended aspects of GBV, such as male survivors as well as children survivors of GBV.

[84] As expressed by two different former service user in Athens

6. CONCLUSIONS

By following a mixed methodology comprising desk review, service mapping as well as field research through Individual Interviews and Focus Group Discussions with service providers, key informants, community members and former service users, the current research indicates that a great spectrum of rights remains unfulfilled, that a series of gaps and shortcomings in the field remain and that barriers to full accessibility are still evident. The below concluding remarks aim to outline ongoing priority gaps and shortcomings by following the different stages of the GBV case management procedure. The research findings suggest that although significant improvements have been made with regard to GBV services' response ability and a series of good practices are in place, under the current conditions, a lot more needs to be done; there are many actions that need to be taken and several milestones that need to be attained. All aforementioned challenges outline the need for more sophisticated and more competent – in terms of gender and cultural sensitivity –GBV service provisions, which will be fully available and accessible to Greece's migrant and refugee population.

W**ith regard to the identification of GBV survivors** that takes place either though institutions and organisations that have the mandate to do so (such as KEELPNO at RICs, state officials and NGOs in the Open Accommodation Facilities and in the urban areas) and/or though procedures where identification might occur (such as Asylum Interviews), there are still important gaps. In particular, vulnerability assessments in overcrowded RICs, where the case load is extremely high, become very challenging and many GBV cases remain unidentified. In addition to that, inadequate and inefficiently trained personnel, whose capability of recognizing the signs of GBV is not guaranteed, limits even more the effective identification of GBV survivors; a shortcoming that becomes particularly evident in cases of male and child survivors of GBV. Further on, identification of GBV within the context of the urban settings, where services are scattered and GBV survivors may lack the tools or information to reach specialised GBV actors, remains a challenge. On a positive note, a significant and systematic increase of self-referrals is widely observed, especially in locations where systematic presence of GBV actors takes place (such as urban Athens) and at places where info-sessions are conducted (such as at Moria in Lesvos and urban Mytilene).

In the overall**, the safety and security of survivors is undermined by the lack of police intervention on the sites.** Evidenced already since the first period and in many instances**, the police's failure to intervene** in emergent GBV incidents occurring in the camps leaves survivors unprotected and the perpetrators legally unaccountable. Security issues are reported (particularly at border locations)**,** where overcrowding renders the "safe" spaces accessible to perpetrators.

Regarding referrals, survivors still have to navigate a complex system that expects them to address different actors in order to receive the services they need, whilst keep tracking of the changes in the referral pathways. Furthermore, service providers don't always have access to interpretation; and even when they do and even when the referral pathways function appropriately, making and/or receiving referrals during weekends and non-working hours remains challenging. Further to that, the **transfer and escort of GBV cases** either from camp settings to public services or among public services are rarely available. This is often the result of limited allocation of funds to local authorities to be used for transfers, even though the service is assigned to them through the Protocol on Cooperation, whereas in other cases it is the outcome of the overall limited capacity of NGOs to provide such services due to lack of funds and/or human resources (e.g. cars and drivers).

With regard to health care provision within the context of GBV, the scarce availability of interpretation in public hospitals is one of the most commonly reported obstacles. Moreover, the lack of adequate human resources in the RICs and some Open Accommodation facilities impedes accessibility to health services. While PEP kits are available all around the country, access to them might be hindered by lack of awareness of their importance by the actor providing care to rape survivors. Efforts have been made to mainstream the Protocol on Clinical Management of Rape to all actors that need it, yet gaps still remain. Overall, the need for more funds to be allocated for the deployment of trained and competent medical and paramedical professionals, sufficient interpretation and transfer is considered a key priority in order for the health care services provided by state and non-state actors to appropriately respond to existing needs.

Regarding **psychosocial services**, the lack of adequate funds causes uneven levels of available human resources and reduces the capacity of providing long term psychological support where necessary. While this is the case for all types of psychosocial support, the shortcomings become more evident when there is a need for professionals specialised in the support of GBV survivors. Moreover, as commonly shared by field staff, the available **GBV psychosocial support** may prove in practice ineffective for as long as major issues regarding the survivors' legal status and livelihood remain in limbo. To underline the above, in cases of camps and mostly of RICs, the living conditions and the whole environment act as aggravating factors to the further deterioration of the psychological wellbeing of survivors.

In regards to legal aid, the existing **legal aid** scheme is not adequate and additional programmes are needed. Free, state -run legal aid is mostly inaccessible, primarily due to the fact that lawyers offering their services are relatively few but also lack the necessary specialisation or have insufficient knowledge of the topic. The fact that only a few non-state actors are able to cover the costs of legal representation at court (legal fees) illustrates how dysfunctional the free legal aid system can be. Additional obstacles related to judicial proceduresarise out of the complexities of regulatory processes, such as the required legal fee of 50 euros to file a complaint (apart from domestic violence cases), inadequate

or improper interpretation services, as well as problems in the cooperation of two judicial systems (Greek and that of the country of origin) in cases of divorce. In light of the above, former service users shared that they have been unable for prolonged periods of time to access the legal and judicial protection they are entitled to.

With regard to safe accommodation and shelters for GBV survivors, there are significant concerns. Regarding shelters for female GBV survivors apart from limited places, female GBV survivors with male children who are older than 12 cannot have access. There are no accommodation provisions for male survivors; child survivors of GBV are often housed in hospitals or in shelters that have no staff specialised in GBV; and survivors who experience mental health issues have to overcome additional barriers and might in practice find it impossible to obtain safe accommodation.

W**ith regard to exit strategies,** sustainable solutions are still missing from the available interventions. Achieving an autonomous living is often undermined by the lack of gender mainstreaming in the cash card programme, which results in female GBV survivors being financially dependent on their husbands and, in several occasions, having no other option than returning to an abusive relationship. Further on, while a number of relevant activities are available (e.g. language courses, job counseling, soft skills and empowerment courses) and some survivors might be able to access them, there is a lack of funds allocated specifically to support GBV survivors' (re)integration, thus making full recovery and autonomous living after their exit of the service system nearly impossible.

7. POLICY AND PROGRAMME RECOMMENDATIONS

**Despite the institutional reformations bringing about changes in the mandates of some state actors since July 2019, the content of the policy recommendations presented remains conclusive.*

The research findings suggest that although significant improvements have been made with regard to GBV services' response ability and a series of promising practices are in place, under the current conditions a lot more needs to be done; there are many actions that need to be taken and several milestones that need to be attained. All aforementioned challenges outline the need for more sophisticated and more competent – in terms of gender and cultural sensitivity –GBV service provisions, which will be fully available and accessible to Greece's migrant and refugee population. To address the identified challenges and upgrade the existing GBV response capacity a series of policy-oriented actions in combination with a number of programmatic improvements are needed. Although most of these actions and improvements are linked to each other, some of these are aimed at all relevant stakeholders, whereas others cut across all levels of the GBV response and address a range of governmental agents from different sectors of policy making responsibilities. More precisely:

Ministry of Migration Policy/RIS

- Strengthening of the screening/identification mechanisms at RICs (Aegean islands i.e. Lesvos, Chios, Kos, Leros, Samos, as well asEvros land border) for all different forms of GBV cases by deploying specialised staff and , adopting a survivor-centered approach at all entry points.

- Ensuring RIC planning addresses women's protection needs including in designing provision of basic protection needs (i.e. lighting,food distribution ,access to hygiene/toilets/baths, police guards) with special care for single women.

- Strengthening of the role of GBV focal points at RICs by preparing job descriptions, offering specialised training and clarifying responsibilities and communication lines.

- Allocation of sufficient resources to Fylakio (Evros), in order to raise its hosting capacity and avoid hosting men and women and/or adults and minors in the same section.

- Establishment of clear GBV referral pathways during non-working hours and weekends for emergency situations, through appointment of GBV focal points at all sites. Provision of 24/7-response to emergency cases.

- Enhancement of the PSEA mechanisms by ensuring that each organization has a PSEA policy and procedures, has an appointed a PSEA focal point and that all humanitarian actors respect humanitarian principles and exhibit zero tolerance to such incidents.

- Provision of regular transportation to facilitate access from Evros RIC to the urban (state and non-state) GBV services.

Male survivors:

- Provision of specialised GBV services for male survivors (i.e. GBV case management, medical services, MHPSS)**.**

- Establishment of accommodation for male GBV survivors (i.e. emergency accommodation, shelters).

GSGE

- Establishment of **shelter and/or safe accommodation** for GBV survivors on the islands, especially for emergency cases in need for immediate removal from the RICs.

- **Revision of the operational rules of the shelters**, in order to allow entrance of female GBV survivors accompanied by their children, irrespective of age and gender criteria, so as to ensure efficient support for women and their children who are fleeing domestic violence.

- Establishment of **an emergency shelter in Athens and Thessaloniki, respectively** where great delays are observed and the available places are not enough for the short-term hosting of urgent GBV cases, namely until a survivor has gone through all the medical exams and other formalities in order to gain entrance into a more permanent (public) shelter.

- Provision of **multilingual interpretation services in all public shelters and in the 15900 helpline,** in order for survivors not to suffer isolation and withdraw.

- **Capacity building** of all GBV focal points, mainly working in sites and RICs, on how to identify and provide first aid services in case of a GBV incident.

- Establishment of a **national system of harmonized GBV cases/incidents data collection** to be shared.

- Revision of the "**Protocol on Cooperation for Refugee Women" of GSGE** to include recent developments i.e. regarding the role undertaken by the major state and non state agents, fill the gaps which have been systematically presented in the findings of the current research and make provisions for survivors living in urban settings.

- Wide **dissemination of the Revised Protocol on Cooperation** accompanied by specific SOPs, both to and within all signatory parties, to guarantee that each participating actor has made the Protocol's information known to all personnel and to establish its role as a binding document for all signatory entities.

- Establishment of a **coordination mechanism** to overview the interventions of all actors, ensuring the participation of state actors i.e. GSGE, KETHI, MoMP, KEELPNO, Asylum service, RICs, IOs and NGOs, focused on services, in order to address and reduce gaps and to reach operational optimization.

Ministry of Health

- Deployment of **specialised professionals** for **the provision of medical and psychosocial support to GBV survivors**, especially at Evros region, where most needed(i.e. child psychiatrist in General Hospitals of Alexandroupolis and Didymoticho and psychiatrist at the Asylum Service)

- Modification of **the Clinical Management of Rape Protocol.**

- Appointment **of female professionals (doctors,) as GBV focal points in selected hospitals,** in order to address the needs of women GBV survivors who mostly prefer to be serviced and examined by women.

- Development of an **FGM Medical Protocol** properly shared to all medical professionals in accordance with the Istanbul Convention, together with information campaigns about this harmful practice.

- Provision of **long-term psychological support services tohelp survivors**(women, men, girls and boys) who in the majority of the cases suffer (severe) psychological /mental health problems and are unable to even ask for help and given the long waiting lists in public hospitals (more than 3 months) for diagnosis and pharmaceutical treatment. To this direction the opening of new pathways to public clinics/centres of psychic health should be beneficial.

- Support and **supervision** of front-line professionals at RICs and the public services on the islands (hospitals, police, social services) to avoid their exhaustion due to the great pressure and stress accompanying their everyday working life, as well as establishment of **clinical supervision** for all personnel working with GBV survivors.

Ministry of Interior/Police

- **Dissemination of the Istanbul Convention** through the appointment of focal points, informed and trained tby GSGE, in various institutions/services (e.g. police, hospitals, educational institutions, social welfare services), in order to raise awareness among public and non-public professionals.

- Establishment of specialized units, i.e. GBV units, within police departments. Appointment of **female professionals, i.e. police officers,**as GBV focal points in selected police departments.

- Assurances for the **enforcement of the "*in flagrante delicto*" procedures**by police officers to increase accountability for perpetrators.

- Wide dissemination of practical **guidelines to police departments on legal developments** and policy measures relevant to refugee population and specifically for the treatment of GBV incidents, in order to address malpractices, occurring from this lack of information.

- **Abolition of the mandatory 50-eurofee** required from a survivor to file a complaint to the police for all forms of GBV (an exemption currently applicable only to domestic violence incidents).

MoLSS/EKKA

Child Survivors:

- **Dissemination of the Clinical Management of Rape Protocol** to all Unaccompanied Children (UAC) shelters, in order for staff to be informed and aware of where to refer survivors.

- Establishment of **legally binding regulations for Child Safe Guarding** to be followed in all accommodation facilitiesfor UAC.

- Provision of **emergency accommodation for children GBV survivors**, as a short-term solution, in parallel to piloting and developing foster care programmes.

- Adoption of a **collaborative response model**among state as well as non state actors that offer GBV case management, so as to ensure provision of support to both mothers/carersand children witnessed GBV throughout case management.

Ministry of Foreign Affairs

Trafficking:

- Greater effort to **respond to Victims of Trafficking (VoT), along with children that are suffering sexual exploitation**, that will include: staff with expertise in identification and screening, operational safety plan (especially for the sites), provision of protected accommodation and shelters and appropriate ways to deal with high safety risks.

- **Completion of the National Referral Mechanism for Trafficking** and wide consultation with all relevant actors about the new 5-year National Action Plan to fight Trafficking.

Ministry of Justice

- **Revision in the eligibility criteria (penury) for public (free) legal aid** so as not to be excluded refugee/migrant GBV survivors

Ministry of Economy & Donors

- Provision of uninterrupted, long-term funding for GBV case management services, emergency services (24/7 response, transport and emergency shelter), and targeted services to under-addressed groups: males, unregistered, LGBTQI individuals, homeless etc

Municipalities/Local Government Actors

- **Support of the Migrant Integration Centres (KEM**) in order to enhance their capacity to inform and refer GBV survivors accordingly.

- **Joint design and implementation of integration programmes** by state and non-state actors to support refugee and migrant survivors of GBV through customised language courses, job searching skills, soft skills, livelihood and empowerment programmes.

- Ensuring the **transfer of survivors** to the relevant services especially in regions which are difficult to reach, as well as from and to camps and in the urban settings, when needed.

- Continuous update of refugee.info, ACCMR platform and other important information-hubs with facilitating access tools for refugees.

IO and NGOs

- Implementation of specialised training on Child Protection and GBV issues to all staff working at RICs, open accommodation facilities and UAC shelters.

- Provision of **GBV case management services in urban areas** for those vulnerable GBV survivors who have no or easy access to public system i.e. males, unregistered, LGBTQI individuals, homeless etc, including legal aid, sheltering, MHPSS/health care.

- Establishment of **prevention, rehabilitation, empowerment, community mobilizing and male engagement programmes,** as well as recreational activities for GBV survivors in the urban and in the sites.

- **Community mobilizing** programmes to ensure systematic involvement of the refugee community in the protection and prevention mechanisms of GBV.

- **Facilitation of the cash card separation** for GBV survivors of intimate partner violence, as the male is considered by default eligible as the head of the family.

- Strengthening of female participation in decision making processes.

- **Provision of support to MoMP in conducting communication campaigns** on GBV related issues to all actors involved in camps (army, police, municipality and other administrative personnel).

Cross cutting

- Ensuring the availability of more interpreters in police, judicial services, hospitals and other social services, including an increased number of female interpreters.

- Conduct of **professional interpretation courses** accessible to all employed interpreters along with the provision of specialised trainings on GBV terminology to enhance cross-linguistic understanding.

- Implementation of **targeted trainings** for both public servants and (I)NGO staff on issues of identification and referral of GBV cases and proper use of interpretation services.

8. ANNEXES

8.1. Key Research Questions

1. What is the overall system of support for GBV survivors and how do the actors involved relate to each other?

- What is the regulatory framework governing the provision of GBV services (legal, policy, procedural)?
- What are the existing state- and non-state services for survivors (male, female and child/adolescent survivors –in camps and urban settings)?
- What are the identification and referral mechanisms in place for these services?
- What are the possible gaps and barriers in the identification, reporting and referral procedure?

2. How available, accessible, acceptable, are the services provided to the GBV survivors? What is the quality of the services?

- How and/or if the cases are followed up after the service is provided?
- Availability: How available are each of the services provided (e.g. medical, psychological, legal)?
- Accessibility: Are they 24/7? Are interpreters/cultural mediators available? Is female staff available? Are the services equipped with post-rape drugs? Is there available transfer for the survivors to the services?
- What is the quality of services offered?

3. What kind of GBV prevention policies/programs are available?

- Are there any gender equality promoting programs and/or programs that promote beliefs and norms that foster respectful, non-violent gender norms?
- Are there any specific policies and interventions taken to safeguard the exposure of the refugee population to a range of environmental specific GBV risks?
- Are there any outreach programs for GBV and gender inequality (i.e. awareness-raising and community training) available?
- Are there any multi-sectoral, (i.e. economic empowerment, psychosocial Counseling) activities available?

4. What are the specific barriers that refugee and migrants might face in accessing appropriate services?

- How do refugee and migrant GBV survivors maneuver through the barriers and what are the coping mechanisms they use?

- Which are the institutional factors in the macro/meso/micro scale that hinder the access to the services?

5. How the policies under planning take into consideration the gaps in the service provision (including the barriers in accessing the existing services)?

8.2. Methodology in details

With regard to the qualitative methods of the Focus Group Discussions, the Semi-Structured Interviews and the Participants' Observation, the following should be noted:

1. Focus Group Discussions

The FGDs were selected in order to identify gaps and/or obstacles, challenges and limitations in the referral system and pathways, account for (exclusionary) procedures regarding knowledge about GBV legal provisions, operational context/mandates, available resources follow up and exit strategies, learned practices in particular in terms of understanding consent. Moreover, latent and dominant attitudes and perceptions on the understanding of GBV survivors' needs and demands (both adults and children), cultural and gender sensitisation/diversification, as well as social ownership were also explored. Specific attention was paid to the (multiple) viewpoints of all relevant actors regarding GBV case management on the risks of gaps and overlaps.

a) Focus Group with Community Members:

Although the initial plan foresaw the implementation of four (4) FGD's with community members, the research team carried out more, in order to better capture the ways in which each setting differentiates the perception of the beneficiaries and in an attempt to better balance the information received from the community with that of the key informants. Male/Female interpreters/cultural mediators in the languages that each FGD was conducted facilitated the discussion. Each FGD lasted approximately 1.5 hours. Two researchers participated, one in the role of the moderator and the other of the assistant. Since the research team had both male and female interviewers and interpreters, the male FGDs were reached by the male researcher (with the aid of a male interpreter) and the female FGDs were reached by the female researchers (with the aid of female interpreters). Cases of child GBV survivors were discussed through fictional stories in the community members' FGDs. Finally, with regard to the physical safety of the participants and the researchers, the research team selected safe environments that were also familiar to the participants. As regards the psychological wellbeing of the participants in each FGD, a psychologist and case worker from the specialised organization DIOTIMA was on stand-by during the FGDs in Malakasa and Skaramagas to provide psychological services in case the participants felt uncomfortable or uncomfortable in the course of the discussion. The psychologist and case worker were not present during the FGD but in a room close to where the FGD took place. With regard to the FGDs in

Iliaktida, Solidarity Now and Melissa, the personnel from the relevant organizations that were present in the premises participated to this study. In Moria, staff members of the INGO Eurorelief, were also available. In none of the FGDs, did any of the participants feel uncomfortable in a manner that would impede the discussion or effectively terminate it.

b) Focus Group Discussions with Service Providers:

Participants had a minimum of half a year experience on the field, and could thus refer to their experiences and efforts with regard to GBV. The language of the FGD was Greek. However, since there were only few English speaking participants on Lesvos, interpretation from Greek to English and vice versa was offered to them. Cases of child GBV survivors were discussed through fictional stories in the FGDs with service providers.In Athens and Thessaloniki, the FGDs took place at DIOTIMA's offices. In Evros the FGD took place in the container of UNHCR in the RIC in Fylakio. In Lesvos the FGD took place in the premises of UNHCR. The FGDs lasted approximately from 1,5 hour to 2 hours. Two researchers participated, one being the moderator and the other one the assistant.

2. Individual Semi-Structured Interviews with Key Informants and Former Service Users

Qualitative data are often textual observations that portray attitudes, perceptions or intentions.[85]. Experiences that often remain hidden and marginalized can be approached via in-depth interviews. With in-depth interviews, researchers sought to explore the lived experience of the respondents.[86]Some of the former service users interviewed provided great insights and facilitated the researchers' understanding for the GBV phenomenon, by taking into consideration a variety of factors including their social, economic, educational, and cultural position in the community[87]. The interviews with Key Informants enabled the researchers to reconstruct their priorities and understanding of the issues related to the context of GBV. In total 33 semi-structured interviews with Key Informants and 10 exit interviews with former service users were conducted.

a) With regards to the Interviews with Key Informant the following should be mentioned:

The Key Informant Interviews aimed at identifying institutional limitations and legal framework constraints in relation to GBV (including female, male and child survivors), administrative deficiencies regarding accommodation, the degree of

[85] Conclusions made from collected qualitative data take the form of informed assertions about the meaning and experience of certain (sub) groups of affected populations. The key contribution of qualitative data is that it provides information about the human aspect of the emergency by acknowledging context to the priority needs of affected populations and with it respecting the core principle of needs-based assistance and ownership by affected populations.

[86] Hesse-Biber, Sharlene Nagy, and Patricia Leavy, 2007, Feminist Research Practice: A Primer. Thousand Oaks, CA, SAGE Publications, p.p. 118-119.

[87] Assessment Capacities Project, Qualitative and Quantitative Research Techniques for Humanitarian Needs Assessment: An introductory brief, ACAPS, Geneva, 2012,available at https://www.acaps.org/library/assessment#resource

comprehension and sensitivity towards an inclusionary and diversified approach to service provision as well as towards the need for reforms and amendments. Bottom up approaches in policy design i.e. consultation procedures, reporting mechanisms etc. were explored to evaluate their interaction. The relation between state and non-state actors, which traditionally are closer to the users under research, the synergies as well as the "competition" over resources, was investigated. Especially for the State actors, questions around the ways of including new users in public services (i.e. refugees/migrants), the resources needed for such an inclusion, as well as long-term strategic plans for their integration in the services-system, were also explored.

The interviewers led the discussion along a list of topics. Given that the aim was to generate narration, if the interviewers introduced other topics, the team tried not to interrupt them. Information on some of the topics was accessible via self presentations of the organizations in the web or in other sources. The interviewer was well informed about organisation/ministry/institution, so that there was no need to get this information through the interviewee. Thus, when questions arose from the public presentation of the organisation, the interviewers included them in the questions asked. Finally, the questions were evidence-based (as much as possible) by making reference to publicly existing reports that were reviewed during the desk research (e.g. Human Rights Watch, Amnesty International, Reports of Ministries, Reports of other NGOs), or by making reference to the first findings from the field. Cases of child GBV survivors were discussed in the interviews with Key Informants.

It is worth mentioning that initially the research team planned to conduct 15 key informant interviews. This increase in the number of interviews is the result of the on-going revision process based on field findings, the sector's complexity and the significance of interventions by other. The main reasons behind the increase of the key informant interviews can be captured as followed:
a. It was very hard for some Key Informants to join the planned FGD's for service providers due to their already fully booked working schedules, b. While scheduling the pre-planned interviews and FGD's, a number of new Key Informants were identified and selected based on the presumed importance of the relevant information they were going to provide, c. Furthermore, a significant number of key informant interviews were added after suggestions/recommendations that the research team received from UNICEF and from the General Secretariat of Gender Equality (GSGE), as well as from other members of the Steering Committee.

For the selection of the interviewees, the following variables (inclusion criteria) played a key role:

- Decision making/policy making capacity
- Knowledge

- Role/job description
- Administration practices
- Relevance (current and/or future)/ engagement in the field

b) With regard to Interviews with Former Service Users the following should be mentioned:

TH4 interviews revealed a number of objective factors such as language, information, knowledge, negotiating power, where support was needed as well as the levels of satisfaction and experiences related to service using, expected and actual assistance received etc. Resilience and agency were also discussed in order to gain valuable insights with regard to the coping strategies of the service users.

Regarding the selection of the interviewees, the team applied a set of criteria (profiling for the selection of the interviewees regarding gender, ethnicity is based on DIOTIMA's rich experience in the field), which were flexible enough to be reformulated when needed.

Out of 10 interviews, 9 were conducted with female users of services and 1 was conducted with a male user. For the purposes of this research, the team included those ethnicity groups within the refugee population (i.e. Syrian, Afghan, Iraqis) with the highest representation in the camps. No participant was under 18. Cases of child GBV survivors were discussed through fictional stories in the FGDs with community members as well as in the interviews with KI and the FGDs with service providers.
Methodological and practical issues for conducting the interviews were addressed as follows:

- Service provision: In order to be able to recruit the most suitable participants for the research, a further variable was considered, namely the timeline of a GBV incident/services provision. The incident should have happened more than 12 months ago whereas the service provision should have been completed in the last 6 months and at a minimum one month ago (with the exception of legal actions because of the specificity of the courts in Greece which need much time to process legal cases). The 12 month limit was based on the expectation that after that period of time, the survivor has taken enough distance from the incident to be able to share her/his own experiences. Moreover, this time limit ensured that no great changes in the service provision level of respond had taken place.

- Selection process: The pool of interviewees was drawn from urban and camp settlements where DIOTIMA is active. Former users of services were identified through DIOTIMA’s own recent registry of beneficiaries. The independence of the research group was highlighted, a fact that ensured the non-partiality of the responses. The principal of

confidentiality was underlined, and the service users were reassured that their responses will not be shared with the service provision department of DIOTIMA.

- Interpretation: Female interpreters were used for the female participants. The male participant was given the chance to choose whether he would like a male or a female interpreter and he decided to have a female interpreter present.
- Contact with former users: The researchers contacted the former users based on the means suggested by the users themselves (i.e. phone). The female researchers contacted both the female and the male service users. The first contact was made by the case workers of the service users in order to obtain the verbal consent that they agree to participate in the research.
- Researchers' sex: All the interviews were conducted by the female researchers according to the request of the service users'.
- Duration: The interviews lasted approximately 1 hour.
- Availability of the service user: The time and date of the interviews were arranged in consultation with the service users and upon their availability.
- Children: For the service users that brought their children, the team provided child care during the interview. This was also communicated to the participants during the arrangement of the interview in order not to pose an extra barrier for them to participate.
- Privacy and safety: In order to maximize privacy and provide a safe environment both physically and psychologically, the option of conducting the interview in DIOTIMA's premises was given to the participants. Thus, all the interviews took place in the premises of DIOTIMA (both Athens and Thessaloniki). Additionally, to avert potential physical, psychological, social and legal risks to the service users, the safety, rights, dignity and empowerment of the service users was a priority at all times, according to the survivor – centred approach the team followed[88].For this reason, a psychologist and case worker from the specialisedorganisation DIOTIMA were standing by during the interview, in order to provide psychological services in case the participants felt uncomfortable or distressed during the discussion. Referral pathways in case of GBV incident disclosure were in place as stated in the Protocol for reporting threats or risk of imminent harm (presented in the Inception Report). It should be noted though, that no such incident took place and all the interviews were concluded uninterrupted.

[88] A survivor-centred approach means that the survivor's rights, needs and wishes are prioritized when designing and developing GBV-related programming. The survivor-centred approach can guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which GBV survivor's rights are respected, safety is ensured, and the survivor is treated with dignity and respect. The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes. The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions. IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action. Reducing risk, promoting resilience and aiding recovery, 2015, pp 46, available https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf

Finally, in all research methods (i.e. FGDs and Interviews) the following material was disseminated to the participants before the discussion:

- a leaflet with relevant information on DIOTIMA'S scope and purpose.
- an Informed Consent Form, consisting of two parts (Information Sheet and Consent Form) translated into the native language of the participants
- a Complaint Form in the native language of the participants addressed to the Scientific Responsible of the research which was available in case the participants wished to report the researchers for maleficence.

3. Participant Observation

Participant observation in camp settings where DIOTIMA'S field teams are present was also used during the research in order for the enrichment of the research's data and results. DIOTIMA has a strong experience in GBV case management. At the beginning of the research and till May 18th of 2018 teams of GBV case workers (including legal aid lawyers) were deployed at Skaramangas, Malakasa, Ritsona, Thermopyles and Larisa/Koutsochero, Thessaloniki and Athens urban areas. The research team, which is totally independent of those field teams, had the opportunity to gain insights and anecdotal information through internal sharing mechanisms (information which is not publicly available but still very significant). Moreover, the research team had the chance to observe coordination/scientific meetings of the field teams and increase, thus, its understanding towards challenges in the field as well as mechanisms/strategies adopted by field professionals and/or survivors themselves.

Axes of questions/Topics of discussion

a) Key Informants
I) Mandate /Role in the GBV response system/Cooperation-synergies/Funding
II) Referrals/statistics/data collection/feedback mechanism
III) GBV programs/services
IV) Good practices, needs, gaps, and challenges

b) FGDs with service providers
I) Service provider's role in GBV response
- What is their response capacity?
- What kind of interventions, policies do they have?
- Do they have prevention policies?
- Have they ever received any training on GBV response?

II) Services / Access
- What services are provided and what are the obstacles in their provision?
- Do they consider the differences in nationality, age, gender of the beneficiaries?
- How do they approach various cultural issues?

III) Referrals/ Access

- How many referrals on average and by time unit - by whom (actors) and what processes are being followed
- How do the referral pathways work?
- How many actors are involved?
- Are they the right ones?
- How do they manage the follow ups?

IV) Good practices, Needs, gaps and challenges

- What worked well? How? Why?
- Gaps identified by service providers and their clients, challenges and solutions, resource needs (human resources, training, specialised tools).
- What can work better?

c) <u>FGDs with community members</u>

I) Protection issues – Safety.

- Do they feel safe?
- What are the protection issues they usually face?
- What kind of support do they need?
- How do they address their safety concerns to the actors?

II) Presentation of a fictional story about a GBV incident.

- Have they heard any similar case in the community?
- How did they handle this?
- If something like this is to happen, would they turn to an actor? Who?
- (If not) Why?

III) Service Provision

- Do they know of the services that are offered with regards to GBV?
- Do they use them?
- Are the services culturally sensitive? (i.e. do they take into account the specific cultural background of the beneficiaries)?
- Are the services adequate? Are they satisfied? What would they suggest as an improvement to the existing services?
- Do they have any example of good practice response to a GBV incident?
- What other services (related to GBV) would they suggest being considered by the GBV actors?

d) <u>Interviews with former service users</u>

i)How was she/he informed about her/his rights?

ii) What kind of services did she/he access?

iii) What kind (if any) of difficulties did she/he experience in the response system (e.g. language barriers, bureaucracy, time of await)?

- How many times did she/he had to visit the relevant services?
- Did she/he feel comfortable?
- Were the services culturally friendly/sensitive?

iv) Privacy (i.e. was any information of her/his case leaked to the community)?

v) Is she/he satisfied with the overall services? Did she/he find the solutions proposed feasible and sustainable? What worked well? Why? How?

8.3. Protection Protocol

Protection Protocol

Accessibility and barriers to GBV services

for refugee and migrant girls, boys, women and men in Greece

1. Background

Since 2015, the arrival of hundreds of thousands of refugees in Greece with very different social realities in relation to ethnic origin, gender, age, cultural background and their emerging needs has put the existing national response and protection system under strain. Several international actors stated from the beginning the need to safeguard human rights and to secure protection and safety of the affected population, in particular of those of vulnerable profile (i.e. unaccompanied children, GBV survivors and/or persons at risk of GBV, aged people, LGBTQI people, pregnant women, singled headed families, people with serious medical needs).

Within the above-mentioned context, the current research aims to identify the barriers in the accessibility to services for Gender-Based- Violence (GBV) survivors (refugee and migrant women, men, girls and boys) in selected regions of the mainland and the islands of Greece.

2. Purpose of the Protocol

Gender Based Violence is considered worldwide a violation of the fundamental human rights. This protocol outlines key principles and actions that will be taken by DIOTIMA research team to safeguard the rights of the participants in the current study, during its implementation.

The protocol will be validated by UNICEF and its external ethics review consultant. No data collection will be carried out before the validation of this instrument.

3. Ethical Considerations

A number of ethical considerations have been taken into account during the conducting of the research. The most important aspects include: confidentiality and safety; the need to ensure that the research does not cause any participant to experience further harm (including not causing the participant further trauma); the importance of ensuring that the participant is informed of available sources of help; and the need for the interviewers to respect an interviewee's decisions and choices. More specifically, the research implemented the following principles:

a. Respect

All evidence generating activities ensured respect for all persons. Respect demands that individuals are treated as autonomous agents[89]. It also relates to respecting the self-determination of participants, and protecting those who lack autonomy, including by providing security from harm or abuse.

b. Voluntary participation

Participation in the study was exclusively on a voluntary basis. No inducements have been made. Where appropriate, incurred expenses (such as for transfer) has been reimbursed. Participants were clear that refusal to participate will not result in any negative consequences. During the FGD refreshments and snacks have been provided.

c. Individual Informed Consent

At the start of all interviews and FGD's, participants have been informed of the purpose and nature of the study through the information and consent form. Signing a consent form or acquiring verbal consent and record that the consent procedure has been administered had been the two main options throughout the field research with regards to consent. As part of the consent procedure, the participants were informed that the data collected will be held in strict confidence. Verbal information on the consent form has been provided (where needed) via an interpreter. To ensure that the participant is aware that the research includes questions on highly personal and sensitive topics, the interviewer(s) forewarned the participant(s) that some of the topics are difficult to talk about. The respondent was free to terminate the interview at any point and to skip any question that he/she did not want to answer. The participants also received an information leaflet with the contact details of the research team and sources of support through the SGBV Working Groups' referral pathways for a range of problems. They have been also provided with an information sheet that was appropriately detailed and explicit about the fact the research contains questions relating to gender-based violence; however, this sheet haven't been left with participants if they did not want it, for safety reasons.

d. Confidentiality

Much of the information provided by the participants has been extremely personal. Confidentiality of the information collected during the survey was of fundamental importance. A number of mechanisms have been used to protect the confidentiality of the information collected, such as:

- All interviewers received strict instructions about the importance of maintaining confidentiality.
- No names have been recorded. Instead, participants have been identified using a unique code. Upon completion of the research, all confidential materials have been destroyed. In all further analysis, the codes have been used to distinguish cases.
- Tapes made of in-depth interviews (qualitative research) have been kept in a locked cabinet. No record of the name of the interviewee has been kept.

[89] An autonomous agent is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons' values, preferences, and beliefs and to recognize their ability to make judgments, to state their opinions and to make choices. In respecting an individual's autonomy, recognition is required that personal agency may be limited due to age, circumstance or personal capacities. In this context, respect for autonomy requires recognition of capabilities, power differentials and the degree of agency that an individual may have. In the context of children and other vulnerable groups respectful evidence generation needs to be situated in their lived experience with recognizing the reality of unequal relationships of power that frequently exist, crelating environments that support these individual's personal agency and dignity. UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis Document Number: CF/PD/DRP/2015-001 Effective Date: 01 April 2015 Issued by: Director, Division of Data, Research and Policy (DRP), available at https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF

- Particular care has been taken during the presentation of the research findings to ensure that the information presented was sufficiently aggregated so that no one community or individual could have been identified. Where case study findings are presented, sufficient detail has been changed to ensure that the source of the information cannot be identified.

e. Non-maleficence

Non-maleficence: The principle of non-maleficence, doing no harm, required avoiding harm or injury to participants, both through acts of commission or omission. While the primary purpose of research, evaluation and data collection and analysis were to generate new evidence, this goal never took precedence over the rights of individual participants. Non-maleficence required an examination of the profile, competencies and skills of researchers and enumerators to ensure no harm comes to participants by virtue of inappropriate, unskilled or incompetent researchers or enumerators. It also required explicit consideration of means to ensure the privacy of participants, their safety and any possible negative impacts arising from participation. The physical safety of interviewees and interviewers has been paramount. If the focus of the research became widely known – either within the household or among the wider community – the topic of the interview might have become known to a perpetrator of violence. For people experiencing violence, the mere act of participating in a research might have provoked further abuse. This might have placed the respondent or the interview team at risk of violence, either before, during or after the interview. For this reason, specific measures have been adopted to ensure that the research topic does not become widely known.

f. Justice

The principle of justice required that consideration is given to who benefits and who bears the burden of the evidence generation. This required that due reflection has been given to determining the appropriateness of proposed methods of selecting participants. Selection should have not resulted in unjust distributions of the burdens and benefits of evidence generation. Such considerations have been taken into account to avoid the injustice that arises from social, racial, sexual, and cultural biases institutionalized in the society.

Additionally, all other necessary steps for ethically appropriate research conduction have been followed such as: the respect and dignity of the research participants, transparency during the process with regards to funding body, conflict of interests and avoidance of biased results. Finally, among other resources/guidelines, the study also followed the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis CF/PD/DRP/2015-001 (UPES) and all tools and deliverables have been advised by Protection Protocols and Guidance Documents shared by UNICEF.

4. Protection Risk Matrix

Risk	Risk Mitigation	Responsibility
Individuals do not want to participate in the interview/focus group	● No data collection exercise will be carried out without obtaining the formal consent from the participant. ● Researchers remind the participant that he/she has the right to interrupt temporarily or definitively the interview/focus group at any time.	● Researchers ● Scientific Responsible

Focus group facilitators, interviewers and field researchers cause distress to participants	● Interviews procedure are designed in order to ensure that: (1) participants can take an informed decision upon participation; (2) participants can interrupt the interview at any time; (3) complaints are timely received and addressed during data collection; (4) possibility to be referred to special psychosocial assistance services. ● Interview tools have been designed in order to ensure an escalation of the question sensitiveness. Time breaks have been introduced to allow researchers to monitor participants' response to the questionnaire and ensure to pre-empt distress.	● Researchers ● Scientific Responsible
Participants express concerns or complaints about the interview / FGD process	● Researchers systematically provide the contact reference of the Scientific Responsible to all participants at the end of the interview and stress the Scientific Responsible's role as focal point.	● Researchers ● Scientific Responsible
Limited / no privacy	● Interviews shall be held in spaces where overhearing is not allowed. ● If privacy cannot be guaranteed the interview is rescheduled and researchers refer to the Scientific Responsible. ● If third parties are interfering with an interview or focus group, the researchers will interrupt the data collection exercise.	● Researchers Scientific ● Responsible
Confidentiality of data is compromised	● The research team designed a comprehensive Protocol for the Protection of Data establishing procedures to ensure that data collection, transmission and storage is secure and to protect the privacy of the participants (for more details, refer to the Protocol for the Protection of Data) ● The Scientific Responsible ensures DIOTIMA researchers comply with the Protocol for the Protection of Data. ● The Protocol for the Protection of Data has been approved by UNICEF during the Inception phase and any modification to the plan will need to be validated by UNICEF before entering into force.	● Scientific Responsible ● Researchers ● UNICEF

Dissemination of findings potentially identify participants	● Draft reports are reviewed by the Scientific Responsible to ensure that information cannot be traced back to individual participants. ● An addition double-check is provided by UNICEF Protection specialists that will make sure that assessment outputs do not entail risks for the participants.	● Scientific Responsible ● UNICEF
Limited / no privacy	● Interviews shall be held in spaces where overhearing is not allowed. ● If privacy cannot be guaranteed the interview is rescheduled and researchers refer to the Scientific Responsible. ● If third parties are interfering with an interview or focus group, the researchers will interrupt the data collection exercise.	● Researchers Scientific ● Responsible
Confidentiality of data is compromised	● The research team designed a comprehensive Protocol for the Protection of Data establishing procedures to ensure that data collection, transmission and storage is secure and to protect the privacy of the participants (for more details, refer to the Protocol for the Protection of Data) ● The Scientific Responsible ensures DIOTIMA researchers comply with the Protocol for the Protection of Data. ● The Protocol for the Protection of Data has been approved by UNICEF during the Inception phase and any modification to the plan will need to be validated by UNICEF before entering into force.	● Scientific Responsible ● Researchers ● UNICEF
Dissemination of findings potentially identify participants	● Draft reports are reviewed by the Scientific Responsible to ensure that information cannot be traced back to individual participants. ● An addition double-check is provided by UNICEF Protection specialists that will make sure that assessment outputs do not entail risks for the participants.	● Scientific Responsible ● UNICEF

8.4. List of participants in the research (Key Informant and Focus Group Discussions with service providers)

- **33 Key Informant Interviews** took place with stakeholders from the following 27 institutions/organizations in the four research regions:

INSTITUTION/ORGANIZATION	LOCATION
Institute of Child Health	ATHENS
UNHCR	ATHENS and LESVOS
IRC	ATHENS
METADRASI	ATHENS
RIS	ATHENS, EVROS and LESVOS
GCR	THESSALONIKI and EVROS
IOM	THESSALONIKI
Pre – Removal Centre in Fylakio	EVROS
AS	EVROS
Counseling Centre	EVROS
Didymotiho Hospital	EVROS
Centre for Psychological Health of Alexandroupoli Hospital	EVROS
ARSIS	EVROS
GSGE	ATHENS
Vostaneio Hospital	LESVOS
Kara TepeAdministartion	LESVOS
Solidarity Now	ATHENS and THESSALONIKI
MoMP	ATHENS
KETHI	ATHENS

A21	THESSALONIKI
EKKA	ATHENS
Ombudsman for the Child	ATHENS
EKEPY	ATHENS
Supreme Court's Public Prosecution Office	ATHENS
Ministry of Citizen Protection	ATHENS
UNICEF	ATHENS
KEELPNO	ATHENS

❖ **4 FGDs with service providers** took place in the 4 research regions with a total of 45 participants:

- 26 front line workers from 17 NGOs:
  - MdM
  - MSF
  - Babel
  - GCR
  - ARSIS
  - PRAXIS
  - METAdrasi
  - Melissa
  - Iliaktida/Perichoresis
  - ILIAKTIDA
  - DRC
  - IRC
  - Solidarity Now
  - Caritas
  - Eurorelief
  - SAO Assosiation - Bashira Centre
  - Showers for SistersRespond
- 7 front line workers from GSGE Counseling Centres and shelters
- 5 front line workers of UNHCR
- 2 front line workers from KEELPNO
- 2 front line workers from Public Hospitals
- 2 police officers
- 1 front line worker from the RIS

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https://www.acaps.org/

Activity Info
https://www.activityinfo.org/

AIDA– Asylum Information Database
https://www.asylumineurope.org/

Amnesty International
https://www.amnesty.org/en/

Council of Europe
https://www.coe.int/fr/web/portal/home

FRA – European Union Agency for Fundamental Rights
http://fra.europa.eu/en

EIGE – European Centre for Gender Equality
http://eige.europa.eu/

EKKA – National Centre for Social Solidarity
http://www.ekka.org.gr/

EUR- Lex – Access to European Union Law
https://eur-lex.europa.eu/

European Commission
https://ec.europa.eu/

General Secretariat for Gender Equality
http://www.isotita.gr/

Human Rights Watch
https://www.hrw.org/

IOM- International Organization for Migration
https://www.iom.int/

IRC – International Rescue Committee
https://www.rescue.org/

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http://www.keelpno.gr/

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http://www.who.int/

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