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To cite this article: Zahra Khazai, Maaïke Muntinga & Petra Verdonk (2025) 'First you are a victim, then a survivor and finally, a warrior': Perceptions of refugee women on sexual and gender based violence in the Netherlands, *Global Public Health*, 20:1, 2574000, DOI: [10.1080/17441692.2025.2574000](https://doi.org/10.1080/17441692.2025.2574000)

To link to this article: <https://doi.org/10.1080/17441692.2025.2574000>



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Published online: 02 Nov 2025.



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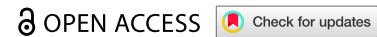


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RESEARCH ARTICLE



'First you are a victim, then a survivor and finally, a warrior': Perceptions of refugee women on sexual and gender based violence in the Netherlands

Zahra Khazai, Maaïke Muntinga and Petra Verdonk

Department of Ethics, Law and Humanities, Amsterdam University Medical Center, Amsterdam, the Netherlands

ABSTRACT

Women forced to flee their home countries face significant challenges, including sexual and gender-based violence (SGBV), which impacts their physical and mental health. Addressing SGBV is complicated by cultural shifts and interaction with new social and legal systems. This study explores how refugee women in the Netherlands perceive SGBV, particularly intimate partner violence (IPV), and how they explain individual and community responses within the resettlement context. We conducted 14 semi-structured interviews and one group interview with 17 women from Syria, Iran, Iraq, and Eritrea. Women's understanding of SGBV evolved over time, influenced by their experiences in the Netherlands. They gained new vocabulary to discuss SGBV and saw the Dutch legal system as a means to break the cycle of violence. However, they also identified context-specific barriers such as double victimization and dependence on partners for residence permits. Women preferred to identify as 'survivors' or 'warriors' rather than 'victims', emphasized supporting other women, and suggested men should also be seen as victims needing support. This study reveals the complex realities and meaning-making processes of refugee women in relation to SGBV. It underscores the importance of focusing on women's agency, and highlights the importance of centering their experiential knowledge in response efforts.

ARTICLE HISTORY

Received 19 February 2025
Accepted 7 October 2025

KEYWORDS

Sexual and gender-based violence (SGBV); refugee women; resettlement challenges; community-based strategies; resilience

Introduction

The world is currently facing a humanitarian crisis at an unprecedented level. The European Commission stated that as of May 2024, the number of displaced persons worldwide has reached 120 million due to factors such as conflict, violence, persecution, and the impacts of climate change (EC, 2024). Sexual and gender-based violence (SGBV) is one of the factors that render forced migration a major public health issue, disproportionately impacting women but also impacting men (Borges & Faria, 2020; Keygnaert & Guieu, 2015; UNHCR, 2021).

SGBV ranges from being a weapon of war and a crime against humanity to being an intimate relational problem, and combines both sexual violence and gender-based violence (Simon-Butler & McSherry, 2018). Sexual violence is defined by the WHO as 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work' (Krug et al., 2002, p149). Gender-based violence (GBV) does not have a universally accepted definition, but covers a spectrum of violence that includes gendered elements and is rooted within gender inequities, harmful norms and power dynamics (Simon-Butler & McSherry, 2018; UNHCR, 2020a). GBV includes partner violence, human trafficking, harmful traditional practices (e.g. female genital mutilation, forced marriages and honour crimes) and emotional and physical abuse (Simon-Butler & McSherry, 2018). SGBV is a major public health issue because of its prevalence and severity (Pharos, 2016; Robbers & Morgan, 2017). Health consequences of SGBV include sexual and reproductive health

CONTACT Maaïke Muntinga  m.muntinga@amsterdamumc.nl  Department of Ethics, Law and Humanities, Amsterdam University Medical Center, De Boelelaan 1117, 1081HV, Amsterdam, the Netherlands

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problems, such as unintended pregnancies and abortion, pregnancy complications, high risk of STIs and mental health problems, such as post-traumatic stress disorder (PTSD) (Pharos, 2016; Robbers & Morgan, 2017; Tavara, 2006).

A growing body of research addresses the experiences of refugee women with sexual and gender-based violence (SGBV) across different stages of forced migration (Phillimore et al., 2018; Keygnaert & Guieu, 2015; Phillimore et al., 2025; Robinson et al., 2025). However, comparatively, less attention has been paid to the continuation, transformation and emergence of SGBV in the resettlement context, particularly during processes of settlement and integration in host countries (Borges, 2024; Charles & Denman, 2013; Ozcurumez et al., 2021). Such attention is imperative, however, because in resettlement countries refugee women's vulnerability to SGBV often continues. In the resettlement context, women might be victimized by strangers, such as employees at refugee centers or other refugee center residents, or by people close to them, such as family friends, relatives or their own partners (Keygnaert et al., 2012).

The social impact of displacement journeys—broken connections and separation from community, a resulting lack of social safety nets, and changing gender norms in partner relationships—may make women particularly vulnerable to victimization (Fisher, 2013; Guruge et al., 2015). At the same time, experiencing violence might disrupt remaining community ties. This is compounded by multiple systemic challenges within the resettlement context: refugee women may face a lack of access to basic resources, racial discrimination, language barriers, lack of opportunities in education and work, and a vulnerable legal position due to, for instance, a dependent residence permit (Bartels, 2021; Borges, 2024; Ozcurumez et al., 2021). Stigma, loss of sexual virtue, internalized blame, and the (fear of) social rejection when experiencing (continued) victimization may exacerbate the loss of identity caused by persistent insecurities in resettlement countries (Yohani & Hagen, 2010). It has been argued that, as a result, women who have experienced SGBV might experience a sense of negative self-conscious emotions and rejection of their bodies, adding to their further marginalization (Kallivayalil, 2015; Mukamana & Brysiewicz, 2008; Papoutsi et al., 2022; Yohani & Hagen, 2010).

Although the international body of work on refugee women's experience with SGBV within resettlement environments is growing (Borges, 2024; Ozcurumez et al., 2021), the ways in which refugee women perceive and make sense of SGBV in the Netherlands is underexplored (Tankink, 2009). Understanding how SGBV manifests and impacts women and their communities during and after resettlement in the Netherlands is important to develop appropriate responses to the violence itself, but also to its short-term and long-term psychosocial effects. Experiences of SGBV do not remain confined to when and where the violence takes place, and the psychological impact of trauma on individual and collective mental wellbeing and relationships, even long after the violence has stopped, warrants an understanding of the interplay between psychosocial and relational factors, cultural norms, and the structural conditions that shape survivors' lives in the resettlement context (Ozcurumez et al., 2021).

For instance, Dutch cultural imaginations of SGBV as a racialized phenomenon might play a role in the way in which victim support services are organized and gained access to. Framing male Muslim bodies as 'the Other,' Western political agendas often associate the masculinities of Muslim men with religious orthodoxy, violence, and deviance. As a consequence, refugee men are frequently viewed as problematic and dangerous rather than as individuals who experienced dangers and who might be in need of support (Boukema et al., 2023), and are therefore often excluded from support programs. Additionally, in forced displacement, culturally defined gender relations and hegemonic masculinities are ruptured and may change in a new country, which increases the risk of victimization for women in relationships with men. In resettlement contexts, these risks are compounded by men's feelings of disempowerment and inadequate responses to shifting gender norms, sometimes leading to attempts to regain control through violence, as well as by additional stressors such as PTSD experienced by partners, the dehumanizing nature of long immigration processes, and acculturation-related challenges (Boukema et al., 2023; Keygnaert et al., 2012).

As regards health care, comprehensive care that accounts for the needs of refugee women who experienced SGBV is sparse. In the Netherlands, refugee women face financial barriers, a lack of culturally sensitive care, social exclusion and long waiting lists for specialized (trauma) care (Pharos, 2016). Services often focus on short-term relief for SGBV survivors, instead of long-term, comprehensive (prevention) strategies that consider the role of SGBV on settlement and integration. Moreover, current health and social

care interventions do not always meet the needs of refugee women, because their perspectives are not included in designing and implementing these interventions; it has been proposed that accounting for women's lived knowledge is essential for facilitating context-sensitive responses in health interventions (e.g. Ozcurumez et al., 2021).

In this qualitative study, we explored perceptions of refugee women in the Netherlands regarding SGBV (in particular intimate partner violence (IPV)), and how they explain individual and community responses to SGBV within the particularities of their resettlement context. The overarching aim of the study was to incorporate women's perspectives in the design and implementation of a series of support groups for refugee women, which were co-developed and carried out as part of a participatory health research project for refugee women in the city of Amsterdam, the Netherlands.

Theoretical underpinnings

To understand experiences of SGBV within the context of refugee women in (post)conflict and resettlement contexts, we used feminist systems theory (FST) and an intersectional approach. Both frameworks help to recognize the complexity and multidimensionality of refugee women's lives (Vaughan et al., 2015). FST particularly addresses gender and environmental marginalization, and as such applies to refugee women with SGBV-experiences. FST builds on cultural ecofeminism and critical systems thinking and includes five core principles (Stephens et al., 2010): (1) gender-sensitive approach; (2) value voices from the margins; (3) incorporate the environment within research; (4) select appropriate methodologies, and; (5) undertake research towards social change (Stephens, 2015; Stephens et al., 2010). The tenets of FST are in line with intersectionality theory (Crenshaw, 1989). Intersectional research approaches aim to platform the experiences of those whose everyday lives are concerned. Theorizing people's experiences as shaped by the compounding impact of gendered, racialized, classed etc. socio-structural processes, intersectionality posits that individuals are uniquely located across intersecting, mutually constitutive dimensions of social identity, and therefore that merely using single categories of analysis (such as 'refugee' or 'women') fails to capture the complexity of lived experiences and realities (Crenshaw, 1989; Crenshaw, 1990; Kapilashrami & Hankivsky, 2018; Vaughan et al., 2015).

Applying the principles of FST provides heuristic and grounded methods for the establishment of sustainable relationships between communities and their environments (Stephens, 2015). Such an approach is timely as over the next decades, the number of displaced persons will increase as a result of cascading problems, such as the climate crisis that push and catalyze forced migration. It is essential to note that intersectional dynamics are not fixed and might change significance depending on time and space; labels associated with privilege or marginalization take on different meanings across settings (e.g. differences between pre- and post-conflict settings) (Sokoloff & Dupont, 2005; Vaughan et al., 2015). During or after migration journeys, previous identities might lose their significance and new identities might emerge—for instance, women who belong to an ethnic majority or a high income group in the pre-conflict setting might find that their ethnicity or financial struggles minoritizes them in a post-conflict setting.

Materials and methods

Study design

We carried out an explorative, qualitative interview study to investigate the experiences of refugee women with SGBV, and to explore their perspectives on community-based approaches as structures of support and care. The study was the first phase of a community-based, participatory health research (PHR) project 'Women & Health' (ZonMw-funded 2020–2023) in Amsterdam, the Netherlands. The aim of the project was to develop, organize and evaluate peer support groups for refugee women who have experienced SGBV, with the intention to facilitate the conversation on SGBV, widen women's access to health care providers, and strengthen collaboration between local community organizations. Following PHR principles, academic researchers, community organizations and refugee women co-developed and organised four peer support groups each consisting of seven group meetings for Tigrinya and Arab speaking women (Khazai et al., 2022a, 2022b).

Participants and recruitment

For the interview study, we used purposive sampling to recruit participants (Green & Thorogood, 2018). When defining refugees, we adhered to the 1951 Refugee Convention of the UNHCR: ‘Someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion’ (UNHCR, 2020b). Inclusion criteria for participants were as follows: women with a refugee background, residing in the Netherlands for a maximum of five to six years (in line with Dutch legal characteristics for permits), 18 years or older and fluent in at least one of the following languages: Dutch, English, Arabic or Tigrinya. Additionally, participants had personal experiences with SGBV and/or have witnessed (the consequences of) SGBV in their social environment. Participants were excluded if they were younger than 18 years old, had no experiences with SGBV and/or have witnessed SGBV in their social environment and no refugee background.

Participants were recruited via networks of the researchers, through project partners (local NGOs) and through snowballing (Beauchemin et al., 2011). In addition, flyers were distributed via social media channels. Participants were contacted via phone or email. Seven interviews and the group interview were held online, in line with social distancing regulations during the Covid-19 pandemic. The interviews were carried out by the first author (ZK), who is a second generation refugee with an Arabic background. When necessary, a cultural mediator (interpreter) in Tigrinya who was trained in discussing SGBV was involved during the interview and participated in asking questions.

Data collection and analysis

Between February and August 2021, 14 semi-structured interviews and one group interview with three participants were held face-to-face or online. Each interview varied between 45–120 minutes and the group interview lasted for 90 minutes. We used an interview guide based on literature and input from project partners. Interview topics included women’s definitions and understandings of SGBV, their experiences with social and legal contexts in the Netherlands, changes in gender relations and dependency, and their narratives of silence and voice in the resettlement context. We collaborated with a team of trauma professionals to offer participants emotional support and referrals to a mental health care professional when needed.

During the interviews and the group interview, a fictional scenario in three parts about a Syrian (‘Samia’) or Eritrean (‘Senait’) woman, written during a creative brainstorm session with project partners, was presented to the participants. The aim of the scenario was to provide participants with an opportunity to discuss SGBV without having to share their own experiences: fictional scenarios are useful when discussing sensitive subjects (i.e. violence and sexuality), to support a less- or non-intrusive conversation and provide opportunities for disclosure of personal experiences only when participant want to (Barton, 2015). Initially, we included two scenarios: one in which the main character (Samia or Senait) experienced sexual violence, and one in which she experienced intimate partner violence. After the first interview, however, it became clear that discussing both scenarios might be too distressing for participants. While still exploring broader understandings of sexual violence, we decided therefore to use only the partner violence scenario as this was more likely to be part of the women’s present lives. Both scenarios can be found in the Appendices.

All interviews and the group interview were recorded and transcribed verbatim with the exception of one interview during which notes were taken. After transcription, the interviews were coded to determine recurring themes and patterns and further thematically analyzed (Green & Thorogood, 2018). Data saturation was reached for this specific topic, within this cohort when during no new themes and topics emerged from successive interviews; additionally, the themes that emerged from the interviews also were brought forward by women who participated in the peer support groups that were later organized as part of the PHR project ‘Women and Health’.

Reflexivity

The first author (ZK) has a background in health sciences and is herself a second-generation refugee from Iraq. She conducted all interviews and speaks Arabic, which enabled direct communication with Arabic-

speaking participants without an interpreter. This shared language and background might have helped to build trust, and might have encouraged participants to speak more freely about sensitive experiences. For the interviews with Eritrean participants, a cultural mediator (translator) was present, which could have affected the depth of responses and introduced additional layers in interpretation. The project leader (PV), a psychologist with a PhD in gender in medical education, is a cisgender older White woman with long-standing expertise in gender and health research and in social movements including the feminist movement. The third researcher on the project (MM) is a white, Dutch, queer-identified medical anthropologist and medical doctor who, at the time of the study, strongly focused her research on applying intersectionality and queer theory to gendered health issues, such as SGBV. The interviewer's, cultural mediator's, and researchers' positionality and interaction dynamics may have influenced data collection as well as interpretation of findings. Shared language and background may have encouraged openness and shaped what participants felt comfortable sharing. Familiarity with certain cultural references may have deepened contextual understanding, but also carried the risk of over-identification or implicit bias. Regular team discussions were held to reflect critically on these dynamics and ensure analytical transparency.

Ethical considerations

According to the Medical Ethical Committee (METC) of Amsterdam UMC-VU University, medical-ethical approval was not necessary for this study under Dutch legislation (2020.0633, January 2021). We received written and/or verbal consent from participants before interviews took place. Interview recordings were deleted after transcription. In order to ascertain confidentiality, we used pseudonyms. References to individuals and places that could potentially identify the respondents were omitted from the transcripts, and transcripts were stored in a secured server of the department of Ethics, Law and Humanities of Amsterdam UMC.

Results

A total of 17 women were included from Syria, Iran, Iraq and Eritrea. Table 1 presents their characteristics and pseudonyms. Two main themes were identified: 'Recognizing, addressing and escaping SGBV' and 'Silencing violence'. In the following paragraphs these themes and their subthemes will be explored.

Theme 1: Recognizing, addressing and escaping SGBV

Participants' accounts revealed how their understanding of violence shifted in the Dutch resettlement context, where new vocabularies, rights and institutional structures both enabled and constrained their ability to recognize and articulate SGBV.

Table 1. Participant characteristics.

	Name (pseudonym)	Age range	Country	Daily tasks and roles
1	Fatima	20–30	Syria	Student Social Work
2	Nazanin	30–40	Iran	Mother
3	Meryem	30–40	Iraq	Mother
4	Amira	50–60	Syria	Mother
5	Sara	20–30	Syria	Student Business Administration
6	Leila	40–50	Syria	Mother
7	Nadia	40–50	Syria	Psychologist and mother
8	Nora	30–40	Syria	Epidemiologist
9	Malak	30–40	Syria	Medical Doctor and mother
10	Bisrat	20–30	Eritrea	Unknown
11 (group interview)	Helen	20–30	Eritrea	Mother
12 (group interview)	Ella	20–30	Eritrea	Mother
13 (group interview)	Winta	20–30	Eritrea	Mother
14	Zula	30–40	Eritrea	Cultural coach
15	Jamila	20–30	Eritrea	Mother
16	Semret	30–40	Eritrea	Cultural coach
17	Lamis	20–30	Syria	Student Engineering

Giving language to violence and victimhood

All participants agreed that the character in the scenario used during the interviews (Samia or Senait, see Appendix) was experiencing 'violence against women' and that her relationship was abusive even without the occurrence of physical violence. Almost all participants clearly distinguished between physical and emotional violence. However, some participants wondered whether verbal abuse should be considered violence against women. Some women called violence 'a robbery of freedom', and the terms 'power', 'control' and 'physical force by men' were mentioned often when participants explained what they understood violence to be. Although most participants could explain what violence against women entailed, they also expressed concerns about the lack of knowledge about this kind of violence among women with backgrounds similar to theirs. They attributed this to education, explaining that they were not taught what SGBV is and how to recognize it. Some participants added that in their country of origin, violence against women was considered regular and therefore not understood as 'real' violence:

I was in Syria last year and I saw my aunt. Her husband had hit her and she had bruises. And she just thought it was normal that she was abused. I was so shocked and asked: 'Wow, what happened here?' My aunt started laughing and said (...): 'You have completely become Western, right?' (Fatima)

Beyond defining what counted as violence, participants also discussed the concept of 'victim', and who could be seen as one. This revealed differences between how Syrian and Eritrean participants understood victimization in the case of SGBV. In contrast to most Eritrean women, who all identified Senait as the victim and her husband as the perpetrator of violence, most Syrian participants pointed out that the husband in Samia's scenario might be a victim too. They suggested that he might have experienced violence himself, possibly suffered from psychological issues or war-related trauma, or had been raised in an environment where violence in intimate partner relationships was normalized. Syrian participants believed that naming men as potential victims was important, because defining them as deserving of support would identify them as part of the solution instead of the problem. Some women spoke from personal experience about men's role in ending violence. Nadia, for instance, mentioned that the abuse she suffered at the hands of a spouse only ended the moment her spouse's male friends intervened. She therefore stressed the importance of involving men in Dutch SGBV-prevention efforts.

Articulating and escaping violence in the social and legal context of resettlement

The social and legal context surrounding the violence influenced whether it could be explicitly articulated. Participants attributed barriers to use the word violence in their home countries to 'an unresponsive system', such as the legal system (i.e. police and courts of justice), because they felt that such systems were complicit in upholding and maintaining the structures and circumstances (such as gender hierarchies) that produced the violence in the first place. Some participants shared that women in their country of origin sometimes were conscious about violence and did understand their experiences as such, but that to publicly acknowledge experiences as violent was dangerous. In such cases, not putting words to experiences or even staying silent might keep and their family or community safer.

For instance, participants explained that one barrier to articulating experiences as violent was financial dependency on spouses, especially when women had children. They said women worry about what might happen to their children if they stand up to or leave their abusive husbands, and therefore stay in abusive relationships. Amira, a Syrian mother, said: '[My children] are the reason I kept trying.' In Syria and Eritrea there is no financial support system for women or organizations to help single mothers. Therefore, participants believed, in the Netherlands such barriers to escaping a violent situation could be overcome, because single mothers could achieve financial independence through paid work or social benefits. Hence, participants understood the Dutch system as more responsive to their needs, and as a system that often worked in their favor. They therefore saw their resettlement country as a place where violence could be more safely acknowledged.

While participants believed that some women in their home countries are aware that what they experience in their relationships is unjust, some participants shared that this awareness emerged after their arrival in the Netherlands. They explained how it took some time for them to realize SGBV was not necessarily 'normal', or could even be challenged. Bisrat, for instance, remembered: 'I began to realize here that I was oppressed all this time'. Meeting other survivors and, for example, non-governmental

organizations (NGOs) in the Netherlands gave them the vocabulary to describe what they or women in their communities were experiencing. For instance, Fatima explained how encountering social organizations had been a turning point for a woman in her community:

A Syrian woman who was in an abusive relationship just wanted to get a divorce. I asked her 'Why now? Why did you wait for five years in the Netherlands?' She told me that she just recently got in contact with organizations that could help her. (...) They [refugee women] do not know anyone in the Netherlands. (Fatima)

Although participants explained that in the Netherlands they were exposed to legal and social frameworks that encouraged them to break the silence about SGBV, they also stressed that such protection did far from eliminate barriers to addressing and escaping violence, and that everyday legal and bureaucratic obstacles remained. Participants made clear that such obstacles were felt deeply in daily life. Systemic factors such as asylum procedures and Dutch refugee laws hinder women's capacity to walk away from violent situations. For instance, under family reunification law, when women join their husbands in the resettlement country, the husbands often have greater knowledge of the local system and culture. According to participants, men sometimes withhold this knowledge from their spouses to keep their dominant position in the household in the resettlement country. Moreover, participants explained how some women depend on their spouses for their Dutch residence permit, which prevents them from leaving abusive situations. Leila shared she was forced to stay in an abusive and sexually violent relationship for five more years before she could finally apply for her own residence permit:

Many women want to get a divorce, but this is because they have experienced violence for many years, also in Syria. Many Dutch people talk badly about you, as if you just want to have your own house. I've been tired for 20 years due to my situation [abusive partner, ZK], can you imagine living for 20 years with a man who rapes you? If you get raped, you can yell, but not if it is your partner. I wanted to be done with this situation, but the laws are not helping here, so I have to stay in this terrible situation, until I get my own residence permit. (Leila)

Changing gender dynamics in the resettlement setting

Although, according to the participants, SGBV among refugees occurred both in their country of origin and the Netherlands, they argued that changes in gender dynamics and hierarchies, including changes in laws and legislation, had reshaped the way in which violence manifested in women's lives in the Netherlands. Some, for instance, had noticed that emotional violence had taken the place of physical violence since arriving in the Netherlands, because men were aware that SGBV was an offense and could have legal consequences.

Participants added that the tension between new possibilities and new constraints in the Netherlands could put pressure on traditional gender roles and disrupt household dynamics. While women in the Netherlands felt increasingly empowered to turn their situation around, they said, their male partners could not always renegotiate their social roles and, consequently, relationship dynamics shifted. Participants had observed that women were faster to adapt to Dutch value systems, while men continued to rely on the traditional gender norms of their country of origin. As Zula explained: 'A lot of Eritrean men are still in Eritrea in their way of thinking, they expect women to do their own duties and men also have their own duties'. As a consequence, for some, intimate partner violence began in the Netherlands. Nadia shared:

He [Nadia's ex-husband] saw two different cultures, two different worlds... and he could not bring those together. The inequality between me and my ex-husband was huge. So actually, he was struggling because I should be not equal to him, and (...) he wanted to live here as we lived in Syria. (...) The law was not in my favor in Syria, but here, it is. (Nadia)

According to the participants, men increasingly wanted to control everything and be in charge of decisions, because they were afraid to lose their status in the relationship, sometimes enforcing their will with violence. In these accounts, participants expressed that resettlement was not only a space of protection, but also a trigger for new struggles over status and authority.

Believes about violence and women's empowerment

Many participants linked experiences of SGBV to the duration of their stay in the Netherlands. The longer you stay, the less violence you experience, they reasoned:

I think that women who have only just arrived in the Netherlands are still very vulnerable to violence. (...) The longer they are here, the more they [...] will hear stories from other people [they come into contact with]. I do not think that women who have been in the Netherlands for a longer period of time still experience violence. There must come a day when they stand up for themselves and say 'no!' (Sara)

The belief that the longer women—both refugee and native Dutch—live in the Netherlands, the less likely they are to experience violence was widely shared among participants. As Ella said: 'I don't think that domestic violence happens to Dutch women. They are taught from a very young age what a woman's position is. We [Eritrean women] are ignorant and we come from a country where oppression exists.' Nora thought Dutch women would be open about their experiences with SGBV and seek help:

I understand from the way Dutch people think [and behave] that a woman going through such a situation wouldn't wait a second to be open about it, because there is an open society, they are open about everything. (...). And I imagine that girls growing up here already are aware how they can seek help if they go through such a situation. (Nora)

However, Nadia, had a different view:

(...) I don't think the educational level determines violence. Even if a country has a very high standard of living and is highly educated, it doesn't mean that sexual and gender-based violence do not exist. I also saw toxic behavior here. I think violence is universal, but the difference is the law and system here. (Nadia)

Others agreed with Nadia's point of view. As Zula put it: 'In every country a man is a man and a woman a woman'. Nevertheless, Zula states that a lot of Eritrean women think that SGBV does not occur in the Netherlands: 'Refugees hold stereotypes about Dutch people. They have the idea that the Dutch woman is empowered and independent. How can she then experience violence?'

Theme 2: Silencing violence

Building on the previous theme, in which women described how they came to articulate violence in the Dutch context, participants emphasized that speaking out was not straightforward: while it could bring relief and strength, it also carried risk of judgement, stigma and further harm.

Sharing experiences

Many participants considered talking about SGBV experiences 'strong'. According to them, there comes a point when women can no longer endure the situation and feel compelled to share their experiences with someone. Nora explained: 'She [Samia] is definitely strong. Because she eventually talked about it. (...) It takes a lot of guts to express yourself.' Others, such as Malak, agreed that sharing your experiences with others can be a relief: 'I think it really helps if she [Senait] talks about her experiences with someone, especially if that person has experienced something similar. This can give [her] strength.' Nazanin explained that sometimes one needs to talk and share their experiences in order to fully recognize the situation they are in. Nadia agreed:

As somebody who has encountered many sorts of violence, what I really wanted back then, is somebody telling me (...) 'You are in an unhealthy relationship'. (...) Back then, I would have really like to somebody to tell me what was going on, because I was very much lost. (Nadia)

At the same time, women explained that talking about SGBV-related experiences in the Dutch resettlement context was not only empowering but also difficult and challenging. Many women were never taught how to express vulnerability or share feelings and problems with others, especially problems related to violence. Nadia explained why:

Usually, in our culture (...) secrecy is the most important thing. They train you not to talk. And they cast you as a bad woman if you disclose what is happening in your house (...). [They say] 'She is not a good woman if she talks'. (Nadia)

According to the participants, sometimes talking to others is not possible at all. Women often stay in abusive relationships because their husbands socially isolate them, or refuse to accept outside help. For instance, participants said men might frame intimate partner violence as an issue that should be resolved between spouses, without outside interference. Winta recalled a discussion she had had with her partner:

I asked my partner: 'How do you see violence?' He said '[violence] happens in a relationship, you need to find a solution together'. But I disagreed, because I feel that men often say such things to prevent outsiders from getting involved.' (Winta)

Participants stressed that these silences were not only culturally imposed, but also reinforced by systematic barriers in the Netherlands. Some women expressed fear of being judged by professional organizations or by other women when they speak up. Nadia, a survivor of domestic violence, recounted how she experienced 'double victimization', because in addition to not being taken seriously by her community, she was also not immediately believed by those who were supposed to legally protect her: when she decided to go to the police, the Dutch police officer's racist assumptions about her background invalidated her experiences: 'But this is your culture', he had said when Nadia reported her story to him. Another woman explained that for Eritrean women, telling their story to the police or to other professional organizations can be very difficult, because they grew up in a country where they learnt to distrust the police.

Moreover, women were told by community members they were 'a disgrace' to their families and communities when speaking up and filing for divorce. Zula condemned how the community contributed to normalizing violence, including women from their own community: 'Actually, it is protecting the crime. When you talk to other women and tell them that you have a problem, they say *just be patient*'. She said that it is therefore sometimes better to open up to professional organizations than peers. Bisrat reflected that women sometimes held themselves and each other accountable for their situations, accusing each other of lack of stamina and loyalty, and trespassing cultural boundaries: 'Women who are oppressed themselves will oppress you by saying, "This is the way you were raised by your mother, she also hanged in there, why do you want to quit? It is your fault"'. In this way, participants noted, women became afraid to speak out against their abusive partners, which allowed the violence to continue. As Nadia put it: 'When you expose him (...) you get feelings of fear and guilt.'

Despite this silencing, participants also emphasized that resettlement offered new entry points for voice. Women who had experienced SGBV themselves said they would be willing to help other women speak out and be 'a role model' for them. They mentioned that in order to start a conversation about SGBV in their communities, important conditions needed to be met, such as mutual trust and access to social support. Moreover, they advised that professional organizations and advocacy groups offer more practical help and actual solutions when they reach out to women. Leila explained:

A professional asked me 'What is your dream?', and I responded 'A room for myself, without my [abusive] partner', and I started crying for the first time in a long time. He then responded 'That is too bad'. Why would you ask me these questions if you won't help me? I was very disappointed and do not have trust in organizations anymore. Talking is good to pour out your heart, but we want real help. (Leila)

Success of efforts to reach communities of women depend on the level of trustworthiness of such organizations and groups. To build trusting relationships with survivors of SGBV, participants emphasized, it is essential that organizations actively seek out and center experiential knowledge and work with women of similar cultural and/or religious background as those they aim to support.

From victim to survivor to warrior

Moving from silence to speech, participants also reflected on the language used to describe women who have experienced SGBV. Several participants were critical of the way in which society portrays women who

experience SGBV, and of the terminology used to describe this group. They disliked the word 'victim'; they understood it as negative and undermining, and felt it had a connotation with weakness. Therefore, participants proposed other terms. Malak said: 'They [women who experience SGBV] might be victims, but [they are] also survivors. In Arabic it is called a 'violated person' [*Mu'annatha*] instead of a 'victim'. I think that is a better term'. Nazanin, who experienced sexual violence during childhood and later with an abusive partner, defined herself by her (super hero) strength: 'I have a clear vision now. I have super power.' Similarly, Nadia emphasized that having experienced SGBV had eventually made her powerful, and that victimhood was only the first stage of the journey toward resilience. Using the metaphor of the soldier, she described how she now stands firmly on her feet: 'First you are a victim, then a survivor and finally, a warrior'.

Fatima shared how proud she was of herself for being able to talk about her own SGBV experiences during the interview, because five years ago she could have never imagined herself doing this. According to her, a necessary part of her and other's transformative process toward 'becoming a strong woman' is speaking up and sharing your needs with others:

It is really beautiful to see how she [a friend of Fatima] has changed and how she dares to speak her mind now. Between five years ago and now, I see two completely different women. Now I see a woman who can stand up for her rights, and can explain what she actually wants in her life. (Fatima)

Sara agreed that speaking up and exchanging about experiences with others is an important step to get out of an abusive situation, but not a necessary one:

[Some] women (...) need to hear from other people that they do not deserve the abusive situation they are in, but some women wake up on their own. They gain this power and strength on their own. (...). *She [referring to women in general, ZK] woke up and knew how to pull this strength out of her. All on her own.* (Sara)

This idea of 'waking up' as a function of individual resilience and tenacity was echoed by other participants. 'A woman has certain gifts', Winta explained. 'She can decide (...) to change her life. By herself.'

Discussion

We explored how refugee women in the Netherlands perceive and give meaning to SGBV, in particular IPV, and how they explain individual and community responses to SGBV within the particularities of their resettlement context. Both Syrian and Eritrean women's past and present views on SGBV were shaped by (perceived) normalization of violence in their home countries and their encounters with Dutch legal systems and value systems, and had evolved over time. Although they had acquired knowledge and developed a vocabulary to discuss SGBV during resettlement, they also faced new barriers to addressing and escaping violence, such as double victimization and dependency on partners for residence permits. Most participants believed SGBV does not happen to native Dutch women, although it was acknowledged by some that such beliefs were shaped by idealized views of Dutch society as liberated and just. Participants rejected the term 'victim', instead preferring to center their own resilience and those of their communities, and felt that refugee women should speak out about their experiences. They imagined a response to SGBV that involved women supporting each other and more concrete help from aid organizations, while Syrian participants urged to involve men in prevention efforts.

Shifting perspectives and non-performativity of protection

Our findings suggest that women's understanding of their experiences with SGBV might change throughout and after resettlement. Women's experiences with normalization and perpetuation of (intimate) SGBV in their home countries (Borges, 2024; Robbers & Morgan, 2017), as well as structural barriers to acknowledge or interrupt it (such as unsupportive legal systems or communities, women's economic or legal dependency on men, or racialized cultural stereotypes) might shape how women give language and meaning to manifestations of SGBV in their resettlement settings. For some participants, adding words to

their experiences did not only result in redefining these experiences as violent and therefore unjust, but also in taking measures, such as seeking divorce (Borges, 2024; Krause, 2015; Perrin et al., 2019). In line with FST and following the recommendations of earlier studies investigating how perceptions of SGBV evolve in various contexts of conflict, displacement, and humanitarian crises, this interplay of meaning and context highlights the salience of the environment in the development of collective consciousness around SGBV. Moreover, as our participants articulated, such coming into consciousness is deeply entangled with the acute availability of protection and support, both formal in informal, and is therefore by definition not an individual but a collective trajectory.

However, our study points to the fact that, in practice, a legally protective system in the resettlement country does not always enable refugee women to escape abuse. As a result of conflicting regulations, such as immigration policies that undermine these protections, legal systems designed on paper to protect victims of SGBV can be non-performative in the real world. For instance, participants highlighted how Dutch family reunification laws tie the legal status of women joining their partners to their spouse's residency, effectively creating a dependency that results in women losing their residency if the relationship ends (Bartels, 2021). As a consequence, the control that this grants men might trigger emotional and physical abuse or intensify pre-existing abuse. Moreover, refugee women who have experienced SGBV run the risk of being stigmatized by their own communities, which contributes to non-reporting of abuse and might (further) deteriorate into social rejection, ill mental health, and even self-harm or suicide (García-Moreno, 2014; Robbers & Morgan, 2017). Racial bias, gendered racism and cultural stereotyping by authorities in the resettlement country, such as the police, leads to double victimization, whereby women who speak out are victimized both by their own communities and within formal institutions.

The Dutch SGBV discourse

Participants in our study asserted that violence against women is often rooted in gender inequality, and, discussing IPV in particular, believed that shifting gender dynamics might lead to conflict between spouses. However, when asked about the occurrence of SGBV among the Dutch population, many dismissed the idea that it was prevalent, or that gender inequality played a role. This dismissal might reflect participants' exposure to dominant national identity narratives, in which the white Dutch population imagines itself, its society and its culture as inherently just and morally advanced ('white innocence') (Wekker & Gloria, 2016), and which racializes SGBV by framing refugees, especially men, as responsible for the cultural import of gender inequality and violence against women (Vietsen, 2016). Such neocolonial discourses on gender (Wekker & Gloria, 2016) associate SGBV with non-white, non-European cultures, while downplaying its presence in 'Western' contexts. In doing so, they risk further marginalizing European women who have experienced SGBV, and at the same time deny refugee women agency. Moreover, such discourses reinforce the harmful stereotype that European/Dutch men do not engage in gendered violence, while framing refugee men as 'dangerous Others' (Chiumbu, 2022; Kusnierkiewicz, 2019; O'Sullivan, 2021). Through such ethnocentric and racist views of European men as civilized and refugee men as backwards (De Schrijver et al., 2018; Keygnaert et al., 2012), (white) Dutch men escape collective accountability (van Huis et al., 2025).

Many male perpetrators of violence do have a history of being victimized (Reingle Gonzalez & Miller, 2014; Peretz & Vidmar, 2021), suggesting that to perceive refugee women as just victims and refugee men as just perpetrators might be too simplistic. Particularly Syrian women expressed the view that male perpetrators were potential victims. They emphasized that men should be involved in conversations about SGBV, and that male perpetrators should be eligible for psychological support. Syrian women's views on who gets to speak and who is deserving of help in the Netherlands interrogates current policies and practices; the (sparse) resources allocated to SGBV prevention and support for victims favor the group of female victims, largely overlooking approaches that involve men (Boukema et al., 2023). As several authors have suggested, ignoring men's experiences with violence might have negative consequences for the wellbeing of refugee men and their social environment (Peretz & Vidmar, 2021; Scheibelhofer, 2012), but might also embolden racist cultural imaginations of refugee men.

Rebuilding connections

Our study suggests that refugee women in resettlement environments seek new opportunities to articulate their lived experiences with SGBV, including giving meaning and voice to the stories and situations of friends and other community members. Participants in our study reported that women are often discouraged from speaking out about SGBV, both in their home countries and resettlement countries. Social norms around what gets to be spoken about - and who gets to speak—strongly influenced participants' decision making around articulating their experiences and seeking help, as many feared to bring shame upon their families. The finding that participants did not always have words for, or spoke about, their experiences resonates with the work of Tankink (2009), who reported that refugee women who experienced sexual violence during wartime often remained silent. Tankink further illustrated how silence might not only be externally imposed, but also upheld by women themselves as part of a collective strategy of protection and belonging (Tankink, 2009). As such, both the choice to speak out as the choice to stay silent can be understood as strategies for survival, and as illustrative of the agency women exercise in shaping their own narratives.

However, participants argued that in discourses around refugee women and SGBV, this agency was not always granted to them, emphasizing that language matters—for instance, the word 'victim' was felt to be undermining of their individual and collective strength and resilience. They prefer terms such as violated persons, survivors or even warriors. This finding is in line with another study among girls who have experienced sexual violence, in which girls explained that preferred to be called 'by their names' (Aussems et al., 2020). Moreover, it resonates with a review on SGBV in forced migration (Ozcurumez et al., 2021). Researchers analyzed empirical data and policy documents, and concluded that in research and policy women are merely represented as victims of SGBV, reproducing the discourse of women as (only) being dependent and vulnerable. The authors concluded that this way of portraying women undermines their agency in resettlement processes, and might even justify violence as an almost unavoidable consequence of men's dominance over women (Ozcurumez et al., 2021). Furthermore, it contradicts many women's realities: across cultural contexts, women actively resist oppressive cultural discourses that deny their sexual and reproductive health rights and in turn, obtain sexual agency (Day et al., 2010; Hé et al., 2012).

In line with Fricker's concept of epistemic justice (Fricker, 2007), we therefore argue that to do justice to women's (collective) knowledge and wisdom, refugee women's perspectives and articulations of their own situations should be centered when designing and implementing interventions that target SGBV. This might also imply that women's agency and strive for justice should be recognized within their own cultural and religious context, rather than in the cultural context of resettlement countries, where Western ideologies of autonomy, individuality, and victimhood dominate. Hence, foregrounding refugee women's role, agency and perspectives in finding opportunities that positively impact on their various relationships is key when developing prevention strategies (Hawkey et al., 2019).

Finally, women in our study made clear that they wanted to support other women and build social support networks. Women with small social networks are less likely to have a confidant and receive support. However, refugee women who have a strong need to belong but simultaneously face risks of social exclusion may be at an increased risk of being left alone with their experiences (Yohani & Hagen, 2010). Thus, social support networks are essential for women's sexual and reproductive health and positive resettlement outcomes, such as participation in society (e.g. McMichael & Gifford, 2010).

Strengths and limitations

This study has both strengths and limitations. It is the first to explore refugee women's perspectives on SGBV in the Netherlands with a focus on the resettlement context. The first author, a second-generation refugee fluent in Arabic, helped establish rapport, particularly with Arabic-speaking participants. For Tigrinya-speaking women, a cultural mediator facilitated translation and contributed valuable insights through her familiarity with Eritrean culture and sensitive topics. However, it should be acknowledged that the presence of a cultural mediator may have influenced the reliability of the data—for instance, if her personal values shaped the translation, if participants did not fully trust her, or if the presence of a third party affected participants' willingness to disclose.

The use of a fictional scenario used in interviews and group discussions encouraged reflection, but may also have directed conversations toward intimate partner violence in particular, which was often the women's most immediate concern. Although existing literature shows that many refugee women experience sexual violence during flight or in asylum centres (Keygnaert & Guieu, 2015; Krause, 2015; Robbers & Morgan, 2017), such experiences were rarely brought up in our interviews.

Participants appreciated the scenario method and suggested it for use in future research and interventions, including peer support groups. Future research should explore how to ethically and safely engage refugee women in discussions about particularly sexual violence, especially when such experiences remain unspoken. Additionally, the study may have included a selective group of women, those more willing to discuss sensitive topics. As a result, it might not reflect the experiences of women with less outspoken views or those in earlier stages of awareness, potentially limiting the diversity of perspectives.

Recommendations for practice and research

It is important that women are offered the opportunity to engage in open dialogues about SGBV, under conditions that are shaped by their own needs, comfort and preferences, and avoid automatically labeling men as 'perpetrators' and women as 'victims.' Moving forward, the integration of support and care systems, especially peer support among women, should be emphasized, as such support remains underexplored (Khazai et al., 2022a, 2022b). To establish successful peer support groups, it is essential to co-develop methods and material together with refugee women and local organizations or advocacy groups, train and adequately reimburse discussion leaders from the community, alternate 'serious' conversations with enjoyable activities, and closely involve trauma-experts to adopt a trauma-informed approach and provide participants with access to professional help. See also the guides for discussion leaders developed as part of the Women and Health project (in Dutch) (Khazai et al., 2022a, 2022b). Policy initiatives, such as providing independent residence permits for refugee women, are also crucial. These measures can help remove systemic barriers, allowing women to leave abusive situations without fearing to lose their legal status.

Future research should focus on developing gender sensitive and culturally sensitive support systems tailored to the specific needs of refugee women. This research should explore various themes, including women's experiences with SGBV, their resilience, but also their perceptions of Dutch society. Understanding these dimensions is vital for creating effective and supportive interventions that address the unique challenges faced by refugee women. Lastly, future research should explore the perspectives of refugee men on SGBV, as perpetrators, victims, or both, and how to support refugee men (Boukema et al., 2023).

Conclusion

This study highlights the complex and evolving perceptions of SGBV among refugee women in the Netherlands. Women's perception of SGBV changed over time as a result of their resettlement context. In the Netherlands, the women whose voices we aimed to platform in this study encountered new vocabularies as well as a responsive legal system, which provided them with opportunities to change their situation. However, as a result of racialized stereotypes and immigration procedures that do not account for SGBV, they also faced new challenges such as double victimization within official institutions and dependency on their husband's residence permits. Recognizing women's strength and agency as well as acknowledging the dual role of men as both perpetrators and victims are crucial for developing effective support systems and interventions for refugee women. Women themselves might want to take an active role in addressing SGBV; they want to discuss it and support other women with similar experiences, but only within their own cultural and religious contexts, on their own terms, and in their own words.

Acknowledgements

The authors thank all participants for sharing their experiences. Special thanks to Selma Khaled and Amy Weldeselase (cultural mediators/translators) for their assistance with data collection, and to Edien Bartels, Petra Wisse, Vera Schuller, and Anouk Devens for their valuable input on the fictional scenario, data collection, and manuscript feedback.

Author contributions

ZK conducted the interviews and collected the data. ZK, MM and PV performed the data analysis. All authors contributed to writing the manuscript and approved the final version.

Disclosure of interest

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Netherlands Organisation for Health Research and Development (ZonMW) under grant number 6366020.

Consent for publication

Yes.

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Appendices

Scenario 1

Note: Samia is an Arabic woman and Senait an Eritrean woman, depending on the participant we've adjusted the names.

Samia/Senait has been in the Netherlands since 2016. She is married and has two young children. The youngest sleeps very poorly and cries a lot: Samia/Senait is therefore very tired. During the day, she is busy learning Dutch. She tries very hard, but her husband does not help her. He often says unpleasant things to her. Through her language school, she got a language buddy—a woman to practice the language with—but her husband does not want her to meet the language buddy alone. He always wants to go with her to the meetings, and if she wants to call her language buddy, he takes her phone away. Samia/Senait thinks her husband does not want her to learn the language.

Recently, Samia/Senait asked her husband if she could go on birth control, because she had heard something about it from a classmate at the language school. She has had two difficult pregnancies and does not want to get pregnant again. She finds it very hard: raising two young children in a new country. If you go on birth control, then you don't get pregnant anymore. That seemed really nice to Samia/Senait! But when she brought it up, her husband became very angry and pushed her so hard that she fell against the door. She was in a lot of pain, and her husband told her that she could no longer go to language school.

Samia/Senait started to become afraid of her husband, but she didn't dare talk to anyone about it. She just stayed at home and began to have gloomy and sad thoughts. She also often had headaches. She felt so sad that she no longer wanted to have contact with people. One day she took her kids to the playground—her husband wasn't home that day—and she ran into her classmate from language school. They started talking and the classmate asked why Samia/Senait never came to class anymore. She kept asking, and eventually Samia/Senait decided to open up to her—and that felt so good. Her classmate had been in the same situation a year earlier; her husband used to do the same thing. She gave Samia/Senait tips on how to deal with it. Samia/Senait no longer felt alone—she realized she wasn't the only one going through this.

Scenario 2

Note: Dania is an Arabic woman and Genet an Eritrean woman, depending on the participant we've adjusted the names.

Genet/Dania is a nurse who fled from Eritrea/Syria in 2014 with her two-year-old daughter. Her husband had already left for Europe earlier. The journey to the Netherlands was very difficult. She had to travel by boat, and when she finally arrived in Greece, everyone had to stay in refugee camps. Those camps were horrible. Genet/Dania found the nights very frightening. There were always shady figures wandering around whom she feared. She didn't trust it, so every night she stayed inside her tent.

One night her daughter became ill. Genet/Dania knew a woman who was a doctor and wanted to go get her to check on her daughter. She had to walk a bit to find her. She left her daughter with a neighbor. On the way to the doctor, a man suddenly dragged her violently into the bushes. He started touching her in places she didn't want to be touched. He also hit her. She was in a lot of pain. When he was done and left, she ran back to her tent.

She was completely confused, but she didn't have time to think about it or to tell her neighbor what had happened. Even when she later arrived in the Netherlands and was reunited with her husband and other children, she didn't dare to speak about that horrific event in the camp. She felt ashamed. What would her husband think? What if he left her, even though she loved him so much? During the day, Genet/Dania kept herself busy with the children, but at night, when they were asleep, she relived that moment in Greece again and couldn't sleep. She tried everything to stop thinking about it, but it didn't work. She also had nightmares, and when her husband asked what was wrong, she didn't want to answer.

When her husband wanted to be intimate, she no longer enjoyed it. She didn't want it as often anymore. She used to enjoy it, but not anymore.

Genet/Dania wanted to become a nurse again in the Netherlands. She started a training program to requalify. She had a mentor named Lena, a very kind woman who helped her with everything. She trusted her, and they often had coffee together. While Genet/Dania was studying for her exams, she often got sudden headaches, felt hot, and became very dizzy. Her mentor noticed and asked where it came from. Was she stressed? Had something bad happened?

When Genet/Dania heard those questions, she really wanted to talk about it. She hesitated... but then Lena said, 'I can see you want to tell me something. You don't have to be ashamed here. Whatever you tell me, I won't tell anyone.' That's when she told her. She felt relieved that someone finally knew. Lena helped her immediately. They went to the doctor together, and the doctor supported her further.