



SWIM

Safe Women in Migration

**Building Capacity
of Front Line Staff to Prevent
and Respond to GBV**

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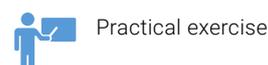
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Information



Foreseen duration



Practical exercise

INTRODUCTION

This Toolkit has been produced by the SWIM - Safe Women in Migration. Strengthen GBV protection for migrant and asylum seeker women, project co-financed by the European Commission and implemented in 5 European countries, Italy, France, Great Britain, Sweden and Romania by an articulate partnership composed by Fondazione L'Albero della Vita, Fondazione ISMU, France Terre d'Asile and the Italian Red Cross, British Red Cross, Asociatia Alternative Sociale and the Svenska Röda Korset.

Drafting of the toolkit was led by Lia Lombardi of Fondazione ISMU, British Red Cross staff designed modules "Responding to gender based violence" and "Understanding and responding to domestic abuse". Other partners - Fondazione L'Albero della Vita, France Terre d'Asile, Italian Red Cross, Asociatia Alternative Sociale and the Svenska Röda Korset – contributed with input with the final version, taking into account the common factors and differing contexts of each country involved in the partnership.

The project is realised on the basis of the EU legislation and policies, in particular the Directive 2012/29/UE and the Reception Directive 2013/33/EU establishing the general principle that the EU Member states have to take special measures for victims of rape, other forms of physical, psychological and sexual violence.

The project aims to contribute to the protection of migrant, refugee and asylum seeking women and girls at risk of GBV (Gender Based Violence) to:

- build capacity of the professionals working in the services to protect and support victims of GBV and apply legislation;
- sensitize and inform women migrant and asylum seeker, victims or at risk of violence, on the access to justice and support;
- design a referral mechanism to enable prompt support to GBV migrant and asylum seekers.

Purpose of the Toolkit

The Toolkit is focused on the first aim of the project "building capacity of front line staff to prevent and respond to GBV", The training is built around this aim.

Background

At the beginning of the project an important needs assessment was carried out across the five countries to identify the main needs and gaps in training of operational staff working with migrant women at risk of GBV.

A quantitative-qualitative research was carried out across several reception centers of the five partner-countries. It dealt of 437 structured questionnaires and fifty in-depth interviews.

The interviewees suggested many training needs and the prevalent of them have been adopted to formulate the four modules and their contents.

The research established the necessity for staff working in the reception system to be trained to identify needs of vulnerable women, adopt a gender sensitive approach and to support them to access support and the justice system. So, three macro-transversal topics have been identified: identification, prevention, take care.

The large scale increase in numbers of people seeking protection in Europe since 2015 has required an increase in the number of professionals employed in the reception system, however often the staff working in the centers are not fully prepared to meet the specific needs of vulnerable women with different cultural backgrounds and barriers to accessing support.

Migrant women, are one of the most vulnerable categories in Europe, due to their legal, political and economic status and due to gendered inequalities may be seen as “doubly” vulnerable to violence as migrants and as women.

In this framework, the toolkit considers the most important training needs of staff in relation to the most important needs of migrant women in Europe, with reference to legislative issues and to the consequences of violence in terms of health and mental health.

It provides guidance and tools to strengthen the response to women who have experienced gender based violence, expanding on the topic of domestic abuse in a supplementary model.

Whom is the toolkit targeted at?

The toolkit is designed for trainers experienced in GBV in the context of migrant women. The intended participants of the training are front line professionals who come in to contact with refugee, asylum seeking and migrant women and girls in their roles, for example working in the reception system; health or advice work.

How to use the toolkit

The training uses a participatory approach promoting engagement in the learning process. The role of the facilitator is therefore to encourage participation in an interactive way in order to valorise the competencies and experiences of the participants.

Trainers are encouraged to spend time preparing activities and case studies that reflect the national context with regards to migrant women and GBV and ensuring they refer to the national and organisational protocols and referral mechanisms for safeguarding vulnerable people from violence and abuse.

1. UNDERSTANDING GBV

Introduction of the module

The module discusses the issue of violence against women by analysing the forms of domination and subjugation that reproduce the violent dynamics of men against women. We will try to discuss some issues that several theories interpret as humus in which violence against women is produced and reproduced. This means highlighting gender inequality and the socialization process, which in turn builds gender identity and reproduces inequality and discrimination.

Specifically, the module focuses on the complexity of violence against women in the context of migration and forced migration. It highlights the risks, different forms of violence and provides an overview of the European, global world situation as well as national context of (partner's country).

1. AIM OF THE MODULE

Main aim

- Provide a global overview about GBV at a European level and related to migration

Sub-objectives:

- Highlight and discuss the definitions and different dimensions of gender-based violence: cultural, social, institutional; direct and indirect;
- Highlight the different forms of gender violence: physical, psychological, sexual, economic, domestic, etc.
- Recognise indicators of SGBV in different contexts
- Show the connection between gender-based violence, social inequality, gender inequality
- Show the global dimension of gender inequality and violence. World, European and national statistical data.

2. INTRODUCING TRAINEES AND TRAINER



- Name
- Professional background
- Expectations for training
- Knowledge and experience about GBV
- Knowledge and experience about migrant women and GBV

Trainer introduces himself/herself and explains how the module is structured: contents, time, methods, exercises.

2.1. Introductory exercise

Brainstorming: Defining GBV– duration 20'

- Ask participants to brainstorm on acts or patterns of behaviour they see as belonging to GBV. Write the answers on a flipchart. After the brainstorming, discuss the results before introducing the international definitions of GBV.

3. THEORY

3.1. International definitions

Violence against women in its various forms has consequences and high costs in terms of the victims' physical and mental health. It severely affects both the management of daily life and the relationships; besides, welfare costs and public health are not so negligible, as several European sources show (EIGE, 2014¹).

Violence against women: "Any act of **gender-based** violence that results in, or is likely to result in, **physical, sexual or psychological harm or suffering** to women, including threats of such acts, coercion or arbitrary deprivation of liberty, **whether occurring in public or in private life.**" *UN Declaration on the Elimination of Violence against Women (DEVAW, 1993)*

Gender-based violence: "Violence that is directed against a woman **because she is a woman** or that **affects women disproportionately.**" *CEDAW General Recommendation no. 19 (1992).*

Violence against women is

- a **manifestation of the historically unequal power relations** between men and women, which have led to domination over and discrimination against women by men
- one of the crucial social mechanisms by which **women are forced into a subordinate position** compared with men
- constitutes a **violation of human rights** and a form of **discrimination** against women (*DEVAW*)
- **Violence against women includes:**
- Violence occurring in the family: e.g. battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- Violence occurring within the general community: e.g. rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- Violence perpetrated or condoned by the State (institutional violence), wherever it occurs. (*DEVAW*)

3.2. European definitions and types of gender based violence

According to the 3rd article of the **Council of Europe Convention on Preventing and Combating violence against women and domestic violence** (12/04/2011), also known as **the Istanbul Convention**², «[G]ender-based violence against women" shall mean violence that is directed against a woman because she is a woman or that affects women disproportionately[...]. The same Convention states that "a. violence against women should be understood as a violation of human rights and a form of discrimination to the detriment of women. This includes all actions resulting in physical, sexual, psychological, and economic harms, or suffering caused to women, including the threat itself of those actions, coercion or arbitrary deprivation of liberty, both in public and in private life; b. 'domestic violence' shall mean all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim; c. 'gender' shall mean the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men; d. 'gender-based violence against women' shall mean violence that is directed against a woman because she is a woman or that affects women disproportionately; e. "victim" shall mean any natural person who is subject to the conduct specified in points a and b; f. 'women' includes girls under the age of 18" (art. 3a, Council of Europe Convention on preventing and combating violence against women and domestic violence, 12/04/2011).

¹ According to the European Institute for Gender Equality report, the gender-based violence costs the EU about 258 billion Euros per year while the actions to prevent it takes only 1% of that figure (EIGE, 2014).

² The Italian government issues Decree-Law 93 of 2013 directed to implement the Istanbul Convention, which became Law 15 October 2013, n. 119.

We can also distinguish between **direct** and **indirect** forms of gender-based violence:

Direct forms of GBV	Indirect forms of GBV
Physical violence in close relationships	Institutional discriminations and inequalities
Sexual violence (including rape, sexual assault, harassment in public and private spheres of life).	Family structure and roles
Psychological violence (including threats, humiliation, mocking and controlling behaviours)	Social and cultural discriminations and inequalities: e.g. education, job, income, political involvement, health, etc.
Economic violence (which means preventing the victim from accessing their financial resources, property, healthcare, education, or the labour market, and denying them the participation in the economic decision-making)	A type of structural violence, characterised by norms, attitudes and stereotypes around gender.
<ul style="list-style-type: none"> • Trafficking in human beings, slavery, sexual exploitation; • Harmful practices such as child and forced marriages; • Female genital mutilation; • Emerging forms of violations, such as online harassment; • Stalking and bullying are also considered forms of direct gender-based violence. 	Multiple forms of discrimination: race, social class, (dis)ability, age, gender.

(EU Council Conclusions of 5 and 6 June 2014).

Types of Gender Based Violence

Female Genital Mutilation (FGM) is defined as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons". It is recognised as a violation of the human rights of women and girls (WHO 2018).

[See Handout 1 for further details](#)

Forced Marriage is the union of two persons at least one of whom has not given their full and free consent to the marriage European Parliamentary Assembly Resolution 1468 "Forced Marriages and Child Marriages"(2005)

Child marriage, or early marriage, is any marriage where at least one of the parties is under 18 years of age. Forced marriages are marriages in which one and/or both parties have not personally expressed their full and free consent to the union. A child marriage is considered to be a form of forced marriage, given that one and/or both parties have not expressed full, free and informed consent. (OHCHR 2018)

Human trafficking is a crime in which people are exploited for other people's personal gain. People who experience trafficking may have been coerced, deceived, threatened or forced into exploitative situations. It can happen to adults and children of all backgrounds. Human trafficking has three specific components which must be present to meet the legal definition of trafficking – the act, the means and the purpose.

[See Handout 2 for further information](#)

'Honour' based violence (HBV) is a form of domestic abuse which is perpetrated in the name of so called 'honour'. The honour code which it refers to is set at the discretion of male relatives and women who do not abide by the 'rules' are then punished for bringing shame on the family. Infringements may include a woman having a boyfriend; rejecting a forced marriage; pregnancy outside of marriage; interfaith relationships; seeking divorce, inappropriate dress or make up.

Intimate Partner Violence (IPV) and Domestic Violence (DV). IPV is one of the most widespread forms of direct violence against women, and includes a range of sexual, psychological and physical coercive acts used against adult and adolescent women by a current or former intimate partner. It is defined as "behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours". It covers violence by both current and former spouses and other intimate partners (WHO 2013).

Domestic violence is defined as "All acts of physical, sexual, psychological or economic violence within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim" (Article 3 Istanbul Convention). The two main forms of domestic violence are intimate partner violence between current or former spouses or partners and inter-generational violence which typically occurs between parents and children (Istanbul Convention Explanatory Report).

According to the EU-wide Survey on Violence against Women conducted by the EU Agency for Fundamental Rights, 22% of women have experienced some form of physical and/or sexual violence by a current or previous partner. According to UNWomen Report, 43% of women in the 28 European Union Member States have experienced some form of psychological violence by an intimate partner in their lifetime. (EU Agency for Fundamental Rights, EU-wide Survey on Violence against Women 2014).

Violence against women is gender-based – it does not occur to women randomly.

- Structural problem embedded in unequal gender power relationships
- Gender dimensions of VAW:
- GBV mainly affects women and girls
- Women and men experience violence differently
- Women are more likely to die at the hands of someone they know
- Women survivors face specific barriers in accessing services
- Fewer resources and options to access justice, care, and support
- Laws and implementing authorities often fail to adequately respond to VAW

GBV is a violation of women's human rights and a form of discrimination against women.

Examples of violated rights:

- Right to life
- Right to be free from torture and inhuman or degrading treatment or punishment
- Right to health
- Right to equal protection by the law

3.3. GBV Dimension

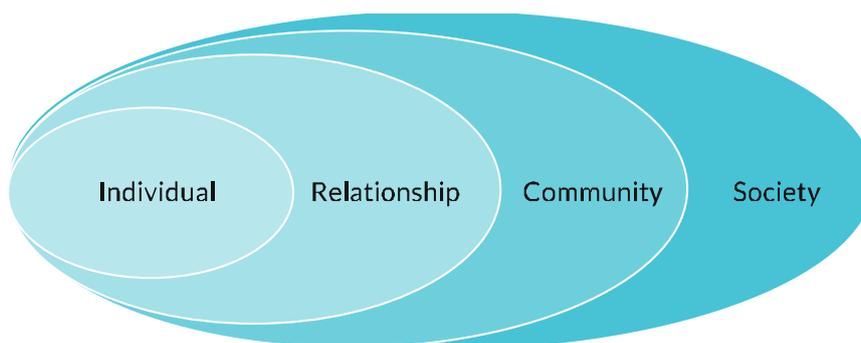
Life-time prevalence rates	Global	Europe
% women who have ever experienced IPV or sexual violence from a non-partner	35%	27,2%
% women who have been in a relationship and who have experienced IPV	30%	25,4%
% women who have experienced sexual violence from a non-partner	7,2%	5,2%

Source: Global and regional prevalence estimates of GBV (WHO et al 2013)

[See Handout 3 for further information](#)

4. CAUSES OF GBV

GBV is caused by a combination of factors that increase the risk of a man committing violence and the risk of a woman experiencing violence.



Source: Heise 1998

The ecological framework

Individual-level factors <ul style="list-style-type: none"> • Biological, personal history • Low level of education • Young age (early marriage) • Past experiences of violence • Pregnancy • Use of alcohol (weak evidence for causal relationship) • Attitudes of violence as acceptable behavior 	Relationship -level <ul style="list-style-type: none"> • Relationships with partners, family, peers • Relationships with partners, family, peers • Men with multiple partners • Partnerships with low marital satisfaction or continuous disagreements • Disparities in education status between partners • Family blaming the woman instead of the man for sexual violence
Community-level <ul style="list-style-type: none"> • Social relationships in school, workplace, and neighbourhood • Societies with community sanctions against violence have the lowest levels of IPV and SV • Poverty – rather a “marker” than a factor increasing risk as such 	Society-level factors <ul style="list-style-type: none"> • Cultural and social norms that shape gender roles • Higher IPV when men have economic and decision-making powers in the household • Ideologies of male sexual entitlement • Social breakdown from conflicts or disasters

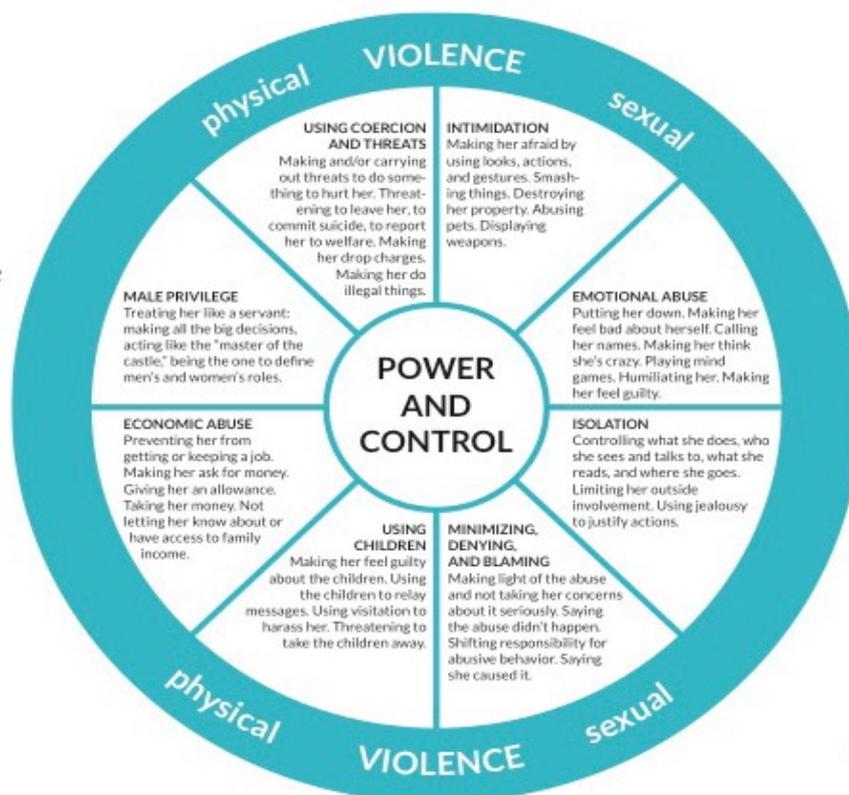
4.1. Importance of Understanding the GBV Dynamics

- Many social and health professionals share the norms, beliefs, and attitudes of broader society.
- Negative attitudes towards survivors can inflict additional harm on them.
- Not understanding the dynamics of violence may cause health and social professionals to wonder why she doesn't leave the abusive relationship and then think that she does not need or deserve help.

Maintain a supportive, non-judgemental and validating attitude towards survivors.

The Power and Control Wheel offers a framework for understanding the manifestations and mechanisms of power and control in an intimate relationship (WHO 2005). This model was developed by the Domestic Abuse Intervention Programs in Minnesota, US, weaving in the experiences of women survivors of intimate partner violence who had participated in focus groups. The wheel consists of eight spokes that summarize the patterns of behaviours used by an individual to intentionally control or dominate his intimate partner: using intimidation; using emotional abuse; using isolation; minimizing, denying and blaming; using children; using male privilege; using economic abuse; and using coercion and threats. These actions serve to exercise “power and control” – these words are in the centre of the wheel. The rim of the wheel is made of physical and sexual violence – this violence holds it all together.

Power and Control Wheel



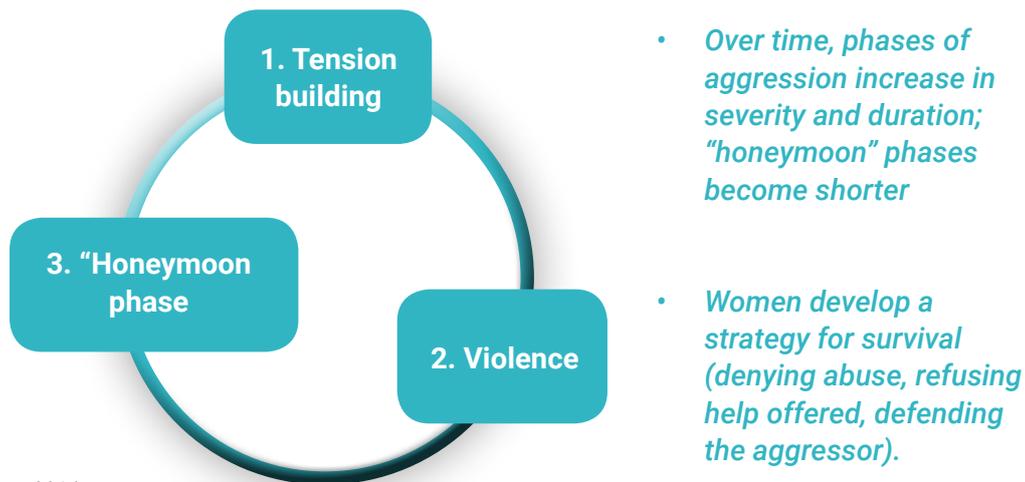
Source: UNFPA, Wave, 2014

The model of the “cycle of violence” was developed by the American psychologist Lenore E. Walker in 1979. It describes the course of a violent relationship in three phases or cycles:

1. In the first phase, tensions gradually build up. The woman tries to appease her partner, generating a false sense of being able to control his aggression and prevent violence.
2. This is followed by the second phase, an episode of physical, sexual and psychological violence which ends when the perpetrator stops the abuse temporarily.

3. In the third phase (“honeymoon” phase), the perpetrator apologizes and promises to change his violent behaviour. The woman believe that there is a “good” side to her violent partner, which she can retain through adjusting to his behaviour by modifying her own (Walker 1979, cited in Stark 2000, WHO 2005).
4. The cycle of violence is being repeated; over time, the phases of aggression increase in regard to both, severity and duration, while the “honeymoon” phases become shorter (BMWfJ 2010). In this situation, women develop a strategy for survival that may include extreme passivity - denying the abuse, refusing help offered and even defending the aggressor (Walker 1979, cited in Stark 2000).

The cycle of violence (Walker, 1978)



Source: UNFPA, Wave, 2014

The Stockholm syndrome

The so-called Stockholm syndrome is used to explain why women remain in violent relationships. It was first observed in 1973, when bank robbers in Stockholm took four people hostage and held them for six days. During this period, the captives developed a close relationship with the robbers and regarded the police as enemies. In a survey of over 400 women survivors of intimate partner violence, Graham and Rawlings identified a similar response pattern among women who experienced violence by an intimate partner. These women tend to develop close bonds and even identify with the perpetrator as a coping strategy in order to survive. If the violent partner is willing to make even small concessions or shows some degree of friendliness, the woman has new hopes and is ready to give the abuser another chance. The Stockholm syndrome may develop under four conditions:

1. The life of the survivor is threatened.
2. The survivor cannot escape or thinks that escape is impossible.
3. The survivor is isolated from persons outside.
4. The captor(s) show(s) some degree of kindness to the survivor(s).

The normalization of violence

The concept of normalization of violence developed by the Swedish sociologist Eva Lundgren explains why women living with a violent intimate partner find it difficult to name and define their own experiences as violence because living in a violent relationship changes their interpretation and understanding of the violence experienced; they adopt the violent partner’s understanding of violence. As a consequence, women might perceive an attack which an outsider would regard as violence as manifestation of their own failure. Furthermore, women survivors are reluctant to identify themselves as “battered women” and their partners as “abusers,” as this would imply acknowledging that they and their partners are deviants from the norm of an equal relationship.

Group discussion: How to break the dynamics of violence 15'

Ask participants to think how it is possible to break the circle of violence. What strategies women can act.

(De) constructing myths about GBV

Social and Health care providers need to distinguish between myths and facts and maintain a professional and impartial attitude.

What are myths about GBV? E.g.

- Battering is not a crime. Men have the right to control their wife's behaviour and to discipline them.
- Some women deserve the violence they experience.
- Battered women allow abuse to happen to them. They can leave if they really wanted to.
- Conflicts and losing control are a normal part of any relationship.
- Domestic violence is a private family matter and therefore the state or service providers have no right to intervene.

Therefore, myths and stereotypical attitudes about GBV:

- are harmful because they blame the survivor and not the perpetrator
- shape society and the social and health sector's perceptions and responses
- may prevent social and health care providers from identifying GBV and providing care

Break time 15'

Quiz and group discussion: Myths about GBV 40'

Distribute handout 4 and ask participants to complete it individually or in pairs (10 minutes). Then facilitate a group discussion in the big group along the questions for discussion listed on handout 5. Distribute handout 5 to present facts contrasting the myths (30 minutes).

5. GBV IN DIFFERENT SOCIAL AND TERRITORIAL CONTEXT AND SITUATIONS 20'

5.1 Women in conflict and post-conflict context

Perpetrators	Consequences	Resources	Reporting
<ul style="list-style-type: none"> • Military personnel • Paramilitaries • Border guards • Resistance units • Male refugees • And more 	<ul style="list-style-type: none"> • Greater risk of unwanted pregnancies, STIs and HIV, and severe sexual and reproductive injuries • Mental diseases • Suicide 	<ul style="list-style-type: none"> • Inadequate infrastructure • Lack of professionals • Lack of basic medicines and health care supplies • Restriction on women's mobility and freedom of movement 	<ul style="list-style-type: none"> • <i>Lower reporting due to:</i> <ul style="list-style-type: none"> • Fear of reprisals • High level of stigma • Fear of exclusion from communities

5.2 Migrant women: risks and facts

- Informal sector- domestic, agricultural, sex work
- Homeless migrant women (without access to material conditions)
 - Lack of legal protection
- Limited access to justice and health care
 - Language barriers
- Lack of information on rights & options
 - Exclusion from national health insurance coverage
 - Non efficiency of protection measures
- Fear of losing residency status
 - May prevent leaving an abusive partner or employer
- Undocumented migrant women: lack of access to protection because of fear of deportation.

[See Handout 6 for further information](#)

Exercise 10'

Checking Your Knowledge – GBV Concepts and Terms

Review what you know about GBV concepts and terms. Read the following scenario and answer the questions below.

A displaced woman fleeing with three children from armed conflict approaches an armed soldier at a checkpoint. The woman has been separated from the rest of her family and community; she is seeking refuge at a town on the other side of the checkpoint. The soldier asks the woman to give him some money to go through the checkpoint (there is no fee - he is asking for a bribe). The woman explains she has no money and nothing of value to offer. The soldier tells the woman that he will let her through if she has sex with him. The woman agrees. The man is very rough and the woman feels pain while he is inside of her. She tries not to cry in front of her children.

1. Did the woman consent to sex?

1. Yes
2. No

2. Is this an incident of gender-based violence?

3. Yes
4. No

3. Why is this an incident of gender-based violence? Check all that apply:

- It was based on an unequal balance of power between the soldier and the woman
- It was harmful to the woman
- It violated the woman's human rights
- She gave her consent to have sex
- It involved the use of force

5.3 Minor girls: risks and facts

Risks for	Consequences	Resources	Lower Reporting
<ul style="list-style-type: none"> • Child marriage • Incest • Sexual violence • Trafficking • IPV 	<ul style="list-style-type: none"> • Low birth-weight for newborns • Higher pre-natal, neonatal, and infant mortality • Morbidity • Pregnancy-related complications 	<ul style="list-style-type: none"> • Less awareness of services • Lack of financial resources to access services • Hesitant to seek services due to lack of confidentiality 	<ul style="list-style-type: none"> • They may not recognize the behaviour of perpetrators as violent • They are afraid of not being believed or taken seriously

5.4 Older women: facts and consequences

Consequences	Resources	Lower Reporting
<ul style="list-style-type: none"> • Fear • Anger • Depression • Exacerbation of existing illness • Confusion and distress • Life-threatening injuries • Economic abuse 	<ul style="list-style-type: none"> • Knowing or depending on the perpetrator limits access to appropriate services • Lack of information about services • Lack of resources 	<ul style="list-style-type: none"> • Fear they will not be believed • Claims may be dismissed as illness or amnesia • They may be accustomed to abuse over time or not recognize abusive behavior as domestic violence

5.5 Women with disabilities

- Stereotypes contribute to sexual violence and lack of credibility when abuse is reported, e.g.
 - Regarding them as recipients of charity, objects of others’ decisions
 - Portraying them as non-sexual beings, being compliant and timid
- Other forms of violence they experience:
 - Withholding of medication or communication aids
 - Refusal of caregivers to assist with bathing, dressing or eating
 - Restricting access to family, friends or phone calls
- Often denied control of sexual/ reproductive choices
 - Can lead to forced sterilization & forced termination of wanted pregnancies

Local data and official report can be shown at this point, if available: e.g. here below some information about the Italian context (15 min).

With regard to the Italian context, in 2015, ISTAT (the national institute of statistics) published the second report on “Women’s Safety” in Italy: it highlights that 6,788,000 women (31.5%, aged 16-70 years) have suffered some form of physical or sexual violence in their lives: 20.2% were victims of physical violence, 21%

were victims of sexual violence, 5.4% suffered severe forms of sexual violence (rape and attempted rape). The numbers related to stalking, too, are very important: 3,466,000 women have been victims in their lifetime (16.1%), 44% of them have suffered violence by former partners and 56% by others.

The most serious acts of violence are committed by partners or former-partners (62.7% of the rapes) while the perpetrators of sexual harassment are mostly unknown (76.8%). Violence against minors is also high and requires a lot of attention and surveillance: 10.6% suffer sexual abuse before the age of 16. The so-called "witnessing violence" is connected to the previous data, and there is an increase of 5% of children who are witness to the violence committed against their mothers (65.2% in 2014).

Separated or divorced women are more at risk of physical or sexual violence than other women (51.4% vs. 31.5%). The situation of women with health problems or disabilities is equally critical: they are twice at risk of being subjected to rapes or attempted rapes compared to other women (10% versus 4.7%) (ISTAT, 2015).

6. CONCLUSION

Lesson learned: discussion on knowledge and practices learned by this module (10 min)

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UN Women, (2015), *Facts and Figures: Ending Violence against Women*, october, <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

UNHCR-UNFPA-WRC (2015), *Initial Assessment Report: Protection Risks for Women and Girls in the European Refugee and Migrant Crisis*. <http://www.unhcr.org/protection/operations/569f8f419/initial-assessment-report-protection-risks-women-girls-european-refugee.html>

UNHCR-UNFPA-WRC (2016), *Report warns refugee women on the move in Europe are at risk of sexual and gender-based violence*. <http://www.unhcr.org/news/press/2016/1/569f99ae60/report-warns-refugee-women-move-europe-risk-sexual-gender-based-violence.html>

Introduction of the module

The problems that refugees face require humanitarian responses and effective interventions, such as reduction in postmigration exposure to different types of violence and threat, access to physical and psychological services, assist with integration, support safe and appropriate cultural beliefs and social practices, provide support for families, stable settlement in host country, concerted action to reduce inequalities in access to resources. Gender and proximity violence related persecution must give rise to claims for international protection. Council of Europe Convention on preventing and combating violence against women (*Istanbul Convention* of 2011) and the Directive 2012/29/EU in establishing minimum standards on the rights, support and protection of victims, contribute to achieve the obligation to “ensure access for victims and their family members to general victim support and specialist support, in accordance with their needs”.

1. AIM OF THE MODULE

Main aim

- Provide an overview of the international and European directive and recommendations about GBV and migrants victims of GBV. Provide information and knowledge on local GBV and migration laws.

Sub-objectives:

- Provide some instruments to manage recommendations and laws for helping migrant GBV victims.

2. INTRODUCTION

Trainer introduces herself/himself and explain how the module is structured: contents, time, methods, exercises (5 min)

1.1. Introductory exercise

- Invite trainees to write what it does mean law, recommendation, directive, act in the legal framework (5 min).
- Invite trainees to write what they know about the rights of GBV victims at international, European and national level (5 min).

3. THEORY

Addressing violence against women is a declared goal of the EU institutions and all EU Member States. Initiatives towards the eradication of gender-based violence have gathered momentum in an international and an EU context over the past 50 years. As regards the European Union institutions, getting violence against women on the EU's agenda took a long time because the issue was considered to be outside the remit of the EU Commission and there was no explicit legal basis in the EU for intervening in the issue of violence against women. This means that EU commitment to combating gender-based violence is relatively recent in comparison to other international bodies.

3.1. International regulations 10'

CEDAW. In 1979 the United Nations General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In 1989, the Committee on the Elimination of Discrimination against Women released **General Recommendation No. 12** on Violence against Women stating that articles 2, 5, 11, 12 and 16 CEDAW require the States parties to act to protect women against violence of any kind occurring within the family, the workplace, or in any other area of social life.

In 1992, the Committee on the Elimination of Discrimination against Women released the **General Recommendation No. 19** on Violence against Women which incorporates violence against women into a framework of discrimination and human rights violations and measures to combat them.

Both recommendations reiterate a state's responsibility to act with due diligence in eliminating violence against women.

The **United Nations World Conference on Human Rights**, held in Vienna in 1993 and the **Vienna Declaration and Programme for Action**, presented gender-based violence as structural and universal. The Declaration also called for the appointment of a Special Rapporteur on violence against women and contributed to the **1993 Declaration on the Elimination of Violence against Women**, adopted by the UN General Assembly in December 1993.

The Declaration **specifies that the measures to end violence against women shall target the structures, contexts, and social and cultural patterns which constitute the root causes of this type of violence (article 4 j)**. It also establishes the relationship between intersecting inequalities and violence.

The Fourth UN World Conference on Women produced the **Beijing Declaration and Platform for Action** (BPfA) in 1995, which comprises a set of **12 critical areas for achieving women's empowerment**, including a commitment to combat violence against women, and **was adopted by 189 Member States**.

The Beijing Declaration shows the **universal and particular nature of violence against women**. It also considers the fear of violence to be a permanent constraint on the mobility of women, limiting their access to resources and basic activities.

Furthermore, the BPfA acknowledges additional barriers faced by women due to such factors as **race, age, language, ethnicity, culture, religion, disability, etc.**

3.2. EU regulations 15'

All EU Member States have endorsed the main human rights instruments, which oblige them to combat violence against women as a human rights violation, and as a specific gender-related form of violence linked to the discrimination of women. This implies an obligation on Member States to end impunity and prohibit all violence, to take measures to prevent it, to provide adequate protection to survivors, and to ensure redress. The EU supports an increased protection of women through soft law (communications, recommendations etc.), providing guiding principles, exchange of best practices, and capacity building (for example through the Daphne Programme).

The Council of the EU. From 1998 onwards, the different Presidencies of the Council of the European Union have generated recommendations, proposed indicators, and developed other non-binding documents on violence against women.

- In December 2009, under the Swedish Presidency, the Council adopted the **Stockholm Programme** (2010-2014), which reinforces the commitment to better address violence against women and children, envisaging greater protection for women victims of violence, including legal protection, comprehensive legislation on victims' rights, and a focus on children's rights.
- Under the Spanish Presidency, the March 2010 **Council Conclusions on the Eradication of Violence Against Women in the European Union** set the agenda for further measures to effectively combat violence against women.
- The 2011 **Council Conclusions on the European Pact for Gender Equality for the period 2011–2020** reaffirm the EU's commitment to closing gender gaps in employment, education and social protection, **promoting better work-life balance for women and men**, and combating all forms of violence against women.

- **Istanbul, 11.V.2011 - Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention).** “Condemning all forms of violence against women and domestic violence; Recognising that the realisation of *de jure* and *de facto* equality between women and men is a key element in the prevention of violence against women; Recognising that violence against women is a manifestation of historically unequal power relations between women and men, which have led to domination over, and discrimination against, women by men and to the prevention of the full advancement of women; Recognising the structural nature of violence against women as gender-based violence, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men ... *continuing* (Preamble, <https://rm.coe.int/168046031c>).

The European Parliament. The European Parliament resolution of 26 November 2009 on the elimination of violence against women provides a mandate to take action to end violence against women, an extreme expression of gender inequality.

The European Parliament has been a supportive actor in the struggle against gender-based violence has adopted several resolutions on gender-based violence. The European Parliament considers the collection of comparable statistical data and the exchange of good practices between Member States to be of high importance.

The European Commission explicitly addresses violence against women through various political instruments, mainly the Strategy for Equality between Women and Men 2010-2015, which follows the Women’s Charter (2010) and the Roadmap for Equality between women and men 2006-2010. In May 2011, the Commission proposed a new legislative package to ensure a minimum level of victim’s rights, protection, support, and access to justice. In line with the Women’s Charter, which foresees putting into place a comprehensive and effective policy framework to combat gender-based violence, the European Commission proposals have resulted in important binding acts:

- Regulation (EU) No 606/2013 of 12 June 2013 on mutual recognition of protection measures in civil matters;
- Directive 2012/29/EU of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime;
- Directive 2011/99/EU of 13 December 2011 on the European protection order;
- Directive 2011/36/EU of 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims, replacing the Council Framework Decision 2002/629/JHA (30). It establishes minimum rules concerning the definition of criminal offences and sanctions in the area of trafficking in human beings, and also introduces common provisions, taking into account the gender perspective, to strengthen the prevention of this crime and the protection of the victims thereof (Article 1);
- Directive 2010/41/EU of 7 July 2010 on the application of the principle of equal treatment between men and women engaged in an activity in a self-employed capacity;
- Directive 2006/54/EC of 5 July 2006 on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation (recast). This Directive defines harassment and sexual harassment as discriminations on the grounds of sex;
- Directive 2004/113/EC of 13 December 2004 on implementing the principle of equal treatment between men and women in the access to and supply of goods and services. This Directive provides a definition of sexual harassment.

These directives play a significant role in shaping the definitions of different types of violence against women and preventing violence against women in its different forms.

In addition, the **2008 EU guidelines** on violence against women and girls and combating all forms of discrimination against them (see: further reading).

The Action Plan to implement the Stockholm Programme and the European Commission's Strategy for Equality between Women and Men 2010-2015 state that 'the Commission will adopt an EU-wide strategy on combating violence against women'.

The European Union's competence for the harmonisation of criminal law has been extended by the Lisbon Treaty, which entered into force in December 2009, offering a new opportunity to develop instruments to combat violence against women.

FURTHER READING

EU guidelines on violence against women and girls (2008), https://ec.europa.eu/anti-trafficking/sites/anti-trafficking/files/eu_guidelines_on_violence_against_women_and_girls_1.pdf

3.3. Italian Laws 30'

Intimate Partner Violence. Criminal Code, Article 572. In Italy, "violence in family or against children" includes all forms of violence perpetrated against a member of his/her own family or the partner.

Observations:

In the case of a long period of victim violation the perpetrator is punished for "abuse". If the survivor was violated "just once" misdemeanours such as aggression, rape or insult are treated as single offence. If from the violence there is a serious consequence or death the perpetrator can be imprisoned up to 24 years.

Rape. Criminal Code, Article 609bis. Whoever, by force or by threat or abuse of authority, forcing another person to commit or suffer sexual acts shall be punished with imprisonment from five to ten years.

Observations:

In February 1996 sexual violence ceased to be a "crime against public morality" and was fully recognized as a "crime against the person". Consequently, the crime of sexual violence is specifically defined by the Penal Code.

Sexual Assault (excl. rape). Criminal Code, Article 609bis. Italy uses the term "sexual violence", which is: whoever, by force or by threat or abuse of authority, forces another person to commit or suffer sexual acts.

Observations:

The same punishment will be given to whoever induces another person to commit or suffer sexual acts by: 1) abusing the conditions of physical or mental inferiority of the victim at the time of the event, 2) misleading the victim hiding own identity.

Sexual Harassment and stalking. Law Decree 23 February 2009, n. 11, "Misure urgenti in materia di sicurezza pubblica e di contrasto alla violenza sessuale, nonché in tema di atti persecutori" converted into Law 23 April 2009, n. 38. The same in Art. 612-bis Penal Code: Atti persecutori.

Continuative harassing, threatening or persecuting behaviour which: (1) causes a state of anxiety and fear in the victim(s), or; (2) ingenerates within the victim(s) a motivated fear for his/her own safety or for the safety of relatives, kin, or others associated with the victim him/herself by an affective relationship, or; (3) forces the victim(s) to change his/her living habits.

Observations:

It is considered to be the same as stalking. In February 2009, Italy adopted an Anti-Stalking Law making a criminal offence, punishable with imprisonment ranging from six months up to four years.

Exercise 20'

- Divide trainees into two groups. Ask each group to discuss about a case of a woman GBV victim and think how to manage the case referring to the national/local law(s).
- Presenting the case studies and discussion

Introduction to the module

GBV seriously affects all aspects of women's health- physical, sexual and reproductive, mental and behavioural health. Health consequences of GBV can be both, immediate and acute as well as long lasting and chronic; indeed, negative health consequences may persist long after the violence has stopped. The more severe the level of violence, the greater the impact will be on women's health. Furthermore, exposure to more than one type of violence (e.g. physical and sexual) and/or multiple incidents of violence over time tends to lead to more severe health consequences (WHO 2002, Johnson/Leone 2005, both cited in WHO/PAHO 2012a). For example, mental health problems resulting from trauma can lead to suicidality, or to conditions such as alcohol abuse or cardiovascular diseases that can in turn result in death. HIV infection as a result of sexual violence can cause AIDS and ultimately lead to death (Heise et al 1999, WHO 2013).

1. AIM OF THE MODULE

Main objective

- This module provides information on the impact of GBV on women's health as well as information on psycho-trauma directly linked to gender-based violence.

Sub-objectives:

- Provide some instruments to recognize the health consequences of GBV, prevent them and take care of the victims.

Structure

- Objective and presentation of the module
- The consequences of GBV on physical and mental health
- How to recognize the consequences of GBV
- How to manage the impact of GBV in reception centers

Introduction to the training and presentation of an external professional (if there is one)

Trainer introduces himself/herself and explains how the module is structured: contents, time, methods, exercises  5'

2. THE CONSEQUENCES OF GBV ON PHYSICAL AND MENTAL HEALTH

Invite trainees to say what they know about the consequences of the GBV on the physical and mental health and write their suggestions on a flip chart.  5'

GBV affects durably and profoundly the physical and mental health of the victims. The exposure to GBV increases the risk of developing certain pathologies and diseases. We can classify the consequences of GBV on the health of the victims in four categories¹:

- An acute or immediate physical traumas;
- The impact on the physical health and development of at-risk behaviors;
- The consequences on the sexual, reproductive and perinatal health;
- The chronic diseases;

¹ La lettre des violences faites aux femmes n° 6-mai 2015, MIPROF

The impact of GBV on the health and behavior of the victims²

 Physical health	 Mental health	 Sexual and reproductive health	 Chronic diseases
Wounds in the abdomen and in the thorax	Post-traumatic Stress Disorder	Gynaecological problems	Arthritis, Asthma
Traumatic brain damages	Depression, anxiety	Chronic pelvic pains	Cancer
Burns and cuts	Eating and sleep disorders	Haemorrhage and yeast infections	Cardiovascular disease
Fractures	Suicidal tendencies	Complications in the pregnancy, miscarriage	Stroke
Disabilities	Addiction to alcohol, narcotics, tobacco addiction	Unintended pregnancy and unsafe abortion	Diabetes
	Risk-taking behaviour	HIV and other STD	Liver, kidney diseases
	Auto-aggressive behaviour		High blood pressure

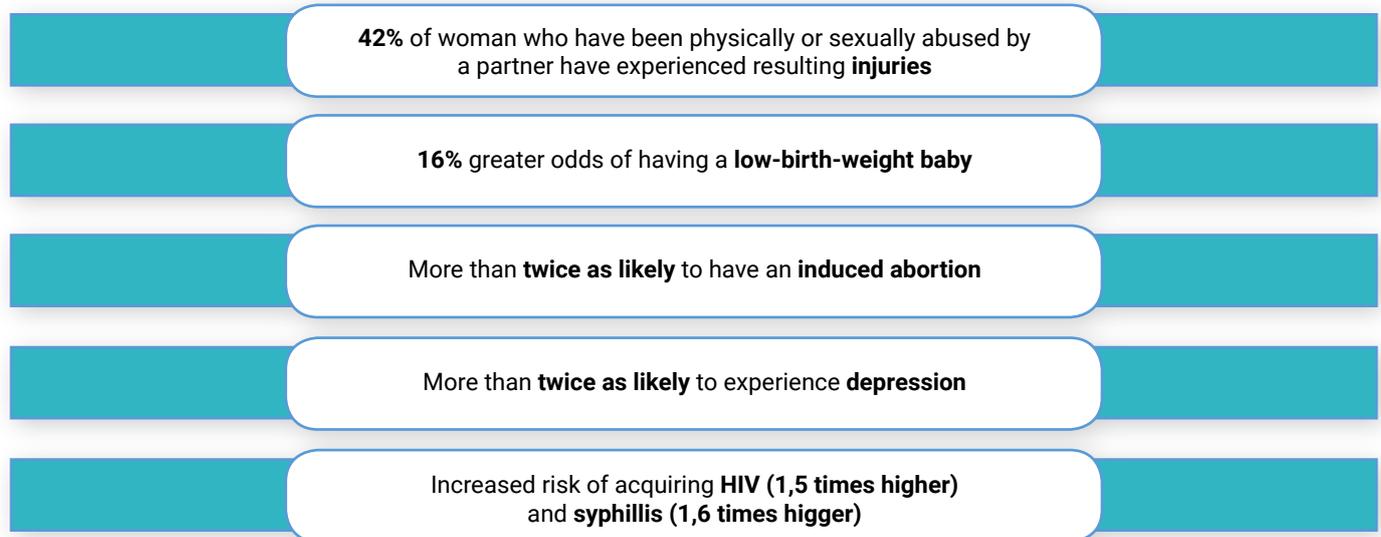
Health Outcomes of Violence against Women and Girls

Nonfatal Outcomes Fatal Outcomes		Nonfatal Outcomes Fatal Outcomes
<p>Physical consequences</p> <ul style="list-style-type: none"> • Injuries • Functional impairments • Permanent disabilities <p>Negative health behaviours</p> <ul style="list-style-type: none"> • Alcohol and drug abuse • Smoking • Sexual risk-taking • Self-injurious behaviour <p>Consequences for reproductive health</p> <ul style="list-style-type: none"> • Pelvic inflammatory diseases • Sexually transmitted diseases • Unwanted pregnancy • Pregnancy complications • Miscarriage/low birth weight 	<p>(Psycho-) somatic consequences</p> <ul style="list-style-type: none"> • Chronic pain syndrome • Irritable bowel syndrome • Gastrointestinal disorders • Urinary tract infections • Respiratory disorders <p>Psychological consequences</p> <ul style="list-style-type: none"> • Post Traumatic Stress Disorder • Depression, Fears, Sleeping disorders, Panic disorders • Eating disorders • Low self-esteem • Suicidal tendencies 	<ul style="list-style-type: none"> • Fatal injuries • Killing • Homicide • Suicide

Source: Hellbernd et al 2004, CHANGE 1999, all cited in PRO TRAIN 2009

² WHO, 2014

Example of health consequences of intimate partner violence (WHO 2013)



Source: Strengthening Health System Responses to Genderbased Violence in Eastern Europe and Central Asia. A Resource Package. UNFPA and WAVE 2014

Psycho-trauma

One of the most serious consequences of GBV is a **psycho-trauma**. American psychiatric association defines psycho-trauma as following:

- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- the person's response involved intense fear, helplessness, or horror.

Note: In children, this may be expressed instead by disorganized or agitated behaviour.

Trauma means wound. In both medicine and psychology, it refers to major physical or mental injuries, including threats to life or physical integrity. As Judith Herman (1992, p.33) phrased it, a trauma is "a personal encounter with death and violence".

A "traumatic event" is one that has the capacity to cause mental or physical trauma. A severe traumatic event often changes the way in which survivors understand the world around them. They may lose their sense of safety and feel vulnerable and helpless. If the event involves acts of violence, trust in other people may be lost and the survivor's interrelational world seriously disturbed. Loss of safety, control and trust may lead to depression, anxiety etc.

If survivors don't receive support and help, these reactions may last for months or even for years. Psychiatrists call this state of mind "**post-traumatic stress-disorder**" (PTSD).

GBV is a distinctive form of trauma because the violation involved is extremely invasive and gives rise to feelings of shame, self-blame and guilt. When combined with fear of being injured or killed, it is traumatizing in almost all cases.

Watch the video on psycho trauma of survivors of sexual and GBV and talk about it during 5-10 minutes. Ask the participants if they have already seen some cases of psycho-trauma in their work and how did they feel about it.

5 | Psychology & Trauma | Conducting Interviews with Survivors of Sexual & Gender Based Violence:

<https://www.youtube.com/watch?v=Z3Dzllpgeg>

3. HOW TO RECOGNIZE THE IMPACT OF GBV

The signs of physical and mental suffering to be detected when working with migrant women³. These signs are related to:

- The behavior: agitation, nervousness, sense of danger, misuse of medical drugs, sleeping problems, self-destructive behavior (self-mutilation, consumption of psychoactive substances, etc.), isolation, avoidance of professionals;
- The emotion: anger, anxiety, sadness, guiltiness, shame, apathy, shock, fears;
- The low self-esteem;
- The speech: confusion, silence, indecision, minimization or rejection of the feelings of distress;
- The minds: self-destructive, obsessing thoughts;
- The physical symptoms: headaches, cardiac palpitations, muscular tensions, loss of weight.

This concerns structures including health care services

The following list presents symptoms that should make health professionals consider asking about GBV, in particular intimate partner violence.

Examples of clinical conditions associated with intimate partner violence

- Symptoms of depression, anxiety, PTSD, sleep disorders Suicidality or self-harm
- Alcohol and other substance use
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Chronic pain (unexplained)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

Source: Adapted from Black 2011, cited in WHO 2013

³ Repérage et accompagnement en centre d'hébergement et de réinsertion sociale (CNRS) des victimes et des auteurs de violences au sein du couple, Anesm

Examples of behaviors that may indicate intimate partner violence

<ul style="list-style-type: none">➤ Frequent appointments for vague symptoms➤ Injuries inconsistent with explanation of cause➤ Woman tries to hide injuries or minimize their extent➤ Partner always attends unnecessarily➤ Woman is reluctant to speak in front of partner➤ Non-compliance with treatment➤ Frequently missed appointments➤ Multiple injuries at different stages of healing	<ul style="list-style-type: none">➤ Patient appears frightened, overly anxious or depressed➤ Woman is submissive or afraid to speak in front of her partner➤ Partner is aggressive or dominant, talks for the woman or refuses to leave the room➤ Poor or non-attendance at antenatal clinics➤ Early self-discharge from hospital
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Source: Department of Health 2005

It is important to keep in mind that none of the above signs automatically indicate that a patient has experienced GBV. However, they should raise suspicion and prompt health professionals to try to see the woman in private to ask her if she has experienced violence. Even if she chooses not to disclose at this time, she will know that the health care provider is aware of the issue and she might choose to approach the care provider at a later time (Department of Health 2005).

Specific psycho-trauma features:

- Depression, mental health problems, anxiety, suicidal behaviour;
- Consumption of alcohol, prescribed medical or other drugs leading to at-risk behavior;
- Psychosomatic disorders, bellyaches, chronic pain etc.;
- Impact on the reproductive and maternity health.

Watch the video **Trauma and the Brain: Understanding abuse survivors' responses made by Mediaco-op.**

<https://www.youtube.com/watch?v=4-tcKYx24aA>

Ask the participants if they have experienced some consequences of GBV on the victims in their work. What were the symptoms? How did they deal with them?

4. HOW TO MANAGE THE IMPACT OF GBV

The needs and challenges:

- The identification of vulnerability and signs of distress;
- The development of physical and mental well-being;
- The access to and continuity of somatic and psychiatric care;
- The central role of the victim in the medical care process.

The recommendations for the professionals working with GBV victims: the inclusion of physical and mental health needs

- Present the access to health care services (external services or internal if there are health care professionals) and contact details;
- Present to the victim its rights to health care and information sharing terms between medical, sanitary and social professionals;
- Analyse the special needs of the victim in terms of basic health care, gynaecological and mental care;
- Estimate the wish of the victim to be accompanied during the first contact with the healthcare specialists;

- Detect the signs of the effects of the violence on the mental health;
- Not to forget a central role of the victim in its health care process (consider together the support in access to health care and to necessary information, highlight the capacity of recovery and resilience of the person);
- In accordance with the principle of doctor-patient confidentiality, find medical and psychological experts in order to allow to a victim to understand the link between the real-life experience and its mental health (flashbacks, dissociation etc.)
- Identify the signs of addiction behaviour and engage a discussion on this issue;
- Provide, by means of communication tools, the information on the various existing therapy methods and different specific services and assure a referral to the specific health services.

Group exercise: the role of professionals in responding to GBV impact 20'

Instructions for participants:

Read the case study below and discuss the following questions in your working group:

1. What, in your opinion, is the role of a professional when being confronted with a case like Anna?
2. List some examples of steps that the professional should undertake.
3. Each group should write the answers and nominate a rapporteur to present the results to the bigger group (10 min. to write + 10 min. for presentation and discussion).
4. What, in your opinion, are the things to not to do as a professional in this case?

Case study – the story of Anna:

Anna, 45 years, is an asylum seeker from Chechen republic. She is married and has three children. Together with her family, she lives in a reception centre for asylum seekers. One day, Anna comes to the centre for her appointment with a social assistant. She is asking a social worker to refer her to a doctor, because of bellyaches and sleep disorders. She looks very tired and lost weight. The social assistant realizes that Anna is unwilling to talk about the nature of her health problems.

4. RESPONDING TO GENDER BASED VIOLENCE

This module builds on the knowledge sections of the previous modules to provide best practice and required skills when responding to migrant women who have experienced gender based violence. The training uses a participatory approach promoting interaction and engagement in the learning process. The role of the facilitator is therefore to encourage participation without being judgemental and by listening with interest and empathy to help the participants to tap into their own abilities and experiences.

1. AIM OF THE MODULE

Main aim

The aim of this module is to: understand and develop skills on best practice when responding to women and girls who have suffered gender based violence

Sub-objectives:

- Understand the basic principles of the survivor centred approach
- Learn and practice communication skills in effectively responding to women who have suffered GBV
- Understand best practice is when responding to a disclosure and be aware of barriers to reporting violence in the context of working with migrant women

Know when and how to make a referral and how this can be done sensitively

Preparing the training – note to facilitators

Facilitators should go through the materials in detail and gather information on the following:

- How can the topics best be presented?
- How do gender roles operate in this context?
- What are the main forms of SGBV in this context?
- What is the legal framework for SGBV in this context?
- What services are available for referral in this context? Are they able to respond appropriately?
- What are the national and organisational procedures for reporting, confidentiality and referrals?

1. Survivor centred approach 45'

Everything begins with the experiences of the survivor. These experiences determine the needs and the need determines the services required.

A survivor-centred approach means giving priority to the rights, needs and wishes of survivors of GBV. It is based on the principles featured in this session and is reflected in the skills used by staff and volunteers in supporting the person who has been subject to GBV.

While we use the term 'survivor' here remember that people affected by GBV may not want to be labelled as a 'survivor', particularly if the threat of violence is ongoing. Allow people to define themselves and in doubt refer to them simply as a person affected by GBV or in need of support.

Identifying the basic principles of a survivor centred approach 20'

Make four sets of cards with one principle written on each card. Use the words safety, confidentiality, respect and non-discrimination on the cards.

Divide participants in to 4 groups. Give each a set of cards with the principles and paper and pens. Give the groups 10 minutes to discuss the following questions:

- What does this principle mean?
- Why is this principle important when working with survivors of GBV?

After 10 minutes, invite each group to present their responses in plenary. Complete the activity by talking about 'the survivor-centred approach' using the information below.

The four principles of a survivor centred approach

The principle of safety

The safety of the survivor and survivor's family should be ensured at all times. Keeping survivors safe should be a number one priority. Survivors of GBV are at heightened risk of ongoing violence (e.g. domestic violence), murder or suicide, as well as social discrimination and isolation. Helpers have to assess safety risks and minimize the risks for survivors and their immediate family members.

Incidents of GBV also affect survivors' sense of security and trust in other people. The world may seem a dangerous, chaotic or unsafe place. Naturally enough, survivors may lose their belief in the goodness of humankind. Helpers should try to support them by staying close and remaining calm, even if the person is extremely distressed. Being genuine and honest will help the distressed person to rebuild a sense of trust and safety and begin the recovery process.

The principle of confidentiality

Maintaining confidentiality means that information about survivors should not be shared with others outside of the immediate organisation without the informed consent of the survivor. This means not sharing information with doctors, other NGOs, family members, the media, etc. without consent. There are certain exceptions to this rule that are about the absolute safety of the survivor and/or immediate family. These exceptions will be discussed in the next session. Disclosure of confidential information can expose survivors to severe social stigma. In some societies people affected by GBV will be punished or at risk of losing their life (together with those of their immediate family). They may be isolated or rejected from their families and the community.

The fact that a person has shared his/her story with you as a service provider is a big step and a sign of trust. All personal information should therefore be treated extremely carefully. Maintaining confidentiality at all times is an important strategy to ensure the safety of the survivor and to minimize the risk of discrimination and isolation.

The principle of respect

Respect means seeing the survivor as the primary actor in the situation. The wishes, rights, and dignity of the survivor have to be respected at all times. The role of helpers is to facilitate recovery and provide resources for problem-solving. Loss of control is a central element of situations of GBV. During the recovery process, a survivor has to gain back a sense of control over his/her life. The failure to respect the survivors' right to find their own solutions can increase their feelings of helplessness and dependency on others. The work of the helper should always be to strengthen self-efficacy, enabling survivors to feel strong and competent. Survivors should therefore be in control of the process and their wishes should determine the actions taken.

The principle of non-discrimination

All people have the right to the best possible assistance without discrimination, on the basis of gender, age, disability, race, colour, language, religious or political beliefs, sexual orientation, status or social class, etc.

When discussing the principle of non-discrimination, invite participants to focus on their own prejudices and experiences of rejection. Ask if there are people they try to avoid or if there are others they prefer to work with (because of feelings of sympathy for them, or because they are the same age, same sex, same ethnic group, etc.). Invite them to reflect on the reasons for this. To offer support in a non-discriminative way, we need to be aware of these preferences or prejudices.



Putting the principles in to practice 25'

Divide the participants into four groups and give each of them a scenario. Give them 10 minutes to think about how they would apply the four basic principles of safety, confidentiality, respect and non-discrimination in this situation. Discuss responses in plenary. Note them down on flipchart paper. Now link these responses with more detailed guidance on putting the principles into practice, using the information below. Close the activity by giving participants copies of the hand-out 'The survivor-centred approach in working with people affected by GBV'

Information for facilitators on putting the principles into practice

Safety:

- Introduce yourself and the services that are available, and be transparent in all the actions that you take.
- Make sure that a room is available; if possible, that is quiet and private.
- Remain calm, even if the person is extremely distressed.
- Stay close.
- Help the person to identify and address immediate safety risks.
- Try to find solutions for ongoing risks.
- Don't do anything that threatens the safety of the survivor or his/her family.
- Stress that the situation of violence is over, that they have survived and they are safe now (if that is the case).
- Develop an individual safety plan with the survivor. Try to find places where he/she feels safe.
- **If the threat of violence is ongoing, refer to your organisation's safeguarding procedure and take appropriate action including emergency action if necessary**

Confidentiality:

- Make sure that all information gathered about a person is stored securely (e.g. files should be locked, documents on the computer secured with password)
- If you need to share information about the person with an outside organization, you must first obtain the survivor's informed written consent or that of a parent or guardian if the person who has suffered GBV is a child.
- Do not pressure the survivor to give consent.
- Share only necessary and relevant information (not all the detail) with others involved in giving help (after having obtained written consent). Informed consent means that the survivor will be informed about which information will be shared, with whom and for what reason.
- Do not share any information about the survivor or their situation (e.g. giving their name or other identifying information) with anyone else – at home or in the workplace
- Avoid identifying survivors of GBV in the way services are provided. Survivors can be at risk of being identified by the community if they attend specialised programmes. This risk can be minimized by addressing the special needs of survivors of GBV within broader psychosocial programmes.
- Never disclose any information about the person you are supporting to a third party, eg relative or friend of that person, not even to confirm that you know them. Disclosing such information could put them at further risk particularly in cases of domestic violence
- Refer to your organisation's confidentiality procedure

Exceptions to maintaining confidentiality:

- When someone might try to hurt herself or himself
- When there is a risk that the person might hurt others
- When a child is in danger
- When national or international laws or policies require mandatory reporting (for example, because of sexual exploitation and abuse by humanitarian staff).

It is very important that the survivors are informed of the reasons for mandatory reporting – preferably before they begin to explain what has happened to them. It must be made clear to them that whatever they say will have to be reported due to national, international laws or policies. This gives them the option to go on telling their story or to stop at this point.

Respect:

- Don't pressure a person to talk and make a disclosure.
- Be patient and kind. Don't judge the person.
- Accept feelings. Survivors sometimes feel that their emotions, thoughts and behaviour are strange. Explain that their reactions are normal.
- Inform the person about available referrals but don't force her/him to take any actions.
- If it is the wish of a survivor to be interviewed or examined by a person of their own sex, make sure that female/male staff is available.
- Minimize the number of times a survivor needs to retell her/his story.
- Some survivors of domestic violence decide to stay in the abusive relationship. Even in these situations, no action should be done against the will of the person affected by domestic violence.

Non-discrimination:

- Reflect on your own prejudices and assumptions.
- Offer support to everybody without discrimination, on the basis of gender, age, disability, race, colour, language, religious or political beliefs, sexual orientation, status or social class.

Remember that a woman is at most risk of serious harm or murder at the point she attempts to leave an abusive partner. Never try to persuade a woman to leave immediately

2. Responding to disclosures and barriers 45'

This section looks at barriers to women being able to disclosure violence and abuse that professionals need to be aware of and how we can overcome these, and best practice and challenges when responding to disclosures of GBV.

Barriers and challenges

Ask the group to stand in a circle facing each other. Ask one member of the group to stand in the middle of the circle. You will need a ball of wool or string for this activity.

Explain to participants we are going to think about what might prevent someone from disclosing that they have been a victim of gender based violence (including domestic violence). Each person names an issue and throws the ball of wool or string to someone else in the group. Keep going until everyone has had a turn or you see signs the group is ready to finish.

A 'spider's web' will form, trapping the person in the middle to demonstrate how 'stuck' they might feel in the face of all these barriers.

The facilitator should write up the issues on the flipchart during the activity as participants raise them. After the activity participants can return to their seats and look the list 'barriers for people affected by GBV' they have generated.

If they haven't already come up these barriers and challenges should be added to the list:

Potential barriers for disclosing an incident of violence:

- Fear of social exclusion and stigmatisation
- Underlying cultural norms
- Feelings of shame

- Not having knowledge about personal rights
- Not having knowledge about or reduced accessibility of services
- Lack of services.
- Discrimination from services
- Fear of further violence

 **Some additional barriers to leaving an abusive relationship include**

- Shame
- Shame and low self-esteem
- Threats by the abusive partner to harm themselves, their partner or children
- Intimidation
- Financial dependence on partner
- Restrictions on movement
- Isolation
- Lack of knowledge about what help they can receive
- Poor or failing health having a negative impact on their ability to make decision and/or act
- Hope that things will change

If they have not come out already, suggest some additional barriers that might affect migrant women specifically:

- For women without legal status, fear about being reported to the authorities and detained/removed from the country
- Fear related to this about being separated from children/children being taken in to authority care
- Perceived underlying cultural norms about 'acceptable' behaviour held by perpetrator, community and potentially services
- Fear of being shunned by the wider 'community' – family, extended family, friends, faith community
- Not knowing the language of host country
- Lack of knowledge about the law, rights and available services in host country
- Lack of available services that meet their needs (language/provision of interpreters; cultural mediators; understanding of immigration status and how this affects options)
- Discrimination from services

 **Facilitator's notes on barriers facing migrant women (also refer to Module 1 hand-out 5)**

We should recognise that women without legal status face multiple disadvantage when it comes to GBV protection and support. These 'intersecting' factors mean that migrant women can be both at increased risk of violence and face increase barriers to accessing support and safety.

As an additional activity, look again at the different types of GBV from the slide and Hand-out attached to Module 1. Ask participants how women with insecure status might be at greater risk of GBV and how services can work to protect them. Using case studies based on women with insecure status to illustrate the material and engage the group can also be effective in highlighting this issue.

Highlight - the protections afforded within the EU Victims Directive in Module 1

 **Challenges for helpers**  10'

On a second piece of flip chart paper the facilitator writes 'challenges for people helping survivors of GBV' and asks participants to name challenges. These could include:

Potential challenges for professionals in the work with survivors

- Not having knowledge on what to do

- Fear of doing harm
- Embarrassment about discussing sexual issues
- Being overburdened
- Lack of supervision
- Not having knowledge on procedures and about the legal framework for GBV
- Lack of specialised services to refer to.
- Being from the same cultural background as the person they are working with – this could be a challenge or a positive depending on the person's perception

Ask the participants if they have ideas about how to overcome the barriers and challenges they have identified and discuss together. Add the suggestions below if they have not already come up.

Some ideas of overcoming challenges could include:

- Awareness-raising on services available
- Ensuring safety and maintaining confidentiality
- Embedding SGBV in general services rather than specific targeting
- Capacity-building on basic helping skills and referral pathways
- Having clear policies and procedures.
- Acknowledging own pre-conceived ideas and

 **Responding to disclosure best practice** ⌚ 30'

Group work discussion:

Facilitator reads out the following scenario:

Ask the group for 5 examples of good responses and 5 of the worst things they could do or say and write the answers up on a flip chart.

Explain that now we will look at disclosure good practice and poor practice. Give 2 examples of disclosure good practice and 2 of poor practice from the list below.

Ask the group to think of more

 **Whole group discussion:** ⌚ 10'

Compare with the Disclosure Poor practice and Disclosure Good practice circles on page 2 and discuss what the group/s may have missed or what the participants have mentioned which is not included:

Responding to disclosure do's and don'ts

Poor Practice - Do Not:

- Make assumptions - don't speculate or make assumptions about what has happened or will happen as a result of the disclosure, for example the actions of authorities. If you are making an assumption about something check it out first.
- Ignore or dismiss – someone might ignore or dismiss a disclosure for a range of reasons (exhaustion, anxiety, time and resource limited) but this is never the right response. Making a disclosure can be traumatic so it is crucial to actively listen to the person and acknowledge what they have said.
- Change the subject – Don't change the subject because you can't cope with it or because you think it's upsetting them. It's their disclosure and they need the opportunity to speak and be listened to in a way which shows them their disclosure is the subject and is being taken seriously.
- Ask leading questions – See investigate below.
- Investigate - It is not your role to investigate. It is more about listening and building up a picture about what has happened and any current risks (to the person and to others). If you investigate it can jeopardize the effectiveness of any future criminal investigations.

- Express shock - It's OK to feel shocked by what the person is disclosing to you but expressing shock can give the person disclosing the message that you are not able to cope with their disclosure and they may terminate or retract the disclosure as a result
- Ask what they did – When you're listening to the person and building up a picture of what has happened, you must not ask what they did to cause the abuse e.g. don't say: "It sounds like they got very angry, what did you do to make them so angry?"

Good Practice Do:

- Take the person's disclosure seriously - worry that a disclosure will be dismissed is a disincentive to disclosure. It is important that you take the disclosure seriously and communicate this through your words and body language. When a person starts to disclose and picks up they are not being heard or taken seriously, it will often result in a retraction.
- Listen and summarise to clarify where needed –actively listen including to what the person wants to happen as a result of making the disclosure. This involves giving your full attention and conveying interest to the person by using both verbal and non-verbal messages such as maintaining eye contact, nodding your head, agreeing by saying 'Yes' or simply 'Mmm hmm' to encourage them to continue. Where needed summarise to clarify. This can give the message that you have listened and give them a chance to feedback if they don't think you have understood.
- Reassure the person that they did a good/right thing in telling you and that you are taking the information seriously.
- No blame - Stress that it was not their fault.
- Non leading questions - When someone discloses to you remember it is your role to listen and take what they are saying seriously, not to investigate. The purpose of asking questions is to show you are listening and begin to build up a picture of what has happened.
- Follow policy - Work within the framework of your organisation's policy and procedure including making accurate notes as near to the disclosure time as possible to avoid reliance on memory
- Appropriate setting - Disclosures often don't take place in an appropriate (i.e. safe and confidential) setting. Where you can, encourage the person to speak with you in privacy.
- Professional – It can be difficult to hear a disclosure; it can bring up issues for the listener and raise concerns about not getting it right. However you're feeling inside, it is important to stay professional – focus on the person and do your best to make their experience of disclosing a positive one where they know you have listened to them and have taken their disclosure seriously and are prepared for the next steps.

When someone has experienced a crisis situation or is in shock, it is a great help if someone offers practical support. A few examples include:

- contacting someone who can be with the person
- arranging for children to be picked up from school
- making sure the person is warm and provided with food and drinks if there is a need
- helping the person with transport home
- helping them to get to the hospital or other support as needed.

Remember, at the same time, to respect the person's wishes and not to take over too much responsibility. Support them to regain control of their own situation, to consider their options and take their own decisions. This will empower them to begin meeting their own needs.

Self-care and stress management

Working with survivors of SGBV can be very challenging for helpers, but it can be very demanding at the same time. Please refer participants to handout 3.

3. **Communication skills for supporting survivors** 40'

Do a short presentation on active listening using the notes below. Active listening includes verbal and non-verbal communication.

Explain to participants that they will have a chance to practise active listening skills after this presentation. Use the notes below to explain what active listening is and how it is part of supportive communication



Information for facilitators on active listening

Active listening is a key element of supportive communication. It means giving full attention to the speaker. This means not only listening to what is being said, but also listening to the 'music' behind the words, and registering movements, body language, tone of voice and facial expressions. The art of listening therefore is to be able to find the meaning, both from what is said and how it is said. Active listening in support situations means focussing on the speaker. It gives the speaker space and time to talk, without the helper interrupting by expressing their own thoughts and feelings.

Elements of active listening include:

- maintaining eye contact (if this is culturally appropriate) without staring
- focusing on the survivor and give them room to talk
- using clarifying questions and summarizing statements, e.g. "What do you mean by saying ..."; "I am not sure I understand what you mean when you mention ..."; "Are you saying that you ..."; "Did I understand you correctly ..."
- avoiding giving opinions or arguing
- trying not to be distracted
- focusing on what the person is saying, rather than guessing, or preparing what you yourself will say next
- using your own body language to convey your attention
- using words like 'yes,' and 'hm,' and 'go on'
- using appropriate facial expressions
- keeping your posture relaxed and open
- being awake and attentive – maintain high energy levels
- allowing time for silence and thoughts.

Point out that this list includes examples of verbal and non-verbal communication. Ask participants to give examples of both.

People affected by GBV often blame themselves. Helpers must communicate that sexual violence is always the fault of the perpetrator and never the fault of the survivor. It is crucial in these circumstances that helpers do not reinforce the stigma and sense of self-blame by being stigmatising in the type or tone of questions they ask, for example "Why didn't you have someone accompanying you that night?"

If, however, survivors have the opportunity of telling their story in a supportive atmosphere, this helps them to understand and come to terms with what they have experienced. A question like, "What were the events leading up to the assault?" is much more appropriate



Active listening and non-verbal communication role play activity 25'

Use a neutral topic from the participants' everyday lives for the activity.

Explain the procedure for the role-play: Ask participants to divide into pairs. In each pair, one person takes the role of active listener/helper and the other the speaker. There is 10 minutes for this activity. Ask the speakers to choose a topic or provide them with one (eg their favourite place and why) Ask listeners to give 100 per cent of their attention to what the speaker is saying, and allow the speaker to talk about the topic in their own way rather than 'interviewing' them. After 5 minutes, ask participants to switch roles with their partner.

End with a group discussion in plenary, using the following questions:

- How was this different from everyday conversation?
- How did you feel when there were silences?
- Were you more comfortable as the speaker or the listener?
- What might hinder you from giving 100 per cent of your attention?
- What factors might enable you to give the speaker your full attention?
- What non-verbal clues was the client expressing?

Wrap up by highlighting the essential points for communication below:

Essential points for communication

- Stay close and calm
- Be non-judgemental
- Accept feelings: Survivors sometimes feel that their emotions, thoughts and behaviour are strange. Everybody responds differently, but explain that their reactions are actually very normal. It is not that their reactions are strange, but the situation they have experienced is not normal.
- Provide practical information
- Challenge stigma
- Promote safety: Stress to survivors that the period of violence is over, that they have survived it and they are safe now (as long as this is the case).

4. Making referrals 25'

Referrals will often be necessary in the course of providing support to survivors of GBV. This session looks at best practice in doing so, with reference to the survivor centred approach, and encourages participants to think about their local, regional and national referral mechanisms for people who have been affected by SGBV.

In preparation for this session, it is very important to find out the procedures for making a referral in the organizations/community where the participants are working. Look specifically at the responsibilities for staff and volunteers. Try also to access information about the support services that are available in the region. Find out if the services match the standards being promoted in this training. They should have a survivor-centred approach and observe the principles of safety, confidentiality, respect and non-discrimination in their practice (specifically many male and female survivors prefer to be examined and interviewed by a woman. It is helpful to know where female staff are located.)

If possible, consider inviting representatives of external agencies from the local area. Choose agencies that follow quality and ethical standards. The agencies can then explain how they deal with referrals and how organizations can refer to them.



Identifying referral pathways and support services

Divide the participants in groups of three or four. Give them flipchart paper and markers. Give the groups 15 minutes to answer the following questions

- What are the procedures for making a referral within your organization? Please describe them step by step if possible
- What support services are available for survivors of GBV in your region?
- How would you ensure the quality of the support service you want to use for the referral?
- What would you do if there were no support services available to meet the specific needs of the person you were supporting?

Ask groups to note down the information they share on the flipchart paper.

Discuss the groups' findings in plenary. Ask each group to stick their flipchart paper on the wall. Refer to the lists of procedures and the lists of support services. This is an opportunity to share information that participants themselves may have about the local area. This information could be helpful to other participants in their work.

Use the information below to conclude the session.

Information for facilitators on making referrals

Knowing when to refer someone is very important. Helpers need to be clear about the limitations of the service they can provide, as well as being aware of their own assumptions and personal limitations. Helpers also need to know what to do in terms of the procedures they are required to follow in their capacity as a volunteer or staff member of an organization.

Knowing why to make a referral is also important. This could be to access specialised help, like medical services to assess injuries or check for sexually transmitted diseases, etc., for example, or legal services.

Sometimes referral is needed when there is a concern for the welfare of the person, for example when there is:

- a significant change in behaviour – whether the individual themselves or people close to them recognize the change
- talk of suicide
- persistent physical symptoms
- dependency on alcohol or drugs
- behaviour which puts self or others at risk
- on-going depression or other mental disorder
- inability to control strong emotions
- problems as a result of abuse or criminal activity
- severe sleep problems.

Knowing **how** to refer a person is important too. Helpers must:

- Observe the four principles of the survivor-centred approach. Always prioritise the confidentiality and security of survivors. Avoid home visits to reduce risks of identifying someone affected by SGBV
- Inform the person what you are planning to do and get their informed consent
- If possible, provide different options. Having a list of local organizations, agencies and networks is essential. Knowing whether female staff is available is very important
- Avoid multiple referrals putting the person in a situation where they are forced to re-tell their story many times
- Follow the procedures set out by the organization you are working for and the requirements of the service you are referring to. Procedures usually involve consultation with and approval by a line manager or supervisor within the organization.

5. **Wrapping up** 15'

Re-visit the learning objectives from the start of the day.

Check in with participants about how they are feeling and any final questions.

Explain that responding to GBV should be closely linked to organisational procedures so staff should be aware of these.

Explain that there is more information in the participants hand-outs and slides.

Invite participants to complete the feedback forms for the training.

5. UNDERSTANDING AND RESPONDING TO DOMESTIC ABUSE

1. Awareness and recognition 1h

Definition of Domestic Abuse 15'

Group Work Discussion



Tell the group you are going to divide them in to two smaller groups. Give each group a minute or two to come up with a definition of domestic abuse.

Domestic Abuse

Domestic violence is the systematic pattern of behaviour on the part of the abuser designed to control his partner.

The abuse can be physical, emotional, psychological, financial or sexual. Anyone forced to alter their behaviour because they are frightened of their partner's reaction is being abused. It can begin at any stage of the relationship. Domestic abuse is rarely a one-off. Incidents generally become more frequent and severe over time.

<https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/domestic-violence/>

The abuse can include but is not limited to the following types:

- Psychological/emotional
- Coercive or controlling behaviour
- Physical
- Sexual
- Financial and material
- Stalking and harassment
- So called 'honour based'
- Online abuse



Write the definition and types on a flip chart paper or refer the group to their participant sheet.



Domestic Violence or Domestic Abuse?

The term 'domestic abuse' is often used to emphasize the full range of types of abuse and break down the commonly held misconception that domestic violence is only about physical violence. Using the term domestic abuse allows us to highlight the psychological and emotional abuse as well as the physical.

Many women's organisations use the term domestic abuse for this reason.

Domestic Abuse is perpetrated by a partner, ex-partner or close family member.

Domestic Abuse is a form of gender based violence. Gender Based Violence (GBV) is a widely used umbrella term for any harmful act that results in, or is likely to result in, physical, sexual, psychological harm or suffering to a child or adult on the basis of their gender. GBV is a result of gender inequality and abuse of power.



Group work Discussion - types of Domestic Abuse in more detail 10'

Look at the types of domestic abuse written on the flip chart. Are these what the participants expected to see, are there any forms of abuse they had not considered as domestic abuse?

Some types of psychological abuse are less widely recognised as domestic abuse but are very common:

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim (*Controlling or Coercive behaviour in an intimate or family relationship, Statutory Guidance Framework. UK Home Office 2015*)

Coercive control relates to behaviour that takes place repeatedly or continuously where:

- The victim and alleged perpetrator are 'personally connected' at the time the behaviour takes place.
- The behaviour had a 'serious effect on the victim, meaning that it has caused the victim to fear violence will be used against them on 'at least two occasions' or
- The behaviour has had a 'substantial adverse effect on the victims' day to day activities'.
- The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she 'ought to have known' it would have that effect.

Highlight that coercive and controlling behaviour is present in most domestic abuse cases and is often the first sign of abuse in a relationship.

Look together at the 'Power and Control Wheel' hand out from module 1. Is this a useful tool for understanding the role of power and control in domestic abuse?

Stalking and Harassment

Stalking is a pattern of persistent and unwanted attention that makes the victim feel pestered, scared, anxious or harassed. Some examples of stalking are:

- Regularly giving unwanted gifts
- Making unwanted communication
- Damaging property
- Repeatedly following or spying on the person at risk
- Threats

(UK Women's Aid 2018)

The effect of such behaviour is to curtail a victim's freedom, leaving them feeling that they constantly have to be careful. In many cases, the conduct might appear innocent (if it were to be taken in isolation), but when carried out repeatedly so as to amount to a course of conduct, it may then cause significant alarm, harassment or distress to the victim.

Recognising Domestic Abuse

Group work  15'

In small groups look at the scenarios and discuss what type of domestic abuse you think is going on. The aim of the exercise is to apply the knowledge about the different forms of domestic abuse and practice recognising them.

 Either print out copies of the scenarios for the group/s or read them and discuss together. Refer back to the types of domestic abuse written on the flip chart and ask participants to identify what is going on in each scenario.

4 x short scenarios produced nationally to include the different forms of DA and some which are not DA but other types of abuse. Include coercion and control, psychological abuse, marital rape. We will re-visit these in a group work exercise in the next session 'Responding to Domestic Abuse'

Domestic Abuse can be difficult to identify. In your work with victims and survivors of domestic abuse what indicators do you look out for?

Some common indicators of different types of domestic abuse include:

- Appearing fearful e.g. flinching when people are nearby
- Self-critical and/or lacking in self-esteem
- Lack of control over finance, personal possessions, clothes and appearance

Who can be subjected to domestic abuse?

Highlight that anyone can be subject to domestic abuse regardless of nationality, ethnic or religious group, cultural background, sexuality, class, or disability.

Highlight that the majority of intimate partner violence is committed by men against women though domestic abuse and gender based violence also happens to men and people in same sex relationships. Look at the national statistics for domestic abuse.

Reflect on these statistics with the group. How can this knowledge inform our practice? We will go on to discuss further when we look at good practice in responding to domestic abuse.

Barriers to seeking and accessing services

While domestic abuse can happen to anyone, for some people there are particular barriers to disclosing abuse and accessing services. . These barriers to support disproportionately affect women from BME communities and women who are disabled.

When supporting people to access support it's important to be aware of institutional racism, homophobia and discrimination against people with disabilities and signpost to services that are for example BME aware. We also need to take into account people's intersecting vulnerabilities e.g. if a person subject to domestic abuse has additional support needs relating to their disability, mental health or immigration status. People who have no recourse to public funds may be directly or indirectly discriminated against when accessing services and support.

Domestic Abuse and cultural norms

Domestic Abuse often occurs due to a power inequality within a relationship. It can be difficult to address when it is perceived as linking to social and cultural norms and expectations about gender roles, which themselves are part of a wider power imbalance in society that violates basic human rights. For example we may hear that in some cultures it is 'normal' for husbands to beat their wives or that it is a man's right to have sex with his wife whenever he wishes.

While staff and volunteers need to be culturally sensitive, we should challenge the concept that domestic abuse and gender based violence more widely are rooted in 'culture' or somehow more acceptable in different cultural contexts.

Group Work 15'

 **Read one of the domestic abuse scenarios to the group.**

Write up the following questions on the flip chart paper before the exercise. Use the questions to guide the discussion

- What are the perceived cultural norms in this situation?
- Who believes them?
- What other factors might be influencing the woman's perception?
- How might this affect her actions?
- What might be the impact of services accepting this perception of domestic abuse as a cultural norm?
- What would be some unhelpful things to say?
- How can we respond and challenge this in a way which is supportive?

Impact of Domestic Abuse



Group Work discussion 15'

Explain that you are now going to look at the impact of domestic abuse on the people you support. Ask the group what they think the psychological and emotional impact of domestic abuse is on the people they support and list them on flip chart paper.

Some impacts include:

Mental health issues

Fear of further abuse

Fear of being disbelieved by others

Suicidal thoughts or attempts

Short term injuries

Physical illness

Self-blame and shame

Social isolation

Domestic abuse often leaves victims with reproductive consequences too, including gynaecological disorders, sexually transmitted infections, pre-term difficulties and pregnancy difficulties

1. Discuss and compare the lists, are there any others not included here?
2. Now discuss how this might impact on the behaviour of the people who access the service you work in.

If it doesn't come up from the discussion draw out that people may:

- be more compliant with processes and requests than they would have been if domestic abuse wasn't part of their experience, or conversely be difficult to engage with services.
- be fearful about interventions in case the perpetrator has threatened death or serious injury if they find out they've told someone else
- have poor or failing physical or mental health which can impact on their decision making capacity.

2. Responding to Domestic Abuse

Acknowledge that it can be difficult to receive a disclosure and concerning if you see or hear something which indicates a person may be at risk of abuse or harm.

Breathe, don't panic and make time to actively listen

Follow your organisational procedure for protecting vulnerable adults.

Remember - a woman is most at risk of serious harm at the point she attempts to leave the abusive partner. Unless her life is in immediate danger, never persuade her to leave immediately without a safety plan in place.

Person centred approach

The basic principles of a person centred approach include a commitment to practice which:

1. engages, supports, encourages and empowers the person so they are able to make their own informed decisions
2. is informed by the principles of respect, dignity, choice and independence for individuals
3. encourages and supports individuals to make decisions based on their experience and enhanced by appropriate professional support and guidance: practice is based on a shift of values from professionals 'knowing best' to them supporting and empowering individuals to take control over their own life and decisions as far as they can, taking into account the constraints of their situation as refugees, asylum seekers or migrants.

When supporting people who have been subject to domestic abuse, work with an awareness and understanding of their experience and respect their right to self-determination as victims, survivors or both depending on how things are for them at that moment in time.

Work to the principles of safety, confidentiality, respect and non-discrimination in line with a 'survivor centred

approach.’ (IFRC, Psychosocial Centre, training on supporting survivors of SGBV)

- 
- Ask the group what they think is meant by a ‘person centred approach’? Ask them to name some aspects and write them on flip chart paper and add to the list if any have been missed. Why is taking this approach important to supporting people affected by domestic abuse?

What might prevent someone leaving an abusive relationship?

Group Activity 15’

- 
- Ask the group to form a circle facing each other, standing up if you have space. If you have space, ask one member of the group to stand in the middle of the circle. You will need a ball of wool for this activity. [If you don’t have one, form a circle with no-one in the middle and use a ball or light object to throw gently around each person in the group.] Explain to participants we are going to think about what might keep someone in an abusive relationship. Each person names an issue and passes/throws the ball of wool or ball to someone else in the group. Keep going until everyone has had two turns or you see signs the group is ready to finish. If using the ball of wool a ‘spider’s web’ will form, trapping the person in the middle to demonstrate how ‘stuck’ they might feel in the face of all these barriers.

Some barriers to leaving an abusive relationship include:

- Shame
- Low self-esteem
- Threats by the abusive partner to harm themselves, their partner or children
- Intimidation
- Financial dependence
- Restrictions on movement
- Isolation
- Lack of knowledge about what help they can receive
- Poor or failing health having a negative impact on their ability to make decision and/or act

If they have not come out already, suggest some additional barriers that might affect the people we work with specifically:

- For women without legal status, fear about being reported to the authorities and detained removed from the country
- Fear related to this about being separated from children/children being taken in to care
- Perceived underlying cultural norms about ‘acceptable’ behaviour
- Fear of being shunned by the wider ‘community’ – family, extended family, friends, faith community
- Not speaking the language
- Lack of knowledge about the law, rights and available services
- Lack of available services that meet their needs (language/provision of interpreters; cultural sensitivity and understanding; understanding of immigration status and how this affects options)
- Discrimination from services

External Referrals

Where possible we should always try to seek advice from or refer to domestic abuse professionals, particularly those who have BME specialism. Refer to local domestic abuse specialists and local and national referral pathways.

Group Activity 15’ *Putting principles in to practice*

- 
- Read one of the domestic abuse scenarios with the group and discuss the following points:
 - What questions would you ask to find out more about the person’s situation?
 - What approach would you take and why?
 - How might they be feeling in disclosing this information?
 - What would your next steps be?

6. ANNEX TOOLKIT HANDOUT

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[Handout 1 - FGM by World Health Organisation](#)

Key facts

- **Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.**
- **The procedure has no health benefits for girls and women.**
- **Procedures can cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths.**
- **More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated (1).**
- **FGM is mostly carried out on young girls between infancy and age 15.**
- **FGM is a violation of the human rights of girls and women.**

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. In many settings, health care providers perform FGM due to the erroneous belief that the procedure is safer when medicalized¹. WHO strongly urges health professionals not to perform such procedures.

FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Procedures

Female genital mutilation is classified into 4 major types.

- **Type 1:** Often referred to as **clitoridectomy**, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- **Type 2:** Often referred to as **excision**, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).

¹ Material provided by the British Red Cross

- **Type 3:** Often referred to as **infibulation**, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
- **Type 4:** This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.
- Deinfibulation refers to the practice of cutting open the sealed vaginal opening in a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth.

No health benefits, only harm

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. Generally speaking, risks increase with increasing severity of the procedure.

Immediate complications can include:

- severe pain
- excessive bleeding (haemorrhage)
- genital tissue swelling
- fever
- infections e.g., tetanus
- urinary problems
- wound healing problems
- injury to surrounding genital tissue
- shock
- death

Long-term consequences can include:

- urinary problems (painful urination, urinary tract infections);
- vaginal problems (discharge, itching, bacterial vaginosis and other infections);
- menstrual problems (painful menstruations, difficulty in passing menstrual blood, etc.);
- scar tissue and keloid;
- sexual problems (pain during intercourse, decreased satisfaction, etc.);
- increased risk of childbirth complications (difficult delivery, excessive bleeding, caesarean section, need to resuscitate the baby, etc.) and newborn deaths;
- need for later surgeries: for example, the FGM procedure that seals or narrows a vaginal opening (type 3) needs to be cut open later to allow for sexual intercourse and childbirth (deinfibulation). Sometimes genital tissue is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks;
- psychological problems (depression, anxiety, post-traumatic stress disorder, low self-esteem, etc.);
- health complications of female genital mutilation.

Health complications of female genital mutilation

Who is at risk?

Procedures are mostly carried out on young girls sometime between infancy and adolescence, and occasionally on adult women. More than 3 million girls are estimated to be at risk for FGM annually.

More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated ¹.

The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries the Middle East and Asia, as well as among migrants from these areas. FGM is therefore a global concern.

Cultural and social factors for performing FGM

The reasons why female genital mutilations are performed vary from one region to another as well as over time, and include a mix of sociocultural factors within families and communities. The most commonly cited reasons are:

- Where FGM is a social convention (social norm), the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice. In some communities, FGM is almost universally performed and unquestioned.
- FGM is often considered a necessary part of raising a girl, and a way to prepare her for adulthood and marriage.
- FGM is often motivated by beliefs about what is considered acceptable sexual behaviour. It aims to ensure premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist extramarital sexual acts. When a vaginal opening is covered or narrowed (type 3), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage extramarital sexual intercourse among women with this type of FGM.
- Where it is believed that being cut increases marriageability, FGM is more likely to be carried out.
- FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are clean and beautiful after removal of body parts that are considered unclean, unfeminine or male.
- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.
- Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.
- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.
- In most societies, where FGM is practised, it is considered a cultural tradition, which is often used as an argument for its continuation.
- In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement.

International response

Building on work from previous decades, in 1997, WHO issued a joint statement against the practice of FGM together with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA).

Since 1997, great efforts have been made to counteract FGM, through research, work within communities, and changes in public policy. Progress at international, national and sub-national levels includes:

- wider international involvement to stop FGM;
- international monitoring bodies and resolutions that condemn the practice;
- revised legal frameworks and growing political support to end FGM (this includes a law against FGM in 26 countries in Africa and the Middle East, as well as in 33 other countries with migrant populations from FGM practicing countries);
- the prevalence of FGM has decreased in most countries and an increasing number of women and men in practising communities support ending its practice.

Research shows that, if practicing communities themselves decide to abandon FGM, the practice can be eliminated very rapidly.

In 2007, UNFPA and UNICEF initiated the Joint Programme on Female Genital Mutilation/Cutting to accelerate the abandonment of the practice.

In 2008, WHO together with 9 other United Nations partners, issued a statement on the elimination of FGM to support increased advocacy for its abandonment, called: "Eliminating female genital mutilation: an interagency statement". This statement provided evidence collected over the previous decade about the practice of FGM.

In 2010, WHO published a “Global strategy to stop health care providers from performing female genital mutilation” in collaboration with other key UN agencies and international organizations.

In December 2012, the UN General Assembly adopted a resolution on the elimination of female genital mutilation.

Building on a previous report from 2013, in 2016 UNICEF launched an updated report documenting the prevalence of FGM in 30 countries, as well as beliefs, attitudes, trends, and programmatic and policy responses to the practice globally.

In May 2016, WHO in collaboration with the UNFPA-UNICEF joint programme on FGM launched the first evidence-based guidelines on the management of health complications from FGM. The guidelines were developed based on a systematic review of the best available evidence on health interventions for women living with FGM.

To ensure the effective implementation of the guidelines, WHO is developing tools for front-line health-care workers to improve knowledge, attitudes, and skills of health care providers in preventing and managing the complications of FGM.

WHO response

In 2008, the World Health Assembly passed resolution WHA61.16 on the elimination of FGM, emphasizing the need for concerted action in all sectors - health, education, finance, justice and women’s affairs.

WHO efforts to eliminate female genital mutilation focus on:

- strengthening the health sector response: guidelines, tools, training and policy to ensure that health professionals can provide medical care and counselling to girls and women living with FGM;
- building evidence: generating knowledge about the causes and consequences of the practice, including why health care professionals carry out procedures, how to eliminate it, and how to care for those who have experienced FGM;
- increasing advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGM within a generation.
- (1) Female Genital Mutilation/Cutting: A Global Concern UNICEF, New York, 2016.

[Handout 2 - Introduction to Trafficking \(provided for inclusion within the SWIM ‘Introduction to Gender Based Violence’ module²](#)

What is human trafficking and modern slavery?

Human trafficking is a crime in which people are **exploited** for other people’s personal gain. People who experience trafficking may have been coerced, deceived, threatened or forced into exploitative situations. It can happen to adults and children of all backgrounds. Human trafficking has three specific components which must be present to meet the legal definition of trafficking.

Act	Means	Purpose
Recruitment Transportation Transit Harbour Receipt of a person	Threats Force Use of coercion Fraud Deception Abuse of power or vulnerability Shame or Stigma Addiction	Forms of exploitation including Sexual exploitation Forced Labour Slavery or servitude Financial exploitation Illegal adoption Removal of organs Criminal exploitation Benefit fraud
=	Human	Trafficking

² Material provided by the British Red Cross

There are many ways people can be exploited. Often people will be exploited in more than one way at the same time. Types of exploitation can include sexual, labour, domestic servitude, criminal activity, illegal adoption, forced marriage, organ harvesting and ritual abuse
Here are some of the most common forms and their indicators.

Sexual

A person trafficked for sexual exploitation performs sexual acts that they do not want to and includes sex work, escort work, massage parlours, brothels and pornography. It can be experienced by women, men and children. It is possible for a person who consents to provide sexual services to be sexually exploited or for that situation to become one of trafficking.

Indicators of sexual exploitation:

- Has the person been deceived about the nature or conditions of the work they are carrying out?
- Has the person been forced or intimidated to perform acts or services of a sexual nature?
- Has the person received threats that their family, community or the wider public will be told of the nature of their work? Shame and stigma are often used as forms of control in sexual exploitation.
- Is the person closely monitored while accessing other services?
- Is the person able to leave the situation whenever they want, choose the volume of work and their working hours?
- Other indicators may include pregnancy through rape, sexually transmitted infections, substance abuse, infertility, over-alertness,, mental numbness and undiagnosed health conditions among others

Labour exploitation

Trafficking for labour exploitation can happen in industries such as construction, care, farming, textiles, car washes, nail bars, and the food industry among others. People may also be exploited in unregulated work places such as cannabis production. People trafficked for labour exploitation often work long hours in poor conditions and for little or no pay. They may remain in these conditions for various reasons, often because they are threatened, physically hurt or controlled by threats of harm to their family.

Indicators of Labour Exploitation:

- Is the person working excessive days or hours?
- Is the person below the minimum wage or receiving no payment?
- Is the person unsure of their work or accommodation address?
- Is the person required to pay for work equipment, food or accommodation via deductions from their pay?
- Is the person working without appropriate health and safety equipment such as protective gloves, a helmet, shoes, masks or other relevant items?

Domestic servitude

Indicators of domestic servitude:

- Does the person rarely leave the house without the employer?
- Does the person have their own private place to sleep?
- Is the person treated differently to other people in the house

Many signs of trafficking may be present across a range of different types of exploitation. These may include:

- Restriction of movement or access to services
- Poor physical or mental health

- Absence of personal identification documents such as passport
- No control of personal finances
- Not being allowed to speak for themselves or voice their own opinion
- Fearful of authorities
- Immigration status may be used as a form of control
- Debt bondage – where services or labour are used to pay off a debt to a trafficker which will often never be feasible to repay

The Difference between smuggling and trafficking

There are many differences between trafficking and smuggling, although the terms are often mistakenly used interchangeably. Migrant Smuggling refers to irregular entry into another country or state. Smuggled people (usually) consent to being transported. Trafficking may also include movement across border, however it can also happen internally within borders. Trafficking occurs without informed and valid consent for the purpose of exploitation. People travelling along migratory trails can be at risk from trafficking, and people who believe they are being smuggled can experience trafficking.

Trafficking	An act against a person	Can happen internally within countries as well as across borders	Includes an ongoing exploitative relationship (or intent to exploit in the case of children)	Can treat a person as a commodity who can be used for repeated gain	Ongoing exploitation
Smuggling	An act against the state	Always happens across borders	Often has no ongoing relationship between the parties involved	Transaction between parties with one off profit	Voluntary Short term

Handout 3 - The dimensions of violence against women

The dimensions of violence in the world are considerable: it is estimated that 35 per cent of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner at some point in their lives. However, some national studies show that up to 70 per cent of women have experienced physical and/or sexual violence from an intimate partner in their lifetime.

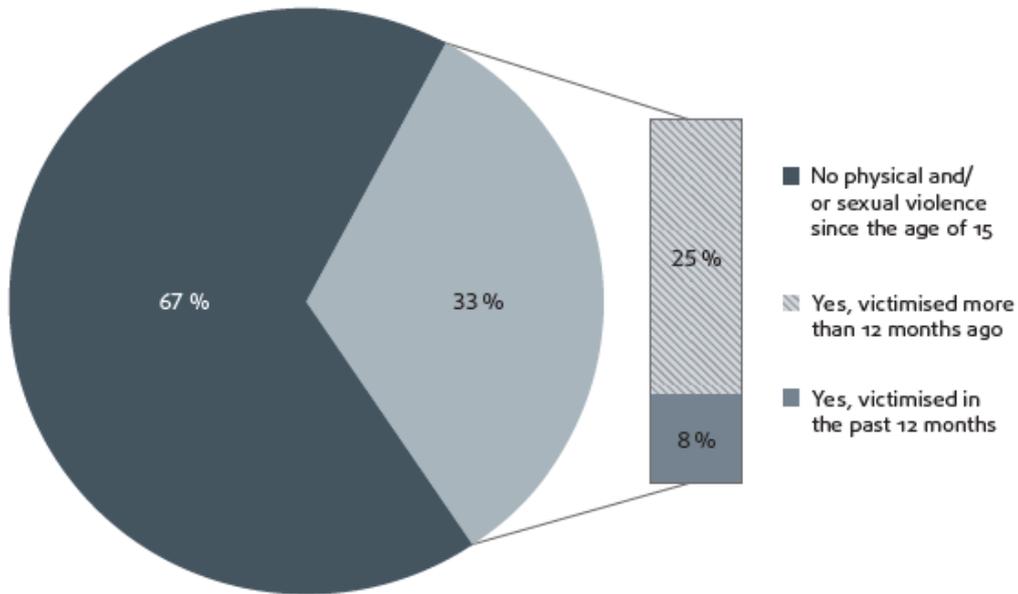
According to UN Women Report, Women who have been physically or sexually abused by their partners are more than twice as likely to have an abortion, almost twice as likely to experience depression, and in some regions, 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner abuse. 43% of women in the 28 European Union Member States have experienced some form of psychological violence by an intimate partner in their lifetime.

It is estimated that of all the women who were murdered worldwide in 2012, almost half were killed by intimate partners or family members, compared to less than six per cent of men killed in the same year. Psychological violence is even more difficult to estimate: in EU member countries, about 43% of women have suffered some form of psychological violence by their intimate partner. There is also some concern regarding sexual cyber-bullying: 10% of women (aged 15 years) are the victims and the risk is especially high for the age group 18-29 years (UN Women, 2015).

According to the survey of the European Union Agency for Fundamental Rights (FRA, 2012), based on 42,000 interviews carried out in 28 EU countries, 7% of women aged 18-74 (13 million) suffered physical violence in the twelve months before the interview; 2% were victims of sexual violence (3,7 million); 5% were victims of a rape since the age of 15. 18 % of women in 28 EU countries have experienced stalking since

the age of 15, and 5 % of women have experienced stalking in the twelve months preceding the survey, this means about 9 million women.

Women experiencing physical and/or sexual violence since the age of 15 and in the 12 months before the interview, EU-28 (%)



Note: Based on all respondents (N = 42,002).

Source: FRA gender-based violence against women survey data set, 2012

Some 12% of women indicate that they have experienced some form of sexual abuse or incident by an adult before the age of 15 (about 21 million women). The results show that 30% of women who have experienced sexual victimisation by a former or current partner also experienced sexual violence in childhood (FRA, 2014). Moreover, half of all women in the EU (53%) avoid certain situations or places, at least sometimes, for fear of being physically or sexually assaulted. In comparison, existing surveys on crime victimisation and fear of crime show that far fewer men restrict their movement.

Handout 4 - Quiz: Myths or facts about gender-based violence?

Instructions for participants: Read the following statements and mark if you believe they are right or wrong.

1. Women allow intimate partner violence to happen to them and if they really want to, they can leave their abusive partners.
 true false
2. Conflicts and discord are a normal part of any relationship.
 true false
3. Men and women are equally violent to each other.
 true false
4. Domestic violence happens only to a certain type of person.
 true false
5. GBV only includes physical abuse (hitting, punching, biting, slapping, pushing, etc).
 true false
6. GBV is caused by substance abuse such as alcohol and/or drugs.
 true false
7. Women should tolerate violence to keep the family together.
 true false
8. Domestic violence is a private family matter, in which the state has no right to intervene. How a man treats his wife is a private matter.
 true false
9. Sex workers cannot experience rape.
 true false
10. A man cannot rape his wife.
 true false
11. Most GBV is perpetrated by strangers.
 true false

Questions for discussion:

Review these statements in light of the following questions:

- » Is the statement true or false?
- » Why is it true or not true?
- » Where does it come from?
- » How does it affect the way you work with patients in your daily work?

Handout 5 - Myths and facts about gender-based violence

Myth 1: Women allow intimate partner intimate violence to happen to them and if they really want to, they can leave their abusive partners.

Facts: In no case does a woman deserve to be abused. The international community has recognized violence against women as a human rights violation that cannot be justified and requires a comprehensive state response. As explained in several theories on the dynamics of violent relationships, such as the Stockholm Syndrome or the Power and Control Wheel, perpetrators use a combination of tactics of control and abuse that make it very difficult for women to escape the violence. It is also important to understand that women who experienced violence from an intimate partner and seek to leave the relationship in order to ensure their own and their children's safety paradoxically face an increased risk of repeating and even escalating violence. Women are also prevented from leaving violent relationships due to feelings of shame and guilt, lack of safe housing, or the belief that divorce is wrong for children (adapted from Hagemester et al 2003).

Myth 2: Conflicts and discord are a normal part of any relationship

Facts: “Everybody can lose control,” is a commonly used excuse to justify intimate partner violence. However, violence is not about “losing” control – rather, it is about “gaining” control through the use of threats, intimidation, and violence, as demonstrated by the Power and Control Wheel. Violence in a relationship is not normal - it is a manifestation of historically unequal power relations between men and women (DEVAW).

Myth 3: Men and women are equally violent to each other.

Facts: The majority of those affected by GBV, in particular intimate partner violence, are women and girls. Worldwide, almost half (47%) of all female victims of homicide in 2012 were killed by their intimate partners or family members, compared to less than 6% of male homicide victims (UNODC 2013). According to EU-wide data, 67% of physical violence and 97% of sexual violence perpetrated against women is committed by men (FRA 2014). This fact is also confirmed by research from the region. For example, a study from Moldova shows that the perpetrators

of violence against women are often family members, the overwhelming majority being husbands or former husbands (73.4%), followed by fathers or stepfathers (13.7%) (UN Special Rapporteur VAW 2009a).

Myth 4: Domestic violence happens only to a certain type of person.

Facts: GBV is a global problem of pandemic proportions. 35% of all women worldwide have experienced either physical and/or sexual violence from an intimate partner or sexual violence from a non-partner (WHO et al 2013). While a number of factors may increase the risk of women experiencing GBV, domestic violence affects all women, irrespective of socio-economic status, educational achievements, ethnic origin, religion or sexual orientation (IGWG undated). While some studies have found that women living in poverty are disproportionately affected by intimate partner violence and sexual violence, it has not been clearly established whether it is poverty as such that increases the risk of violence or rather other factors accompanying poverty.

Myth 5: Gender-based violence only includes physical abuse (hitting, punching, biting, slapping, pushing, etc.).

Facts: Physical abuse is just one form of violence. International law defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women” (DEVAW, Art. 1). For example, prevalence research from Romania shows that 18,5% of women experienced psychological violence from family members including intimate partners; the percentage for economic violence was 5,3% (Centrul de Sociologie Urbana si Regionala 2008). Some studies show that women often consider psychological abuse and humiliation more devastating than physical assault (Casey 1988, cited in Heise et al 1994).

Myth 6: Gender-based violence is caused by substance abuse such as alcohol and/or drugs.

Facts: While substance abuse is present in many domestic violence cases and may lower inhibitions, it is a contributing factor, not the cause of violence (see also chapter 1.3). Neither should alcohol or drug abuse be used to justify violence (IGWG undated). Not all perpetrators of violence use drugs or alcohol, and not all those who use drugs or alcohol are violent (Roberts 1984, cited in Hagemeister et al 2003).

Myth 7: Women should tolerate violence to keep the family together.

Facts: Every woman has the right to safety, dignity and a life free of violence. Every woman survivor of GBV has the right of self-determination- she can decide to stay with her abusive partner or to leave him and either way she is entitled to support and protection from the state. The argument that women should stay in an abusive relationship is often justified for the well-being of the children. However, it is well established that the safety and health of children are negatively affected when children experience or witness domestic violence. State support for perpetrator programmes teaching violent men to adopt non-violent behaviour in interpersonal relationships is key for preventing further violence and changing violent behavioural patterns (Art. 16 Istanbul Convention). This is of particular importance in situations where women are not willing or able to leave a violent relationship, for instance, due to economic dependence and risk of stigmatization by the community, particularly in rural areas. At the same time, perpetrator interventions should supplement, but not replace, or withdraw resources from, the work of women-specific support services.

Myth 8: Domestic violence is a private family matter, in which the state has no right to intervene. How a man treats his wife is a private matter.

Facts: Violence against women is a human rights violation, no matter whether it occurs in the family or in the public sphere. Under international human rights law such as CEDAW or the Istanbul Convention, states are not only entitled to eliminate all forms of violence against women, they are obligated to do so.

Myth 9: Sex workers cannot experience rape.

Facts: International definitions of rape and other forms of sexual assault (WHO 2013) focus on the type of violent acts committed, without consideration of who is the perpetrator or the victim. Accordingly, any man who forces a woman into a sexual act against her is committing rape, whatever her profession. A survey from Bosnia-Herzegovina demonstrates the high amount of violence experienced by sex workers- three out of five sex workers surveyed reported experiences of sexual violence (PROI 2011).

Myth 10: A man cannot rape his wife.

Facts: As mentioned earlier, rape is defined by an action and not by the identity of the perpetrator or the victim. Accordingly, any forced sexual intercourse is rape, irrespective of whether the woman survivor is married to the perpetrator or not. This statement is also grounded in international human rights law definitions, which encompasses all forms of physical, sexual, psychological or economic violence against women, no matter if they are committed in the family or in public. Even though international human rights law obliges states to criminalize and prosecute rape, not all jurisdictions recognize marital rape as a criminal offence, resulting in impunity of rape committed by intimate partners.

Myth 11: Most GBV is perpetrated by strangers.

Facts: The majority of women experience GBV at the hands of a person close to them, as confirmed by the 2013 Global Study on Homicide. It is estimated that women make up 79% of all persons killed by their intimate partners. Additionally, 47% of all women killed in 2012 were killed by their family members or intimate partners; for men, the respective percentage totals 6% (UNODC 2014). This statement is confirmed for instance by a study from Kyrgyzstan, of which 3% of the women interviewed have been victims of sexual violence, with 98% of the perpetrators being current or former partners or husbands (National Statistical Committee 2012).

Handout 6 - Violence against migrant and refugee women

Violence against women is one of the most pervasive global and systemic forms of human rights violations that exist today. Even though many migrant women do not encounter violence and benefit from migration, for some of the 105 million international migrant women worldwide (UN DESA, 2009), violence and discrimination can appear at the very start of the migration process.

On arrival in the country of destination, violence and discrimination continue to be part of the lives of many migrant women as they experience dual vulnerability to violence. This is primarily due to their status as women, reflecting gender inequalities existing in both origin and destination societies, as well as their status as foreigners. Often, these two main causes of vulnerability intersect with additional risk factors (IOM, 2016, Fact-sheet).

The risk of facing violence is increased by – but not limited to – factors such as legal status, age, class, culture, ethnicity, religion, sexual orientation, gender identity or disability. In addition, the lack of local language skills, inadequate access to appropriate jobs, limited knowledge of their rights and, in certain cases, earlier experiences of violence in their home communities all combine to reduce migrant women's capacity to protect themselves against abusive situations (Steibelt/IOM, 2009).

Migration can create situations where harmful practices associated with the social norms of a particular group are imported into the host society. Harmful practices include, *inter alia*, dowry-related violence, female infanticide, female genital mutilation/cutting, early and forced marriage as well as the so-called "honour" crimes. In situations where integration is difficult, such harmful practices can also

be used as a way of consolidating traditional gender roles and controlling women's behaviour and sexuality (UN Special Rapporteur, 2007).

Violence and discrimination in the public sphere are acts of physical, sexual and psychological violence occurring within the receiving society. Migrant women are at risk from physical violence by state actors, such as police officers, customs officers or workers in detention centres, throughout the migration cycle. Acts of violence may also be committed by employers or by members of the general population. When travelling, women may be compelled or forced to exchange sex for transportation, food or accommodation, which puts them at increased risk of violence (IOM, Infosheet, 2013; Lombardi 2017). The end result is usually the systematic disempowerment of migrant women, which further increases their vulnerability to various forms of discrimination and violence.

Migrant women workers are therefore exposed to violence in unconventional forms, including exploitative working conditions such as long working hours, non-payment of wages, forced confinement, starvation, beatings, rape, or sexual abuse and exploitation. Unskilled and/or irregular workers, particularly domestic workers, are generally more vulnerable to violence, as they are often dependent on a single employer and may face deportation if they attempt to leave. In 2011, the International Labour Organization adopted the Convention concerning Decent Work for Domestic Workers, requiring States to take specific protective measures for these workers; however, as of March 2012, only four member States have ratified the Convention (IOM, Infosheet, 2013; Lombardi, 2017).

Numbers of migrant women and girls fall prey to traffickers who exploit them. In transit or at their destination, trafficked victims are exposed to severe forms of exploitation, including forced labour, sexual exploitation, begging, forced marriage and other practices similar to slavery. IOM has been working to counter the phenomenon of trafficking in persons since 1994 and has implemented roughly 800 projects in over 100 countries and provided assistance to approximately 30,000 trafficked persons, two-thirds of them women and girls.

Violence against migrant women has severe consequences and costs in terms of health, well-being and inclusion in the arrival society. The health-associated consequences of violence against migrant women include physical symptoms and injuries, mental health trauma, and transmission of HIV and other sexually transmitted infections. Threats of violence and actual or perceived danger of sexual assault by strangers may limit the freedom of movement of migrant women and can generate self-imposed restrictions, resulting in a possible withdrawal from the host community (Steibelt/IOM, 2009; 2013; Lombardi, 2017).

The following table shows the prevalence of violence among women with migrant background, living in EU. In the following, the survey respondents are examined in four categories: 1. citizens of the country of residence, and who have lived in the country all their lives; 2. citizens of the country of residence, and who have lived in the country for 30 years or more (but not all their lives); 3. citizens of the country of residence, having lived in the country for less than 30 years; 4. non-citizens of the country of residence. The results indicate that women who are not citizens of their current country of residence have somewhat higher rates of physical and/or sexual violence since the age of 15 by partners and non-partners, but there are no notable differences with regard to other forms of violence examined (stalking and sexual harassment since the age of 15; and physical, sexual or psychological violence before the age of 15). See Table 1.

Table 1
Prevalence of various forms of violence by women's assessment of their migrant background (%)

	Citizen, never lived outside the country of residence	Citizen, lived in the country of residence 30 years or longer	Citizen, lived in the country of residence less than 30 years	Non-citizen of the country of residence
Any physical or sexual violence by any partner (current or previous) since the age of 15a	22	20	21	27
Psychological violence by any partner (current or previous) since the age of 15a	43	41	47	54
Any physical or sexual violence by non-partner since the age of 15b	21	22	25	27
Any sexual harassment since the age of 15 b	54	58	59	56
Any stalking since the age of 15 b	18	18	19	16
Any physical, sexual or psychological violence before the age of 15 b	34	39	34	37

Notes: a Women who have a current or previous partner and who are (1) citizens, never having lived outside the country of residence n = 25,785; (2) citizens, having lived in the country of residence 30 years or longer n = 9,326; (3) citizens, having lived in the country of residence less than 30 years n = 2,932; (4) non-citizens of the country of residence n = 1,665.

b Women who are (1) citizens, never having lived outside the country of residence n = 27,045; (2) citizens, having lived in the country of residence 30 years or longer n = 9,573; (3) citizens, having lived in the country of residence less than 30 years n = 3,234; (4) non-citizens of the country of residence n = 1,744.

Source: FRA gender-based violence against women survey dataset, 2012

Handout 7 - The survivor-centred approach in working with people affected by GBV

Safety	<p>The safety of the survivor and survivor’s family should be ensured at all times. Keeping survivors safe should be a number one priority. Survivors of GBV are at heightened risk of on-going violence (e.g. domestic violence), murder or suicide, as well as social discrimination and isolation. Helpers have to assess safety risks and minimize the risks for survivors and their immediate family members.</p>
Confidentiality	<p>Confidentiality is paramount in all aspects of support for survivors. The threat of stigmatisation, social isolation and punishment is very real for those affected by SGBV. Maintaining confidentiality means that information about survivors should not be shared with others without the informed consent of the survivor. There are certain exceptions to this rule that are about the absolute safety of the survivor and/or immediate family (please see below).</p> <p>If information needs to be shared with another organization, always obtain the written consent of the survivor or of a parent or guardian if the survivor is a child. Informed consent means that the survivor will be informed about which information will be shared, with whom and for what reason. It is not ethical to share personal information about the survivor or their situation (e.g. giving their name or other identifying information) with anyone else – at home or in the workplace.</p> <p>Avoid identifying survivors of SGBV in the way services are provided. Survivors can be at risk of being identified by the community if they attend specialized programmes. This risk can be minimized by addressing the special needs of survivors of SGBV within broader psychosocial programmes.</p> <p>Exceptions to maintaining confidentiality</p> <ul style="list-style-type: none"> • When there is a risk that survivors might try to hurt themselves • When there is a risk that survivors might hurt others • When a child is in danger • When laws or policies require mandatory reporting (such as in the case of sexual exploitation and abuse by humanitarian staff)
Respect	<p>The wishes, rights, and dignity of the survivor must always be respected. The survivor-centred approach empowers the survivor, with helpers offering assistance, facilitating recovery and providing resources for problem-solving but never taking any decisions for survivors. This can be especially difficult if a survivor decides to remain in the violent relationship or location. A lack of respect by helpers can increase survivors’ feelings of helplessness and shame. It can prevent survivors from regaining a sense of control over their lives. It can reduce the overall effectiveness of interventions, and may even cause further harm.</p>
Non-discrimination	<p>All people have the right to the best possible assistance without unfair discrimination on the basis of gender, age, disability, race, colour, language, religious or political beliefs, sexual orientation, status or social class.</p>

Source: IFRC

Handout 8 - Self-care and stress management

Sources of stress for helpers

Working with people affected by SGBV can be very fulfilling, but it can be very demanding at the same time. Some sources of stress may include:

- hearing stories of violence
- dealing with the sensitivity of the topic (e.g. taboo and stigma)
- working with very distressed people (e.g. survivors may be angry, frustrated, anxious)
- working with people who might be a risk to themselves
- having idealistic expectations of what helpers can do
- feeling that helpers have to solve all the problems for the person/s they are helping
- feeling guilty about paying attention to one's own needs for rest or support.

Signs of stress. Some common signs of stress include:

- emotional exhaustion
- a decrease in energy and a feeling of constant tiredness
- loss of enthusiasm and motivation
- lowered work efficiency
- pessimism and cynicism
- loss of a sense of personal accomplishment in one's work
- alcohol or drug abuse
- changes in attitude or behaviour (e.g. risk-taking behaviour, temper outbursts, withdrawing from colleagues and loved ones).

Self-care

Self-care is very important when working with people affected by SGBV. Self-care refers to the ways of looking after body and mind at work and at home.

Helpful strategies include:

- getting enough rest (regular and sufficient sleep)
- setting limits and take breaks from work
- limiting the number of hours spent on difficult tasks
- talking with your colleagues about your feelings and difficulties in helping (be very careful to maintain confidentiality)
- seeking support from the programme manager/supervisor
- spending time with friends
- taking time to be quiet and reflect (e.g. relaxation exercises, religious practices)
- eating and drinking regularly
- taking physical exercise.

Source: IFRC

Handout 9 - Indicators of SGBV

Term	Indicators
Child sexual exploitation (CSE)	<ul style="list-style-type: none"> • go missing from home, care or education. • be involved in abusive relationships, intimidated and fearful of certain people or situations • hang out with groups of older people, or antisocial groups, or with other vulnerable peers • associate with other young people involved in sexual exploitation • get involved in gangs, gang fights, gang membership • have older boyfriends or girlfriends • spend time at places of concern, such as hotels or known brothels • not know where they are, because they have been moved around the country • be involved in petty crime such as shoplifting • have unexplained physical injuries • have a changed physical appearance, for example lost weight. <p>https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-exploitation/signs-symptoms-and-effects/</p>
Child sexual abuse	<ul style="list-style-type: none"> • they might avoid being alone with people, such as family members or friends • they could seem frightened of a person or reluctant to socialise with them. • Show sexual behaviour that's inappropriate for their age • a child might become sexually active at a young age • they might be promiscuous • they could use sexual language or know information that you wouldn't expect them to • anal or vaginal soreness • an unusual discharge • sexually transmitted infection (STI) • pregnancy <p>https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/signs-symptoms-effects/</p>
Forced marriage	<ul style="list-style-type: none"> • the person or her family come from a community where Forced Marriage and 'Honour' is culturally embedded • an announcement of engagement to a stranger not previously mentioned • there may noticeable levels of absenteeism, lateness – school, college or employment • there may feel like an element of 'surveillance' and control by the family or community members • Significant personality changes may become evident. The person may appear depressed, withdrawn, anxious or suicidal. There may be noticeable deterioration in their self-esteem and appearance • they may run away, go missing from home or have a fear of returning home • they may talk about a family holiday abroad and may seem anxious about this • may fail to return home from a visit to the family's country of origin • early and/or unwanted pregnancy • reports of self-harm or suicide attempts, particularly in the early stages of marriage • domestic incidents or crimes at the family home. The fact that a victim was forced to marry may only reveal itself years after the marriage has taken place • Person appear to be dominated - subject to financial control, no access to mobile phone, internet etc <p>https://safeguardinghub.co.uk/forced-marriage-signs-and-tactics/</p>

Child marriage	<ul style="list-style-type: none"> • A family history of older siblings leaving education early and marrying early; • Depressive behaviour including self-harming and attempted suicide; • Unreasonable restrictions such as being kept at home by their parents ('house arrest') or being unable to complete their education; • A child being in conflict with their parents; • A child going missing / running away; • A child always being accompanied including to school and doctors' appointments; • A child talking about an upcoming family holiday that they are worried about, fears that they will be taken out of education and kept abroad; or • A child directly disclosing that they are worried s/he will be forced to marry <p>http://www.londoncp.co.uk/chapters/forced_marriage_ch.html#recognition</p>
Sexual abuse / violence	<ul style="list-style-type: none"> • Bruising, particularly to the thighs, buttocks and upper arms and marks on the neck • Torn, stained or bloody underclothing • Bleeding, pain or itching in the genital area • Unusual difficulty in walking or sitting • Foreign bodies in genital or rectal openings • Infections, unexplained genital discharge, or sexually transmitted diseases • Pregnancy in a woman who is unable to consent to sexual intercourse • The uncharacteristic use of explicit sexual language or significant changes in sexual behaviour or attitude • Incontinence not related to any medical diagnosis • Self-harming • Poor concentration, withdrawal, sleep disturbance • Excessive fear/apprehension of, or withdrawal from, relationships • Fear of receiving help with personal care • Reluctance to be alone with a particular person <p>https://www.scie.org.uk/safeguarding/adults/introduction/types-and-indicators-of-abuse#sexual</p>
Female Genital Mutilation (FGM)	<ul style="list-style-type: none"> • a long holiday abroad or going 'home' to visit family • Come from a country where FGM is practiced. • relative or cutter visiting from abroad • a special occasion or ceremony to 'become a woman' or get ready for marriage • a female relative being cut – a sister, cousin, or an older female relative such as a mother or aunt. • have difficulty walking, standing or sitting • spend longer in the bathroom or toilet • appear withdrawn, anxious or depressed • have unusual behaviour after an absence from school or college • be particularly reluctant to undergo normal medical examinations • ask for help, but may not be explicit about the problem due to embarrassment or fear. • difficulties urinating or incontinence • frequent or chronic vaginal, pelvic or urinary infections • cysts and abscesses • pain when having sex • infertility • complications during pregnancy and childbirth <p>https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/signs-symptoms-and-effects/</p>

Breast ironing	<ul style="list-style-type: none"> • Unusual behaviour after an absence from school or college or work including depression, anxiety, aggression, becoming withdrawn • Reluctance in undergoing medical examinations • Some may ask for help, but may not be explicit about the problem due to embarrassment or fear • Fear of changing for physical activities due to scars showing or bandages being visible • Cysts and lesions • Breast cancer • An inability to produce breast milk • Complete or partial eradication of single or both breast <p>https://www.hampshiresafeguardingchildrenboard.org.uk/professionals/fgm-breast-ironing-honour-based-violence/</p>
So called 'Honour' based violence (HBV)	<ul style="list-style-type: none"> • They or their family come from a community where the idea of 'Honour' is culturally embedded. • there may feel like an element of 'surveillance' and control by the family or community members. In the case of adults this might present where the victim is routinely accompanied to and from a place of work. In children or young people, they may be driven to and from school, not able to walk or travel on public transport with friends. • they might field a high number of phone calls from family members or their spouse. They may look uncomfortable taking the calls, quiet and withdrawn afterwards. • They may be accompanied to the doctors by a family member or spouse. • there may be noticeable levels of absenteeism, lateness – school, college or employment. • significant personality changes may become evident. He/she may appear and behave depressed, withdrawn, anxious or suicidal. • there may be noticeable deterioration in the victim's appearance, a lack of grooming. • physical injuries apparent, often frequent injuries, with the victim explaining them away as 'accidental'. • they may dress unusually to disguise bruises or injuries i.e. neck scarf in hot weather. <p>https://safeguardinghub.co.uk/honour-based-abuse-the-facts/</p>
Domestic abuse	<ul style="list-style-type: none"> • Low self-esteem • Feeling that the abuse is their fault when it is not • Physical evidence of violence such as bruising, cuts, broken bones • Verbal abuse and humiliation in front of others • Fear of outside intervention • Damage to home or property • Isolation – not seeing friends and family • Limited access to money • Appear withdrawn, distracted. • Low mood • Always on their phone, answering calls. • Disengaging with professionals • Change in appearance • Lack of freedom to do day to day activities <p>https://www.scie.org.uk/safeguarding/adults/introduction/types-and-indicators-of-abuse#domestic</p>

Handout 10 - GBV Scenarios

Scenario 1

Leila is from Iran and sought asylum with her husband 6 months ago. She attends a drop in where she discloses to a female worker that her husband has become very controlling, forbidding her from leaving the house when he's at home, and has been verbally and from time to time also physically abusive. Leila is very worried for her own safety and wellbeing. She cries a lot and has nightmares. She doesn't know many people in her new country and feels very isolated and helpless. She has been told that separating from her husband would have consequences in terms of her asylum application. Besides everything that is happening to her, she also finds out that she is pregnant. She feels trapped and devastated, not knowing what to do, where to get help.

Scenario 2

Aliya met a man who she fell in love with, but her family did not approve and threatened to kill her on many occasions if she married him. When Aliya married her husband she continued to receive threats to her life from her family and they said they never wanted to see her again. She was scared that someone from the community would tell her family where she was living so she rarely left the house. Aliya felt alone and depressed that she no one to talk to and she was sad that she had lost contact with her family. Aliya had repeated thoughts to end her life and didn't feel that she could talk to her friends about the threats she was receiving from her family as they were all from the same community.

Scenario 3

Aisha is from Ethiopia and as a young daughter. Her relationship with her child's father has broken down and she has no legal status to remain in the country. She has repeated flashbacks about being cut, but has never had a professional confirm FGM. Aisha is concerned about her daughter if she were to return to Ethiopia. She attends a specialist medical clinic where she is examined and type 1 FGM is confirmed (removal of the clitoris). She receives support to help to cope with the flashbacks but suffers stigma from the Ethiopian community because she is separated from the father and her daughter has not been cut.

Scenario 4

Rosa lives with her husband and their three children. They married five years ago and at the beginning everything was fine. Rosa works as a cleaner and her husband has a job in construction. But during the last year things have changed. Rosa's husband often blames her for being a lazy, stupid woman. He says that it was a mistake to marry her and that he regrets it a lot. He takes the money she earns for himself and she does not have enough money to buy food for the family. At night Rosa is often very tired, but her husband forces her to have sex with him. Sometimes when he is in a very bad mood, he even beats her. Rosa is very sad and upset with the situation, but she does not know what to do.

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