Translating Pain Into Action
A Study of Gender-based Violence and Minority Ethnic Women in Ireland
FULL REPORT

The Women’s Health Council
Combairle Shláinte na mBan
Translating Pain into Action

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February 2009
The Women’s Health Council

The Women’s Health Council is a statutory body established in 1997 to advise the Minister for Health and Children on all aspects of women’s health. Following a recommendation in the Report of the Second Commission on the Status of Women (1993), the national Plan for Women’s Health 1997-1999 was published in 1997. One of the recommendations in the Plan was that a Women’s Health Council be set up as ‘a centre of expertise on women’s health issues, to foster research into women’s health, evaluate the success of this Plan in improving women’s health and advise the Minister for Health on women’s issues generally.’

The mission of the Women’s Health Council is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. Its membership is representative of a wide range of expertise and interest in women’s health.

The Women’s Health Council has five functions detailed in its Statutory Instruments:
1. Advising the Minister for Health and Children on all aspects of women’s health
2. Assisting the development of national and regional policies and strategies designed to increase health gain and social gain for women.
3. Developing expertise on women’s health within the health services.
4. Liaising with other relevant international bodies which have similar functions as the Council.
5. Advising other Government Ministers at their request.

The work of the Women’s Health Council is guided by three principles:
♦ Equity based on diversity – the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women
♦ Quality in the provision and delivery of health services to all women throughout their lives
♦ Relevance to women’s health needs

In carrying out its statutory functions, the Women’s Health Council has adopted the WHO definition of health, a measure reiterated in the Department of Health’s ‘Quality and Fairness’ document (2001). This definition states that

‘Health is a state of complete physical, mental and social well being’.

Other outputs of this research study include a summary report, principles of best practice for service providers, and a resource document on gender-based violence. All can be downloaded from the website of the Women’s Health Council, www.whc.ie.

The views expressed in this report do not necessarily reflect the views or policies of the Women’s Health Council or of the Department of Justice, Equality of Law Reform.
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PART ONE: Background

1 Introduction

This report presents the findings of the first major study conducted in Ireland on gender-based violence (GBV) and minority ethnic women. It is both timely and relevant. GBV is one of the most prevalent social problems in the world. Not only is it a violation of women's human rights, it has devastating physical and psychological health consequences for victims/survivors (WHC, 2007). While all women are at risk of experiencing it, a range of factors place minority ethnic women at higher risk than the rest of the population. They include the twofold discrimination of gender and ethnic origin, migrant status, increased isolation and social norms that are defined by patriarchal values. Some minority ethnic women come from cultures where harmful traditional practices are carried out, such as female genital mutilation (FGM) and forced marriage. Those who seek asylum in another country may have experienced conflict-based rape and/or rape during the migration journey. Others arrive in a destination country as the victims/survivors of trafficking for the purposes of sexual exploitation.

Often these issues can also create additional barriers to receiving support. The double discrimination of gender and racism has created a situation in which minority ethnic women are not always able to access the services they need. In addition, their economic and social circumstances, as well as migration and residence laws may militate against their ability to access services. Other barriers include language and absence of interculturally competent services. And yet, an acknowledged paucity of research remains, at an international level, on the issue of gender-based violence among minority ethnic women. Ireland is no exception, despite dramatic increases in migration levels over the past 15 years. According to Census 2006, 12 per cent (n. 246,441) of the female population in Ireland are members of minority ethnic groups. Among this population, just under five per cent belong to the only indigenous minority ethnic population in Ireland, the Traveller community. Legal statuses of non-indigenous minority ethnic women include asylum seeker, refugee, student, European Economic Area (EEA) migrant workers, non-EEA work permit workers, those on a Spouse Dependent Visa (SDV) and those who are undocumented. In 2007, 244 callers to Women’s Aid National Free-phone Helpline were identified as minority ethnic callers, among whom 70 per cent were made by migrant women (Women’s Aid, 2008).

The voices of minority ethnic women who have experienced GBV play an essential role in this attempt to address this the current knowledge gap in Ireland. This study was only made possible through the courage and generosity of those victims/survivors who agreed to participate in the research, and the support of those organisations that facilitated their involvement. These interviews also provided invaluable additional insights into the findings of surveys of GPs, other mainstream health and social services, GBV organisations and minority ethnic organisations, all of which indicate that this is indeed an issue that warrants serious attention.

Many of the findings presented in this report will be representative of the experiences of all victims/survivors of GBV in Ireland. In this regard, the report highlights the universal nature of this phenomenon. However, the emphasis of this report is on illuminating the specific risks of GBV faced by minority ethnic women and the particular barriers they can face in accessing services in Ireland. It is on the basis of this information that this report sets out principles of best practice for service providers and makes recommendations regarding national policy and legislation, service planning and service delivery.

In Ireland, recent developments at government level reflect a commitment both to eradicating violence against women and to ensuring that policy and service planning reflect intercultural competence. In 2005, the National Action Plan Against Racism was launched. This was followed

2 Throughout this report, acronyms of key terms are used, including those relating to gender-based violence, for ease of readership. It is acknowledged that their use may have the unintended effect of distancing the reader from the graveness of the issue. For a full glossary, please see Appendix A.
by the first *National Intercultural Health Strategy 2007-2012* in Ireland, developed by the Health Service Executive (HSE) in 2007 and launched by the Minister of Health and Children in 2008. In June 2007, Cosc, the National Office for the Prevention of Domestic, Sexual and Gender-based Violence was established under the Department of Justice, Equality and Law Reform, with the aim of ensuring ‘the delivery of a well co-ordinated “whole of Government” response to domestic, sexual and gender-based violence’.³ This was followed by the creation of the Office of the Minister for Integration in July 2007, and the publication of the national policy statement, *Migration Nation* in May 2008.

However positive these developments, effective responses to the issue of GBV and minority ethnic women can only be made on the basis of relevant and accurate information. The purpose of this research is to address the existing knowledge gap in Ireland on this issue. In doing so, it is hoped that it will facilitate an equal and interculturally competent response to the needs of all women in Ireland who have experienced or are experiencing GBV, regardless of their ethnicity or migration status.

The aim of this research is to identify how services in Ireland can best respond to the needs of minority ethnic women who have experienced GBV. More specifically, its objectives are:

- To document the experiences of minority ethnic women in relation to various forms of GBV;
- To document the current level of service provision in the area;
- To identify existing barriers to the delivery of current services to minority ethnic women; and
- To provide key principles of good practice for service providers.

A mixed methodology approach was adopted for this study. Secondary research methods included a review of international research literature and an analysis of key national policy and legislative documents. Primary research methods included qualitative interviews with victims/survivors of GBV, and surveys with GPs, other mainstream health and social services, GBV organisations and minority ethnic organisations.

### 1.1 Outline of the Report

The report is comprised of four sections and eleven chapters. Section one presents the findings of the review of literature, national policy on the topic of gender-based violence and migration, and the project methodology. **Chapter two** is a review of literature on GBV. It outlines an ecological model for understanding minority ethnic women’s experience of GBV, before going on to explore research literature regarding domestic violence and minority ethnic women, pre-migratory experiences of GBV, harmful traditional practices and trafficking for the purposes of sexual exploitation. The final section of this review addresses barriers to accessing services experienced by minority ethnic women and highlights guiding principles and good practice measures to ensure interculturally competent service delivery. **Chapter three** deals with the policy and legislative context of GBV experienced by minority ethnic women. This outlines the international development, whereby GBV became recognised as a human rights violation. It goes on to question the perception of tension existing between the concept of multiculturalism and that of human rights, specifically in the field of gender equality, before considering the intercultural competence of policy on GBV in Ireland. Further sections of this chapter focus on asylum policy, migrant rights and trafficking policy and legislation, drawing on international models before considering the Irish context. **Chapter four**, the final chapter in section one, outlines and explains the mixed method research design adopted for this report.

The second section presents the qualitative research findings. In **Chapter five**, participants’ experiences of abuse are explored, as well as their experiences of accessing services in Ireland. **Chapter six** presents an exploration of pre-migratory experiences of GBV, including forced marriage, FGM and conflict-based rape.

Section three presents the quantitative findings. **Chapter seven** outlines the findings of a survey conducted with GPs, Social Work Departments, Directors of Public Health Nursing and Sexual Assault Treatment Units (SATUs). **Chapter eight** documents the findings of surveys with two sections of the voluntary sector, namely non-governmental GBV organisations and minority ethnic organisations. **Chapter nine** presents the referral pathways through all relevant services experienced by minority ethnic women who seek support regarding GBV.

The final section of this report is concerned with the research findings and research outputs. **Chapter ten** uses the ecological framework to discuss the key findings of the research and recommendations that arise from them. **Chapter eleven** sets out principles of best practice for service providers.
2 Review of Literature

This review explores the research literature regarding a range of forms of gender-based violence (GBV)\(^4\), that relates to the experiences of minority ethnic women. Forms include intimate partner violence (IPV) and domestic violence perpetrated by other family members, sexual violence that occurs outside of the home, including conflict-based rape, trafficking for the purposes of sexual exploitation and harmful traditional practices, such as female genital mutilation (FGM) and forced marriages.

In recent years, a growing body of research literature has emerged that attempts to explore this issue and identify risks and causative factors relevant to minority ethnic women. This research has pointed to pre-migratory contexts from which some minority ethnic women have escaped, such as war which can lead to conflict-based rape, and cultures in which harmful traditional practices such as FGM and/or forced marriages take place. The experience of migration itself also emerged as a high risk factor, both in relation to heightened vulnerability of minority ethnic women during the migration journey and aspects of their experience in the destination country. Relevant aspects can include unequal gender relations both in their own community and in the dominant culture, while, as a member of a minority group, they are prey to experiences of racism (Kasturirangan et al., 2004), and social inequality. The trafficking of women from developing countries to industrialised countries such as Ireland, for the purposes of sexual exploitation is another form of GBV which is experienced by minority ethnic women.

All of these issues combine to place minority ethnic women as a group at a higher risk of GBV. As noted in one study of East Timorese asylum seekers in Australia, “patriarchal culture, persecution in the country of origin, post trauma and resettlement issues in the country of sanctuary are all identified as contributing factors in the development or intensification of domestic violence” (Rees, 2004: 5). Research has also emerged regarding restrictions to relevant support services experienced by minority ethnic women, including language and other cultural barriers, shame and stigma associated with GBV, all of which can be compounded by fewer options for interculturally sensitive interventions.

Minority ethnic women have been identified as an under-researched group in the field of GBV (UN, 2006). While a relatively large amount of research has been conducted into this subject in North America, in Europe, academic research in this field has been described as still being in ‘its early stages’ (CAHRV, 2007). In Ireland, very little research has been conducted on this issue; as a result, this review of literature focuses almost solely on international research literature, most of which was conducted in the US, Great Britain and Australia.

2.1 Understanding Minority Ethnic Women’s Experience of GBV

The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) defines GBV as any form of violence that targets individuals or groups of individuals on the basis of their gender. While men and boys can be victims of GBV, the vast majority of GBV is carried out against women and girls. Therefore, the term GBV is often used synonymously with violence against women (VAW). The UN Declaration on the Elimination of Violence against Women (DEVW) 1993 defines VAW as:

“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, 1993).

Intimate partner violence (IPV) is the most common form of GBV among all women, including those from minority ethnic groups (Watts and Zimmerman, 2002; Heise et al, 1999; UN, 2006). Other

\(^4\) Throughout this report the two terms of VAW and GBV will be used interchangeably and other terms, such as intimate partner violence, will also be used reflecting their use in the literature.
forms of GBV include harmful traditional practices such as FGM, conflict-based rape and sexual violence against women prisoners. This list is not exhaustive. Figure 1 below displays the wide range of forms of GBV that occur throughout the world. It shows that women and girls are at risk of GBV across the life cycle, from sex selective abortion and female infanticide, to abuse of widows.

### Figure 1. Violence against women over the lifespan

<table>
<thead>
<tr>
<th>Pre-birth infancy</th>
<th>Girlhood/adolescence</th>
<th>Reproductive age</th>
<th>Elderly</th>
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<td><strong>Perpetrators</strong></td>
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<td>Family members</td>
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<td>Intimate partner</td>
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<td>Others</td>
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<td><strong>Violence</strong></td>
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<td>Violence organised or perpetrated by states (e.g. rape in war)</td>
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<td>Forced prostitution, trafficking for sex</td>
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<td>Acid throwing</td>
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<td>Non-partner coerced sex/rape/harassment (including child sexual abuse)</td>
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<td>Abuse of widows/elder abuse</td>
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<td>Dowry deaths/honour killings</td>
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<td>Differential access to food/medical care</td>
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<td>Psychological abuse by family members</td>
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<td>Coerced sex/rape/harassment (including child sexual abuse) by family members</td>
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<td>Physical violence by family members</td>
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<td>Violence in pregnancy</td>
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<td>Psychological abuse by intimate partner</td>
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<td>Physical violence (by current or former partner)</td>
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<td>Sexual violence (by current or former partner)</td>
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**Source:** Watts and Zimmerman, 2002.

Today, it is accepted that violence against women is a manifestation of gender inequality and serves to maintain an unequal balance of power (Watts and Zimmerman, 2002). The 2006 report on the State of the World’s Populations describes GBV as “the ultimate manifestation of unequal relations between men and women” (UNFPA: 39), while the 10 year review of the Beijing Platform for Action on Violence Against Women notes that,

“VAW is a manifestation of the historically unequal power relations between men and women that is perpetuated through socialization and legitimization of violence as an acceptable form of conflict resolution.”

(UN INSTRAW, 2005: 1)

The most comprehensive explanation for the problem of VAW comes from what has been called the ‘ecological model’. This model provides a useful structure within which to consider those risk factors faced specifically by minority ethnic women (see figure 2 below). This was developed in a study which synthesised the findings from 48 population based studies, including international and cross-cultural research (Heise, 1998). This study drew only on factors which have been shown to reliably predict the risk of GBV. The ecological framework was subsequently adopted by the WHO in its multi-country study on violence against women (Garcia-Moreno, 2005).

The ecological framework conceptualises GBV as a “multifaceted phenomenon grounded in an interplay among personal, situational, and socio-cultural factors” (Heise, 1998: 263). It is comprised
of four levels: the personal, the familial, the community and societal level. The first level refers to the ‘features of an individual’s developmental experience or personality that shape his or her response to stressors’ at the other three levels, namely, witnessing domestic violence as a child and experiencing physical or sexual abuse as a child. Level two, the family, refers to the immediate context in which the violence takes place; identified risk factors include marital conflict and patriarchal family structure. Level three, the community, refers to both formal and informal social structures that impact on the immediate context, such as unemployment, low socio-economic status, isolation of the woman and family, and delinquent peer associations. Finally, level four, society, represents the general views and attitudes of a culture (ibid.). It relates to state structures and processes that legitimise and institutionalise gender inequalities. It both informs and defines almost all of the risk factors that present under the preceding three levels by positing them within the context of cultural norms. For example, a definition of masculinity that is linked to concepts such as dominance and honour is linked to increased incidence of rape and sexual coercion (ibid.: 278). As noted by the UN, no act of GBV can be fully understood without consideration of this level (2006).

Figure 2: The Ecological Framework for Understanding GBV


Recently, an ecological model for understanding culture as a determinant of women’s health in general has been proposed that takes into consideration gender, migratory experience, social status, as well as culture (Thurston and Vissandjee, 2005). This study includes violence against women as one of many negative health consequences experienced by minority ethnic women. It attends to factors at the individual level, while emphasising those social factors at meso and macro levels. Identified stressors of immigrant women’s health include income, loneliness and social isolation, feelings of loss of social status, language barriers, culture shock, working in unsafe or unhealthy working conditions, prejudice and discrimination, lack of knowledge of existing services, and feelings of vulnerability due to prolonged uncertainty.

The next section considers research literature regarding domestic violence. Domestic violence is the most prevalent form of GBV worldwide, as well as from our research findings to be explored in the next section, and most of the literature regarding GBV and minority ethnic women is specifically concerned with domestic violence.

2.2 Domestic Violence and Minority Ethnic Women

Domestic violence occurs across all boundaries, such as race, class, ethnicity and nationality. Over the past two decades, research studies have begun to explore differences in women’s experience of domestic violence. Through this, the intersectionality of a range of factors emerged (Rai and Thiara, 1997; Batsleer, 2002). Much of this research is relevant to the experience of domestic violence among minority ethnic women.

Conflicting evidence exists regarding the prevalence of domestic violence among minority ethnic women. Homicide data both from New York City and London indicate that minority ethnic women are disproportionately represented among female victims of partner perpetrated femicide (Frye et al, 2000; Raj and Silverman, 2002; Richards, 2003). A national study of violence against women in Canada found that Aboriginal women had experienced higher rates of violence (57%) than non-

Level 4: Society
Level 3: Community
Level 2: Family/relationship
Level 1: Personal history of abuser
Aboriginal women (21%) (Cohen and Maclean, 2004). However, an analysis of the British Crime Survey found little variation in the prevalence of domestic violence by ethnicity (Walby and Allen, 2004). In Canada, there is some evidence that immigrant women experience slightly lower rates of domestic violence, compared with Canadian born women (Cohen and Maclean, 2004).

A range of risk factors specific to minority ethnic women has emerged in relation to domestic violence. The next section explores the relationship between domestic violence, the process of migration and culture. It also includes a section relating to the relationship between domestic violence and poverty, in relation to minority ethnic women.

2.2.1 Stressors and Risk Factors

Culture, Patriarchy and Domestic Violence

The consideration of culture in relation to GBV is an “intensely debated” issue (Humphreys, 2007: 124). Sokoloff and Dupont point out that: “culture should not be confused with patriarchy” (2005: 47). While culture is a fluid phenomenon that tends to change over time, patriarchy has shown itself to be a consistent feature of all society, regardless of the cultural contexts. For example, in America, high rates of domestic violence have been found among women in casual and longer-term romantic dating relationships, one of many culturally specific forms of social relations between men and women (UN, 2006). Culturally specific preoccupations with women’s sexuality are reflected across a spectrum of control measures, from enforced chastity, to the commoditisation of sexuality in the media. Conversely, every culture has different tenets that empower women (Dasgupta, 1998). The UN in-depth report on VAW notes that “the ways in which culture shapes violence against women are as varied as culture itself” (ibid.: 31). A further issue then is “how patriarchy operates differently in different cultures” (Sokoloff and Dupont, 2005: 47). It is also necessary to take into account other relevant factors:

“Although culture is crucial to understanding and combating domestic violence, we cannot rest on simplistic notions of violence. Rather, we must address how different communities' experiences of violence are mediated through structural forms of oppression, such as racism, colonialism, economic exploitation, heterosexism and the like” (Sokoloff and Dupont, 2005: 45).

Research has shown, however, that some cultural settings are more patriarchal than others. The WHO multi-country study (2005) found that although some differences could be accounted for by variables such as a woman’s age, education and marital status, countries with the highest prevalence of domestic violence were more likely to endorse traditional views of violence and women’s sexual autonomy (Garcia-Moreno, 2005). Research literature on minority ethnic women and domestic violence also confirms the relationship between patriarchal values and GBV. Related risk factors include definitions of manhood that are linked to dominance, toughness or male honour, sense of male entitlement over women, general approval of public chastisement of women, general approval of male control of women, strict adherence to rigid gender roles and perception of marital rape as a male right (Heise et al, 1999; Midlarsky et al, 2006; Guru, 2006; Haj-Yahia, 1998).

Raj and Silverman identified a relationship between patriarchal values and the nature of violent attacks experienced by minority ethnic women, in which the perpetrator used traditional aspects of the culture to control and abuse women (2002). These included infidelity/threats of infidelity, verbal abuse in front of children, family or friends, and criticism of looks, cooking ability, mothering and modesty.

Both men and women who uphold patriarchal expectations within a family are more likely to believe that a man has the right to maintain his status through use of physical force (Haj-yahia, 1998). Minority ethnic women are found to be at greater risk of domestic violence in communities where it is believed to be acceptable for a man to ‘discipline’ his wife using physical violence, if the woman veers from her prescribed role (Raj and Silverman, 2002; Rees, 2004). In Ireland, it was found through focus group research that neither marital rape nor sexual assault were perceived to be serious offences among Traveller and immigrant women (Watson and Parsons, 2005).
Cross-cultural research has found that one of the strongest predictors of societies with low levels of domestic violence is whether members of a community or family would intervene (Heise 1998). When a high level of importance is placed on the family’s right to privacy, domestic violence can become perceived as a private matter that does not warrant intervention (Midlarsky et al., 2006). When husband and wife relations are considered outside of public scrutiny (Heise, 1998), the risk of domestic violence increases for women.

When a violent relationship occurs, the centrality of the family unit in some cultures can act as a barrier to leaving the abusive relationship for minority ethnic women (Midlarsky et al., 2006). The presence of other family members can be used as a tool in continuing violence against women (Kasturirangan et al., 2004; Fernandez, 2006). For example, among Chinese communities, the mother-in-law can be in a dominant position over the woman (Lee, 2000). Other impediments to leaving caused by patriarchal values include financial dependence on the perpetrator, lack of an alternative support system and the stigma of divorce within the community (ibid.).

Minority ethnic women can also face prejudice and discrimination from the majority culture, while simultaneously experiencing sexism against them, both from their own community and from the dominant group (Narayan, 1995; Shetty and Kaguyutan, 2002; Kasturirangan et al., 2004). This intersection of racism and sexism can make it more difficult to seek help and leave the relationship. The stress of living within two cultural contexts can have further effects on domestic violence among minority ethnic women.

**Caught Between Two Cultures**

A complex relationship emerges between belonging to a minority culture and domestic violence. Living within two cultures can lead to the acculturation of minority ethnic communities, namely the modification of behaviour, culture, belief and values, through borrowing from or adapting to a dominant culture. This has been related to high stress levels within minority communities which can lead to domestic violence (Sorenson, 1996). However, strong attempts to resist acculturation by maintaining a rigid set of cultural norms enforcing their traditional customs and beliefs (Kasturirangan, 2004) can also exacerbate the experiences of minority ethnic women who experience domestic violence. When a minority culture feels threatened by the dominant one, members can feel pressure not to speak out against problems such as domestic violence, for fear of stigmatising that culture. Fear of both psychological and literal banishment can lead minority ethnic women to avoid speaking out about their experiences of domestic violence, or seeking help for it (Dasgupta, 1998).

Differences that can exist in gender roles between the dominant and minority communities have also been related to domestic violence. New employment opportunities for women can sometimes result in a woman becoming a family breadwinner. This change in gender roles within a family can, in turn, lead to tension, marital conflict and domestic violence (Kasturirangan et al., 2004). There is evidence that changes in gender role ideology occurs more quickly for women than for men (Raj and Silverman, 2002), which can lead to women being less willing to conform to traditional roles. Men may then make increased efforts to control women, including the use of violence to re-establish their position of control (Lee, 2000). Violence may also be employed by men in this situation to overcome feelings of shame caused by the change in gender roles (Raphael, 2001). Conversely, research from the US has highlighted cases of domestic violence in which the perpetrator’s hastens acculturation on the victim/survivor, by enforcing ‘Americanization’ on her, through forcing her to diet and inflicting punishments of forced fasting, public humiliation, silence and withholding of affection (Midlarsky et al., 2006). All of these issues are further compounded when the victim/survivor is socially isolated.

**Isolation and Domestic Violence**

Women who are isolated from the rest of their community, friends and neighbours face a higher risk of domestic violence (Heise et al., 1999). Both indigenous and migrant minority ethnic women are at a heightened risk of isolation. Efforts at resisting acculturation by a minority community can also lead to the increased isolation of women when relatives restrict their social network in the host country (Raj and Silverman, 2002).
For migrant women, the process of immigration from their home country is often a very difficult and traumatic experience (Dasgupta, 1998). It can mean separation from family and friends, which can then create pressure on a woman to stay with her nuclear family (ibid.). For women who do not speak the language of the destination country and for those who are not in paid employment, the perpetrator may be the only connection a woman has to her home country, and her only source of companionship in the destination country (Kasturirangan, 2004; Lee 2000). Undocumented status has been found to heighten this risk of isolation, as has experience of arranged marriage, both between members of one minority ethnic group, and the arranged marriage of a minority ethnic woman to a male member of the dominant culture (Raj and Silverman, 2002).

Perpetrators engage in a range of control tactics against migrant women in order to enforce this isolation (Kasturirangan et al, 2002). Tactics include limiting their contact with family, prohibiting long-distance phone calls and trips to the country of origin, prohibiting friendships with women from the host community and prohibiting the wearing of Western clothes, or learning or speaking English (ibid.).

Other control tactics adopted by perpetrators regarding migration status include refusing to file immigration papers, threatening to deport the woman and/or her children, keeping, destroying or threatening to destroy her immigration papers and passports, begin deportation proceedings, accusing her of marriage fraud, leaving her in her country of origin without resources to return to the host country, prohibiting working and limiting access to money (Midlarsky et al, 2006).

**Domestic Violence, Poverty and Minority Ethnic Women**

A growing body of research studies conducted in different countries have found that domestic violence is more common in families with low incomes (Heise, 1998; Kasturirangan, 2004; Walby and Allen, 2004; Sutherland, Sullivan and Bybee, 2001; Sokoloff and Dupont, 2005). One recent research study in the UK identified significantly higher numbers of women on low incomes reporting domestic violence (Walby and Allen, 2004). Women in households with a total income less than £10,000 were 3.5 times more at risk of domestic violence than households with an income of £20,000 or more (ibid.). It has also been found that socio-economic stresses on family relations can lead to violence in contexts in which violence is a socially accepted norm (hooks, 1982, cited in Guru, 2006). Evidence also suggests that male unemployment contributes to risk of domestic violence (Bourgois, 1996; Silberschmidt, 2001). In her review of the literature, Humphreys warns against the use of simplistic answers to explain the compounding effect of poverty that could lead to domestic violence being overlooked in the rest of the population. She cites evidence that related factors, such as crowding, hopelessness, increased stress and frustration and a sense of inadequacy among men may contribute to the risk of domestic violence occurring. Partner/ex-partner debts and single motherhood may lead to poverty among those already experiencing domestic violence, rather than the reverse (Humphries, 2007).

Kasturirangan et al (2004) criticise research studies on minority ethnic communities for overlooking socio-economic factors such as poverty in relation to GBV, positing that this issue is possibly the most significant variable in understanding specific associated risks, and is inseparably intertwined with the experience of being a member of a minority ethnic group. Sokoloff and Dupont found that when socio-economic factors are excluded from the equation, ethnic differences in the rate of intimate partner violence largely disappear with them (2005). A secondary analysis of the UK National British Crime Survey found no differences in rates of GBV across different minority ethnic groups when income is controlled (Walby and Allen, 2004).

Study findings which have focused specifically on the minority ethnic women’s experiences of domestic violence mirror those of general population studies in relation to poverty and violence. They also highlight the complexity of the relationship between social exclusion and domestic violence, as they highlight a range of relevant factors. Loss of socio-economic status through the migration process can, in turn, lead to financial instability and poverty, leading to an increase in levels of environmental stress and the likelihood of abuse (Kasturirangan, 2005; Sorenson, 1996; Raj and Silverman, 2002). The strains of moving to a new environment, racism combined with unemployment and low income, “can lead to frustration that finds its outlet in the abuse of female
partners” (Kasturirangan, 2005: 39). In Ireland, research on drug use among the Traveller community highlights the relationship between that drug dependency, social exclusion, stress on family relationships and violence (Fountain, 2006).

- **Migration and Domestic Violence**
  A recent study of six domestic violence services in Ireland found that migrant women accounted for one quarter of all clients accessing the majority of these services (Fagan, 2008). In the UK, it has been found that immigration and asylum legislation exacerbates women’s vulnerability and risk of experiencing domestic violence (Burman et al, 2005). A growing body of research provides evidence that negative changes following migration can be risk factors of domestic violence on migrant women. These include changes in income and status, gender roles and traditional supports (Mason and Hyman, 2008).

In the US, the Family Violence Prevention Fund has identified the following forms of control and violence carried out by perpetrators of domestic violence that are specifically related the migration status. Not all are relevant to all migrant women’s experience, as each experience varies from case to case. Many of these aspects are also relevant to the experiences of non-indigenous minority ethnic women, specifically those that relate to issues of culture.

Table 1 *Migration-related form of Violence*

<table>
<thead>
<tr>
<th>Emotional Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying about her immigration status.</td>
</tr>
<tr>
<td>Telling her family lies about her.</td>
</tr>
<tr>
<td>Calling her racist names.</td>
</tr>
<tr>
<td>Belittling and embarrassing her in front of family and friends.</td>
</tr>
<tr>
<td>Causing her to lose face.</td>
</tr>
<tr>
<td>Telling her that she has abandoned her culture and become ‘white’.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Economic Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forcing her to work ‘illegally’ when she does not have a work permit.</td>
</tr>
<tr>
<td>Threatening to report her if she works ‘under the table’.</td>
</tr>
<tr>
<td>Not letting her get job training or schooling.</td>
</tr>
<tr>
<td>Taking the money her family back home were depending upon</td>
</tr>
<tr>
<td>Forcing her to sign papers in English that she does not understand -- court papers, tax forms, immigration papers.</td>
</tr>
<tr>
<td>Harassing her at the only job she can work at legally, so that she loses that job and is forced to work ‘illegally’.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calling her a prostitute or a ‘mail order bride’.</td>
</tr>
<tr>
<td>Accusing her of trying to attract other men when she puts on make-up to go to work.</td>
</tr>
<tr>
<td>Accusing her of sleeping with other men.</td>
</tr>
<tr>
<td>Alleging that she has a history of prostitution on legal papers.</td>
</tr>
<tr>
<td>Telling her that ‘as a matter of law’ in the destination country that she must continue to have sex with him whenever he wants until they are divorced.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Using Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threatening to remove her children from the destination country.</td>
</tr>
<tr>
<td>Taking the money she was to send to support her children in her home country.</td>
</tr>
<tr>
<td>Telling her he will have her deported and he will keep the children with him</td>
</tr>
<tr>
<td>Convincing her that if she seeks help from the courts or the police the legal system will give him custody of the children.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Using Citizenship or Residency Privilege</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threatening to get her deported.</td>
</tr>
<tr>
<td>Failing to file papers to legalize her immigration status.</td>
</tr>
<tr>
<td>Withdrawing or threatening to withdraw immigration papers filed for her residency.</td>
</tr>
<tr>
<td>Using the fact of her undocumented immigration status to keep her from reporting abuse or leaving with the children.</td>
</tr>
<tr>
<td>Telling her that the police will arrest her for being undocumented if she calls the police for help because of the abuse.</td>
</tr>
</tbody>
</table>
**Intimidation**
- Hiding or destroying important papers (i.e. her passport, her children’s passports, ID cards, health care cards, etc.)
- Destroying the only property that she brought with her from her home country.
- Destroying photographs of her family members.
- Threatening persons who serve as a source of support for her.
- Threatening to do or say something that will shame her family or cause them to lose face.
- Threatening to divulge family secrets.

**Isolation**
- Isolating her from persons who speak her language.
- Not allowing her to learn English or not allowing her to communicate in a language she is fluent in.
- Being the only person through whom she can communicate in English.
- Not allowing her to meet with social workers and other support persons.
- Cutting off her subscriptions to or destroying newspapers and other support magazines.
- Not allowing her to meet with people who speak her language or who are from her community, culture, or country.

**Minimising, Denying, Blaming**
- Convincing her his violent actions are not criminal unless they occur in public.
- Telling her that he is allowed to physically punish her because he is the ‘man’.
- Blaming her for the breakup of the family, if she leaves him.
- Telling her that she is responsible because she did not do as he wished.

*Source: Family Violence Prevention Fund, 2008*

### 2.2.2 Health Consequences of Domestic Violence on Minority Ethnic Women

In general, research literature on the consequences of domestic violence among minority ethnic women mirrors the findings of general studies on this issue. At a psychological level, they include loss of self-esteem and identity, depression anxiety and post-traumatic stress syndrome (Midlarsky *et al.*, 2006). Physical health consequences include sleep problems, fatigue, pains in limbs and chest, gastrointestinal and respiratory problems, menstrual problems, and infection of HIV and other sexually transmitted diseases (Sutherland, Sullivan and Bybee, 2001). Fatal consequences include murder, sometimes carried out in the name of ‘honour’, and suicide. Figure 3 overleaf summarises the range of negative health consequences of domestic violence.

Figure 3. Health repercussions of VAW.

<table>
<thead>
<tr>
<th>Fatal outcomes</th>
<th>GBV</th>
<th>Non-fatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS related</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical</th>
<th>Chronic</th>
<th>Mental</th>
<th>Negative health behaviours</th>
<th>Reproductive health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>Chronic pain</td>
<td>PTSD</td>
<td>Smoking</td>
<td>Unwanted pregnancy</td>
</tr>
<tr>
<td>Functional impairment</td>
<td>syndrome</td>
<td>Depression</td>
<td>Alcohol and drug abuse</td>
<td>STIs/HIV</td>
</tr>
<tr>
<td>Permanent disability</td>
<td>Irritable bowel syndrome</td>
<td>Anxiety</td>
<td>Sexual risk-taking</td>
<td>Gynaecological problems</td>
</tr>
<tr>
<td>Poor subjective health</td>
<td>Gastrointestinal disorders</td>
<td>Phobia/panic disorders</td>
<td>Physical inactivity</td>
<td>Unsafe abortion</td>
</tr>
<tr>
<td></td>
<td>disorders</td>
<td>Self-harm and</td>
<td>Eating disorders</td>
<td>Pregnancy complications</td>
</tr>
<tr>
<td></td>
<td>Fibromyalgia</td>
<td>parasuicide</td>
<td></td>
<td>Miscarriage/LBW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pelvic inflammatory diseases</td>
</tr>
</tbody>
</table>

*Source: adapted from WHO, 2002.*
Some evidence exists to show that minority ethnic women can be at a higher risk of psychological consequences of domestic violence. Humphries (2007) cites one US hospital-based study, which found that domestic violence was a contributory factor for 48.8% of attempted suicide cases by minority ethnic women, compared with 22.2% for white women. In the UK, a similar study found that rates of self-harm among young Asian women were 2.5 times that of white women and seven times that of Asian men and that minority ethnic women are over-represented in cases of suicide (Bhugra et al, 1999). A qualitative study on this subject found that domestic violence was a strong contributory factor for self-harm and attempted suicide among young Asian women (Yazdani, 1998). Identified risk factors of attempted suicide and self-harm include a sense of entrapment and feeling there is ‘no way out’ (Humphries, 2007).

The next section considers the experiences and needs of minority ethnic women who experience GBV in pre-migratory contexts. Though this affects a much smaller proportion of minority ethnic women, consequences are just as severe and wide-ranging as those outlined above.

### 2.3 Conflict, Migration and Sexual Violence

According to the United Nations High Commissioner for Refugees, around 80 per cent of all refugees are women and children. Many of these refugees are fleeing conflict in their home country, and throughout the refugee process face a heightened risk of GBV. For many women, the migration process is caused by conflict-based rape. Conflict-based rape is a deliberate strategy in conflict and is committed by armed soldiers in order to undermine community bonds, weaken resistance to aggression, force people to flee, and even to perpetrate ethnic cleansing through impregnation (Krug et al, 2002). Documented evidence of this abuse exists from Korea during the Second World War, Bangladesh during the war of independence, as well as Algeria, India, Indonesia, Liberia, Rwanda, Uganda and East Timor. Its physical and psychological consequences are wide-ranging and far-reaching. As one commentator noted, “such sexual violation of women erodes the fabric of a community in a way that few weapons can” (IRIN, 2004: 5). Many women are reluctant to disclose conflict-based rape, either due to fear of reprisal or because of the associated stigma (UN, 2006).

Rape has also found to be a significant problem in refugee camps (Krug et al, 2002). A study in Monrovia, Liberia, found that women under 25 years were more likely than those aged 25 years and over to experience attempted rape and sexual coercion during the conflict (cited in Krug et al, 2002). Women who were forced to cook for a warring faction were also found to be at significantly higher risk. In destination countries in Europe, it has been found that both female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several forms of GBV (ICRH, 2008). This vulnerability to sexual violence continues throughout the migration process (UNFPA, 2006) and can remain on arrival at the destination country. This has been related to gender inequality in their home country, which can result in inadequate knowledge and awareness of rights and entitlements in the destination country and work opportunities there (UNFPA, 2006).

Table 2 overleaf summarises the types of violence a refugee/asylum seeker woman is at risk of, up to the point of living in the country of asylum.

---

5 For a more in-depth exploration of the health consequences of violence against women, see the Women’s Health Council’s report *Violence Against Women and Health* (2007).
Table 2. GBV During the Refugee Cycle

<table>
<thead>
<tr>
<th>Phase</th>
<th>Type of violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>During conflict, prior to flight</td>
<td>Abuse by person in power, sexual bartering of women, sexual assault, rape, abduction by armed members of parties in conflict, including security forces, mass rape and forced pregnancies.</td>
</tr>
<tr>
<td>During flight</td>
<td>Sexual attack by bandits, border guards, pirates; capture for trafficking by smugglers, slave traders.</td>
</tr>
<tr>
<td>In the country of asylum</td>
<td>Sexual attack, coercion, extortion by persons in authority, sexual abuse of separated children in foster care, domestic violence; sexual assault when in transit facilities, collecting wood, water, etc.; sex for survival/forced prostitution, sexual exploitation of persons seeking legal status in asylum country or access to assistance and resources; resumption of harmful traditional practices.</td>
</tr>
</tbody>
</table>

Source: adapted from UNHCR, 2003.

In Ireland, the Galway Rape Crisis Centre (GRCC) established an Asylum Seeker and Refugee Clinic in 2004, in order to meet a growing need, one that has also been identified by other Rape Crisis Centres across the country (GRCC, 2007). From 2005 to 2007, this clinic provided 534 individual counselling sessions and 25 group counselling sessions. Seventy nine per cent of clients experienced rape, of whom 62 per cent of perpetrators were Armed Forces in the country of origin.

Harmful traditional practices are another form of GBV to affect a smaller proportion of minority ethnic women in Ireland. These practices are the focus of the next section.

2.4 Harmful Traditional Practices and Minority Ethnic Women

Harmful traditional practices (HTP) have been defined as

“a range of practices rooted in sets of beliefs, values, cultural and social behaviour patterns … [that] seek to control women and girls” (Kelly and Regan, 2007: 6).

HTPs are more culturally bounded than other forms of GBV (ibid.). According to the Office of the High Commissioner for Human Rights, they usually have been practiced for so long that they are considered an acceptable part of cultural practice. Due to globalisation and migration, HTP have become matters of concern within many countries that are the destination of migrant workers, refugees and those seeking asylum (Kelly and Regan, 2007). Even when experienced prior to migration, longstanding health consequences can lead to significant implications for health and social service delivery in host countries.

2.4.1 Female Genital Mutilation

Female Genital Mutilation (FGM) involves the removal of all, or parts, of the external female genitalia. It is generally performed on young girls, but is sometimes performed on infants, adolescents and women (WHO, 2000). It is normally performed without the use of anaesthetic or hygienic surgical tools. Where possible, the procedure can be carried out in a hygienic, medicalised setting if the family can afford it; however, this is the exception rather than the rule (ibid.). Instruments known to be used in performing FGM include sharp rocks, razor blades, kitchen knives, broken glass, or even teeth (Barstow, 1998). Four broad types of FGM were identified in 1997 by a range of agencies. In 2008, a new interagency statement was published, in which the four classifications incorporated some modifications and clarifications. This is outlined in table 3 overleaf.

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6 For a more in-depth exploration of this subject, see the Women's Health Council Report Female Genital Mutilation/Cutting. A Literature Review, (2008).
Table 3. Types of FGM

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type I</td>
<td>Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).</td>
</tr>
<tr>
<td>Type II</td>
<td>Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).</td>
</tr>
<tr>
<td>Types III</td>
<td>Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).</td>
</tr>
<tr>
<td>Type IV</td>
<td>All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.</td>
</tr>
</tbody>
</table>


Approximately 2 million women and girls every year are at risk of FGM (UNFPA, 2006) and it has been estimated that more than 130 million girls and women alive today have undergone FGM (UN, 2006). The practice is prevalent in Africa, some countries in the Middle East and among immigrant communities in Europe, North America and Australia (ibid.). There is some evidence that this practice is beginning to decline, which has been attributed to increasing opposition from women’s groups, higher female education levels and female access to economic resources (UN, 2006; UNICEF, 2005).

Table 4. Prevalence Rate of FGM by country

<table>
<thead>
<tr>
<th>Prevalence rates</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-100%</td>
<td>Guinea, Egypt, Somalia, Eritrea, Mali</td>
</tr>
<tr>
<td>70-89%</td>
<td>Sudan, Burkina Faso</td>
</tr>
<tr>
<td>40-69%</td>
<td>Cote d’Ivoire, Central African Republic</td>
</tr>
<tr>
<td>20-39%</td>
<td>Yemen, Nigeria, Kenya</td>
</tr>
<tr>
<td>5-19%</td>
<td>Niger, Togo, Tanzania</td>
</tr>
</tbody>
</table>

Source: adapted from Kelly and Regan, 2007.

The meaning of FGM is embedded in localised and specific historical, social and cultural practices (WHC, 2008), and is often considered an acceptable and inextricable cultural practice. The OHCHR refers to it as a ‘custom or tradition synthesized over time from various values, especially religious and cultural values’ (2008). Stated reasons for maintaining the practice include religion, custom, decreasing the sexual desire of women, decreasing a woman’s ability to seek sexual pleasure outside of marriage, hygiene, and culturally specific notions of beauty and femininity (WHC, 2008). Taking a historical perspective, Whitehorn notes that it is and has been practised in a wide variety of cultural, religious and national contexts, including nineteenth century Britain (2002).

Consequences of FGM can be severe. Physical consequences include high mortality and morbidity due to haemorrhage and infection, as well as infertility, urinary retention and infection, haematocolpos, formation of fistulae, and increased risk of contracting HIV (Whitehorn, 2002). Psychological consequences includes post-traumatic stress disorder, anxiety and depression, and psycho-sexual problems (ibid.).

Refugees and asylum seekers have been identified as being at particular risk of past experience of FGM (UNFPA, 2006). The UK organisation FORWARD estimate that there are 74,000 first generation African immigrant women in the UK who have undergone FGM and as many as 7,000 girls (under 16) within the practising communities who are at risk of FGM. FGM is not legal in the United Kingdom and some doctors have been struck off the medical register for carrying out this practice. In some cases, minority ethnic girls are sent abroad to undergo the procedure, to avoid legal restrictions (Whitehorn et al, 2002).

Haematocolpos is the accumulation of menstrual blood in the vagina.
The practice of FGM among immigrant communities has been related to a reaction to the migration and acculturation process. Among immigrant populations, difficulties associated with the refugee process, such as stress, post-traumatic stress, poverty and separation from family are compounded by the difficulties in arriving to a new country. If a minority ethnic group in which FGM is practiced feels its identity threatened or challenged by a dominant culture, it may strive to preserve their culture by a stringent enforcement of traditional practices, such as FGM (Whitehorn et al., 2002). In these circumstances, the practice of FGM may be seen as an affirmation of cultural identity.

To date, there is no documented evidence of FGM taking place in Ireland. However, recent research has shown that there are at least 2,584 women currently living in Ireland who have experienced FGM in their country of origin (Patel, 2008). In a survey of 38 services for women who experience GBV and services for minority ethnic groups, eight women had disclosed experience of FGM in their country of origin to a service provider (AkiDwA, ICI, Women’s Aid, 2006).

2.4.2 Early and Forced Marriages

Early marriage is the marriage of girls below the age of 16 years, in some cases before the girl reaches sexual maturity (Kelly and Regan, 2007). Early marriages take place all over the world, but have been found to be most common in sub-Saharan Africa and South Asia (UN, 2006). Forced marriage is that without consent of both parties, and involves the use of coercion or force. The family of the girl or woman can be involved in her forced marriage. It is relevant to note that a clear distinction exists between the concept of an arranged marriage and a forced marriage. The arranged marriage is a tradition that has operated successfully for a long time (Foreign and Commonwealth Office, 2004). The following distinction has been provided:

‘In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangement remains with the young people. In forced marriage, one or both spouses do not consent to the marriage and some element of duress is involved. Duress includes both physical and emotional pressure’ (Foreign and Commonwealth Office, 2004).

Risk factors of early and forced marriages include poverty, living in a rural area, cultural relation made between marriage of daughters and family honour, and experience of unstable social periods (UNICEF, 2005). Girls who marry before they are 18 are found to be less educated, have a higher total fertility rate (Adhikari, 2003) and are married to men who are significantly older (UNICEF, 2005). They are also more likely to believe that it is acceptable for men to beat their wives (UNICEF, 2005).

Early marriage can refer to both formal and informal union. Countries where the proportion of women married by the exact age of 18 is over 50 per cent include Cameroon, Uganda, Nepal, Mozambique, Central African Republic, Burkina Faso, Guinea, Bangladesh, Mali, Chad and Niger (Kelly and Regan, 2007). Identified incentives for perpetuating child marriages include parents ensuring their daughter’s financial security, parents ensuring their daughter’s virginity and chastity and the perception of marriage as a protective mechanism against pre-marital sexual activity, unintended pregnancies and sexually transmitted infections (Nour, 2006).

Health consequences of child marriage are wide ranging and can be severe. They include increased risk of domestic violence, increased mortality risk due to pregnancy-related causes, higher level of neonatal mortality, increased risk of infection with STIs, such as HIV, and an increased risk of cervical cancer. The children of those who experience child marriage also face a higher risk of both illness and death. Social consequences include lower literacy rates and fewer educational opportunities (Nour, 2006). Women who marry early also have a higher total fertility rate (Adhikari, 2003).
Table 5. Prevalence of Child Marriage

<table>
<thead>
<tr>
<th>Region</th>
<th>Country</th>
<th>Percentage of women aged 25-29 married by 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>Ethiopia</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Nigeria</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>Mozambique</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Cameroon</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Kenya</td>
<td>10%</td>
</tr>
<tr>
<td>Asia</td>
<td>Bangladesh</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>Nepal</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Indonesia</td>
<td>11%</td>
</tr>
<tr>
<td>Middle East</td>
<td>Egypt</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Turkey</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Morocco</td>
<td>5%</td>
</tr>
</tbody>
</table>


Minority ethnic women from particular countries of origin may be at risk of experiencing, or having experienced, early marriage. A Forced Marriage Unit in the UK intervenes with 300 cases of forced marriage every year (UN, 2006) but there is a noted paucity of research on this issue (UN, 2006).

2.4.3 Other Harmful Traditional Practices

Other forms of harmful traditional practices include, but are not limited to, so-called ‘honour crimes’, dowry related violence, practices of son preferences, and maltreatment of widows. Both the family and community may be involved in these forms of GBV (UN, 2006). So-called ‘honour crimes’ refer to the violence and, in some cases, murder inflicted on rape victims and women suspected of premarital sex, who are perceived to have dishonoured the family and/or husband (Kelly and Regan, 2007). Such crimes take place in countries in the Middle East and North Africa (UNIFEM, 2003). Some female homicide cases within minority ethnic groups in the UK have been related to so-called honour crimes (Humphries, 2007). Such killings have also taken place in the Netherlands, among the Turkish community there (Humphries, 2007; Sev’er and Yurdakul, 2001). According to the UNFPA, an estimated 5,000 women throughout the world are murdered by family members each year, in the name of ‘honour’.

Other forms of HTP include dowry violence, in which demands for dowry payments by a husband from his wife’s family can lead to violence against the wife and in some cases to her death. Practices of son preference include prenatal sex selection and female infanticide. There is no documented evidence of these forms of HTP taking place against among migrant communities in Ireland to date.

The final category of GBV considered in this review is that of trafficking for the purposes of sexual exploitation. This form of GBV is a global concern with devastating consequences for victims/survivors (Kelly and Regan, 2007).

2.5 Trafficking for the Purposes of Sexual Exploitation

Trafficking for the purposes of sexual exploitation is a growing phenomenon. Whereas in the 1990s sexual trafficking was believed to be largely concentrated in Asia, it has since become globalised (Kelly and Regan, 2007; Hodge and Lietz, 2007). Main regions of movement of trafficked women and children are Eastern Europe, industrialised nations and, to a lesser degree, the Commonwealth of Independent States (Hodge and Lietz, 2007). Exploitation tends to take place in wealthy countries (ibid.). However, trafficking does not necessarily entail the movement of victims across international borders: internal trafficking occurs at a significant and growing rate. Within regions, a similar trend has been identified, with the most vulnerable being victimised (Flowers, 2001).

Both supply and demand factors contribute to trafficking for sexual exploitation. At a demand level, the existence and growth of trans-national criminal networks, coupled with the high profit and low risk nature of sexual trafficking has been identified as the principal cause in the rapid growth in the field of trafficking for the purposes of sexual exploitation (Hodge and Lietz, 2007). Other identified demand factors have been located in the broader context of globalisation, and include the increase in single male workers leading to an increase in demand for commercial sex; migration leading to
marked differences in income levels within regions; increasing ease and frequency of international travel; growth in consumerism, which encourages the sale of women and children; weak law enforcement to penalise offenders; and male client preferences for younger women and children due to fear of HIV infection (UNIFEM 2002; Hodge and Lietz, 2007; Kelly and Regan, 2000). UNIFEM have also identified demand factors of male attitudes and perceptions of women in society and women’s unequal socio-economic status (2002).

Supply factors include the feminisation of both poverty and migration, inadequate educational and employment opportunities and a lack of awareness of legal rights (UNIFEM, 2002). All of these risk factors create further vulnerability in families where daughters are expected to financially contribute to the family (Hodge and Lietz, 2007). Economic and social disruption can force large numbers of people into prostitution, including refugees fleeing armed conflicts or natural disasters (Krug et al., 2002). Glamorous media images of the industrialised world can also act as a supply factor (Hodge and Lietz, 2007). In a European study of the health risks and consequences of trafficking, factors that were found to influence trafficked women’s decision to migrate included poverty, single parenthood, a history of interpersonal violence, and coming from a disrupted household (Zimmerman et al., 2003).

Trafficking women for the purposes of sexual exploitation takes place in a range of settings, involving a wide range of actors (UN, 2006). In a review of literature on the subject, Hodge and Lietz (2007) identified four main recruitment strategies for the sexual trafficking of women. One strategy involves apparently legitimate organisations, such as supposed employment and modelling agencies, making false promises of a better life in the industrialised world through employment opportunities. Another involves direct recruitment of healthy, non-drug dependent women engaged in prostitution in their country of origin, through promises of higher salaries in the destination country. Kidnapping is a less common strategy, but may occur to those who are approached but refuse, as well as unsuspecting individuals who have never been approached. The least common strategy is the purchasing of a girl or woman from a family or guardian who are living in poverty. The most vulnerable are often targeted, such as women with a disability, women with no literacy skills, and women from a rural background, with no experience of urban life.

Traffickers demand payment from victims for the costs of the journey, a process known as ‘debt-bondage’. When a woman arrives at the country of destination she is informed of her debt and her passport is often seized. Trafficked women are extremely isolated through culture, language and unawareness of rights and entitlements. Common explanatory factors within a wide and growing variety of nationalities among trafficking victims include traffickers seizing upon any targets of opportunity for exploitation and relying on vast distances and cultural and linguistic differences to increase the vulnerability of victims (US Department of State, 2007).

2.5.1 Consequences of Trafficking for Sexual Exploitation

Women who are trafficked for the purposes of sexual exploitation are the victims of extreme forms of violence against them, as traffickers use physical, sexual and psychological violence to control the woman, both during the transportation to the destination country, and their exploitation once there. In a study on the health consequences of trafficking, it was found that during the transit stage, women were faced with the risk of arrest, illness, injury during the journey as well as the risk of death from dangerous modes of transport, high-risk border crossings, and violence. Before starting work in a destination setting, nearly half of the 23 trafficked women interviewed for the research had been confined, raped, or beaten. It was also found that during the transit stage, women can experience trauma, triggering survival responses with symptoms of extreme anxiety, which can inhibit later memory and recall. Women interviewed rarely had access to health information or care while in transit (Zimmerman et al., 2003).

At the destination stage, interviewees reported broken bones, contusions, pain, loss of consciousness, headaches, high fevers, gastrointestinal problems, undiagnosed pelvic pain, complications from abortions, dermatological problems, unhealthy weight loss, and dental and oral health problems. Women were deprived of food, human contact, valued activities and items, and
held in solitary confinement. All women interviewed reported having been sexually abused and coerced into involuntary sexual acts, including rape, forced anal and oral sex, forced unprotected sex, and gang rape (Zimmerman et al, 2003). One study found that trafficked women for the purposes of sexual exploitation were forced to work up to 18 hours per day (Hodge and Lietz, 2007).

Psychological control tactics used by traffickers to manipulate women and create dependency included, intimidation and threats, lies and deception, emotional manipulation, and the imposition of unsafe and unpredictable events. Victims may be told they have committed a crime by coming to the destination country, and the safety of her family at home may be threatened if they do not conform to the demands of the trafficker (Hodge and Lietz, 2007). These tactics served to keep women intimidated, uncertain of their immediate and long-term future, and therefore obliged to obey the demands of the traffickers (Zimmerman et al, 2003).

In addition to this violence inflicted on them by traffickers, trafficked women also face the heightened risks of violence against them by their ‘clients’, which are faced by all women who are engaged in prostitution. Research on violence against women engaged in prostitution shows that women engaged in prostitution are highly vulnerable to both physical and sexual violence as well as verbal abuse from clients, pimps, club owners and law enforcement officers (Watts and Zimmerman, 2003; O’Connor and Healy, 2006). A qualitative-based, cross-country study of women who have been trafficked for the purposes of sexual exploitation identified a range of extreme injury experienced by interviewees, including head trauma, bone fractures, severe bruising and vaginal bleeding (Raymond et al, 2002). The risk of femicide has been found to be much higher for women engaged in prostitution: a mortality study in the US of 1,600 women engaged in prostitution found that murder accounted for 50 per cent of the deaths of women in prostitution (Farley, 2004, cited in O’Connor and Healy, 2006).

2.5.2 Prevalence of Trafficking for Sexual Exploitation

The vast majority of people who are trafficked throughout the world are women and children, and 80 per cent of people are trafficked for the purpose of sexual exploitation (UN, 2006). It is a phenomenon which has grown dramatically over the past ten years (Hodge and Lietz, 2007). Due to its hidden and illegal nature, trafficking in women for the purposes of sexual exploitation is “not amenable to traditional forms of data collection or social research” (Kelly and Regan, 2000: 5), and therefore estimating its prevalence is very difficult (Hodge and Lietz, 2007; Curtol et al, 2004). Though it is known that hundreds of thousands of women and children are trafficked globally each year, the number of victims of trafficking and traffickers that come to the attention of authorities is very low (UN, 2006). In a review of trafficking across Europe, the International Organization for Migration (IOM) concluded that it was “not possible with any level of accuracy to produce accurate estimates for trafficking in women” (cited in UN, 2006: 68). The International Labour Organisation (ILO) estimates that there is a total of 12.3 million people in forced labour or sexual exploitation globally. Minority ethnic women are at higher risk of trafficking (UNIFEM, 2002). Refugees and illegal immigrants have also been identified as being at particular risk (UNFPA, 2006).

In Ireland, strong evidence exists that women are being trafficked into the country for the purpose of sexual exploitation. A study concluded that a minimum of 76 cases of trafficking into Ireland for the purposes of sexual exploitation between 2000 and 2007 had been identified (Ward and Wylie, 2007). In 2007, the NGO Ruhama, an organisation working with women involved in prostitution, stated that since 2000, they had come into contact with up to 150 presumed victims of cross border trafficking into the sex industry and that they were aware of other trafficking victims through these contacts (2007). The US Trafficking in Persons Report identified Ireland as a potential destination country for women and girls trafficked trans-nationally from Eastern Europe, Africa, Latin America,

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8 Both human trafficking and people smuggling involve movements of people. However, a key distinction between the two distinct crime types is the purpose of the movement. For human traffickers, the purpose of moving people is the intended exploitation at destination. For people smugglers, the purpose of moving people is in furtherance of a contract with a migrant, to steal them across a national border. The intent ab initio is not to control the migrant, nor to extort or exploit, but to move the person (United Nations, 2003)
or Asia for the purposes of commercial sexual exploitation (US Department of State, 2007). A study on trafficking of unaccompanied minors provided 16 examples of one or more children on whom trafficking investigations were conducted by a state authority (Conroy, 2003). Of 23 children identified in this study, half were less than 12 years old.

 Trafficking for the purposes of sexual exploitation is most effectively challenged and eradicated through policy and legislation. This issue is explored in the next chapter, which is specifically concerned with policy and legislation regarding each form of GBV. The next section of this chapter is the final stage of the review of literature, and moves on to explore barriers faced by minority ethnic women in accessing required support regarding GBV and identifies good practice guidelines for services to address these barriers.

2.6 Accessing Support: Barriers and Good Practice Guidelines

This section focuses on research findings regarding the experience of minority ethnic women in seeking and accessing support for VAW. It outlines the informal support and coping mechanisms identified among minority ethnic women who have experienced GBV. It goes onto to identify barriers minority ethnic women face in accessing mainstream health and social services. The final section outlines several good practice principles, primarily for violence against women services, in responding to the needs of minority ethnic women with regard to domestic violence and other forms of GBV respectively.

2.6.1 Coping Strategies, Resilience and Survival

There is a paucity of research on the survival strategies and informal support mechanisms used by minority ethnic women who experience domestic violence. The limited literature that does exist on this subject clearly shows that minority ethnic communities can provide a range of support mechanisms for those who experience domestic violence. For many women, the importance of the family in many minority communities can mean strong informal support and can reduce the risk of isolation (Kasturirangan et al, 2004). Close ties with extended family members can also reduce the risk of poverty, acts as a childcare resource, and provider of emotional comfort (Kasturirangan et al, 2004; Fernandez, 2006). Older people can often act as monitors and inhibitors of abuse in societies where elders are granted respect and power within the family. Due to the importance of community in some minority ethnic groups, women also reach out to friends and, in some cases, religious leaders (Bui, 2003).

Cultural and religious practices and beliefs have been found to prevent GBV and to act as sources of comfort and support for victims/survivors (Sokoloff and Dupont, 2005; Dasgupta and Warrier, 1996; Kaufman et al, 1994). For example, shared values can provide a sense of connection to counter isolation (Kasturirangan, 2004). In minority communities that adopt a collectivist worldview, problems can be resolved through collaboration rather than conflict or confrontation (Midlarsky et al, 2006). A crime against one’s wife can be conceived as a crime against the community as a whole. Defying group norms can lead to a penalty of shame, which can inhibit perpetrators carrying out violent acts. Opportunities for creative expression, such as cultural celebration, preparation of food and art forms can also provide comfort and therapeutic release for women who have experienced GBV (Kasturirangan et al, 2004).

Finally, on an individual level, research literature has also identified a range of coping strategies employed by minority ethnic women who experience GBV (Morton, 1997). These include justifying their husband’s behaviour as an outcome of severe stress (Midlarsky et al, 2006), refusing to cook (Mehotra, 1999), secretly duplicating the house and car keys and keeping personal legal documentation in a secure place (Midlarsky et al, 2006).
2.6.2 Barriers to Accessing Support regarding Domestic Violence

Despite the serious consequences of domestic violence to women’s health and wellbeing, research literature from South America, the US and Canada shows that minority ethnic women who reported domestic violence were less likely to seek social services and legal redress than the rest of the population (UNFPA, 2006; Mason and Hyman, 2008). Reasons include language and cultural barriers, higher levels of social exclusion, economic disadvantage and discrimination. All of these factors are compounded by the intersectionality of gender and ethnicity, whereby minority ethnic women experience a ‘twofold discrimination’ based on their gender and ethnic origin (UNFPA, 2006). Among those who do seek help from services, available options are heavily impacted by the absence of interculturally competent services. This section explores these barriers in more detail. It is important to note that many of these barriers are experienced by all victims/survivors of domestic violence and are not limited to those of minority ethnic identity.

- ‘Cultural’ Barriers and Absence of Interculturally Competent Services

Cultural barriers that can emerge in these contexts include traditional meanings of marriage, the importance in communities of keeping a family together over the individual wellbeing of the mother, the unacceptability of divorce in some communities, acceptability of ‘fate’, and tolerance towards the abuser (Dasgupta, 1998). In particular, marriage and the notion of family honour have been found to have a significant effect on help seeking behaviour of minority ethnic women (Morton, 1997). In such cases, a sense of stigma and shame can act as a serious barrier. It is related to fear of disgracing family members, being perceived to fail in domestic responsibilities and letting down the community (Dasgupta, 1998). The perception within community that the divorced victim has hurt her children by removal of the father, or hurt her sisters by reducing their chances of marrying, further contributes to this barrier (Raj and Silverman, 2002; Kasturirangan et al, 2004).

These barriers are reflected in the responses minority ethnic women can experience in accessing support from family, friends and religious leaders. One qualitative study found that fear of shame and of the abuser prevented them from seeking support, even at this informal level (Bui, 2003). For those who did confide in someone from their community, some received practical support and encouragement to leave the relationship. Others, however, found that friends and family did not wish to intervene, perceiving domestic violence as a private matter (ibid.). In their review of research literature in the US, Raj and Silverman found that in turning to family or community members for help, victims all too often find the violence condoned, or are encouraged to place family and community first (2002).

Kasturirangan et al (2004) argue that typical services in a Western context are developed within a linear, or individualist context, that focus on helping the woman to leave the situation of abuse. This can lead to a lack of understanding of the needs of those who face additional barriers to leaving a violent relationship. For example, one US study found that domestic violence counsellors interpreted Native American women’s stories of experiences of and responses to domestic violence as signs of weakness, bad decision making, and dysfunction (Sokoloff and Dupont, 2005).

- Migration: Isolation and Restrictive Immigration and Social Welfare Policies

Many migrant women leave behind an extended network of female relatives and friends on whom they can rely for emotional support in their home country, finding themselves in a very isolated situation in the destination country (Midlarsky, 2006). For those who experience domestic violence, the perpetrator may be the only source of support for the woman experiencing abuse. Some may not have access to basic survival skills required to survive alone in the host country, such as language, driving, and even using facilities such as banks and public transportation (Dasgupta, 1998). For those who come from countries where domestic violence services do not exist, there is no reason to expect that such services exist in their destination country. In the absence of information on available services, women cannot access them (Sorenson, 1996; Lee, 2000). For some women, this issue is compounded by lack of information about their legal status and the fear that contact with any service could lead to deportation (Lee, 2000; Midlarsky et al, 2006). Financial dependence on the perpetrator poses another barrier. This has been described as “one of the most
paralyzing problems that battered immigrant women encounter when leaving their husband” (Dasgupta, 1998: 215).

Restrictive immigration laws have been described as a trap for immigrant women experiencing domestic violence in the US (Dasgupta, 1998), in Great Britain (Rai and Thiara, Morton, 1997; Batsleer, 2002; Southall Black Sisters, 2004), Australia and Canada (Fagan, 2008). In the US, a campaign by women activists resulted in an amendment to immigration law in 2000 to allow migrant women who have experienced domestic violence to secure legal status independently of their husband. In the UK, campaigns led to the Domestic Violence Concession or Rule, which provides for indefinite stay for migrant women who can provide evidence of domestic violence. Though welcomed, this development has been criticised for the quantity and nature of evidence required (Fagan, 2008). In Australia, the Domestic Violence Provision was also brought about by campaign work and allows for permanent residency to be afforded to those whose relationship has broken down as a result of domestic violence (Fagan, 2008). Immigration law in Sweden also permits immigrant women who are victims of domestic violence to attain a permanent residence permit (UNFPA, 2006).

Stringent welfare policy may also be described as a trap for migrant women experiencing domestic violence: by withholding welfare entitlements to immigrant women, those in relationships can be made economically dependent on their husband (Rai and Thiara, Morton, 1997; Batsleer, 2002; Southall Black Sisters, 2004; Burman et al, 2002). In the UK, it has been found that immigration and asylum legislation severely curtails their ability to leave a violent relationship, due to lack of recourse to necessary funds (Burman et al, 2002; South Black Sisters, 2004).

In Ireland, the Spouse Dependent Visa is provided to spouses of migrant workers. Most of the women who have this visa are not permitted the right to work and if they leave the relationship they lose the right to remain in the state and become undocumented. The Habitual Residency Condition limits access to social welfare payments to those who have been living in the country for two years or more. Both the Spouse Dependent Visa and Habitual Residency Condition have been identified as deepening the vulnerability of minority ethnic women who experience domestic violence (Migrants Rights Centre Ireland, 2006, Women’s Health Council, 2006).

- **Lack of Funding for Services**
  Under-funding of violence against women organisations in general has also been identified as a service barrier for minority ethnic women (Burman and Chantler, 2005). Stringent budgetary and social welfare policies outlined above can result in reduced income for refuges, particularly those which provide support for migrant women (Rai and Thiara, 1999).

- **The Criminal Justice System**
  Bui (2003) found that many minority ethnic women only report experiences of domestic violence to the police after years of abuse, and often only when they reach a crisis point. Some felt that the police did not want to help minority ethnic women. Others feared their husbands may receive harsh treatment from the police, due to racial discrimination, a perception also identified by Midlarsky et al (2006) and Sokoloff and Dupont (2005). Studies have also found that fears regarding immigration status acted as a disincentive to calling the police regarding GBV (Midlarsky et al, 2006; Sorenson, 1996). Focus group-based research conducted in Ireland with Traveller and immigrant women found that women from both groups felt a strong reluctance to seek help from the police, a factor that is further compounded for immigrant women by fears relating to their legal status and, for some, by the the risk of deportation (Watson and Parsons, 2005). These issues can be further exacerbated by a lack of knowledge of the role of the police and/or language barriers. Sorenson found that minority ethnic women only reported severe physical violence to the police (1996). This resulted in police records recording only extreme experiences of violence among minority ethnic women, giving the misleading impression those are the norm among the minority ethnic population. For various reasons, therefore, official police data can be biased. Sorenson recommends that community research on GBV should be conducted on an ongoing basis, with the aim of providing more accurate data on the issue (1996). These data could be used to contextualise official police, prosecutorial and judicial official records and responses.
When the police are called, intervention required often includes assistance in calming down the perpetrator, explaining the illegality of violence against women, and ordering the perpetrator from the home. In the US, many problems have been documented regarding this process, including increased use of force, and over reliance on incarceration of perpetrators (Sokoloff and Dupont, 2005). In some cases, police intervention can lead to unwarranted removal of children into social care and the prosecution of victims/survivors for being involved, even peripherally, in criminal conduct (ibid.).

- **Fear of Discrimination**
  An evaluation of refuges in three EU countries, including Ireland, which included data from 97 women in Irish refuges, one third of whom were Traveller women, identified very positive perceptions among Traveller women regarding the degree to which their needs were met by the refuge and the respect shown towards their ethnicity by service providers (NNWRSS, 2007). This finding is supported by the ongoing National Refuges Outcome Evaluation Research (NNWRSS, forthcoming).

Notwithstanding these positive findings, it is important to note that when minority ethnic communities are subject to racism from the majority ethnic group, this can cause a dual barrier (Morton, 1997; Rai and Thiara, 1999). Women fear rejection from their own community if they leave and cannot rely on external services for required support. Their options are confined to staying in a violent relationship, or leaving, with no hope of support.

Assumptions and expectations, particularly anxieties in mainstream services about engaging with cultural issues and fear of charges of racism, can have a significant impact on accessibility of domestic violence services for minority ethnic women (Burman *et al*., 2004). This compounds the already widespread ‘culture of privacy’ of many communities who do not wish to acknowledge the extent of domestic violence within their midst. The lack of visibility of the problem as well as a lack of awareness of existing services creates a double barrier for women wishing to access services.

### 2.6.3 Towards Principles of Best Practice for Service Delivery

Research literature presents some guiding principles to services for responding to the needs of minority ethnic women who experience GBV. These are: reflecting the community, developing cultural competence, acknowledging complexities, making prevention culturally relevant and promoting grassroots organising. A final section briefly outlines some specific evaluated good practice measures from the UK. Some of the literature included the role of health and social services and the criminal justice system and this is also outlined here in relevant subsections.

- **Reflecting the Community**
  In order to respond to the needs of minority ethnic women, services that provide support for victims/survivors of GBV must be interculturally congruent, reflecting awareness and understanding of cultural issues that may affect the abused woman’s situation. One approach is the provision of culture and language specific domestic violence service programmes targeting single immigrant populations (Raj and Silverman, 2002; Kasturirangan, 2004). In some situations however, this can be inappropriate and can even compromise the safety of victims/survivors. In the UK, it has been found that the whereabouts of refuges provided for women on a specific culture became known in the minority community, with the result that perpetrators could, and did, access the refuge. Services can take other steps to provide an interculturally competent service. They include the hiring of refuge staff who share the same background of clients (when feasible), employing bilingual staff members, and engaging in outreach work with minority populations.

The potential role of religious institutions has also been highlighted in preventing GBV, particularly in minority communities within which community or religious leaders play an important role (Sorenson, 1996; Fernandez, 2006). In the US, some violence against women activists have called on Black churches to take a stand on violence against women, by reinforcing the message that violence against women means going against religious principles (Sokoloff and Dupont, 2005).
Organisations that attempt to address such barriers face considerable challenges, one of which is concern within a minority ethnic community that dedicated service provision may create a negative impression of their culture within the general public. For example, Sokoloff and Dupont (2005) describe how this resulted in the closure of a hotline established to respond specifically to Korean women who have experienced GBV. In order to avoid this, work in this area should involve close collaboration with minority groups. Raj and Silverman (2002) recommend the collaboration of violence against women services with community, culturally based services with a view to sharing information and increasing understanding on both sides.

### Developing Intercultural Competence

In providing an interculturally competent service, a distinction must be made between culture, “the positive transmission of rituals, celebrations and stories” (Midlarsky, 2006: 297) and human rights violations such as GBV. All cultures have both negative and positive aspects to them and GBV occurs in every culture in the world. Cultural relativism cannot be used to justify practices that negatively impact on women’s health and wellbeing, even if this means questioning tradition (Meleis, 2003).

Rai and Thiara (1999) found that the most important factor in refuge service delivery for Black women was sensitivity in meeting needs. Interviewees felt more comfortable and less isolated when they stayed in refuges where other Black women were staying, and felt that specialist refuges were better able to understand specific culturally-related problems and provide appropriate support. According to Fernandez, interculturally informed domestic violence strategies and interventions call for a “sensitive assessment, development and delivery of services that will be experienced as beneficial and viable by [all] the female victims” (2006: 255). She goes on to advocate a cultural cost-benefit analysis to this end, citing this as an “integral component in the development of domestic violence research and interventions” (2006: 255).

Mainstream/generic violence against women services can, with appropriate staff training, resources and service planning, provide an effective and accessible source of support for minority ethnic women who experience GBV (Kasturirangan et al, 2002). In order to facilitate intercultural competence, cross-training should be provided for staff of minority ethnic organisations and staff of violence against women organisations, by each other. Formal plans should be developed for the collaboration between the two fields, to best serve the needs of minority ethnic women. This could involve the collaborative development of outreach and education strategies, ensuring shared access to translators trained in domestic violence, and the development of protocols and materials to provide culturally tailored services (Midlarsky et al, 2006).

Practical implications of developing interculturally competent services should follow from appropriate staff training, and are wide ranging. They include taking into account cultural requirements of clients and facilitating dietary and cooking needs (Sorenson, 1996). Shelters, help-lines and other relevant services need to be provided in languages spoken by those who need assistance (Sorenson, 1996; Kasturirangan, 2004). Staff should be provided with appropriate training regarding the cultural backgrounds and requirements of clients (Kasturirangan, 2004). Acceptable terminology should be used when working with clients, for example, in some cases it may be necessary to refrain from using terms such as ‘rape’, which may shock the client, thus deterring them from seeking help (Midlarsky et al, 2006; Raj and Silverman, 2002).

Ensuring the delivery of an interculturally congruent service may involve taking account of differing world views. For example, services should reflect understanding of varying perceptions of womanhood, by taking into account how they affect women’s sense of autonomy, perception of them in their own communities, self-concept, as well as ability to assume an independent role (Fernandez, 2006). According to Midlarsky et al (2006), Western style interventions assume individualistic constructs, which can conflict with collectivist values, such as ‘family first’ and ‘loss of face’. Models designed for women to leave the perpetrator may not be appropriate for some minority ethnic women. A paradigm shift in service delivery could allow service providers to work towards women being safe in their own home, rather than requiring them to leave in order to be helped. Ensuring effective translation therefore goes beyond the issue of language. It also
requires understanding of different cultural values, such as mores about childcare, dating, marriage, insider and outsider relationships, and factors that can compel women to tolerate abuse. It requires service providers to understand the influential role of community/religious leaders in some minority ethnic groups and to respect the reasons why some women feel compelled to stay silent about the abuse they experience. It should also involve exploration of interculturally appropriate means of preventing and combating GBV. For example, public shaming and ostracisation of the perpetrator has been identified as a useful means of preventing and combating domestic violence among Native American and other minority ethnic communities in the US (Sokoloff and Dupont, 2005; Fernandez, 2006).

### Acknowledging Complexities

Sokoloff and Dupont (2005) recommend that the theoretical framework from which services are developed also need to adapt to acknowledge intersectionality: interculturally competent services should reflect mindfulness not only of cultural issues, but also of underlying intersectional ones of poverty, isolation, racism and sexism. These issues affect the reality of many minority ethnic women’s daily life, and compound and exacerbate experiences of GBV. This approach acknowledges the combined effect of constructions of culture, racism, class and gendered inequality on maintaining women in violent relationships (Burman and Chantler, 2005). It is also informed by the fact that for many minority ethnic women, leaving a violent relationship does not necessarily guarantee safety (ibid.). Within this approach, it is recognised as paramount that relevant support should connect anti-racist with gender-sensitive practice (Burman and Chantler, 2005). Service response should acknowledge victimisation and agency among all women who experience GBV, while simultaneously reflect awareness of how such experiences may differ, “depending on social and historical circumstances” (Sokoloff and Dupont, 2005: 55).

Burman et al (2004) found that many steps can be taken to improve the accessibility of services through addressing the organisational principle of ‘cultural privacy’ that has developed in violence against women organisations. They found that traditional/generic community organisations both operating from gender-sensitive and anti-racist approach, can and should be improved, and can play an important role in helping women. They recommend a range of distinct but coordinated responses, including campaigning against unfair immigration practices, to improved funding and support for violence against women and minority organisations. They also recommend that legal and mental health strategies are required, in order to address the complex interaction between policy, service planning and delivery with racism, class and gender inequality, so that more sensitive and accessible ways of providing support for minority ethnic women are developed.

At a practical level, Burman and Chantler recommend interventions such as the provision of affordable childcare; a flexible, humane welfare policy; affordable alternative housing; employment practices recognising religious and cultural commitments, as well as measures to tackle racism and sexism in the workplace. They also recommend that both lawyers and mental health workers should contribute to service development, “as key professionals engaged in working at the borders of public and private space of relationships and service intervention” (2005: 69).

Sokoloff and Dupont (2005) also recommend a multi-disciplinary approach in addressing the needs of minority ethnic women who experience GBV, which acknowledges multiple concerns and facilitates the woman to prioritise her service needs. To do this, services should be accompanied by meaningful material resources to be made available to the poorest and most disadvantaged, so that they can leave/change their situation. Immediate availability of safety without threat of losing their children, along with prolonged support can lessen the propensity of domestic violence for minority ethnic women (Fernandez, 2006). Fernandez also points to the need for the incorporation of personal safeguards for victims before initiating investigations and programme implementation (2006).

A number of models of good practice exist that reflect the multi-disciplinary approach. One model that is being replicated in many countries in Asia, as well as other countries, is the one stop shop model for victims/survivors of violence against women (UN, 2006). In a centre based on this model, a client is firstly examined and treated by a doctor. She is then seen by counsellor within a
24 hour period. Emergency shelter is then arranged. If a woman chooses to return to her home, she is encouraged to return to see a social worker. She is informed of her rights and entitlements and is encouraged to make a police report. Each centre includes a police unit for this purpose. With severe injury, police see the patient while in hospital to record a statement and commence investigations.

- **Making Prevention Culturally Relevant**
  Kasturirangan *et al* argue that prevention messages should be conveyed with “cultural authenticity” (2004: 328). This issue includes the provision of information in relevant languages. However, it also extends to the meaning and effectiveness of preventive messages within each community. Community education is recommended as an effective means of prevention (Raj and Silverman, 2002; Midlarsky *et al*, 2006). This training should also be used to spread awareness of available resources and educate women on their legal rights and service entitlements.

  Raj and Silverman also recommend the provision of training for minority ethnic organisations which will then be in a position to develop outreach programmes to the community they represent, noting that receptivity to prevention messages may improve if it is brought by members of that community (2002). Community elders and/or religious leaders should be facilitated and encouraged to play a lead role in disseminating prevention messages (Kasturirangan *et al*, 2004).

- **Grassroots Organising**
  Local grassroots organisations can provide an important source of support. In order to promote grassroots consciousness, Kasturirangan points to the potential role of “organised grassroots resistance against violence” (2004: 325), whereby women from minority ethnic groups are facilitated to develop their own responses and solutions to these issues.

  Sokoloff and Dupont (2005) identify the North Gottingen Drop-In Centre Halifax, Nova Scotia as a model of good practice. Here, female victims/survivors of domestic violence created an informal support group, from which emerged a cooperative catering business. With the funds raised by this process, the members were able to provide practical, as well as emotional support for each other. The reduction in economic inequality which it caused also played a preventive role in further experiences of domestic violence.

  Fernandez (2006) recommends the establishment of coalitions for women, citing Campbell who found that in cultures where the coalition of women is supported and there is a diminished expectation for males to establish their position with male peers, a reduction in the male/female aggression patterns has been found.

  Finally, a grassroots approach to the development of outreach services is recommended as a means of providing an effective model for reaching women who cannot access mainstream services, often including those who are most vulnerable. Firstly, this approach involves the identification of where women gather. Focus groups are suggested as a useful approach for uncovering how a particular problem is defined within a community. An important principle for this model is to give control to the community in terms of identifying problems and solutions.

### 2.6.4 Some Good Practice Measures

A 2005 study by the Home Office in the UK, based on the evaluation of several relevant initiatives throughout the country, identified a range of specific means by which services for victims/survivors of domestic violence can respond to the needs of Black and minority ethnic women. These measures are grounded in the principles raised in section 2.6.3 above and their implementation would significantly enhance the intercultural competence of services in this field.
In terms of improving accessibility, identified positive measures included:

- Advertising in different languages to avoid exclusion of some women; use of pictorial information;
- Providing information on discreet cards can enable women to carry them easily and maintain privacy;
- Tailoring, person-centred services and responses to individual women, rather than a blanket response to all;
- Use of creative ideas that make the client feel special;
- Re-housing, when possible, should happen in less isolated areas. For example, a Muslim woman may appreciate being housed in an area with access to halal food and mosques.

In relation to provision of advocacy and support, measures included:

- A tailored, proactive and intensive approach: in-depth work was found to lead to the woman feeling greater satisfaction regarding the progress of her case. This also led to a greater likelihood of reporting incidents to the police and to pursue legal remedies. It also reduced feelings of isolation and bolstered emotional support.
- Relationship built on trust and empathy: workers who had built a relationship of trust and who showed empathy towards the woman’s situation were more likely to help her to pursue her case to the end, be it legal or situational.
- Understanding agencies’ structures, ways of working and developing close working links with key agencies. This involves working with, rather than resisting other relevant agencies and services leading to greater cooperation from statutory agencies and a positive outcome for clients’ cases. Services that took this approach were also found to be better able to persuade and challenge other agencies to respond to the best interests of the woman.

2.6.5 Service Need regarding Other Forms of GBV

- **Multiple Traumatic Events**
  Women who have escaped conflict in their country of origin usually arrive in the destination country as programme refugees or asylum seekers. Often these women have survived multiple traumatic events, which can include forced migration, captivity by rebels, conflict-based rape, separation from family members including children, torture, wrongful incarceration and sexual violence in prison. Some may also have past or ongoing experience of domestic violence. Women and girls who experienced sexual violence during conflict are highly vulnerable to further exploitation in post-conflict settings (Ward and Marsh, 2006).

  For these women, post-traumatic stress disorder is a significant consequence of these experiences (White et al, 2002). Survival of more than one traumatic event leads to more than one service need. In these cases, a multi-sectoral response has been strongly advocated (Ward and Marsh, 2006; UN, 2006). This should involve “holistic inter-organizational and inter-agency efforts across the health, social services, legal and security sectors” (ibid.: 15). This approach should involve inter-disciplinary cooperation, collaboration and coordination across sectors. The particular importance of psychosocial support has been stressed (IRIN, 2004). It should include access to safe abortion and counselling, as well as provide shelter, provision of basic necessities, community services and education (UN, 2006).

  Care should extend to providing appropriate housing, training and employment opportunities, and facilitating ongoing communication with health and social service providers (Pumariëga et al, 2005). Throughout this process, the victim/survivor should have a central role in prioritising needs and service responses.

- **Female Genital Mutilation**
  In a review of healthcare in Europe for women who have survived FGM, a number of recommendations for best practice were made regarding healthcare and other relevant service providers (Leye et al, 2005). Women should have direct access to appropriate clinical care as well as culturally sensitive counselling. It found that affected women can be deterred from contact with
services that are unable to provide appropriate and sensitive treatment. Because of this, this study concluded it was of paramount importance to assess the health seeking behaviour of these women and their needs regarding FGM. Relevant protocols and guidelines need to be developed on the delivery of antenatal, delivery and postpartum care to relevant healthcare providers, as well as the performance of gynaecological examinations for the different types of FGM.

Regarding those who provide counselling services, guidelines and information need to be provided regarding deinfibulation9, reversal operations, caesarean sections, prevention of FGM in newborn girls and successful communication strategies. Guidelines should also be available for all health care professionals regarding referrals when they do not have the adequate skills or time to give appropriate care for a woman with health problems due to FGM, or where to report or refer a girl at risk. Finally, this review cites the need for assessment of the training needs of healthcare professionals. Training should deal with clinical care, the prevention of FGM, counselling, communication and attitudes (e.g. open communication skills), and ethical issues, such as medicalisation. It also recommends that FGM should be included in the required course work of medical students, nurses, and midwives. On a national level, it recommends that such guidelines should be established through an interagency approach, which should include the participation of representatives of affected communities (Leye et al, 2005). All of these recommendations are supported by the WHC in their 2007 report on FGM.

- **Forced Marriage**
  The UK Foreign and Commonwealth Office have identified the following warning signs that may indicate the possibility of an impending forced marriage:
  - Extended absence from school/college, truancy, drop in performance, low motivation, excessive parental restriction and control of movements and history of siblings leaving education to marry early
  - Poor attendance in the workplace, poor performance, parental control of income and limited career choices
  - Evidence of self-harm, treatment for depression, attempted suicide, social isolation, eating disorders or substance abuse
  - Evidence of family disputes/conflict, domestic violence/abuse or running away from home (UK Foreign and Commonwealth Office, 2008).

  The Office stresses the importance of interagency working in relation to this issue and have published detailed guidelines for police, social workers, healthcare workers and education providers (ibid.).

- **Trafficking for the Purposes of Sexual Exploitation**
  A US study that sought the perspective of trafficking survivors made a number of recommendations regarding good practice in early intervention strategies which emphasised the important role to be played by healthcare providers (Family Violence Prevention Fund, 2005). The following required steps were identified:
  - Education for healthcare providers about the prevalence and dynamics of trafficking, how to effectively assess and intervene on behalf of trafficked victims;
  - Training for healthcare providers on screening and identifying patients, and cultural sensitivity;
  - Protocols should be developed for healthcare providers to assure the safety of the victim;
  - Further research should be carried out on healthcare as a point of early intervention for trafficking victims.

  This study also drew attention to the need for outreach work with trafficking victims. This includes the provision of outreach and education programmes that reach trafficking victims at all stages. This should involve information on rights and entitlements, education on leaving and ongoing services afterwards and peer-to-peer outreach programmes.

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9 Deinfibulation (or defibulation) opens up the scar tissue to restore the normal vaginal opening. It is commonly called “reversal” although this wrongly implies that the procedure can be undone and tissue replaced (FGM National Clinical Group, UK).
Finally, this study identified the need for dedicated funding for healthcare and other relevant services in enabling victims to leave the trafficking situation and to access appropriate services after they have left.

2.7 Key Points

- GBV is a human rights infringement and public health concern that affects women of all cultures, socio-economic statuses and nationalities. It is a manifestation of gender inequality and serves to maintain an unequal balance of power.

- The ecological framework for understanding GBV has been adopted by the World Health Organization. This approach conceptualises GBV as a multifaceted phenomenon grounded in an interplay of personal, situational, and socio-cultural factors.

- GBV is a manifestation of patriarchy. Patriarchy exists in every culture in the world but patriarchy itself is not culture. Some cultural contexts are more patriarchal than others. Women living in these contexts face a higher risk of GBV.

- A relationship exists between migration and social isolation. This can be exploited by a perpetrator to further isolate the victim/survivor from potential sources of support.

- A relationship exists between poverty and domestic violence. Both migrant and indigenous minority ethnic women face a higher risk of poverty than the rest of the population.

- Restrictive immigration laws have been identified as a trap for immigrant women experiencing domestic violence. In response to this issue, many countries have adapted existing immigration law to allow residency for victims/survivors of domestic violence.

- Approximately 80 per cent of all refugees are women and children, who face a high risk of GBV at all stages of the refugee cycle. Those fleeing conflict are vulnerable to conflict-based rape. During the migration journey, and while staying in refugee camps, migrant women and girls face the risk of sexual assault.

- Approximately 2 million women and girls every year are at risk of FGM. To date, there is no documented evidence of FGM taking place in Ireland. Victims/survivors of FGM need services that can provide appropriate and sensitive treatment. Guidelines should be established at national level through an interagency approach to address these issues.

- The vast majority of people who are trafficked throughout the world are women and children, and 80 per cent of people are trafficked for the purposes of sexual exploitation. A study conducted in 2007 concluded that 76 was the probable minimum number of cases of trafficking into Ireland for the purposes of sexual exploitation between 2000 and 2007. Estimates by the organisation Ruhama are even higher, suggesting there are over 150 victims/survivors for the same time period.

- Minority ethnic women display great resilience in surviving GBV. Research also points to a range of supports within minority ethnic communities for victims/survivors of GBV. These include strong family and community support networks, the monitoring role that can be afforded to older people, and the use of penalties against those who defy group norms, such as ostracisation.

- The health consequences of GBV are wide-ranging and severe. A limited body of research suggests that the psychological consequences of GBV can be more severe than the physical ones for minority ethnic women.

- Minority ethnic women can face particular barriers to accessing support. Traditional gender roles in marriage, the importance of keeping a family together, the unacceptability of divorce in some communities, acceptability of fate all act as barriers, as does the stigma and shame accompanied with leaving a violent relationship.

- Fear that the perpetrator may be arrested, or fears relating to immigration status and lack of trust in the police can all act as deterrents to seeking support from the police for minority ethnic women.

- For those who have survived multiple traumatic events, a multi-sectoral response is required, involving inter-disciplinary collaboration and coordination across sectors.

- Mainstream healthcare providers have been identified as an important point of intervention for victims/survivors of trafficking for sexual exploitation. The valuable role of outreach work in reaching trafficking victims has also been identified.
3 Policy and Legislation: Towards a Human Rights Approach

3.1 International Developments: GBV as a Human Rights Issue

Gender-based violence (GBV) is recognised as the most pervasive human rights violation in the world (Bond and Phillips, 2001; Burch 1990). In 1992, the Committee on the Elimination of Discrimination against Women asserted that violence against women constituted a form of gender-based discrimination. This statement marked a key stage in the process of violence against women being recognised as a human rights abuse (UN, 2006). In 1993, the World Conference on Human Rights in Vienna “saw a global mobilization to reaffirm women’s rights as human rights” (UN, 2006: 15). Later in the same year, the Declaration on the Elimination of Violence against Women was passed, which described violence against women as “a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women” (UN, 1993). The process culminated in 1995, when recognition of GBV as a threat to women’s health and human rights was fully formalised in the Platform for Action of the 1995 United Nations’ Beijing World Conference on Women (UN, 2006). 189 governments signed this platform, including Ireland. It explicitly recognises that violence against women creates an obstacle to the achievement of the objectives of equality, development, and peace at the national level and violates the human rights of women at the individual level (UN, 1995a).

Many commentators have highlighted the value of adopting a human rights approach to combating GBV, both in international treaties and in national policy (Kelly and Regan, 2007). The UN Report on Violence Against Women (2006) identifies the following advantages to this approach:

- It clarifies binding obligations on States to prevent, eradicate and punish such violence and their accountability if they fail to comply with these obligations;
- It provides a “unifying set of norms that can be used to hold States accountable for adhering to their obligations, to monitor progress and to promote coordination and consistency”. In doing so, it empowers women as active rights-holders and enhances the participation of other advocates;
- It has enabled human rights discourse and practice to become more inclusive by encompassing the experiences of women;
- Rather than precluding other approaches to the issue, such as health, the human rights approach encourages a “holistic and multi-sectoral response that adds a human rights dimension to work in all sectors” (UN, 2006: 18).

The human rights approach has also provided a useful framework in countering cultural relativist arguments that seek to protect forms of violence against women as justifiable on the grounds of culture or religion (Bond and Phillips, 2001; Principe, 2004; Heise et al, 1999; Maris and Saharso, 2001). For some, this has signified a tension between human rights and policies promoting multiculturalism.

3.2 Multiculturalism and Women’s Human Rights: A ‘Likelihood of Tension’?

Over the past decade, a debate has surrounded the relationship between culture and violence against women, with some commentators perceiving conflicting interests between certain cultural values and women’s human rights. Susan Moller Okin’s 1999 article entitled Is Multiculturalism Bad for Women? articulates this point of view. Here, she proposes that feminism and multiculturalism, rather than being ”both good things which are easily reconciled”, are concepts with “a considerable likelihood of tension between them” (Okin, 1999: 2). Regarding multiculturalism, Okin is referring specifically to the idea of group rights for minority cultures. She perceives culture and gender inequality as inseparable, as “most cultures have as one of their principal aims the control of women by men” (ibid: 4). Calling attention to several harmful traditional practices, such as FGM and forced marriages, Okin argues that “Western liberal cultures” have come closer to equality between the sexes than other cultures. According to her, “many of the cultural minorities that claim group rights are more patriarchal than the surrounding cultures” (ibid: 5). For this reason,
national policy promoting group specific rights for minority ethnic communities could lead to increased risk of GBV among minority ethnic women.

Others have rejected this perceived irreconcilability between multiculturalism and the protection of women’s human rights. Narayan (1997) criticises the perception of culture as relating to separate ‘packages’ which are “sealed off from each other, possessing sharply defined edges and contours, and having distinctive contents that differ from those of other ‘cultural packages’” (cited in Langvasbraten, 2008: 36). Phillips (2005) argues that as both gender equality and multiculturalism are concerned with achieving equality for those who suffer discrimination, they are of mutual interest. Langvasbraten points out that rather than being an ‘abstract ideal’, equality is “in common with other norms concerning gender, deeply embedded in culture both in majorities and minorities” (2008: 36). She argues that claims such as Okin’s are over-stated, and that when conflicts between gender and culture do arise, “they should be addressed and balanced in the concrete situations in which they appear” (ibid: 36).

Commentators have also questioned the way in which incidences of GBV among minority communities are framed in the West. Narayan draws attention to the way in which dowry murders in the US are perceived as ‘Indian-specific’ phenomenon, while domestic violence murders in the US are not perceived as a result of ‘American culture’ (1997). Langvasbraten, in her analysis of gender equality policies in Denmark, also criticises a perception of the ethnic majority of themselves as a “non-ethnic, neutral category” (2008: 43). Dasgupta points to the ways in which different cultures empower women, and asks why it is that “beliefs and customs that oppress women gain recognition as ‘culture’ in society and the aspects that enable women are doomed to obscurity” (1998: 217). Such tendencies contribute to the perception that GBV is synonymous with minority cultures and that minority ethnic women are victims of their culture.

Noting that “the ways in which culture shapes violence against women are as varied as culture itself” (2006: 31), the UN emphasise the dangers associated with narrow conceptions of what constitutes ‘culture’ when seeking to understand this complex relationship (ibid: 30). It argues that culture is most usefully viewed as a ‘shifting set of discourses, power relations and social, economic and political processes, rather than as a fixed set of beliefs and practices’ (ibid: 31). In a similar vein, broad and fixed classifications of ethnicity have been criticised for causing racialisation, through overemphasis on homogeneity and failure to reflect the variety of identities that can exist both across different ethnic groups and within one ethnicity (Bradby, 2003; Watt and McGaughey, 2006). Rather than being an isolated entity then, ‘definitive and timeless’ (Karlsen and Nazroo, 2006), culture is dynamic, changeable and moving (Bolaffi et al, 2003), located within a specific historic and spatial position (Karlsen and Nazroo, 2006). This interpretation of culture clarifies the limitations of Okin’s argument, which depends on a sharp delineation between ‘Western liberal cultures’ versus ‘other cultures’.

This is not to deny the relationship between patriarchal values and GBV. Nor is it to deny the fact that some cultural settings are more patriarchal than others. As noted in the review of literature, the biggest multi-country survey on GBV conducted by the WHO (Garcia-Moreno, 2005) found that those settings in which patriarchal values were upheld had significantly higher levels of GBV. However, patriarchy is not culture. Rather, it is a feature of society common to all cultures and periods of time, reflected in facts such as FGM occurring in nineteenth century Britain and intimate partner violence, the most common form of GBV, occurring within every culture in the world. An important issue in policy development on GBV in a multicultural setting, therefore, is to reflect cognisance of the different ways in which culture, including that of the majority ethnic group, impacts on the manifestation of patriarchy and GBV. Equally important is the recognition of all cases of GBV as an intolerable infringement on women’s human rights. In the US, the concept of multiculturalism has been successfully used to defend acts of GBV, including femicide, in courts of law (Dasgupta, 1998). This has resulted in the perpetrator being given significantly reduced sentences or being acquitted, because of judgments that he had “probably acted in accordance with his cultural beliefs” (Dasgupta, 1998: 209). Such judgements are based on the misconception that GBV is an inseparable aspect of certain cultures and represent a failure to uphold the human rights of victims/survivors.
Developing an interculturally competent policy on GBV is not without challenges. Langvasbraten’s analysis of relevant policies in Nordic countries shows that even in settings with a strong commitment to gender equality, difficulties can emerge (2008). In Sweden, the concept of ‘gender-based power structure’ whereby women are subordinate to men due to structural reproduction of gendered hierarchies, underpins gender equality and GBV policy. This concept is applied to all forms of GBV and to all ethnicities in Sweden. As noted in a Private Bill submitted, the Swedish Left Party ‘denies the fruitfulness of any culture oriented focus on violence against women … as it constructs illegitimate boundaries between … native Swedes and people with foreign backgrounds” (Langvasbraten, 2008: 40).

Conversely in Norway, increasing, if ad hoc, attention has been placed on minority ethnic women, specifically in relation to harmful traditional practices. Rather than integrate multicultural issues into mainstream gender equality or VAW policy documents, separate programmes regarding FGM and forced marriages were developed. The problem with this approach is that “the only gendered ‘multicultural problems’ worth public attention and governmental policy initiatives” (ibid: 44) were culturally specific forms of GBV. This can have a stigmatising effect on minority populations while simultaneously excluding these issues from mainstream policy development. Regarding Denmark, Langvasbraten criticises national policy for marking gender equality as a ‘Danish’ value, one not presumed to be found in minority ethnic cultures. This approach is likened to Narayan’s ‘cultural package’ critique, with the ‘cultural package’ of Denmark positioned in contrast to other cultures. Langvasbraten concludes that an interculturally sensitive gender equality policy should include all women, regardless of ethnicity (2008). It should address the specific problems and challenges of minority groups without generalising or stigmatising those cultures. In addition, the UN emphasises the importance of women’s agency in challenging oppressive cultural norms and articulating cultural values that respect their human rights (2006).

### 3.3 Integration Policy in Ireland

Recent developments at government level reflect a commitment to ensuring that policy and service planning are interculturally competent. Though relevant policy documents do not consider the issue of GBV specifically, if implemented their actions will play an important role in addressing risk factors and increasing the accessibility of relevant services for victims/survivors. They include the National Action Plan on Racism (NAPR) developed by the Department of Justice, Equality and Law Reform in 2005, the National Intercultural Health Strategy 2007-2012 (NIHS) published by the HSE in February 2008, and Migration Nation, the ‘statement on integration strategy and diversity management’ published by the relatively new Office of the Minister for Integration, in May 2008.

The aim of the NPAR is “to provide strategic direction to combat racism and to develop a more inclusive, intercultural society in Ireland based on a commitment to inclusion by design, not as an add-on or afterthought and based on policies that promote interaction, equality of opportunity, understanding and respect” (Department of Justice, Equality, and Law Reform, 2005: 27). Its second objective, Inclusion, addresses economic inclusion and equality of opportunity for minority ethnic groups (ibid: 31). Its third objective, Provision, is concerned with accommodating cultural diversity in service provision. Action 3.5 under this is to develop targeted initiatives focusing on access to key public services for Travellers, refugees and migrants. The NPAR was also a key driver of the National Intercultural Health Strategy 2007-2012 which set out a range of actions regarding improving accessibility of services and developing an interculturally competent health service, including those relating specifically to women.

As already mentioned, Migration Nation, the government’s national policy on integration, was published in May 2008 and it is “based on equality principles and taking a revised and broader view of social inclusion which builds on the experience of other countries” (Office of the Minister for Integration, 2008: 65). The Office of the Minister for Integration, in charge of delivering the policy, is also due to “support the services offered by ethnic-led non-Governmental organisations working with the immigrant community, in particular those that provide for the educational, cultural and linguistic needs of migrant workers” (ibid.: 65). This latter role is particularly relevant to
empowering minority ethnic women and helping those who are victims/survivors of GBV to access support. However, both Travellers and those seeking asylum are excluded from the remit of the Office. Certain policies and strategies are more directly related to the issue of GBV and the experiences of minority ethnic women regarding this. They are the focus of the next section.

3.4 Interculturalism and GBV Policy in Ireland


The *Report of the Task Force* (1997) calls for the establishment of a national, integrated strategy on violence against women, which would be based upon the following two principles:

- A total acceptance that violence against women is wrong, that it is a criminal offence and that there is no acceptable or tolerable level of violence;
- Neither society nor the judicial system should ever regard violence inflicted on a woman by a man she knows as being less serious than violence inflicted by stranger.

The *Report of the Task Force* (1997) does address some of the particular service needs of Traveller and other minority women, regarding GBV. While no reference is made in these policy documents to harmful traditional practices, such as FGM and forced marriages, or to trafficking, required measures are identified regarding service delivery for victims/survivors of domestic violence. Actions concern staff training on intercultural issues, as well as the training of women from all marginalised groups to deliver culturally appropriate responses within their own communities. Another relates to the training and employment of Traveller women within existing crisis and emergency services, especially refuges. These actions, which have not been implemented, would play an important role in increasing minority ethnic women's agency in this field. In addition, the *National Women’s Strategy* addresses the issue of trafficking and identifies a range of actions in this field. These are considered in section five on trafficking, below.

None of the above documents provides a conceptual framework of GBV to underpin policies, such as the ‘gender-based power structure’ informing policy in Sweden. Moreover, the only reference made to the relationship between GBV and culture is made in the section of the National Women’s Strategy that is concerned with GBV in overseas settings (Government of Ireland, 2007). In a section entitled, ‘Gender-based Violence in Conflict, Post-Conflict and Development’, the following quote is drawn from the White Paper (2006) on Irish Aid overseas:

“Promoting gender equality is about helping women to realise their human rights. These rights are set out in the Universal Declaration on Human Rights and other international human rights instruments. There is no valid exemption from the basic principles enshrined in those instruments through special provisions based on national, cultural or religious considerations” (Government of Ireland, 2007:105).

This statement implies endorsement of the human rights approach to combating GBV. However, culture is identified therein as being in potential conflict with human rights and gender equality, bringing to mind Phillip’s cautioning against the tendency to perceive gender equality and multiculturalism as “two distinctly different projects in eternal conflict” (quoted in Langvasbraten, 2008: 36) based on the misperception that equality is a cultural feature of ‘liberal’ cultures.

In terms of existing national policy on GBV, the relationship between culture and GBV has not yet been addressed. However, the fact that this research has been supported by Cosc, the National Office for the Prevention of Domestic, Sexual and Gender-based Violence, does reflect a commitment to attend to this issue on a national level. The national strategy on domestic, sexual, and gender-based violence currently being developed by Cosc presents an ideal opportunity to
provide a conceptual framework of GBV to underpin policies, and to develop an interculturally competent strategy on this issue.

- **GBV in Minority Ethnic Policy Documents**
  The *Traveller Health Strategy 2002-2005* identified specific barriers to accessing support faced by Traveller women who experience domestic violence, namely discrimination in services and absence of interculturally appropriate service provision, literacy issues, and the often conflicting relationship between the Gardaí and the Traveller community. Actions laid out in this strategy include ensuring access and improving intercultural competence of women’s refuges for Travellers; representation of Traveller women on national and regional VAW committees; provision of support for Traveller organisations promoting special initiatives regarding VAW; support for VAW initiatives working with Traveller men, and funding for Traveller organisations to train and employ Traveller women as refuge workers and counsellors.

  The 1995 *Report of the Irish Traveller Task Force* also refers to the issue of violence against Traveller women. It states that institutionalised violence towards Traveller women requires detailed examination and responses. It also notes that culturally appropriate ways to support Traveller women who experience violence within their community, and to respond to the issue of male violence, need to be worked on with Traveller women.

  The *HSE Intercultural Health Strategy 2007-2012* (2008) also refers to the specific vulnerabilities and risk factors faced by minority ethnic women regarding GBV. These include disruption of gender roles for immigrant women, stigma surrounding GBV, legal restrictions, increased risk of poverty, isolation and absence of extended family support (HSE, 2007). However, as with existing GBV policy documents, this does not consider the relationship between GBV and culture. Nor does it make recommendations concerning GBV and minority ethnic women. Finally, in the *National Action Plan on Racism*, measure 5.3.4 cites the development of an intercultural approach to the services provided to women and children from cultural and ethnic minorities experiencing domestic violence as an example of good practice (2005).

  An equally important factor in national policy is cognisance of how GBV intersects with other factors, such as socio-economic status, experience of poverty and social exclusion and immigration law. The latter issue has clear significance for minority ethnic women and is the focus of the next section.

3.5 Asylum Policy and GBV

In 1999, the UNHCR identified a trend across States to “move gradually away from a law or rights-based approach to refugee protection, towards more discretionary and ad hoc arrangements that give greater primacy to domestic concerns rather than to their international responsibilities” (UNHCR, 1999: 14). This has had a negative effect on women asylum seekers, both in relation to asylum claims that relate to GBV, and in the protection of female asylum seekers from domestic violence. This is evidenced in the findings of the UK CEDAW Thematic Shadow Report (2003), in which the UK asylum system is criticised for taking a gender-blind approach to women’s asylum claims and for its continued perception of violence in the family as a private violation and not the responsibility of the State (Sen *et al.*, 2003). Other identified barriers in the UK for asylum seeking women during the asylum process include failure to interview women separately from male relatives, lack of understanding among immigration officials as to why women may delay disclosing details of their experiences, poor practical arrangements at interviewing stage, such as absence of childcare arrangements, impeding women’s ability to make a claim or attend relevant appointments. At the decision making stage, the downgrading of medical evidence, temporary or exceptional grounds for women’s asylum pleas related to GBV was also identified (Sen *et al.*, 2003).

Regarding asylum seeker women awaiting the outcome of their claim in the UK, there is also evidence of sexual harassment and absence of appropriate supports for victims of domestic
violence in mixed sex asylum seeker centres (ibid.). A two-tiered social welfare system, whereby asylum seekers are paid only 70 per cent of standard payments can push some women into prostitution (ibid.). For those women whose claim is rejected, options are restricted to forcible deportation back to her country of origin, where she may be at risk of GBV, or becoming destitute, whereby she is at risk of becoming involved in prostitution (Malfait and Scott-Flynn, 2005).

The UK CEDAW Shadow Report (2003) identified a number of steps needed to ensure that asylum seeker women are protected from GBV. Given the similarities shared by the UK and Irish system, it is probable that these steps might be equally applicable in Ireland. One of the most important steps recommended is that GBV be identified as a categorical basis for asylum. In addition to this, it identifies other steps regarding the process of making an asylum claim. These include the importance of systematically informing all women asylum seekers of their right to make independent claims for refugee status, and of ensuring their complete confidentiality throughout the asylum process. It also highlights the need for the introduction of gender guidelines into the asylum decision making procedures and the need for training on the same for staff. Other recommended steps include:

- Childcare provision throughout the asylum procedure for women;
- Safety and wellbeing ensured for those asylum seeker women under the care of the government;
- Equal access to social benefits;
- Resources committed to those local women’s organisations providing support on GBV to asylum seeking and refugee women.

3.5.1 Asylum Policy in Ireland and GBV

The new Immigration, Residency and Protection Bill (2008) was introduced by the Minister for Justice, Equality and Law Reform in January 2008 and provides an integrated statutory framework on immigration policy. At time of writing, this has not been enacted. A number of concerns have been raised regarding the new Bill, concerning the rights of asylum seekers, including long delays, lack of transparency and independent appeals process and lack of clarity around many of the provisions, such as long-term residency permits and family reunification. Regarding GBV, acts of a gender-specific nature and acts of physical or mental violence, including sexual violence, are included in the Bill as examples of acts which may amount to acts of persecution. These acts must fulfil demands regarding severity and frequency of occurrence in order to constitute a “severe violation of basic human rights” (2008: 70), or must occur alongside other measures. No reference is made to GBV as a specific form of persecution.

The UNHCR has developed guidelines on international protection for gender-related persecution regarding the 1951 Convention relating to the Status of Refugees, of which Ireland is a signatory. The aim of the guidelines is to provide legal interpretative guidance for relevant stakeholders in determining refugee status. They show that the refugee definition, properly interpreted, covers gender-related claims, such as GBV. They also elucidate that women comprise a social group, which is an identified ground for persecution both in the 1951 Convention and in the new Bill. The implementation of these guidelines in Ireland would therefore lead to current immigration legislation protecting women seeking asylum from experiencing GBV in their country of origin.

The current system of direct provision accommodation, which places those seeking asylum in large hostel style accommodation units on a full-board basis, has been criticised as a discriminatory practice, leading to the social exclusion of asylum seekers (Irish Refugee Council, 2001). Asylum seekers are not entitled to social welfare benefits, and are given a weekly allowance of €19.10 for adults and €9.60 per child. This system severely curtails access to relevant services for those who experience domestic violence, even more so for those living in direct provision centres in isolated rural locations. It also provides these women with extremely limited options for leaving a violent relationship during the asylum process.

Asylum legislation also has relevance for victims/survivors of FGM. Some women, who cite risk of FGM as a basis for asylum or refugee status, or have undergone the procedure, come to Ireland
out of fear for themselves and/or their daughters (Irish Council for Civil Liberties, 2000; Pillinger, 2007). Cases for asylum have, however, been rejected on the basis of the country of origin being declared as a ‘safe country of origin’ in relation to FGM. This situation must also be rectified in light of the international recognition of FGM as a human rights abuse. It is also essential for Irish policymakers to be familiar with national and international legislation regarding FGM and women’s rights in general, when considering the cases of women asylum seekers.

3.6 Migrant Policy and GBV

Migrant women whose legal status is dependent on their husband’s immigration status are unlikely to report domestic violence for fear of deportation (UN, 2006). Such restrictive immigration laws have been identified in the US (Dasgupta, 1998), in Great Britain (Rai and Thiara, Morton, 1997; Batsleer, 2002; Southall Black Sisters, 2004), Australia and Canada (Fagan, 2008). In the US, a campaign to rectify the situation led to an amendment to immigration law in 2000, to allow migrant women who have experienced domestic violence to secure legal status independently of their husband. In the UK, campaigns led to the Domestic Violence Concession or Rule, which provides for indefinite stay for migrant women who can provide evidence of domestic violence. Though welcomed, this development has been criticised for the quantity and nature of evidence required (Fagan, 2008). In Australia, the Domestic Violence Provision was also brought about by campaign work and allows for permanent residency to be afforded to those whose relationship has broken down as a result of domestic violence (Fagan, 2008). In Sweden, immigration law also permits immigrant women who are victims of domestic violence to attain a permanent residence permit (UNFPA, 2006).

Stringent welfare policy can also trap migrant women experiencing domestic violence: by withholding welfare entitlements to immigrant women, those in relationships can be made economically dependent on their husband (Rai and Thiara, Morton, 1997; Batsleer, 2002; Southall Black Sisters, 2004; Burman et al, 2002). In the UK, it has been found that this issue has severely curtailed migrant women’s ability to leave a violent relationship, due to lack of recourse to necessary funds (Burman et al, 2002; South Black Sisters, 2004).

3.6.1 Migrant Policy and GBV in Ireland

While the current immigration system allows the authorities to deal with the immigration aspects of cases involving domestic violence on a case-by-case basis, the discretionary nature of this system often leaves women uncertain about their rights and entitlements and afraid to leave a violent relationship for the fear of jeopardising their immigration status (Immigrant Council of Ireland, 2008). Moreover, certain legal categories for migrants in Ireland do not adequately protect women against GBV. The Spouse Dependent Visa (SPV) is provided to spouses of migrant workers who do not possess a work permit. For those on a SPV, their legal status is reliant on their continued relationship with their spouse. In January 2007, new arrangements were introduced by the Department of Enterprise, Trade and Employment, whereby in certain circumstances, spouses and dependants of employment permit holders could apply for a permit to work. However, many women on a spouse dependent visa are not entitled to access paid employment. For those on a SDV, their legal status is reliant on their continued relationship with their spouse. In January 2007, new arrangements were introduced by the Department of Enterprise, Trade and Employment, whereby in certain circumstances, spouses and dependants of employment permit holders could apply for a permit to work. However, many women on a spouse dependent visa are not entitled to access paid employment. Moreover, even if a woman on a SDV does gain access to a work permit, she loses her entitlement to work if she leaves her spouse/partner. Regardless of their employment status, all spouse dependent visa holders become legally undocumented once they leave their partner. Similarly, a migrant woman who experiences domestic violence may be obliged to leave her employment in order to escape a violent home. In such cases, she too will become undocumented. Migrant workers are also unprotected if GBV occurs in their place of employment. Those engaged in domestic work may be at particular risk in this regard, as existing evidence show that some can suffer inequitable employment relationships (MRCI, 2004). The majority of workers in this field are female. If a migrant worker left her place of employment due to this issue, she would also become undocumented.
Voluntary organisations have called for a temporary ‘bridging visa’ for those who find themselves in this situation (Immigrant Council of Ireland, 2006). However, no concession is made in the new *Immigration Residence and Protection Bill* (2008) for those women on a Spouse Dependent Visa who experience domestic violence in Ireland, despite the fact that the discussion document preceding the Bill, published in 2005, stated that this issue would be given consideration (Department of Justice, Equality and Law Reform, 2005). Moreover, the Habitual Residence Condition, which disentitles immigrants from social welfare benefits, means that someone in this situation would have recourse to no funds to enable escape, or to employment. Both the Bill and the Habitual Residence Condition have been identified as deepening the vulnerability of minority ethnic women who experience domestic violence (Migrant Rights Centre Ireland, 2006; Women’s Health Council, 2006).

Isolation from a family and support network was identified in the review of literature as a major barrier to receiving required support for victims/survivors of domestic violence. In this regard, a clear and transparent approach to family reunification is very important. The *Immigration Residence and Protection Bill* provides for entitlement to family reunification for refugees and protection holders. However, it has been criticised for neglecting this right for other migrant women and voluntary organisations have called for provision for family members to stay in Ireland following a change in family circumstance, such as domestic violence (Immigrant Council of Ireland, 2006).

### 3.7 Trafficking Policy and Legislation

International awareness on trafficking for the purposes of sexual exploitation developed during the 1990s, leading to the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, known as the Palermo Protocol. This establishes an internationally agreed definition of trafficking and sets out measures that should be taken on national level to combat this issue. This defines trafficking as ‘the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs’. Due to ambiguity surrounding the term ‘sexual exploitation’, this definition has been the subject of intense debate. While the Coalition Against Trafficking in Women (CATW) maintains that the Protocol includes any form of sex work under trafficking, others hold that the absence of a clear definition of sexual exploitation in the Protocol is a compromise between this position and that which argues for the rights of sex workers (Outshoorn, 2005; Saunders, 2005). What is agreed is that as the central feature of this definition is exploitation, rather than consent, it places responsibility on the State to protect all victims of trafficking, rather than attempt to ascertain guilt or innocence (Hodge and Lietz, 2007). However, the Protocol has been criticised for focusing on law enforcement, over the rights of the victim (Ward and Wylie, 2007). The Council of Europe Convention on Action Against Trafficking in Human Beings (2005) aimed to address this issue, and outlines a range of measures required to protect the rights of trafficking victims (ibid.).

The UK CEDAW Thematic Shadow Report (2003) identifies the following policy measures to ensure the protection of trafficking victims in the development of national legislation on this issue:

- Ratification of the UN Convention Against Transnational Organised Crime and Protocol on Trafficking of Women and Children;
- Ensure that legal migration routes to host country are equally accessible to men and women;
- Treatment of trafficked women as victims;

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10 For the purpose of this Protocol, the full definition of “trafficking in persons” means the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.
- Implementation of the EU directive for provision of temporary visas for a ‘reflection period’ and victim support services. In relation to this it is important that this is long enough to enable assessment of safety for potential return;
- Investment in reintegration programmes in country of origin, in order to prevent vulnerable women from being re-trafficked;
- Allocation of confiscated assets from traffickers and exploiters to relevant support services in country of origin and host country (Sen et al, 2003).

Regarding the provision of a reflective period for victims, research conducted in the UK found that the majority of trafficking victims required up to three months in order to experience a significant improvement in their mental health (Zimmerman et al, 2006). This is offered in the Netherlands and is recommended by Amnesty International UK, the Joint Committee on Human Rights and the Parliamentary Assembly of the Council of Europe (Amnesty International UK, 2007).

3.7.1 Trafficking Policy in Ireland

In June 2008, the Criminal Law (Human Trafficking) Act 2008 came into force in Ireland. This Act separates the offences of trafficking for labour and sexual exploitation. It also makes it an offence to sell or offer for sale any person, adult or child, for the purposes of sexual exploitation and applies to offences that take place in private and public places. Measures are provided for protecting the anonymity of victims, such as allowing for evidence to be given through a television link from either within the State or abroad. Additional provisions are also set out in the Immigration, Residence and Protection Bill, most notably allowance of a ‘reflection period’ of 45 days, as well as temporary residency status of up to six months in order to facilitate the Gardaí with case enquiries.

The Trafficking Act has been welcomed. However, concerns have been raised regarding the level of protection provided both in it and in the Immigration, Residence and Protection Bill for trafficking victims and the associated danger of women being re-trafficked following return to their country of origin. In particular, the 45-day reflection period has been criticised for being too short (Bacik, 2008). It has also been pointed out that both this and temporary residency provisions should be provided solely on humanitarian grounds and should not therefore depend on the victims willingness to assist the Gardaí (Immigrant Council of Ireland, 2007; Amnesty International, 2007).

Trafficking is given significant consideration in the National Women’s Strategy. Among a range of actions, it identifies the need to put in place appropriate support mechanisms for victims of trafficking to enable them to re-establish their lives. In order for this action to be implemented, the above issues need to be acted upon. Other required actions set out in the National Women’s Strategy are:
- Continue to take a proactive approach to the prevention and detection of human trafficking and prosecution of offenders;
- Deprive perpetrators of trafficking of the proceeds of their criminal activities;
- Foster collaboration between Garda Síochána and NGOs in relation to ‘intelligence’ on trafficking;
- Bring forward legislation to comply with EU Framework Decision on Combating Trafficking in Human Beings;
- Undertake media campaigns to promote awareness of trafficking in human beings and its linkages with the ‘sex industry’ (Government of Ireland, 2007).

Many of these actions are addressed in the new Act on trafficking. In addition, in 2007, an Anti-Human Trafficking Unit was established in the Department of Justice, Equality and Law Reform with the remit of coordinating the State’s response to human trafficking. A High Level Group on Combating Trafficking in Human Beings was also established, whose terms of reference include the development of a National Action Plan to Combat Trafficking in Human Beings (Department of Justice, Equality and Law Reform, 2007). A campaign to raise awareness among the general public, Gardaí and other professionals of the indicators of human trafficking and to discourage demand for the services of victims of sexual exploitation and forced labour was also launched by
the Department of Justice, Equality and Law Reform in October 2008. Finally, training to recognise indicators of trafficking is also being delivered to immigration and other relevant officials by the International Organisation for Migration.

3.8 Key Points

- In 1995, Ireland signed the Platform for Action of the UN Beijing World Conference on Women which recognises GBV as a violation of women’s human rights.
- Culture is a dynamic, changeable and moving phenomenon. Patriarchy and GBV are features of all cultural contexts. While some cultural contexts are more patriarchal than others, patriarchy in itself is not culture.
- An integrated strategy on violence against women should be interculturally competent and should include a conceptual framework on GBV. The planned national strategy on domestic, sexual and GBV by the executive office Cosc represents an ideal opportunity to develop such a strategy for Ireland.
- GBV needs to be identified as a categorical basis for asylum, women asylum seekers should be informed of their right to make independent claims for refugee status, and gender guidelines and training should be provided asylum officials.
- Those women on the Spouse Dependent Visa become undocumented if they leave a violent relationship. A special concession should be available in cases of GBV.
- The recently enacted Criminal Law (Human Trafficking) Act 2008 makes a welcome improvement on Irish legislation regarding trafficking of women for the purposes of sexual exploitation. However, evidence suggests that the reflection period for victims should be 90 days rather than the existing 45 days, in order to ensure victims/survivors have adequate time to recover.
4. Research Design

4.1 Research Questions and Design

The research question plays a fundamental role in developing a research design strategy (Bryman, 2007). In the case of this study, four research questions presented themselves:

- What are the experiences and needs of minority ethnic women living in Ireland with regard to gender-based research?
- What services are currently available to them that meet these needs?
- What barriers exist for minority ethnic women in accessing required support regarding ongoing experiences of GBV?
- How can these barriers be overcome?

Two populations were identified as being relevant: minority ethnic women who have experienced GBV, and the services that respond to their needs. Regarding minority ethnic women, a qualitative approach clearly presented as the most appropriate method. A qualitative approach can yield an in-depth understanding of the nature of an experience.

Quantitative data, on the other hand, can determine the extent of an issue and can be used to identify the most common needs and experiences within a population. In relation to service providers, a quantitative approach was taken to explore the most common needs and experiences of minority ethnic women presenting to services, the range of services used by this population regarding GBV, the most common barriers presenting to service providers, and the most popularly identified measures among this group for addressing these barriers.

4.1.1 A Mixed Method Approach

A debate surrounds the adoption of a mixed method approach in social research studies. Some commentators argue that as qualitative and quantitative approaches are grounded in such different, even opposing philosophical viewpoints, they cannot be effectively used in one study, to answer the same research question(s). Others, while acknowledging this basic difference, argue that there is value to bringing the two methods together (Ritchie and Lewis, 2006). For this study, a mixed method approach was adopted. In doing so, we align ourselves with the pragmatist approach, as identified by Ritchie and Ritchie (2006). Our concern is with ensuring “a suitable ‘fit’ between the questions posed and research methods used, over the degree of philosophical unity of different methodologies” (ibid: 43).

Table 6 summarises the different contribution the two methods bring to each research question.

<table>
<thead>
<tr>
<th>Question</th>
<th>Qualitative</th>
<th>Quantitative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiences and needs</td>
<td>To explore/understand:</td>
<td>To determine:</td>
</tr>
<tr>
<td></td>
<td>▪ The nature and experience of different forms of GBV,</td>
<td>▪ The most common needs and experiences of this cohort presenting to services</td>
</tr>
<tr>
<td></td>
<td>▪ Meaning attached to experience of support in Ireland,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Unmet needs</td>
<td></td>
</tr>
<tr>
<td>Services currently available</td>
<td>To explore/understand:</td>
<td>To determine:</td>
</tr>
<tr>
<td></td>
<td>▪ Awareness of relevant services, experience of these services</td>
<td>▪ Commonly used services of this cohort</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Common referral pathways</td>
</tr>
<tr>
<td>Barriers in accessing support</td>
<td>To explore/understand:</td>
<td>To determine:</td>
</tr>
<tr>
<td></td>
<td>▪ Barriers minority ethnic women face in accessing required support,</td>
<td>▪ the most common barriers to meeting the needs of this cohort by service providers</td>
</tr>
<tr>
<td></td>
<td>▪ How these barriers are dealt with</td>
<td></td>
</tr>
</tbody>
</table>
4.2 The Qualitative Stage: A Collaborative Process

A phenomenological approach was adopted to carry out the qualitative component of this research. This is concerned with understanding the essence of experience surrounding a phenomenon (Miller and Salkind, 2002). It “describes the meaning for several individuals of the lived experiences surrounding a concept or a phenomenon” (Creswell and Maietta, 2002: 151). This approach is best suited to a study that aims to reach the ‘essence’ of an experience. As the purpose of this stage of the research was to elicit in-depth, exploratory data on the experiences of violence among minority ethnic women, their perceptions of service provision in Ireland and views on barriers to accessing same, this approach was considered most appropriate. The value of a qualitative approach has also been identified in studies of sensitive subjects and with hard to reach populations.

Literature on conducting research on sensitive topics and on minority ethnic groups highlights the value of the participation of communities being studied in the research process itself (Crigger et al, 2001; Fontes, 2004). This approach contributes to ensuring that interviews are conducted in a culturally sensitive way (Crigger et al, 2001; Campbell and Dienneeman, 2001; Atkin and Chattoo 2006). It ensures inclusion of those who do not speak the English language. Finally, evidence suggests that this approach increases the likelihood of participation of minority ethnic women (Johnson, 2006). For these reasons, a collaborative approach was adopted, whereby minority ethnic women acted as peer interviewers for its qualitative component. A consultation process conducted with relevant service providers prior to the research regarding this approach found that all services supported this approach.

Nine minority ethnic women were recruited through voluntary services to act as a panel of qualitative interviewers. A rigorous three-day training programme was carried out with these women. This addressed the concepts of GBV and gender inequality, challenging myths regarding GBV, qualitative research, in-depth interviewing skills, displaying sensitivity, ethical issues, confidentiality, ongoing assent, role play and safety issues. This was a dialectical process. Peer interviewers made an input to the development of the interview guide and on ensuring cultural sensitivity. Interviewers also had the opportunity to conduct practice interviews. External experts contributed to this training programme. Their input ranged from a global overview of GBV, to dealing with the issue of vicarious trauma. Peer interviewers came from Poland, Ukraine, South Africa, Libya, Uganda, China, the Traveller community, and the Roma community.

4.2.1 Accessing the Participants

Ethical considerations played an important part in developing a research strategy for accessing qualitative participants (see section 4.5 below). Service providers who supported minority ethnic women regarding GBV acted as gatekeepers. This was in order to ensure that all interviewees had access to support and were at the time of interview living in a safe environment. An information pack was distributed to relevant service providers throughout the country, which included a copy of the information sheet for interviewees (see appendix B). Following receipt of this information pack, service providers were asked to consider whether any of their current or past service users may be

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11 See appendix C for further detail on this training programme.
interested in participating in this study. The service provider was then asked to approach such a service user regarding the research, and to pass on a copy of the information sheet.

Service providers emphasised the voluntary nature of participation. A free-phone number was set up for the purpose of the research. Service providers and clients were invited to call this number if they wished to discuss the research in further detail. If a client was interested in participating, a meeting was arranged. Each participant was given the choice of being interviewed by the senior researcher/project coordinator or by a trained peer interviewer closer to their own ethnic identity. In order to protect the confidentiality of those who wished to read the information sheet, service providers were asked to offer potential participants a safe place to store the information sheet.

When a potential participant decided that they wished to participate, a date and time was arranged. The interviewee’s wishes and views of the service provider involved guided the location of interviews. Locations included private rooms in the gatekeeper service, a community centre, the offices of the WHC and on some occasions, in the residence of the participant. At this stage, interviewees were given another opportunity to read the information sheet before signing the consent form. Through this process, a total of 26 interviewees participated in the qualitative aspect of this research.

4.2.2 Analysis
A thematic content approach was used to analyse the qualitative data, which comprised of verbatim transcriptions of each conducted interview. The primary concern of this method is to capture and interpret meaning contained in the data. The coding stage of this analysis process was aided by use of the software package nVIVO. An iterative approach was taken to all stages of the analysis, whereby the raw data set was repeatedly returned to, in order to confirm and validate conclusions drawn at later stages of analysis.

4.3 The Quantitative Stage

The quantitative dimension of the research provides descriptive data on the scale and nature of service provision available in Ireland to minority ethnic women regarding their experience of GBV. It also provides information on the perceptions of service providers regarding barriers to meeting the needs of this group and how these barriers should be addressed.

Three postal surveys were carried out. Firstly, one was conducted of all GPs registered in the Irish Medical Directory (n. 2,226). 498 (25%) GPs responded, of whom 169 (34%) had one or more female patients from a minority ethnic group who disclosed experience of GBV over the past year. In an effort to include other relevant mainstream health and social services, this questionnaire was also distributed to Directors of all hospital and community-based Social Work Departments (n. 77), Directors of Public Health Nursing (n. 34) throughout the country and Directors of the four Sexual Assault Treatment Units (SATU) in Ireland (n. 4). The average response rate for this group was 42 per cent.

Two postal questionnaires were also conducted with GBV organisations and minority ethnic organisations within the voluntary sector. In the absence of a comprehensive national database of either category, existing databases were collated. The databases used for GBV organisations were the National Network of Support Services and Refuges for Women, the Rape Crisis Network in Ireland and Women’s Aid. A total number of 62 organisations were identified and a response rate of 77 per cent was achieved. Regarding minority ethnic organisations, databases included the Integrating Ireland membership list, the Immigrant Council of Ireland’s Directory of Immigrant Services, and the Irish Traveller Movement (ITM) list of Traveller organisations. A response rate of 31 per cent was achieved for this category.

All quantitative data were entered into the statistical computer programme SPSS. Survey data of health and social service providers were analysed separately to the surveys of GBV organisations and minority ethnic organisations of the voluntary sector.

12 See appendix D for copies of questionnaires.
4.4 Ethical Considerations

Due to the sensitive nature of the subject of this study, ethical considerations were a principle focus in the research design. The framework developed for this research adhered to ethical guidelines of the Social Research Association (SRA) and the Sociological Association of Ireland (SAI). Key principles included avoiding undue intrusion, obtaining informed consent, ensuring participation was voluntary, protecting the interests of subjects, enabling participation and confidentiality. In addition, this study followed the ethical guidelines for conducting qualitative research with victims/survivors of GBV developed by the World Health Organization (2001). Only those who were aged 18 years or over, were linked into a support service and whose experience of GBV was in the past were invited to participate. All interviewees were offered the option of attending a counselling session after the interview, if they felt in any way distressed by issues raised therein. The information sheet and consent form were translated in other languages as required. Service providers in the field of GBV acted as gatekeepers to all potential participants. Interviewers were also given the option of attending counselling after conducting interviews.

Ethical approval was granted for this study by the Research Ethics Committee of the Irish College of General Practitioners (ICGP) in November 2007.

4.5 Study Limitations

It is important to note that this research only represents the experiences and needs of those women who had accessed services for support in dealing with GBV. Regarding victims/survivors of domestic violence, this means that it also only represents the experiences of those who had left a violent relationship. However, as shown in the literature review, this should not be perceived as the only option for all victims/survivors and this is a point that should be reflected in the delivery of an interculturally competent service. This is a very necessary limitation of this study, from an ethical point of view. It is also a common issue in qualitative studies on vulnerable groups. Most interviewees faced similar barriers in accessing services and these data give some insight into the needs of those who do not come forward.

Due to the voluntary nature of participation, it was not possible to ensure representation of all forms of GBV, or other factors such as legal statuses. Victims of trafficking were entirely excluded from the study, as relevant services tend to work with women in crisis situations. In the final sample of minority ethnic women, there was quite a high representation of the Roma community (n. 7) while none were from some of the larger nationality populations in Ireland, such as the Polish community. Regarding this, it is worthwhile to note that risk factors and barriers faced by minority ethnic women in relation to gender-based violence are not related to country of origin or the size of a minority ethnic group. Rather they reflect much broader social concerns, such as intersectionality of racism and gender inequality, immigration law, the migration journey, isolation, cultural differences, patriarchy, social deprivation and pre-migratory experience.

Regarding the quantitative stage of the research, variations in record keeping across services, particularly within the voluntary sector, meant that statistical data are estimates only. Though guidance on definitions of minority ethnic groups was provided in a cover note accompanying questionnaires, the fact that ethnic identifiers have not been developed also affected this statistical information. Finally, due to the specialist nature of this research, response bias is likely, whereby those services which have been accessed by minority ethnic women regarding GBV are more likely to respond.
PART TWO: Qualitative Findings

This section presents the analysis of the qualitative interviews which were conducted over a six month period with 26 minority ethnic women in Ireland, all of whom survived a past experience of gender-based violence (GBV). The aim of this research is to identify how services in Ireland can best respond to the needs of minority ethnic women who experience GBV. This qualitative stage of the research corresponds to the first objective of the research, namely to document the experiences of minority ethnic women in relation to various forms of GBV.

A age of participants ranged from 18 to 59 years. Domestic violence was experienced by the majority of participants. Other forms of GBV included sexual violence outside the home, conflict-based rape, sexual assault in prison, FGM and forced marriage. Many participants experienced more than one form of GBV. This is outlined in the table below.

Table 7. Forms of GBV, by location

<table>
<thead>
<tr>
<th></th>
<th>Prior to Ireland</th>
<th>In Ireland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Sexual assault outside home</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Conflict-based rape</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Sexual assault in prison</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>FGM</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Forced marriage</td>
<td>7</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>15</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

This sample includes women from the Traveller community, the only indigenous minority ethnic community in Ireland and the Roma community, a minority ethnic group that has had minority ethnic status both in Ireland and in their country of origin. It also includes refugees, asylum seekers and migrant workers. Available data suggests that this sample reflects the population being studied. A recent analysis of national statistical data collected by 14 participating Rape Crisis Centres (RCC), which included data by country of origin of clients (Lyons, 2006) found that among female face to face service users, 6.9 per cent (n. 112) were asylum seekers, 0.4 (n. 7) were Eastern EU citizen and 0.2 (n. 4) were refugees.

A number of cross-cutting themes emerged, primary among them being the perpetrator’s control over the victim/survivor. This finding has emerged in many studies of GBV generally. In this context, this control manifests itself in exploitation of patriarchal values, cultural factors and migration. Other themes include the issue of isolation and the negative impact this has had on these women’s lives, and the compounding impact of racism from the majority community. In terms of accessing services, barriers include patriarchal values as well as a lack of interculturally competent services and an absence of information on services, rights and entitlements.

It is hoped that these data will provide a useful illustration of the experiences of GBV among minority ethnic women in Ireland. More importantly, it is hoped that in doing so, the data will identify gaps and barriers faced by minority ethnic women, from the level of immigration law and social welfare policies to domestic violence service provision.

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13 Please note the number of forms of GBV does not equal the number of interviewees, because some interviewees experienced more than one form of GBV.

14 Countries of origin for these interviewees included Indonesia, Russia, Lithuania, Uganda, Nigeria, South Africa, Zimbabwe, Botswana and Rwanda.
5. Domestic Violence and Minority Ethnic Women

Twenty two interviewees for this study had experienced domestic violence. This included physical, sexual, financial, and verbal abuse at the hands of the perpetrator, and many experienced all of these forms of violence. They had remained in such a violent relationship for periods varying from two years to 17 years. Physical health consequences of domestic violence described by interviews were varied, often serious and sometimes chronic in nature. Injuries sustained included open head wounds, fractured ribs, collapsed lung, teeth being knocked out and knife wounds. Some interviewees suffered from long term physical health problems which they attributed to domestic violence, such as hypertension, eyesight and gynaecological problems. As serious as such conditions are, there was a perception among interviewees that the psychological effects of domestic violence were much worse than physical problems. Enduring domestic violence had a deep and long lasting psychological effect. Interviewees spoke of a very poor sense of self worth, feeling loss of control over their own life and constant sense of fear:

‘You think, am I a grown person? You can’t shake your head, you can’t smile, you can’t think. You’re in your own house and … it’s impossible’ (Bayo).

Symptoms of anxiety and depression were described by all interviewees who were victims/survivors of domestic violence. Seven had attempted suicide.

5.1 Domestic Violence, Control and Unequal Power Relations

A common theme across all of these interviews was the issue of control. Interviewees described a relationship based on the perpetrator’s constant desire to demonstrate the control he had over her. One way in which this was achieved by the perpetrator was in the random and irrational nature of justifications provided for sporadic attacks of physical attacks:

‘First he says, I’m not to wake him up when [he is] sleeping. … Until the next time, it’s another thing, it’s another thing. And then, you don’t know what to do again. Because you’re walking on eggshells. The first time he says it was because I wasn’t organised, I go out, the second time he says you shouldn’t talk all the time, the third time – you know, there is always one reason or the other. And then you also, you kind of, ok, I’m not going to go out until he lets me out, I’m not going to talk with these persons – and you’re kind of, you’re thinking of, what should I do now? Because I don’t want this situation so… there’s no real reason for anything. You are doing all these things, and you’re still getting beaten’ (Bayo).

Repeated infidelities emerged as another tactic used by perpetrators which, as well as leading to significant emotional distress for interviewees, also served to illustrate his control. When the victim/survivor protested, it would result in attacks of physical violence:

‘He would be like, ‘no, you have to stay with the baby, hey, you have to stay home.’ By that, he was having chance, you know, to see his girlfriends and all those things. … When I ask it’s a big fight, we start fighting. And things just changed … Things just changed. Changed totally’ (Kagiso).

‘I had to ask him, have you got anything that you’re hiding? … To him, it was an argument, that I’m always looking for trouble, when we’re happy, I’m not happy about it, then I’m looking so…it must be me…A few days after that, he went and got himself drunk and he came home and he decided to tell me that, you know, he has two children, two children…and from there we started having problems and the fighting became too much’ (Etinosa).

15 Many of these interviewees experienced other forms of GBV in addition to domestic violence.
16 All names have been changed in the interest of confidentiality.
Verbal attacks which focused on putting the victim/survivor down, such as calling her “a nobody”, “stupid” and “useless” reinforced this message, while serving to increase his control over her by lowering her self-confidence. Financial violence was yet another common form of attack that was related by interviewees to this issue of control:

‘He can’t just give me money, like, ‘take money.’ You know? He will go himself and do the grocery. He can’t even say, ‘let’s go together’, you know, ‘what we need for the house?’ He would go himself, get grocery, food…I could only get new clothes if I went home’ (Kagiso).

‘I used to work in the bank. I had to give up my work when I had my baby…I used to have the independence [then]. I don’t have any money…and between the financial, and he’s trying to get his way, he’s threatening, and I’m really, really scared because…you hear things like if you don’t be quiet now, you’re just looking for trouble and it’s your fault, you know?’ (Bayo).

‘[I had to] have food at every call for him, when he’d need it or want it. And he never gave you money. Now the money was not a lot, because it’s the dole. And he’d go off and drink the dole, so that’d leave me and the children begging’ (Margaret).

Not surprisingly, overcoming financial violence was perceived as crucially important in reducing this control and as a necessary first step in order to leave the violent relationship. The perpetrator showed awareness of the significance of this form of violence. One interviewee described how on securing a paid job, the perpetrator coerced her into having her payments made into his bank account, rather than open an account for herself, as she had hoped to do.

Another way in which perpetrators demonstrated their control over interviewees was forcing them to work, arguably a form of violence in itself:

‘I used to help out in this shop where he had a job. So, by the time I come from the shop and I come back home, I have to cook and clean, I have to wash and he doesn’t have to do anything in the house. When he comes home from work, he just comes and sits down and he has his beer or he goes out with his friends. So I felt in this relationship, it only had to be me. You know? I’m going out to work as well and I’m coming home and having to do his washing and his ironing and his food and when he comes home at a certain time, he expects me to wake up, even if it’s three in the morning, to warm his food for him to eat. And then if he’s not happy with it, that causes an argument’ (Etinosa).

‘I sell swag, we call it swag, household bits of things, like clothes pegs and needles and things like that…And then he’d be saying, ‘well how can you’ – he’d be cursing, saying well you have feckin’ enough what you’re getting out of that…Once you go out and sell it, you would maybe get a fiver in the day …Well he’d think that was a fortune, you were after making a fortune, you’d get no dole after that’ (Margaret).

One interviewee who had married an Irish man, described how her life in Ireland became dominated by running a Bed and Breakfast service which he owned:

‘I was very tired with the B&B. I was awake from seven until twelve o’clock at night, you know, ironing, doing this and that’ (Riya).

Interviewees felt that the issue of control was related to patriarchal social values which led to unequal power relations between men and women. Many interviewees described such social norms in their community:

‘The woman is subjected to the man. She is not allowed to go outside, she has to stay in the house, she has to keep her children in the house, to clean and cook’ (Dika).
'If I had to send a message to...women, it wouldn't be of any use because it doesn't depend on them. If their husbands are mean, then they will live according to their customs. I don't wish for any woman in this world to be beaten up and to suffer like I have' (Florica).

'The Travelling man is always the boss. Like most men. But he's the boss. ...What he'd say would have to be really done' (Margaret).

In communities where traditional gender roles were associated with the concept of honour, interviewees described how accusations of transgressing such norms would lead to attacks of physical violence. Factors related to honour included virginity before marriage and fidelity to their husband during marriage:

'On our wedding night, my husband discovered that I was not a virgin. He started to be very violent with me. He grabbed my hair, he threw me off the bed on the floor, he spat on me. His parents heard the noise and came inside; they started giving out to me as well, they whipped me, they kicked me out and mocked me' (Donka).

For many interviewees, sexual violence was contextualised in a sense of duty arising from such social norms:

'[H]e will force you into it when you don’t want. Because, I’m telling you that if immediately you discover that your husband is sleeping out, you can need to keep quiet. And you also lose that heart, of loving him in any way that you can feel like going with him to bed. You know? But then it is always the man with all his power. What can you do? You know? What can you do?' (Kagiso).

'Sometimes he’d come out from a club really drunk at whatever time in the morning and he’d be there, he’d wake me up...You’d feel like it’s your duty, that you have to fulfil. Whatever. So it got to a point where I could not enjoy it anymore. It was like a job that I needed to do and get on with it’ (Etinosa).

Interviewees did not conclude that unequal gender relations lead all male partners to be violent against their wives. However, they perceived their own experience of intimate partner violence as examples of how the right of men to control the behaviour of their wife can and does lead to domestic violence:

'Back home, even with my husband, we used to fight, that kind of thing. And there’s that culture of people hit at you, you’re not supposed to say anything, because it’s a man. The man is – he has the power to do, you know?...They mostly share the same look. That a husband may beat you or getting another woman, that kind of thing’ (Kissa).

5.1.1 Unequal Power Relations and the Extended Family

For some interviewees, domestic violence was perpetrated against them by members of their husband’s family. Sometimes this occurred in addition to that perpetrated by the interviewee’s partner:

'He would tell me to stay at home and take care of the house...One day my husband wanted to go to the city and I wanted to go with him. I asked for permission from my mother-in-law, but her answer was that I have work to do at home, to help her do the laundry and help her clean. She told my husband not to take me with him. After my husband left to go to the city, I was in the yard crying. She grabbed my hair and pushed me aside. She was swearing at me, telling me to go and do some cleaning...He was the only one allowed to have fun. I wasn’t even allowed to ask him questions’ (Donka).

For others, extended family members were the principal perpetrators:
'My mother-in-law tried to turn both my husband and my father-in-law against me. She would have been very happy if he had beaten me' (Lyuba).

'I had problems with a sister-in-law. She wouldn’t let me sit at the table and eat with them. She would chase me away, she didn’t like that I was living with her brother, but he didn’t want to divorce me' (Florica).

One Traveller interviewee’s whole experience of domestic violence was defined by that carried out by members of her extended family; she reported that her husband himself was never physically violent towards her, though she did hold him equally responsible, due to his refusal to protect her from these attacks. She survived repeated and, often, extreme physical attacks of violence over a period of 17 years. Problems arose almost immediately following her marriage to her husband, when his family members attempted to control her:

‘They were just the kind of people that you couldn’t get on with. They wanted to be like them, to live like them…It’s hard to describe…They didn’t communicate with other people. They didn’t go out - They just wanted to build a wall around me’ (Brigid).

In such cases, the relationship between desire to control and attacks of violence emerged in their attempts to curtail her community involvement. Again, the issue of control emerged regarding violence perpetrated by extended family members. One interviewee described how a visit to her brother resulted in a severe physical and verbal attack by her husband’s mother and sister when she returned. She spoke of how her life had become dominated by their constant attempts to control her behaviour:

‘So much of hearing things, like the words, do you know? The rules that they had. You could hear them in your ears. Even when you lie down you’d hear them in your ears. I used to hear them in my ears…Their rules’ (Brigid).

5.2 Domestic Violence, Control and Migration

Interviewees who had migrated to Ireland described how their migrant status was used as another tool of control by the perpetrator. One interviewee who arrived in Ireland on a Spouse Dependent Visa described how he became physically violent only after migration, even though they had been married for five years prior to migration:

‘When he was returning from work, like he shouting on her [interviewee’s daughter] because he just lose his temper or something…but like he’s never [physically] violent, because I didn’t let him do that. He was…violent when he’s drunk [in country of origin]. Like violent, but he never beat. He say abuse, you know?’ (Laima).

For her, it was her dependent legal status, along with the financial dependency on him which it necessitated, which led to an increase in the level of control he had over her. Any plans for their future were proposed by him:

‘The plan is to get mortgage here. The plan is having another baby…And he knows I’m always dreaming about small car…Because I have driving licence for many years. And he said, yeah, we will buy. We can do this’ (Laima).

Months after she followed him to Ireland, she survived a severe attack of physical violence at his hands and, with her daughter, was forced to leave the relationship. Concern for her daughter’s safety played an important role in her decision to leave.

In other cases, in order to prevent the victim/survivor from leaving, the perpetrator went so far as to keep and even destroy relevant legal documentation belonging to the interviewee, such as their passport:
‘Then he called me and tell me that, ‘I have torn all your papers.’...All of them – he told me that he tore them. My passports, my papers which he had. I said, ‘how can you tear them, why didn’t you give them to me?’ At least that time he could have given me my passport’ (Kagiso).

Traumatic pre-migration experiences were also exploited by perpetrators in their efforts to control the victim/survivor. Specifically, perpetrators attempted to exploit mental health problems that arose from these experiences, and to further erode low self-confidence of victims/survivors, in order to manipulate their behaviour. In itself a form of emotional violence, this tactic was described as one of the most painful experiences survived by interviewees. One interviewee described this as ‘going from the frying pan into the fire’. In her case, her decision to marry was partly fuelled by her need to leave the context in which her experience of sexual violence had occurred. Following this experience, she was constantly frightened. Unable to receive appropriate therapeutic support for this, she sought an escape:

‘I was afraid for a long time. Like, I was afraid they were going to turn up around the area and they were going to see her [friend who was also raped], where she lives or something like that…I suppose for me also to agree to move, like, I just didn’t feel safe anymore you know, so. And when he said this on the way, to maybe get married, you know – I probably wouldn’t be accepting that if this didn’t happen’ (Veronika).

Another interviewee who had survived both intimate partner violence, as well as emotional and physical violence at the hands of a family member, also sought refuge from this trauma in coming to Ireland. This interviewee accepted an offer of support from the friend of a friend, an Irish man, who she met in her home country in Africa. For her, the psychological consequences of GBV had led to her view that coming to Ireland was the only choice that could save her from suicide:

Everything he described [about life in Ireland] described me and the kind of life I wanted. So I say ok. I’m going to decide to take my life, or to go to Ireland...I think about all that violence. At least I’ll see my son grow. Yeah? And we’ll take a chance and go there. And X is a good person. I just convinced myself. I had to convince myself' (Mbali).

In her case, the perpetrator reinforced her negative self-image, with the result that she was unable to leave the relationship:

I came here already stressed, and he knew what I was going through, so he used everything against me. Like, ‘that’s why your family doesn’t care about you, you’re a bad person.’ And that’s what I was told and I believed it. I mean, it’s like you’re telling a killer that you killed someone and he says he hasn’t. A drug addict, ‘you’ve been taking drugs’ – ‘no I haven’t been taking drugs.’ Maybe that’s what’s happening to me. Maybe I am a bad person. And I’m in denial like the rest of them’ (Mbali).

Often, the result was self-doubt, and the abusive relationship continued:

‘You kind of also feel that it was your fault. Maybe I was too argumentative about all those things. Maybe I should have just let go. Maybe that wouldn’t have happened. Maybe I was too difficult to understand, maybe I shouldn’t have stopped and asked him some kind of [question]. I always [thought] back like that. Maybe if I hadn’t done something’ (Bayo).

One interviewee, who was abused by her husband in her country of origin had a low sense of self-worth and a limited sense of control over her life when she followed him to Ireland with her daughter. Her very decision to do so was in itself an outcome of the perpetrator’s efforts to coerce her to follow him, under false pretences. Once here, she was informed he was living with another woman, leaving her with no choice but to go to Dublin alone and to present to the Refugee Application Commission:
I was confused. Then he was telling me, those people are going to give you accommodation, they will take you to the hostels, you will be staying there. And then when you settle, that is when we will see how we will do things’ (Kagiso).

Under his instructions, she sought asylum as a citizen of his country, which was at that time going through a civil war, rather than her own. He also persuaded her to provide false names for her and her child:

‘When we got here, he changed the baby’s name. He said, when you go to Justice, tell them this name. Even you, change your name or we’ll get a problem. Tell them this name…I didn’t have money to say I wanted to go home. What could I do? If I had money, I could say, no, tomorrow I’m going home. What would I do with this? At home I’m not suffering too much, to come and change my name in people’s country. We changed the name, he gave me a paper, big paper like this. You tell the story, that if you go to Justice, tell them this. You must read this, put it in your head…These are lies, that is not mine…Me, I didn’t know really where it was – everything I didn’t know. I didn’t know where to go. You know?’ (Kagiso).

For some interviewees, exploitation of legal status intensified after they left the violent relationship. One interviewee described how her husband, who was Irish, repeatedly contacted the embassy of her country of origin, in an attempt to have her incarcerated for possession of two passports:

‘He made trouble for me. He [was] hassling the…Embassy, telling the embassy what to do, you know? Like, ‘I know in your country, you’re not allowed to have two passports, my wife has two passports, did you know that? Why don’t you do something about that?’ Basically, he wanted me to go to jail’ (Riya).

Others described how the perpetrators threatened them with deportation:

‘He said when I leave him, I’m going to suffer and he’s going to see to it that the Irish Government will receive my name. That they’ll kick me out like a dog’ (Mbali).

One perpetrator persuaded a friend to call her under the pretence of being a barrister, with a view to exploiting her lack of familiarity with the Irish justice system, in order to intimidate her into returning their son to him. He exploited this by arranging a court date and not informing her of it, with the result that full custody was initially awarded to him. He also attempted to exploit the fact that she was relatively new to the area to slander her:

‘He tell everybody, ‘oh, this bitch, that bitch is stealing my money through the bank for four years. Shifting the money. Thousands.’ Some people believe, but most of them don’t’ (Riya).

Another described how her Irish partner had taken advantage of her unfamiliarity with Irish culture to convince her that Irish people were highly racist and would not provide her with any support. This had such a strong effect on her that when her neighbour called a refuge on her behalf, she was certain she would not be accepted on grounds of her nationality:

I saw she was going through the telephone directory and called [service]…They put me onto her and she spoke to me. ‘Where are you from?’ ‘I’m from [country of origin]’. She said, ‘come right now’. I said, ‘I said I was from [country of origin]’. She said ‘yes’, she said, ‘come’…And I thought to myself, I was saying [country of origin] to myself, and it wasn’t coming out. So I had to say it a few times. You know? To make sure that she heard’ (Mbali).

5.2.1 Domestic Violence and Direct Provision Accommodation

None of the interviewees for this study had experienced domestic violence in direct provision accommodation. However, other interviewees living in such accommodation spoke of how asylum
seeker status and direct provision accommodation could act as further barriers to leaving an abusive relationship:

‘I can only speak from the position of someone who has been in the whole asylum seeking point. [There is a need to] stop someone feeling that they are outside, you know, of society...If you are in a hostel and your husband is beating you up, you can at least, [that] you have a right to come to [a service] or wherever, and say, you know what, I’ve got a problem, can I be helped? So without being stuck in that position, saying, well if I say this, how will this affect this? How will it affect my [asylum case]. And you suffer in silence. And it happens a lot. It happens a lot’ (Imara).

This issue was also raised during the consultation process with service providers. Moreover, service providers pointed out that if a woman does experience domestic violence while living in direct provision accommodation, it can be very difficult for her to be moved to another such accommodation base for asylum seekers. Even if she is successful in doing so, privacy cannot be guaranteed at her new address, due to the small number of direct provision hostels and the fact that their whereabouts are available for public knowledge.

5.3 Domestic Violence, Control and Isolation

For migrant women, isolation was a significant feature of their experience of domestic violence. Migration could lead to the loss of important social support networks. This emerged as a very real barrier to leaving a violent relationship, one that countered expectations of a better life in a Western country:

‘When you are home, you talk about Europe, and laws, the way laws are about women and children, those kinds of things. You think someone will change and be afraid of the law. But you now find that things are even getting worse, in a foreign land. No auntie, no sister…’ (Kagiso).

‘Number one I don’t have the energy. Number two, I’m not as strong as I used to be. Number three, I’m alone in this country. I know no one. You know, no mum, no dad’ (Bayo).

One interviewee found herself almost completely dependent on her husband for social contact when she arrived in Ireland on a Spouse Dependent Visa. Living in a large recently built housing estate in the suburbs of Dublin city, she rarely met another person and spoke virtually no English. Following a severe physical attack of violence against her by her husband, which resulted in an open head wound and temporary loss of consciousness, she managed to escape from the house in which they lived:

‘with no shoes, only…the night dress. And no shoes, so nothing. I’d seen about how far he could fight. I had only phone in my hand, you know?...I didn’t get any help and my husband didn’t let me back in the house’ (Laima).

She phoned 911, remembering this number from American films she had viewed in her home country. However, though emergency services did answer, language proved too great a barrier to overcome: she was unable to provide the address to her home:

‘That time I speak English very, very little, like, ‘hello’, ‘my name is’, and I tried to get help, but I didn’t have any phone number you know? Then I remembered from the TV 911...I tried to call but – actually, I don’t know who it was but they kept me on and they started talking to me. But the problem was, I can’t properly tell my address’ (Laima).
Traveller interviewees described how their own strong family based networks, once such an important source of support and wellbeing, could not necessarily be regarded as a source of support, once they became victims of domestic violence. Although family members were sometimes used as a short respite solution to the violence inflicted on them in their home, this could never be seen as a long term solution, or even one that could be used more than on a very infrequent basis. Two reasons were put forward for this. One was the shame and stigma that surrounded domestic violence in their local community:

‘You try to keep it into yourself. You try to keep it hidden. You try to say to other people that’s not happening, it’s not going on. But they do see you coming out with black eyes and they do see the windows broken, the house and they do know what’s going on. But you wouldn’t really sit down and tell them all about it’ (Frances).

A second reason put forward was their concern that in doing so, they would be endangering the safety of their family:

‘I didn’t want to go back around me mother and father because I didn’t want the hassle on top of them. I thought that, going back to them, although they’d welcome me with open arms at any time – but I just didn’t want to bring the trouble back up to them’ (Brigid).

‘I couldn’t go to such a one, let’s say an aunt of mine or a cousin of mine to stay with. I’d know myself that the trouble would be onto them then. See, with Travellers, it’s different with Travellers. You know what I mean? The blame then would be put on me’ (Brigid).

‘You have to put up with it because you don’t want to get your family involved. Like if you go to your mother and father, if they were living…or going to your sisters, that’d only be making trouble for them’ (Margaret).

‘You’d be making sure that you wouldn’t be going to your family, because he could follow you to there, and maybe get your brothers and sisters in trouble’ (Margaret).

‘You see, you can’t go back to your family. Because you get them into trouble, as well as yourself into trouble. And you don’t want to see that happening. So therefore, when he comes to collect you…promising you that he won’t do it no more, just in order for your family not to get into trouble, you’ll just go back. And then you go back and it starts all over again’ (Frances).

One interviewee implied that this endangerment to her family members would be partly caused by an obligation that would be felt by family members to address the unequal power relation experienced by the interviewee in her new home, which could lead to conflict between the two families:

‘I wasn’t that long with my own parents. And the reason for that was, I never wanted them to see what I was going through. Because I had brothers that might get into arguments with him and make more trouble’ (Margaret).

Both Traveller and migrant interviewees found that the perpetrator exploited this factor by further enforcing this sense of isolation. This was done in order to control their behaviour and to prevent them from seeking independence and help. Interviewees described how their opportunities to meet other people in the community were severely curtailed, often through guilt:

When I call into my friends…he’ll say, oh, if you were home on time. I could have got a [taxi] run to X. He would make me feel guilty. He lost out on €100 or €200 because I was having coffee with my friends. ‘If you weren’t having coffee with your friends, I’d be making €200’. ‘Why didn’t you call me?’ ‘There’s no point’…He’s just making me feel bad, you know?…There’s always something’ (Riya).
'He would say, ‘who is that on the phone?’ All the time. ‘Who is that on the phone?’ And I would just say, ‘oh it’s my friend in Africa’. He would say, ‘oh, you are taking too much time consulting with your family. You are married now, you should focus on your marriage’” (Rufaro).

Often, the perpetrator would limit or completely prohibit the level of contact between the interviewee and her family or friends, as well as discourage the formation of new friendships:

‘I could go [home to visit parents] not often, not often, you know, because it was, everything was to ask. If it’s yes, it’s yes and it will only be yes if he knows that…that weekend he want to be free’ (Kagiso).

‘I didn’t have friends that visited me at my house…But I had a lady that I used to go to her house. But I was just going there because I want to but he was like, ‘don’t visit that woman, that woman is not good, she drinks, she smokes, she do this, she will teach you bad things,’ you know? And then I was like, but if I stay, I’m just in one room myself in that small tent, alone, the whole day’ (Kagiso).

‘I would see my parents once every two to three years and he would give me ten minutes with them, and then I would have to repeat to him all the conversation I had with my parents, without leaving out any details’ (Aishe).

Perpetrators also attempted to enforce isolation by quashing attempts to attend further education. On one occasion, this was done through belittling the ability of the victim/survivor as well as by an attempt to forbid it:

‘He said…’what do you think you’re going to do in college? Why didn’t you do college in [country of origin] or something like that. ‘Why you go to college here, what do you think you can do? what sort of a job would you be capable of? You can’t do anything. Bugger all that, you’re finished. You’re married to me now’” (Rufaro).

One interviewee described how she began further education in Ireland. Her husband was unemployed at the time. Eventually she was forced to leave her third level course, just before her final exams. This was ascribed to the fact that when she was attending college, he was responsible for caring for their children. This reversal comprised a transgression of patriarchal, traditional gender roles, a transgression, which she discovered, could not be tolerated for very long:

I was going to college. And he was minding the kids…he was on social welfare…I’m getting something I feel I can do. But he didn’t like that. He didn’t like the fact I was going out and coming back a lot so he has to mind the kids and blah, blah, blah…I had to stop it. I had to stop it because it was too much - I would come back from college and there was always something, this, this, this…I didn’t even have a lunch time, because at lunch time, I ran home to take care of the kids, and change nappies and make lunch and do that. But still, there was the complaining’ (Bayo).

‘I didn’t think that was asking too much…I felt so sad. After all my hard work. Then he kind of get angry. He say, you don’t work all day, la, la, la…And even though you do everything as a wife can, you get pushed, you know?’ (Bayo).

5.4 Racism

None of the non-indigenous interviewees experienced racism in their use of services in Ireland, or in their encounters with the general public. The only incidents of racism among this group were encountered by those women whose husbands were Irish. In such instances, verbal attacks carried out against them could betray deeply racist views:
'He said, 'oh no, you’re not going anywhere. Where do you think you’re going? What do you think you’re doing? Who do you think is going to listen to you?...You bitch'. You know, things like that. ‘I know you didn’t want to marry me, you married me because of my status...You horrible bitch, you in Africa.’ You know, all sorts of...terrible things, you know. ‘Your mother didn’t teach you good manners. I’m your husband. You’re too much focusing on what you want to do, what you want.’ (Rufaro).

Non-indigenous interviewees whose husband was Irish expressed a sense of unequal power relations in the relationship. One described how, at a very young age, she was enticed to marry an Irish man holidaying in her home country. While working as a waitress in a hotel, she described being dazzled by his promises of a life of wealth and luxury; promises which later emerged to be untrue:

‘I worked in the hotel, the restaurant, and he was on holiday...He invited me over here. And it was wonderful from the first day. Everybody likes the little things, like a nice life. Who would refuse it? Of course, yeah, go. [I was] very young. 21. And he was 11 years older...It’s nothing like his promises. He said, ‘oh, you want to go shopping on London? To Paris? I’ll give you plenty of money...Who doesn’t like to shop?’ (Riya).

Later on in the interview, she returned to this point, noting that fear also played a role in her acceptance of his offer of marriage. Though she did not describe her relationship with him as being violent at this point, she had been so concerned about his reaction should she refuse, that she felt obliged to accept, suggesting unequal power relations between her and the perpetrator at this very early stage:

‘The reason I get married is not 100 percent because of love, right? Because I thought, God, if I said no, what might he do to me?’ (Riya).

For members of the Traveller community, discrimination was perceived as a significant factor impacting negatively on the welfare of the community and in turn on the support options for a victim/survivor of domestic violence. For example, interviewees described how discrimination against the Traveller community led to unemployment:

‘He does nothing for a living because there’s only the dole. You won’t get anything. Travellers won’t get anything for work. Because you’re discriminated, like, by the Government for a job. If I went looking for a job, I wouldn’t get a job either because I’ve no education and I’m a Traveller’ (Margaret).

Interviewees from the Roma community recounted discrimination and racism when they lived in Romania, which negatively affected their access to health and social services, as well as the police:

‘I had problems [with the Romanian Police] because of my husband; they would interrogate me as well...Our right was taken away in many things because we were gypsies’ (Aishe).

‘If I was in pain, they [healthcare providers] would call me stupid and say that I was lying’ (Donka).

‘Once, he hurt my head, I had to get stitches...I called the ambulance, and I didn’t get any help; if you have money to give to the doctors, they will help you, otherwise they would let you die slowly...They don’t help us, they laugh at us, and they avoid us. They wouldn’t place us in the same room with the Romanian women, they would place us in a separate room, where the conditions are not that great, and they ignore us’ (Lyuba).

Roma interviewees described their experience of discrimination as being worse in Romania than in Ireland. Unsurprisingly, these experiences negatively affected Roma interviewees’ perception of
the potential role of such services in Ireland in relation to their experience of domestic violence, though Roma interviewees did speak positively of their experience of health services in Ireland.

5.5 Exacerbating Factors

5.5.1 Alcohol

Many interviewees noted that the perpetrator had an alcohol dependency issue which emerged as an exacerbating factor. In particular, alcohol abuse was associated with the worst physical attacks survived by interviewees:

‘He came back and he was so drunk, and he took to sleep with me but I resisted. And when I resisted, he beat me up. He wanted to lock the door…so I could not escape…he came into the bedroom where he started to force me. To force me into having sex…I refused, totally refused…Then he had to use force…I resisted…He became so angry…he got me in the corridor…He got me in the face. His hand entered my mouth. He’s crashed me…I think it doesn’t matter what I do. I think he just wanted to kill me. He held me in my ribs. And my rib wanted to break. He held me so tight’ (Dhakiya).

‘I remember that one night he came home late. He was drunk, you could smell the alcohol all over him. He came to me and I told him to leave me alone. He started hitting me. He tied me to the bed with his socks and abused me sexually, while he was hitting me at the same time’ (Donka).

‘My man used to be an alcoholic, used to beat us up, used to kick us out of the house. We couldn’t even eat quietly nor sleep. Because he was an alcoholic, he used to cause problems very often. My life was torture with him’ (Aishe).

‘One night, it was around ten pm when he came home, [he] kicked me and the children out of the house and he locked himself in the house…it was cold and it was winter time. The children and I were almost naked, with no clothes, we were outside in the cold…He was drunk. He kept us outside the door for a very long time’ (Donka).

‘He goes off and gets the dole…and he goes off and drinks it. And he comes back and he will beat you. Beat you. More or less blaming you that he has no money and more or less blaming you that there’s no money for him to keep drinking. Especially when they start drinking, the violence happens more and more’ (Frances).

One interviewee who had pointed out that most of her experience of domestic violence had been perpetrated by family members of her husband, noted that when drunk, her husband was also violent towards her:

‘He started drinking, he would come home drunk, he would pick a fight with me, he would slap me sometimes’ (Florica).

Drug use did not emerge as an exacerbating factor for the interviewees of this study, but the evidence suggests that it could be one for many Traveller women who are victims/survivors of domestic violence. As noted in the review of literature, there is a high level of drug dependency within the Traveller community.

5.5.2 Financial Strain

Finally, low income emerged as another exacerbating factor on domestic violence. For some it was migration which led to financial strain:

‘We would really, really, really be the best for months again. And then out of the blue he would say something…and you know, that was when we were here, because then there
was no money...It was really, really tough...There wasn’t any jobs. He couldn’t get any job. And he was on social welfare’ (Bayo).

Traveller interviewees described how discrimination against the Traveller community led to high unemployment levels, which in turn causes poverty. Denied the opportunity to achieve financial independence, Traveller women can become trapped in a violent relationship:

‘You have no money to go anywhere. The poor income that’s coming in, you haven’t the price of taxis to get yourself and your family [away]. You don’t know where to go. You’ve no information’ (Frances).

5.6 Resilience, Survival and Coping Strategies

Interviewees who survived domestic violence related a range of valuable coping mechanisms they had developed during the abusive relationship. For some, religious belief was perceived to be an essential survival tool:

‘I go to mass every Sunday anyway. That’s one thing he didn’t stop me from doing’ (Frances).

‘It’s a fact that [religion] gave me the comfort. Sometimes, you know, God makes things happen for a reason. And yeah, it’s very difficult, you cry and this and that, but you get through it. You know you will get through the bad times’ (Bayo).

On the other hand, one interviewee recounted a loss of faith due to her experience of domestic violence:

‘Sometimes I’d pray to God. Sometimes. You know what I mean? I often wonder sometimes if there was a God up there—I often felt that. Like, if there was a God up there, why can’t he hear me saying those words, ‘please help me’?’ (Brigid).

Interviewees spoke of their love for their children as a source of strength that enabled them to continue through the worst experiences:

‘The kids used to keep me going. If I hadn’t got the kids, then...I would probably have ended up in an asylum...They were the only thing I had to hold onto...If I didn’t have them, I don’t think I would have been strong enough to go on, to be honest with you’ (Brigid).

A Traveller interviewee successfully persuaded her husband to move their caravan to the site at which her family lived. Though this move did not signal the end of the abusive treatment of her by her husband’s family, this resilience led to a substantial reduction in the frequency of physical and verbal attacks.

Some interviewees who experienced GBV in their country of origin did benefit from informal support through family members and friends. For them, this support comprised a valuable coping mechanism, both providing emotional relief as well as more practical aid:

‘I felt very well, it felt like my mind was peaceful, my soul, I was set free...They would tell me not to get upset over everything anymore, not to cry, and to endure so that I can have a family. They comforted me as much as they could’ (Donka).

‘He had to buy everything...if I got a nice thing, it’s only from my mother, if I went home. And maybe my mother just say, ‘I hate how you seem not to have clothes,’ and she will buy for me and the baby’ (Kagiso).
‘When he slept was when I took my things. My brother’s wife collected me. She saved my life’ (Dhakiya).

5.7 Accessing Support

All interviewees reached a point where they had to leave. For some, this occurred following a very severe attack of violence. One interviewee described how her husband returned home drunk one evening and physically beat her, causing an open head wound. The suddenness and physical force of this attack made her fear for her life. Immediately after this attack, she ran out of the house and sought help. Another change that led to this first step was migration to Ireland in itself. For some, this was associated with opportunities for increased financial independence and greater support from external services:

‘Now that I [had] come to Ireland, I knew that it was the one thing - I should have a way to get out. At that that stage, no. It just had to stop…I knew that here you can call the police and everything (Bayo).

An important finding was the low level of awareness of services and entitlements among these interviewees. This was reflected in the crucial role sometimes played by casual acquaintances or even complete strangers to the interviewee in providing help when it was needed, usually in the form of linking the interviewee into appropriate services. One interviewee found herself on a residential street in a city, after sustaining a blow to her head. She recounted how she ran into a shop, with a view to getting out of sight of the perpetrator. A woman, who happened to be there, provided the help needed for her to leave the relationship. Another interviewee described how she befriended a neighbour, despite the efforts of the perpetrator to isolate her. When he returned home drunk one night and began to be verbally abusive to her son, she sent her son to her neighbour, following herself once it was safe for her to leave. Another described how her husband on returning home drunk one night was physically violent to her and forced her from the house for part of the night. Her knowledge of English was very limited and she had only one friend in Ireland at that point. In her case, flatmates with whom she and her partner had been living with for a short period of time provided this link after her husband left for work that morning, driving her to the family courts service. Indeed, in all of these cases, these informal supports played a crucial role in linking the interviewee with relevant services.

5.7.1 Patriarchy as a Barrier to Accessing Support

Not only did patriarchal social norms emerge as a causative factor in the experience of domestic violence, they also acted as a barrier to accessing required support from both informal and formal sources.

Many found that such normalised values regarding gender inequality meant that neither formal nor informal support mechanisms were available to them at all, both in their country of origin and in Ireland. To avail of informal support was to risk increased social isolation and condemnation:

‘The biggest problem in [country of origin’ is, if you go and talk to somebody about [how]…you’ve been abused by your husband, to them that is normal. That if you do something, you might be disciplined by your husband. So to you, whoever you tell, they’ll want you to be on your husband’s side. Whatever it is, if you’ve done something wrong, then you need to be disciplined. And now what he would do, he would stand around and say I did something wrong, and he was just disciplining me’ (Etinosa).

‘I knew the minute I picked up the phone to call, I know everybody would go against me. Even my own father. Because I know everybody would be – that’s the worst thing you can do…They believe that a woman should never leave her house…They feel very strong. Because people who are working and doing this and doing that, just picking up the phone and calling the guards on your husband – you shouldn’t do that…There’s no surprise to
them about it. They believe so much in everything. And I knew that I took the risk of really getting isolated if I did that. Because I wouldn’t have much support’ (Bayo).

This norm led to an aura of shame and stigma around the experience of domestic violence, and particularly around reporting it to the outside world:

‘You are ashamed to tell other people because, you know, you kind of also feel that it was your fault. Maybe I was too argumentative about all those things. Maybe I should have just let go, maybe that wouldn’t have happened...And, there wasn’t many help out there…It would be kind of your duty to make things work on your own. You know, you just have to accept it’ (Bayo).

One interviewee, who received emotional and practical support from her parents, identified this as a key factor in enabling her to leave the violent relationship she was in. She expressed her gratitude for this, but also noted that in returning to her parent’s home, she brought shame on them from the rest of the community in which she lived:

‘So I was quite happy to be with my parents but then I was there. You know in my country, if someone is married before and then they go back to their parents, it seems like you are bringing shame on your family so people...talk, of the village...It doesn’t make it easier. It makes you feel like you are in the wrong place’ (Etinosa).

On some occasions, interviewees described this factor being further compounded by a general view that their partner was a ‘respectable’ person, unlikely to commit violent acts:

‘I didn’t have a friend I could go to because even if I go tell them, he will not believe that he is capable of doing that. Because he’s a very respected person’ (Etinosa).

Unsurprisingly perhaps, two interviewees expressed a sense of distrust regarding the advice they may receive from friends,

‘People give you different advice. There are some who give you some advice. You can’t take all the advice people give you. You could also make it out to be sham’ (Dhakiya).

‘Outside, people don’t really understand that what happens is violence. It is only the person who is in need who really understands what happens. And it is only that person that can really know the way out. Because while other people don’t really know, that person really know’ (Bayo).

To seek support from formal services was often considered unthinkable for the same reason. Regarding the criminal justice system, one interviewee who had survived domestic violence both in her country of origin and in Ireland noted,

‘Here in your country you can go to the guards and they will help you. You don’t understand, you cannot do that in [country of origin]. You know? There’s no police that will answer you on that’ (Bayo).

When asked if she ever reported domestic violence to the police, another interviewee responded, ‘no, because I was afraid he would kill me.’ She went on to note,

‘One time I told a friend who was one of his relatives. That lady told him about it and he beat me up and made me suffer for a long time. He wouldn’t let me go out of the house for a week, so since then I haven’t told anything to anybody’ (Dika).

5.7.2 Domestic Violence Services
Interviewees had past experience of staying in refuges, housing association accommodation for victims/survivors of domestic violence, or of use of outreach domestic violence services. Often,
refuges led on to transitional housing. Referral methods included self-referral, referral by a friend or acquaintance, and referral by a social worker. All of these interviewees were at time of interview either living in their own accommodation through the private rented sector or local authority, or were living in independent accommodation provided directly by the organisation, such as transitional housing units. Interviewees who had migrated to Ireland had had no knowledge of relevant services prior to contacting them either themselves at a moment of crisis or through the assistance of a stranger or acquaintance.

For all interviewees, one of the most important aspects of the care from domestic violence services was being listened to in a non-judgemental and empathetic way. When this occurred, it could overcome barriers such as stigma and shame:

‘Then, I talked to X. She really made me confident. In the beginning, I was thinking, oh, God, I’m not going to say stuff like that…I didn’t meant these things to happen. It’s not nice, you know…People say, oh why she’s leaving, whatever. So, X and the [service provider], they’re both listening…And they make me confident. You know, and make me. Very nice, very good, very understanding. It’s support…It’s not judging me. I am so surprised. Because, maybe because I don’t have that experience in [country of origin]. I don’t think I would find good, would feel like this if I was in [country of origin]’ (Riya).

Other important features included help with practical issues such as accessing accommodation and childcare facilities. The importance of private accommodation was also raised:

‘You have your own home. You have your key to your own front door. It means you can go in, sit down, and make your own tea. It’s like your own home…It’s your own private space. Where, if you’re in a refuge, you’re stuck in the one room. Kids are on top of you in the one room, you know what I mean. Then if you go out to the sitting room, you’re surrounded by people you’ve to talk to and stuff like that. It’s still not your own home…[Now] I have the key to me own door’ (Brigid).

Clear information on all the options available was key:

‘At that time, there could have been more information about you know what I mean, I didn’t know at that time that X was available…They could have been telling me about the houses and stuff, you know what I mean?…Like, if they took you into a room, let’s say here, and said, listen Brigid, you have loads of options here…I think the best thing ever happened was [service provider]. If I had known that years ago…things wouldn’t have been so bad’ (Brigid).

5.7.3 Barriers to Receiving Support from Refuges for Traveller Women

Traveller interviewees sought and received support from refuges. Some very positive experiences were shared regarding this support, and are represented in section 5.7.2. However, certain barriers were specifically raised by Traveller interviewees who used refuges as a temporary respite from a violent relationship. These interviewees would spend approximately one week in a refuge before returning home. One noted that she had stayed in most refuges in the country for short periods of time. The benefit of this was limited, as it could lead to increased attacks on her return:

When you’re living with him, you’re at home, you had no peace. So you don’t win anyway. You know what I mean? If you go or stay, you win nowhere’ (Brigid).

This interviewee did not stay longer than a week, due to fear of her children being placed in care. This concern was partly due to the fact that her children often had to stop attending school when living in a refuge:

‘Mostly what drove me back was the children from school. Like they’d be missing school. And then I’d be getting phone calls saying that the kids are missing out of school and why
are they not in school? I was just scared that the children would be took away from me’ (Brigid).

A second cause of the brevity of these stays, which also led to her staying in different hostels, was a suspicion that service providers in the hostel could also take her children from her. She noted that she was not alone in this view:

‘Most Traveller women do think that. That’s the biggest fear of them, is their children being took off them…Traveller women do think that if you go into a refuge, that they do be setting them up…I mean that’s what I felt. For years when I went in, I thought they were saying this and giving it to all the social workers. I’d say, she wants to get me children took off me…Because they never said anything like, well there’s such a thing out there for you, that will help you try and get a house. If was always, ‘does your husband beat your kids? Does he beat you?’ That was it then. That was all the information you got. Like, that would frighten anyone…You’d just feel in your own mind, what are you doing here? You’d be better off to go home’ (Brigid).

When asked, Traveller interviewees shared the view that having a Traveller woman as a staff member of a refuge would address this issue:

‘It would be grand if there was a Traveller woman working in there. A Traveller would know there was a Traveller there for them…and you would feel comfortable and go in and sit down then and talk to her and tell her your problems. You can’t be telling your problems to other people’ (Margaret).

‘If it had been a Traveller at the time, you’d understand, like it’d be one of your own people, they’re not going to get your kids took away…And they’d know where you’re coming from and your background and stuff like that’ (Brigid).

Another stated barrier included the fact that boys aged over 14 years were not allowed residency in refuges:

‘If they can’t fix you up with the big boy, 14 or 15 years of age, you’re not going to go in yourself and let him out the streets roving…Because sometimes the father has a bad temper, he’ll beat the children as well’ (Margaret).

5.7.4 Mainstream Health and Social Services

Stigma surrounding the issue of domestic violence prevented interviewees from disclosing their experiences to their GP. Traveller interviewees in particular related their sense of frustration over this issue: in their view, this sense of shame would have been overcome had their GP raised the issue him/herself:

‘I’ve often gone down with black eyes to the GP and she never asked me what’s the name. So therefore, I wouldn’t tell her when she wouldn’t ask me. I think it’s up to her to ask me questions as well, if they want to help you. But they don’t ask you any questions. They just – you just walk in there and get your prescription and you’re gone out the door and that’s it…The GP won’t ask you no questions. And I think they should. Because you might open up if they put questions to you’ (Frances).

However, another noted that they would not confide in their GP, due to a perceived threat of the GP communicating this to the Gardaí, a fear that highlights a general mistrust of mainstream services:

‘You’d say that an accident or something happened, because you’d be afraid if the doctor rang the guards, if he’ll tell the guards, that the story will get back to him then and then you’re in for more torture’ (Margaret).
Traveller interviewees described a constant fear of their children being taken into care should they seek support from mainstream health services:

‘You’d wait until your bruises would be gone, because you’d always be thinking if you went into hospital, where were the children going to go?...You’d leave it for a while’ (Margaret).

‘Well, the social workers is always inclined to put the children away...We haven’t a lot of trust in putting children into care, because, with the way that you hear on television about those places, that the children is better off with you than they are putting them into care. Because it’s not care. We look on it that it’s not care’ (Margaret).

One interviewee only sought support from a social worker after her children had been taken into care. This occurred at what this interviewee described as the lowest point in her life – she had attempted suicide and had escaped from a psychiatric ward of a hospital. When the threat of her children being taken away was removed, she was willing to trust her social worker to provide the support she needed. She was successfully referred by the social worker to a voluntary housing association for victims/survivors of domestic violence. Soon afterwards her children were returned to her and at time of interview she was living there in safety, and regarded the move as the most positive step she had taken since she married her husband.

Another interviewee even described how sexist values acted as a barrier to her receiving required care from healthcare services. Her fear was that her husband would reveal the reason behind his abuse of her to healthcare staff, namely that she was not a virgin when she became married. This she felt would be cause unbearable shame:

‘I was left with stripes on my body and bruises, but I did not want to go to the hospital and did not go out at all so as not to be seen like that because then my husband would have had to say why he had done this and I did not want that’ (Nadya).

5.8 The Criminal Justice System

Most interviewees had some level of contact with the criminal justice system regarding their experience of domestic violence in Ireland. Many contacted the Gardaí for protection when the perpetrator was being physically violent towards them. In such situations, some migrant interviewees described the difficulty involved in making initial contact. In the country of origin of these interviewees, the police were never called upon to intervene in cases of domestic violence, which was perceived as a private matter:

‘Here in your country you can go to the guards and they will help you. You don’t understand, you cannot do that…There’s no police that will answer you on that’ (Bayo).

Moreover, there was a high level of stigma associated with informing anyone outside the family of domestic violence. In doing so, the victim/survivor risked denunciation from other family members and even ostracisation, for bringing shame on the family.

They believe you are protecting your family by not calling the Garda...No matter what he has done. So you pick up the phone and call the guards, he’s drunk. [They say] well, you shouldn’t have done that. Why can’t you call another? (Bayo).

Most interviewees were aware that the Gardaí could be contacted to intervene regarding domestic violence. However, they still feared a negative reaction from their community for taking such a step. This interviewee described how for a long time after her arrival in Ireland, she would pick up the phone determined to call the police, but could not bring herself to make the call. When she finally contacted the Gardaí, she did not immediately initiate court proceedings against her husband. However, the experience helped her to gain a sense of control, and she subsequently used it as a strategy of survival:
‘I always know information is power. It’s because I know this is wrong. I will go to the cops for it. So I know these things. So I say, I’m going to call the police. And I’m going to go to the court. So he would go’ (Bayo).

Migrant interviewees also shared their experiences of accessing an interim barring order. Generally, the process was described positively. However, absence of an informal support structure in Ireland emerged as a potential barrier. One interviewee, who was brought directly to the family courts service by a flatmate the morning after sustaining a physically violent attack, got a one week barring order on the day she presented to family courts service. She was told to return to her home with the barring order and present it to her husband. A member of the Gardai was to call to her home at six that evening. However, she feared that in the meantime, she would be left alone with her husband:

‘They say to me, go back. We cannot help you…Go in your home and go in X Garda station. This is for Garda and this is for you…6 o’clock it’s time when the Garda must come… I said, if I go in house, he gonna kill me, you know? And I’m crying. All the time I’m just crying, you know. But it’s just crying, like you know, it’s hard because it was really bad, you know?’ (Laima).

While the barring order did enable her to leave the violent relationship, having no friends or family in Ireland acted as a significant barrier at this point. All of this was compounded by the fact that she did not speak English and that the interpreter provided spoke a second language of the interviewee, which she did not speak fluently:

‘They said I must go back in my house. And I’m just crying because I don’t understand if there is barring order for me. I don’t fully understand what they say…It was French, you know? If you don’t have a translator you know? But that was the main word’ (Laima).

It was then recommended to her that she ask her local Garda station to send a Garda to wait with her until her husband arrived. Then she would be referred to a hostel. On this advice she left. However, this support was not provided to her at her Garda station. This problem was exacerbated by the general isolation the interviewee felt in this traumatic situation she found herself in, in a foreign country:

‘I got only ten euro in my pocket…I don’t know Dublin, it was really difficult. But it was like dream, you know? Everything was like go like, you know…Pain in my head, still open, you know? And just everything was shaking’ (Laima).

Fortunately, she had one acquaintance in the country who she successfully contacted and who agreed to act as intermediary until a member of the Gardai arrived. When the Garda arrived, she and her daughter left the house and moved into emergency accommodation.

Traveller interviewees also spoke of the negative perception within their community of contacting the Gardai regarding domestic violence. In addition, Travellers spoke of a perception among the Gardai they did contact that domestic violence is a part of Traveller culture, and that their intervention was not appropriate:

‘Sometimes you don’t get much help from them [Gardai]…When they know that you’re a Traveller – ‘oh, sure that’s just for the time being, you’ll fix that up a different way, you know?…It’s more a kind of a laugh that they make of you, the guards, to be honest about it’ (Margaret).

‘When you’re getting beat, when the police…comes up, and they see you, it’s just a man and wife, forget about them, it’s only a family affair…And then if you want a barring order…He has the Gardai’s permission as well as your own…That just leaves things worse’ (Frances).
One Traveller interviewee called the Gardaí because her husband would not leave her accommodation after she had secured an interim barring order. When she called the Gardaí, he locked himself in the bathroom. The support she received from them was limited and the perpetrator was not arrested:

‘He locked himself from the inside, and they locked him from the outside…They just stood around for- they said like, we can’t get in at him…There’s nothing we can do, we can just lock him from the outside…I said to meself, that’s just a waste of time really, calling the police’ (Brigid).

**Court Accompaniment**

The final issue raised by interviewees regarding the criminal justice system was the experience of appearing in court, which was described as intimidating and frightening. Those who benefitted from court accompaniment from a VAW organisation, spoke extremely highly of its value. For them, the daunting nature of appearing in court was heightened by the fact that the language was not their own, and that they were unfamiliar with the justice system it represented. Court accompaniment gave greater confidence:

‘The difference when I got in contact with [service provider], and they went with me to court. I was just walking in and he saw me with two people and he didn’t know them. He can’t scare them away, he can’t look at them. So now, he doesn’t know how far I’ve gone. Because, he doesn’t know…maybe they’re coming to take him to jail and whatever. And two new people! Because, you know, what are you telling new people? About our history…And now I’ve told these two people, and he’s like, who are they? And I was so much at ease’ (Bayo).

‘First of all my English – it’s not so good. And it gave me confidence. See, even if I spoke English, it’s different with other people – it make my English more confident. And X maybe can…fix…what needs fixing. But like, in court, like it’s all big language. She was there. She gave me support’ (Riya).

### 5.9 Immigration Law as a Barrier

One interviewee, who migrated to Ireland on the spouse dependent visa found herself and her daughter in very vulnerable circumstances when she left her husband. With only one acquaintance in Ireland, she was dependent on support services, such as refuges. This interviewee was affected by the Habitual Residence Condition. Having been in Ireland only a matter of months when she left her husband, she found herself only with access to emergency social welfare. Through the help of a voluntary organisation, she was given emergency accommodation in a direct provision hostel for asylum seekers, where she lived for seven months. This accommodation was substandard:

‘One month we cannot eat for the smell, for the even toilet using and everything, you know?…And we’re living in – my room was smaller like than this kitchen…Like this (indicates box room size). Only bed…And toilet was downstairs. Like you want at night-time toilet, you must go out. And I bought small bowl, because it’s difficult carry daughter, you know, down all the steps, you know, it was very difficult’ (Laima).

She describes how, as a consequence of this, she and her daughter suffered ill-health:

‘My daughter fell sick. I start to get, you know, in my legs, because it’s probably food and vitamins. All the night, I had pain in my leg, you know?…I’m crying from the pain…. It was very long wait [to receive medical card] you know, because I was on emergency money. I was nothing, you know? The rules in this country for get any help after a woman stay two year, after you can get this’ (Laima).
During this period, this interviewee received abusive text messages from her husband. She noted that had he sent messages asking forgiveness or asking her to return home, the circumstances she found herself in would have made her feel very vulnerable to doing so:

‘Thank God he didn’t write this. Because when you are alone, and you have no money, you can do mistake, you know?’ (Laima).

It was over a year later that this interviewee was granted residency status.

5.10 Key Points

- Physical health consequences of domestic violence included injuries such as open head wounds, fractured ribs, collapsed lung, teeth being knocked out and knife wounds, hypertension, eyesight and gynaecological problems. Psychological consequences were perceived as being much worse. Interviewees spoke of a very poor sense of self worth, feeling loss of control over their own life, a constant sense of fear and anxiety and depressed moods. Seven had attempted suicide.
- An underlying theme running through all interviews was the perpetrator’s constant desire to demonstrate the control he had over the victim/survivor. This control was manifested through irrational justifications for violent attacks, repeated infidelities, verbal attacks aimed at decreasing the victim/survivor’s self-esteem, financial abuse, sexual abuse, and forced labour.
- A number of issues can increase the perpetrator’s control over the victim/survivor, including her legal right to reside in Ireland being dependent on his immigration status, increased financial dependency when not allowed to work, and social isolation caused by language barriers. For those seeking asylum, moving from one direct provision centre to another can be very difficult to achieve. Even then, the small number of such centres limits the degree confidentiality regarding the victim/survivor’s new address.
- Social isolation was a strong theme. Migration led to the loss of important social networks of support. Traveller interviewees described how their own family-based networks, once such an important source of support and wellbeing, could not necessarily be regarded as a source of support once they became victims of domestic violence, except on an infrequent respite basis.
- Traveller women spoke about how discrimination against the Traveller community leads to high levels of unemployment and poverty, factors which can trap women in violent relationships. Low income was also described by migrant women as a compounding factor.
- Interviewees showed great resilience in surviving violent relationships. Important factors included religious belief, love of children, and support from friends.
- There was a low level of awareness of services and entitlements among interviewees. This was reflected in the crucial role often played by casual acquaintances or even complete strangers in providing help when needed.
- One of the most important aspects of care from domestic violence services was being listened to in a non-judgemental and empathetic way. These features could overcome the barriers of stigma and shame. Other important features included help with practical issues such as accessing accommodation, childcare facilities, clear information on all options available and a person-centred approach.
- Traveller interviewees used refuges for temporary respite from a violent relationship. Barriers to accessing support from services included fear of reprisals from the perpetrator(s) and fear that their children would be taken into care. Another stated barrier included the fact that boys aged over 14 years were not allowed residency in refuges. Traveller interviewees felt that having a Traveller woman as a staff member would help to make them to trust service providers more.
- Stigma surrounding the issue of domestic violence prevented interviewees from disclosing their experiences to their GP. Lack of trust in GPs was expressed by some Traveller interviewees, who did not disclose domestic violence to their GP due to a perceived threat of the GP communicating this to the Gardaí. This was also related to the fear of their children being taken into care.
- Most interviewees were aware that the Gardaí could be contacted to intervene regarding domestic violence. However, they still feared a negative reaction from their community for taking such a
step. Accessing the Gardaí helped interviewees gain a sense of control, and was used by some as a strategy of survival.

- Garda presence is not guaranteed when the victim/survivor presents the barring order to the perpetrator. Both migrant and Traveller women face barriers in involving friends and/or family in their experience of domestic violence, and so cannot rely on their presence in this situation either.
- Among Traveller interviewees there was a perception that domestic violence was seen as a part of Traveller culture by the police, which reduced their motivation to enforce barring orders.
- The intimidating nature of appearing in court was heighted by language barriers and unfamiliarity with the Irish criminal justice system. In such cases, court accompaniment was invaluable.
- The Habitual Residence Condition emerged as a significant barrier. For one participant, over a year passed after she left a violent relationship, before she was granted residency status. During that time both she and her daughter suffered negative health due to deprived living circumstances.
6 Other Forms of GBV and Minority Ethnic Women

This section documents the experiences of minority ethnic women who survived GBV in a pre-migratory context. Specifically, it explores such experiences in a context of violence, such as conflict-based rape and harmful traditional practices, namely forced marriages and female genital mutilation (FGM). In many ways, the experiences and needs of these women are very different to those who survived domestic violence in Ireland, and it is for that reason they are presented separately here. However, common themes emerge, such as patriarchy and maintaining control over the victim/survivor. All interviewees had needs resulting from these experiences on arrival to Ireland, even including the small number who did not experience further forms of GBV in Ireland.

6.1 GBV in the Context of Violence

For many interviewees, pre-migratory experience of GBV was contextualised against a background of violence. Such contexts included civil war in countries such as Rwanda and Uganda, large-scale displacement of refugees in Botswana from Burundi, racial tension in South Africa and general social instability in Russia following the collapse of the Soviet Union. For these interviewees, their experience of GBV was caused by such instability, which often led to multiple experiences of GBV. For some, such contexts formed at least part of their need to migrate.

6.1.1 Multiple Traumatic Experiences in the Context of War

Some interviewees with the legal status of asylum seeker had experienced a range of traumatic events in the context of war, which ended immediately prior to their migration to Ireland. Such experiences included conflict-based rape, rape during the migration journey, wrongful incarceration, separation from their family, bereavement, being in captivity, forced labour and torture.

Those who had been taken into captivity by rebel soldiers endured forced labour, with daily duties including collecting firewood and preparing food. A brutal regime was described:

‘The soldiers, they are very brutal... Some of them have ended up in the bush for all these years. Because the war has been going on for 20 years... And they knew nothing apart from killing or doing these things. They’re not long in a home, they don’t know. Some of them, when they were taken, they were made to kill their parents or do anything, kill somebody, to make them strong’ (Kissa).

This brutal regime was maintained by physical violence, and sometimes murder:

‘Yeah they were violent. They can kill. They can order you to do anything. You see people killed’ (Kissa).

Sexual assaults were carried out under threat of murder:

‘And everyone come to say, if you don’t, it means that you will die. It means that you will have no trace and they would take you by force then. They don’t have to ask you’ (Jendayi).

Living conditions were extremely poor; privacy was not possible. Captives lived under the constant eye of rebel soldiers. One interviewee described witnessing captured children, male and female, being trained to become rebels themselves. She described other female captives giving birth in that context, with no medical aid:

‘And some girls were pregnant. And they would give birth there, right in the bush. They don’t see anyone. The family don’t see’ (Kissa).
The emotional trauma was acute. One witnessed the brutal murder of her friend that was also captive there. Both interviewees believed they would not survive the experience and lived under the constant fear of death:

‘So you live with that fear. You can’t even sleep. Sometimes you stay awake, thinking they are going to kill you’ (Kissa).

Another interviewee was raped during her migration journey, following the outbreak of war in her country. She felt unable to confide to her mother and sisters with whom she was travelling, which she partly attributed to the fact that they had survived conflict-based rape during the war, which she herself had witnessed:

‘You have soldiers that came into our house and...my mother and the rest of the women who were there got abused by the soldiers. And we were all on the side, just watching it happen...They were raped. Because...they just came in with guns, and my mother and those other women were being held. They were all from the X tribe’ (Imara).

Her mother and sisters never spoke about their experience of conflict-based rape, due in part to the high crisis situation they found themselves in immediately afterwards, as migrants escaping a war zone.

‘You know, when that was taking place...everyone is moving around. There is no time to think. You think, you die. So the whole point was...get yourself a place and then maybe you see what happens. But then when we got into [country of transit], we couldn’t stay there because we thought, especially with my mother, we thought the whole thing can happen again because the same people you are running from in the country are the ones that are coming out of the country. So we got into [country of transit] and [it] was also about hiding and then we moved into [country of transit]. But this whole time it’s - nobody says anything because you don’t know who you are in the country. You don’t know who is – no one is offering you help, no one is saying you can stay in this country, you can be safe, you can seek help. So you’re stuck in the middle, so no one says anything...My mother never said anything. And, now that I look back on it, she might have been suffering, but it looked like she was going on still’ (Imara).

This negatively impacted on her own ability to seek support from her family:

‘Afterwards, I couldn’t say anything. I couldn’t tell anyone anything. The only – the closest person was my mother but even, I knew we couldn’t talk about what happened to her so I couldn’t talk about what happened to myself...[It's like] it’s something to be ashamed of, you know? Or something you don’t talk about. You just go through with it. And I know in my family most of the time they used to say, what is the point of talking about it? It happened, bury it, put it under the carpet and go away with your life. Continue with your life, because there’s nothing you can change. It’s in the past now’ (Imara).

Two interviewees were wrongly incarcerated, and while in prison they were victims of repeat sexual assaults. One of these interviewees also survived physical and psychological torture and both were kept in isolation. One contracted malaria while in prison, the other contracted a sexually transmitted infection. Neither received any medical attention.

Chance, courage and unexpected sources of help were common threads running through interviewee’s narratives of their final escape from captivity. One interviewee held captive by rebel soldiers was given the opportunity to run away by one of the soldiers themselves. This occurred following the murder of her friend by another rebel

‘He said, can I tell you something. I said what. He said, you can go now. You go. I'll let you go. Because the same thing is going to happen to you. I say, ‘how can I go in this place? I don’t even know where to start walking.’ He said where to go. He said, 'I’m going
This unexpected act of friendship led directly to a 20-kilometre trek through the jungle that took days, alone, where the threat of wild animals and other rebels was very real. Another interviewee took advantage of a rare moment of being unwatched to escape through the jungle. After many days, she finally found support in an NGO camp.

For those who were incarcerated, escape was made possible through further acts of friendship from unexpected sources. One interviewee was helped escape by a relatively high ranking Government soldier working in intelligence who arranged for her migration to Ireland, bestowed because of an old family favour. Another interviewee’s uncle paid Government personnel to facilitate her escape and migration. None was given the opportunity to return to their hometown or to say goodbye to their children. The escape process was described as one that moved fast:

‘I didn’t go back home. I went with that man. He took me to a town. He told me, ‘I’m going to come with somebody… I didn’t even have my travel documents [because] I ran away from home…. He brought me in his car to a travel agent… We went to X and from there drove through Y… He told me… that the travel agent was going to look for a travel document for me… We left there about nine in the morning’ (Mangeni).

‘I wanted to get my children but there was no time. ‘I’ve come to help you’, and that’s it… This lady she gave me some second hand clothes, two clothes and a bag. And this man came in the evening. He said ‘tomorrow, we are travelling away. We are going to take you to another place because I know you’re not safe here.’ And I asked him if I can see my children. He say no. So, the following day… he came and collected me… We went and got a flight from there to X… Then we boarded another flight. I don’t know the time of the night. Because everything was just – I thought I was dreaming… I was frightened because I did not know the man. I didn’t know. The other man said, ‘you don’t worry’ ’ (Kissa).

‘Actually, where we landed I do not know. They don’t speak English. Everything was just like a dream. Then again we got into a plane. And we came here’ (Kissa).

For these interviewees, escape led directly to their journey of migration to Ireland, where they became registered as asylum seekers.

6.1.2 GBV in a Violent Society
A relationship emerged between living in a society with a high level of violence in general and GBV. In contexts where social order is diminished, following a war or other destabilising factor, there was a perception among interviewees that the level of violence in society in general, including GBV, increased. For example one interviewee described her country of origin around the time she left there as a place where law and order had largely broken down, resulting in high levels of violence:

‘There was lots of criminal activity… The government didn’t know what to do, people did whatever they wanted, there were criminal structures penetrated through different structures of the society, including the police or whatever… I had heard of my friends who were raped in different circumstances you know. One of them was raped in a police station by a policeman… So, it’s scary… You obviously didn’t want this to happen to you, but it wasn’t taken that seriously by anybody’ (Veronika).

Another interviewee related longstanding racial tensions in her country arising from the country’s past as a key factor in the high level of violence in that country. This violence had a real impact on day-to-day life:
'At home, we have every sort of crime imaginable. Like it’s a beautiful country. Oh it’s beautiful. You’ve got the beaches, you’ve got the sun, you’ve got everything. But you can’t enjoy it. You just can’t enjoy it…Because of the danger. Our doors are constantly locked, locked. You have a door and then you have…a gate’ (Mbali).

One of these interviewees described how she and a friend were abducted from a bar by a group of men, who then drove them to their living quarters on the outskirts of the city in which she lived. There, they were separated and were both raped. The perpetrators emerged to be involved in criminal activities:

‘They brought us back to the jeep and they were started driving. And they had several stops. And they said, ‘you in the back seat you have to duck down.’…I was saying to myself, why? Well, because they had guns. And they were going around from place to place, racketeering or something, you know? He actually, one of the guys picked somebody up outside, they got back into the car, and drove us back to where they’d taken us’ (Veronika).

An interviewee who experienced domestic violence while living in a refugee camp also spoke of an absence of social order, and the way in which this led to high levels of violence:

‘I wasn’t feeling safe, because you know refugees are dangerous people, especially in [continent of origin] where they can just fight, they can just do their own thing anytime. They hate you. They think maybe you are a spy or something…Maybe you are reporting them to the police (Kagiso).

One reported outcome of living in a society in which there is a high level of violence is that violence almost becomes normalised, an aspect of life that is to be expected. When this happens, it emerged for these interviewees that often blame can be at least partly attributed to the victim for not sufficiently protecting herself:

‘I didn’t want to think about it. The only thing I thought to myself is, it’s lucky I am still alive…You’re hearing these stories all the time and it’s awful. Because say for example, my school friend’s sister, once she was coming back from work, she disappeared, they found her in a couple of weeks time in a forest…mutilated. You know? All these kinds of things. Nearly considered normal. You know. The rape is even, doesn’t even compete with it…What are you complaining about? It’s your life, it’s your own fault, you didn’t have to have a drink, you didn’t have to go out late, you didn’t have to do all those things. You should have been home safe and whatever. So it’s all your own fault. And it’s always been kind of put out this way’ (Veronika).

It also emerged that higher tolerance for violence in general was associated with a greater acceptance of domestic violence. This context naturally had a negative effect on perceived options for support and protection following the incident.

It also emerged that living in a wider context of violence trapped women in domestic violence situation:

‘There’s every kind of crime. So, if you want to be safe, you should belong to a certain group. If you don’t belong to the alcoholics, if you don’t belong to the drug addicts, if you don’t belong to the bullies, you are on your own…And that is dangerous, to be on your own’ (Mbali).

For this interviewee, the necessity of living within a group meant living in high population density areas:

‘It’s safer to live in a compound, because we look out for each other, because it’s very rough. Because there are drugs and child abductions and all these things, rape and stuff
like that. It’s better, it’s safer to live in a compound. Where you are all looking out for one another’ (Mbali).

Because of the isolation she lived in, partly caused by the violence of the outside world, this interviewee remained living in her violent relationship for many years. It was only when she realised that her son’s welfare was the only thing preventing her from committing suicide that she faced this danger and left the compound to seek support from her church:

‘I knew I had reached the end. I couldn’t do it anymore…Just thinking of the best way to end my life…That’s why I’m here today. Because I just couldn’t figure out how to deal with my son…I just took everything of mine and I put them outside and I just sat there. My son…said, ‘mum, is there something wrong? Why are you crying? Where are we going?’ I didn’t know where we were going. Then, a pick-up that was passing…stopped. He saw all my bags, he said, ‘where are you going?’ I said ‘to the church.’ And I just went to the church because I was blank, I didn’t know what to do’ (Mbali).

### 6.2 Harmful Traditional Practices

#### 6.2.1 Forced Marriage

A total of eight women interviewed experienced forced marriage in their country of origin. Interviewees described this as typically taking place at the age range of 12 to 14 years. The young age of brides was causally related to the importance placed on women’s ‘honour’, which was proven by their sexual purity:

‘Our women get married when they are 13 or 14 years old, because they have to prove honour; they have to prove that they haven’t had sexual relationships with another man before’ (Aishe).

Interviewees perceived a strong economic basis behind their experience of forced marriage. They distinguished between arranged marriages in general and those that are forced on the woman, against her own will:

‘The parents go and arrange everything. Even if the girl doesn’t agree, the parents still continue with the arrangements, they ask for money in exchange for her, her opinion doesn’t count but she has to accept it’ (Donka).

One interviewee, who had escaped a forced marriage in Africa, described how some women in her community would have perceived her marriage in a positive light, due to the elevated social status it created. In doing so, she illuminated how it is only through the subjective viewpoint of those directly concerned that a forced marriage can be distinguished from an arranged one:

‘People had mixed feelings. Some people like [it], especially those who don’t go to school, because they…eat in the inner court and they get to sit on special chairs. So some like that’ (Abbo).

Payment made in advance of the wedding ceremony secures the girl to her future husband:

‘When the girls are still little, the boy’s parents go to the girl’s parents and they get her engaged, leaving a certain amount of money for the girl, to make sure her parents do not give her away to someone else’ (Nadya).

Tradition and duty were also associated with its occurrence:

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17 As noted in the review of literature, a distinct difference exists between a forced marriage and an arranged marriage. Whereas with the latter, the final choice to accept or reject the arrangement remains with the couple concerned, in a forced marriage, one or both parties do not consent to the marriage and some level of physical and/or emotional pressure is involved.
‘Well, when I was 12, my aunt…was married to the head of the village. Of my village. And it was her duty to look for someone to replace her before she died …Because in our village there are some particular families that a king marries from’ (Abbo).

Parents played a principal role:

‘When I was supposed to get married to the guy that I liked, [my mother] stepped in with the guy that she wanted me to marry. She asked me to marry the guy she wanted for me, because he was rich and [said] that I shouldn’t marry the guy that I liked…Whatever my mother did, I ended up married to…the rich guy’ (Dika).

Forced marriages caused significant suffering and distress. One interviewee described how the experience made her feel like a material possession, a transaction that led to a severe reduction in the rights and level of respect afforded to her by her new husband and his family:

‘It’s not good. You feel like you are sold to them and now you owe them. For me, the moment my parents got the money, I felt like I was being sold. Then of course, they have the right to mock you, to make you suffer. Even if you go through difficulties, you have to endure’ (Donka).

‘How I feel? I feel very bad. I realise, ‘oh why am I a lady? You know? Probably if I was not a lady, this would not have happened to me’ (Abbo).

Others described feelings of helplessness over the situation, which they partly attributed to their young age at the time, despite their unhappiness. For one interviewee, the sense of joylessness at the time of the marriage has stayed with her, suggesting that this early experience of being treated as a material possession may have had a long-term negative effect on her self-esteem:

‘I didn’t really feel any joy…it was strange for me. I was still young, I had no clue what was going on, I didn’t know what it meant to be happy to get married. Even now, I don’t really feel any joy’ (Florica).

Interviewees related forced marriage to unequal power relations in their community. The interviewee who was forced into the marriage of a chief of her village noted, ‘it’s somebody with authority, there’s nothing they can do.’

‘If the people who are in charge are set aside, if you tell them, traditionally it’s not bad, but some aspects of tradition is bad. It’s sometimes ignorant. Those first marriages, they are not, they think they are right to do that’ (Abbo).

Though not a finding of these interviews, anecdotal evidence exists to suggest that some landlords in Romania carry out sexual assault against the daughters of their tenants from the Roma community. In such circumstances, girls can be married in order to prevent the perpetration of sexual assault by these perpetrators.18

6.2.2 Female genital mutilation

The practice of FGM is strongly associated with belonging to a particular culture. It was experienced by one interviewee in this study. Another interviewee from Kenya also belonged to an ethnic group in which the majority of women experience FGM. However, in a development that reflects the subtle and complex nature of cultural identity, she escaped this experience due to her family’s conversion to Christianity before her birth.

As with forced marriage, the interlinking of the notion of honour with a woman’s virginity played a key role in the rationale for FGM. The interviewee who experienced FGM shared this explanation her mother gave her for it being carried out on her when she was very young:

18 Personal communication with Ronnie Fay, Director of Pavee Point.
'[She said] that it’s a good thing. I was still a virgin…it keeps me there until I get married…when the woman has the urge, she just finds the one to sleep with her. So that would make her sleep around. So they’re trying to reduce, to bring, to make the woman more the sense’ (Seyi).

This rationale, the perception of a sexual deviance inherent in all women that must be controlled and restrained, was strongly rejected by the interviewee:

'It would not make me sleep around before getting married. When I got married, I was still a virgin. And my mummy came to congratulate me. She was happy, telling me, ‘you see, if I wasn’t circumcised, my husband wouldn’t have married me as a virgin. And I told her, if I wasn’t circumcised, I would still have been a virgin. Because I’m circumcised, that doesn’t mean – I would have been just myself. I would just have been myself. That would not have made me sleep around’ (Seyi).

Other reasons were also discussed by the interviewee included the perception of female genitalia being ugly and the belief that if the clitoris touches the child’s head at birth, it results in a stillbirth. She did not recall the experience itself, as it happened when she was an infant of two years. What she did recall, itself a very traumatic experience, was how the impression that she was a victim of this form of GBV was raised during a biology class in school, a suspicion later confirmed by her mother:

‘I didn’t know about genitalia, I didn’t know about pain. I don’t know about circumcision. I just wanted to find out about myself. If that was done of me. And I was surprised that yes [it had been]…I made research. I found out something about it…I had been done already’ (Seyi).

The interviewee’s reaction had been one of shock and hurt. She described feeling anger, and a sense of betrayal regarding her mother, and the continuous challenge of understanding what took place and forgiving those involved. As with forced marriage, this interviewee’s experience of this harmful traditional practice was entirely negative. She spoke vehemently about how she would never allow it to be carried out on her own daughters. In doing so, she drew attention to the fact that FGM is a violation of women’s human rights:

‘At this time of my life, no one can circumcise my daughter. Never. Because I know what I’m going through now. I would never do that to someone again…No one can do that to my daughter. I believe it’s a right. That girl has a right. She lives, she eats, she goes around everyday. It serves a purpose’ (Seyi).

Though this interviewee experienced FGM long before she came to Ireland, during the interview, she described a range of consequences that she was faced with still. One was the way in which her perception of her cultural identity in general was damaged. Unlike most other study participants, when questioned about her ethnicity, she considered it unimportant and irrelevant to her life. During the interview, she referred to FGM as ‘the culture’, implying that in her view, this experience was inseparable from other aspects of her cultural identity.

Another significant negative consequence of FGM on this interviewee was her resultant inability to enjoy sex, which in turn adversely impacted on her relationship with her husband. Perceived stigma surrounding FGM prohibited her from discussing the issue with him:

‘I’m ashamed to ask him that. Even though it is not my fault. I am scared that if he finds out…he might not love me again. Or he might even want to find somebody on the outside that is not circumcised…That might cause problems in my marriage’ (Seyi).
As a result, sexual relations with her husband came to be perceived as a duty to be endured, rather than enjoyed. Though she pretended to enjoy it for her husband’s sake, in reality a painful experience which she dreaded:

‘When I’m not in the mood, and he wants it, I just have to give it to him. It’s one of my duties, as a wife. To please him, when he’s ready. But I’m never ready. The pain, the pain is there. It pains me’ (Seyi).

‘When he does it like once, and he wants it again, I just move. A lot of the time he complains: ‘why am I not like most women? Most women want to do it, but why am I running away…from having sex?’ I tell him I’m just tired. I…give him some excuses, like I’ve got to attend to the children, I’m sick’ (Seyi).

‘My view about sex, I just think, well that is for procreation. You know? When I’m ready for another baby. Then…I miss him sexually. During sex, I can see he enjoys himself. And I don’t know, he asks me, darling did you enjoy it? I just say yeah. That’s what I say. I really just dread it…it’s painful. It’s painful. At times, I really try to take away the pain. I would try and try, I will enjoy this. But the desire is not there…I try to tell myself I’m enjoying it. I get confused myself. But I can’t, I can’t derive any enjoyment from it.’ (Seyi).

Besides her mother, this participant never had the opportunity to discuss her experience with other victims/survivors. She noted that if she learned that a friend also had experienced FGM, “probably then I’d confide in her.” Otherwise, feelings of shame and embarrassment, caused by a perceived stigma over both the experience of FGM and the resulting impact on ability to enjoy sex, prevented her seeking such support:

‘Most people I’ve seen tell me, oh, they’re not circumcised, they’re enjoying it. So when they ask me are you, [I say], ‘no, no, no’. If they ask me if I have, I answer them no, I’m not. And I just change the subject’ (Seyi).

6.2.3 Needs on Arrival to Ireland

Interviewees who experienced GBV in their country of origin were suffering varying levels of emotional distress when they arrived in Ireland. For those who were victims/survivors of multiple traumas in the context of war, a matter of days passed between traumatic experiences and their coming to Ireland. The result was a feeling of numbness and fear. For example, this interviewee had been incarcerated for a six-month period before her arrival, during which time she had survived both physical and psychological torture, as well as beatings and sexual violence:

‘I was just numb. But at the same time I was really scared because it’s a strange place. I knew nobody’ (Mangeni).

Their reception at frontline services such as the Refugee Application Commission played an important role in allaying immediate fears:

‘The people at the Refugee Application [Commission] were so helpful…I think they were doing their best…Because I’m very scared if someone is shouting or – oh my God – but that helped me…It made me feel I was in the right place. It gave me hope like, that things will get better’ (Mangeni).

On moving to direct provision accommodation, asylum seeker interviewees described coping mechanisms they adopted to deal with psychological distress. Many spoke of the importance of keeping busy. This comment was made by an interviewee who escaped a forced marriage in her country of origin:

‘I don’t think it’s something that can go easily…It’s really hard. I just try to – how I cope with it is, I try to make myself busy. When you’re busy, you forget’ (Abbo).
Some engaged in voluntary work in order to keep busy. The altruistic nature of voluntary work had an added therapeutic value:

‘[Voluntary work] is pretty good because it keeps me busy and at the same time, I feel good than if I’m only staying in the hostel. People are there and need a service. People out there need my service. I feel good. Like I’ve done something to help other people out there who need a service’ (Mangeni).

An important aspect of keeping busy was avoiding isolation. Being alone was a time when they were most at risk of emotional distress, as their thoughts would return to past traumatic events.

‘It’s not very easy to forget about it. You just have to move forward. Yeah, move forward and make friends, always try to make friends you can talk to and not to be by yourself. Because the moment you are alone, the whole thing just comes back’ (Mangeni).

For asylum seekers, many of whom engaged in voluntary work, keeping busy could be more difficult. Two interviewees noted how the limited weekly allowance severely curtailed her ability to fill their time. Others referred to a problem in information reaching women living in direct provision accommodation regarding relevant services. This was caused by perceived poor mental health and fear of jeopardising their asylum plea. In relation to GBV, stigma prevented women from seeking support services:

I came to [service provider], I came here, but many others, they stay in hostels, they don’t know what happens. They don’t have the same facilities I was talking about. It’s not their fault…they have rights to know what happens because [then] it can be better for them. Because sometimes when you see them, they don’t hope with their life. But…when you speak to others, you see that it’s ok. You feel better’ (Jendayi).

‘The information filtering down to us, to people who are in the hostels, there’s a problem with the information getting down there…You fear about speaking out, because you don’t know, what are my rights, who am I in this place? What can I say and what can’t I say? You know? And then you keep quiet, and then, it’s even worse when you’re coming from a background where maybe people normally, people don’t tend to speak out and say what happened to them, you know, or they keep things to themselves. You get here, and you’re not really sure, how do I act?’ (Imara).

Another referred to a sense of apathy caused by uncertainty around the future. Voluntary work helped her:

‘You feel lonely. Nothing to do until you get [refugee status]. The psychologist helped me. She said it is better to get out of that place. Because [then] you don’t think too much. So, I started voluntary work…It was good. It kept you busy’ (Kissa).

Spirituality comprised another important source of strength for these interviewees, both in their country of origin and in Ireland:

‘I would say my prayers. I didn’t have nobody to talk to. The only person I spoke to was God’ (Mangeni).

In addition, all interviewees who had experienced GBV in a pre-migratory context had since had some level of contact with health services in Ireland. Some had received counselling since they arrived in Ireland; all of these interviewees found this beneficial:

‘He try to help me because when you speak [about] these things, you could forget them. The things [are] gone. It means I share. It means I don’t have everything on my back. I have someone to share [it] with. And that helps’ (Jendayi).
‘She’s been very helpful because it makes you slow [down], and encourages you to begin
to think of these things’ (Mangeni)

Some of these interviewees also received treatment for health problems that resulted from past experience of GBV. Two required surgery.

‘I was able to be treated…I came with a lot of pain from them doing the beating…I’m
going to receive surgery…I don’t have to pay any money for it’ (Mangeni).

The need for support networks established for victims of harmful traditional practices emerged in relation to forced marriage and FGM. It emerged that a perceived stigma surrounding this practices and an associated sense of shame among victims/survivors made it difficult for them to access the support they needed from friends and people they lived with, who did not have such experiences.

‘As an African, probably because of my upbringing…when it comes to sex, you don’t think
of it as a thing for the public. So I just think, keep it quiet. Secret, keep it a secret’ (Seyi).

Interviewees spoke of the therapeutic value of sharing your experiences with others who have gone through similar trauma and of the benefit of learning of others who have survived what they are going through:

I think it is a good idea to do this research because if the people have the access to read
that research, they will know that some people are suffering. And it would be even better for
the others that they have suffered, like me, that they will know it’s not only them. Yeah,
there is other people who are going through the problems we are…That can help because
when you know that there is someone who suffers as you and is strong, who continued life,
who continued to build something better, it’s better. It can give you hope, it can help you
cope in your life’ (Jendayi).

‘To give them support…maybe organise workshops for them…If you go and talk to
somebody, you know? Somebody who has gone through your own situation. You can at
least get one thing’ (Abbo).

The value of local women’s support organisation was rated highly by those who had come into
contact with them:

‘The psychologist showed me some organisations that can help me. Such as the woman’s
group…Before I come [there] I wasn’t very good, but now it’s ok because I have the people
I can talk to, and they help…me in my life, in everything…(later)…there, there is many good
people who come and teach and give us an open mind about what happens here in Ireland’
(Jendayi).

‘They [service provider] organised some social groupings. And training. You know?…It’s
important. Everything helps, to get a job, to keep you busy. To have something you can do’
(Kissa).

Interviewees who had experienced GBV in the context of war had survived multiple traumatic
events, including incarceration, torture, separation from their children, being held in captivity,
dangerous escape journeys, as well as sexual and physical violence. As a result, they had many
needs on their arrival in Ireland. As one interviewee pointed out, such experiences led to the need
for a flexible, person-centred service, in which all such experiences are identified and addressed:

‘I think part of the reason that the problem is, that when you come here, you know, you are
maybe running away from the war, or you’ve got other problems. And you’re bringing all this
luggage. And you come here and part of maybe you being sexually abused is just part of all
the problems. So I think sometimes, all those problems, they can, you get lost, they can get
lost, you don’t have that space where you can say you need to talk to someone and speak about my problems, because this, you have to worry about saying your story, without bringing up other problems that are related to it’ (Imara).

What can happen instead is that victims/survivors of multiple trauma find that their experience is separated and divided, according to the particular role of the service provider in question. This problem was exacerbated for asylum seekers, among whom was a perception that seeking help might negatively impact on their asylum case:

‘When you go speak to the doctors, they’re not hearing about your life. They just want to hear about what brought you here. If you’re lucky, you get someone who says, you know, I can see there’s something wrong, tell me about it. But they just want to hear about the part that brought you here. That part...Until they tell you, yes you can live here, you’re stuck in the middle, you don’t know who you really are or what your rights are here’ (Imara).

‘Sometimes he [GP] don’t really see what happens. Maybe it’s because he’s rushing to do something else’ (Jendayi).

6.3 Key Points

- Some interviewees experienced a range of traumatic events in the context of war, immediately prior to their migration to Ireland. Such experiences included conflict-based rape, rape during the migration journey, wrongful incarceration, separation from family, bereavement, being in captivity, forced labour and torture. The escape process was described as one that moved fast, leading directly to their journey of migration to Ireland, and their request for asylum. Survival of multiple traumas led to a need for flexible, person-centred and interagency approach service delivery.
- Forced marriages typically took place when the interviewee was aged from 12 to 14 years. Interviewees perceived a strong economic basis behind this form of GBV. Other factors included tradition, duty and unequal power relations. It was the cause of significant suffering and distress, and had long term negative consequences on the self-esteem and emotional wellbeing of its victims/survivors.
- The practice of FGM is strongly associated with belonging to a particular culture. A participant who experienced FGM felt anger, a sense of betrayal regarding her mother, and the continuous challenge of forgiving those involved. A significant consequence was her resultant inability to enjoy sex, which in turn adversely impacted on her relationship with her husband. As a result, sexual relations with her husband came to be perceived as a painful duty to be endured.
- Besides her mother, this participant never had the opportunity to discuss her experience with other victims/survivors. Feelings of shame and embarrassment, caused by a perceived stigma regarding FGM prevented her seeking such support.
- Spirituality was an important source of strength for interviewees, both in their country of origin and in Ireland.
- Being alone was associated with being at greatest risk of emotional distress, as thoughts would return to past traumatic events. Some engaged in voluntary work to avoid this, and found that its altruistic nature had an added therapeutic benefit. For asylum seekers, opportunities to do so were curtailed by the limited weekly allowance they received and a lack of information regarding relevant services and support groups. Opportunities to seek relevant information were hampered by poor mental health and fear of jeopardising their asylum plea.
- The reception of these women at frontline services such as the Refugee Application Commission was described positively and played an important role in allaying fears.
- All interviewees who had experienced GBV in a pre-migratory context had some level of contact with health services in Ireland. Some received treatment for health problems resulting from past experience of GBV. Two required surgery. Of those who received counselling in Ireland, all found it to be beneficial.
- A need emerged for support networks for victims of forced marriage and FGM. Interviewees spoke of the therapeutic value of sharing their experience with others who have gone through similar trauma.
PART THREE: Quantitative Findings

This section addresses the second and third objectives of this study, namely to document the current level of service provision regarding minority ethnic women and gender-based violence (GBV) and to highlight barriers to the delivery of services to this group regarding this issue. The findings of three surveys conducted with relevant service providers are considered. The first of these was conducted of mainstream health and social (MHS) services. General practitioners (GPs) were the biggest cohort, as the questionnaire was sent to all GPs listed on the Irish Medical Directory. Out of a total sample of 2,226 GPs, 498 (22%) responded. The reason for including such a high number of GPs was that general practitioners have been shown to be the third most frequent choice after family and friends for victims/survivors to disclose abuse and seek help (McGee et al., 2002). The survey was also circulated to Principal Social Workers in hospitals and the community, Directors of Public Health Nursing and Directors of Sexual Assault Treatment Units. The table below summarises population sizes and response rates for each service.

Table 8. Response Rates from Health and Social Service Providers

<table>
<thead>
<tr>
<th>Service</th>
<th>Returned</th>
<th>Total Pop</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioners</td>
<td>498</td>
<td>2,226+</td>
<td>22%</td>
</tr>
<tr>
<td>Hospital Social Work Dept</td>
<td>21</td>
<td>43</td>
<td>49%</td>
</tr>
<tr>
<td>Community Social Work Dept</td>
<td>12</td>
<td>32</td>
<td>38%</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>9</td>
<td>32</td>
<td>32%</td>
</tr>
<tr>
<td>SATU</td>
<td>2</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>Total</td>
<td>542</td>
<td>2,337</td>
<td>23%</td>
</tr>
</tbody>
</table>

The other two surveys were conducted with two sets of organisations within the voluntary sector. The first of these concerned GBV organisations throughout the country. This sector plays a central and vital role in responding to all victims/survivors of GBV, including minority ethnic women. The second was conducted of minority ethnic organisations. Research literature has shown the potentially valuable role to be played by this sector both in meeting needs and in referring victims/survivors to other services. No comprehensive database exists in Ireland either of GBV organisations or minority ethnic organisations. The first task was therefore to attempt to establish a database of each category through the amalgamation of a range of existing lists and directories, with duplicates and others removed as appropriate. In order to maximise representation, questionnaires for each survey were distributed to all identified organisations. A total of 62 GBV organisations and 173 minority ethnic organisations were identified through this process. Questionnaires were distributed to all identified organisations in order to ensure maximum representation in the survey findings.

7. Mainstream Health and Social Services

One of the most striking findings of this survey was the high percentage of GPs to whom minority ethnic women had disclosed GBV. In total, one third (n.163) of GP respondents reported that at least one such disclosure had been made to them by a minority ethnic woman at some stage in the past. Among these GPs, 93 per cent (n. 149) stated that such disclosures had been made within the previous year. Within this period, a total of 544 minority ethnic women disclosed GBV, of whom 228 were Traveller women and 316 were non-indigenous minority ethnic women. The number of disclosures made to these GPs ranged from one to 20, with an average number of disclosures of 3.6 per GP.

A high number of other health and social services were also accessed regarding GBV by minority ethnic women. Among 44 services included in the survey of other health and social services, only four reported that no such disclosure had been made to them. Services to whom disclosures were made included:
- Hospital Social Work Departments (n. 18)
- Community based Social Work Departments (n. 12)
- Public Health Nursing (n. 9)
- Sexual Assault Treatment Unit (n.2).

Over a one-year period, a total of 299 minority ethnic women disclosed GBV to these services, of whom 119 were Traveller women and 180 were non-indigenous minority ethnic women. The number of disclosures ranged from one to 33 and the majority were made to hospital and community-based social work departments.

Though a likely response bias means that these figures cannot be extrapolated across the entire population of GPs and other service providers, they still indicate a considerable population of minority ethnic women who are victims/survivors of GBV. This is especially so when we consider the fact that the majority of victims/survivors of GBV do not access services regarding this issue (Garcia-Moreno, 2005).

### 7.1 Forms of GBV

Physical violence by an intimate partner was the most common form of GBV disclosed. Seventy four per cent of MHS said that this had been disclosed to them by Traveller women and 70 per cent said that it had been disclosed by non-indigenous minority ethnic women. This supports international research literature on GBV, which shows that intimate partner violence is the most common form of GBV for all women.

Sexual violence by an intimate partner was disclosed to a substantially lower percentage of mainstream health and social (MHS) services. This was particularly the case for GPs. Among those to whom GBV had been disclosed by a minority ethnic woman, only 23 per cent had sexual violence disclosed to them by Traveller patients and 17 per cent had this disclosed to them by non-indigenous minority ethnic patients. For other MHS services, 44 per cent of the latter group disclosed sexual violence. As research literature shows a high degree of correlation between physical and sexual violence perpetrated by an intimate partner, this suggests that minority ethnic women are less likely to disclose sexual violence than physical violence to health and social service providers. Findings from the SAVI (2002) study also found that disclosure of sexual violence to MHS professionals to be very low, indicating that any barriers regarding this form of GBV are not unique to minority ethnic women.

Other forms of GBV were disclosed by non-indigenous minority ethnic women, namely FGM, conflict-based rape and trafficking for the purposes of sexual exploitation. FGM was disclosed to over one quarter of all MHS services. Conflict-based rape was disclosed to one quarter of participating GPs and 16 per cent of other service providers, all of which were social work departments. Finally, trafficking for the purposes of sexual exploitation was disclosed to seven GPs, four social work departments and two Public Health Nurses.

Chart 1 overleaf presents the percentage of MHS services to whom each of the above forms of GBV were disclosed, for both Traveller and non-indigenous female patients.
MHS services identified a range of barriers in the provision of care for minority ethnic women who disclose GBV to them. The most commonly identified barriers were:

- The patient’s reluctance to disclose
- ‘Cultural’ barriers and
- Language.

Four fifths of MHS services identified the patient’s reluctance to disclose as being either a major or moderate barrier to meeting their needs regarding GBV. This suggests that GPs and other MHS service providers suspect GBV among minority ethnic patients who do not disclose the issue. The qualitative chapters showed that stigma attached to GBV, lack of trust in mainstream services (particularly for Traveller women) and fear of ostracisation from their community all prevent minority ethnic women from disclosing GBV. This finding suggests that these issues are serious barriers to seeking help for a high number of minority ethnic women who experience GBV.

Chart 2. % MHS who identified ‘Patient’s Reluctance to Disclose’ as a Barrier
Perceived cultural issues also emerged as a significant barrier to responding to patients' needs. Almost one quarter identified this as a major barrier, and over one third identified it as a moderate one. Many of those who identified cultural barriers in this regard elaborated on their perception of what constitutes such barriers. Some referred to perceived acceptance of violence and by extension domestic violence among some minority communities. This was applied to both the Traveller community and non-indigenous ones. A related factor was that of unequal power relations between men and women and different perceptions of gender roles, which could lead to GBV as well as prevent the victim/survivor seeking help. Some noted that this issue could be compounded when the patient was reliant on her partner to act as translator to the service provider. Perceived unwillingness to seek help due to fear of ostracisation was also raised, both in relation to both Traveller and non-indigenous minority patients. A related factor was a sense of loyalty to that community, fear of bringing shame on it by seeking help and in some cases, a fear of reprisal. All of these issues are also relevant to reluctance among patients to disclose GBV.

Other MHS service providers focused on those barriers caused by their own lack of understanding and awareness of their patient's cultures. Such comments included feeling inadequate in conducting culturally sensitive questioning with patients, as well as a lack of knowledge of different cultures. Some pointed to a greater need for understanding among service providers regarding minority ethnic groups in Ireland. Others felt that the patient felt reluctant to disclose to them, due to their fears that the GP would hold opposing views to them regarding gender roles, and would therefore not be receptive to their needs.

Chart 3. % MHS who identified 'Cultural Barriers' as a barrier

In 2005, a free interpretation service was established for GPs in the Eastern region, in collaboration with the Irish College of General Practitioners (ICGP) which could be accessed by telephone and also provided face to face interpreting as appropriate. However, this service was not referred to by any GP respondents. In fact, the issue of language emerged as the third highest barrier for health and social service providers. This was identified as a major barrier by 20 per cent of GPs and 33 per cent of other MHS services. Among those service providers whose minority ethnic patients who disclosed GBV were all non-indigenous, language was identified as a barrier for almost all of them. These findings indicate that further measures could be usefully employed to increase GP usage of the free interpretation service in HSE Eastern region, such as face-to-face instruction on its use, and increased dissemination of information regarding it.\(^{19}\)

\(^{19}\) Useful recommendations for interpreting and translating services can be found in the NCCRI’s report *Developing quality cost effective interpreting and translating services for government service providers in Ireland* (2008).
Finally, the absence of necessary training to respond to the needs of these patients also emerged as a barrier for a substantial percentage of MHS services. Over two fifths identified this as a minor barrier, and almost a third found it to be a moderate or major one. On a related question, 69 per cent reported feeling powerless to help these patients and over one third perceived this to be either a moderate or major barrier. These findings signify the need for the provision of guidelines and training for GPs and other MHS services on GBV and providing interculturally competent care.

7.2.1 Barriers to Providing Appropriate Referrals

MHS services identified a range of issues that posed as barriers to appropriate referral pathways for minority ethnic patients regarding GBV. One such barrier was the reluctance of patients to use onward referral services, which was identified as either a major or moderate barrier by over three quarters of MHS services.

Absence of interculturally competent services was identified as another significant impediment to successful referrals. Fifty seven per cent of GPs and 71 per cent of other MHS services identified this issue as either a major or moderate barrier. Yet another referral barrier was the existence of long waiting lists in referral services. Over two fifths of GPs and one quarter of other MHS services reported this to be either a major or moderate barrier.

Finally, lack of information on community resources was identified as a barrier to referral by 80 per cent of GPs, over half of whom identified this issue as a major or moderate barrier. This comprised a barrier for only 50 per cent of other MHS services, and was a major barrier for only five per cent of them. This indicates that GPs may have less access to information on relevant community based services than Public Health Nurses and Social Work Departments. It highlights the need to include this issue in GP training, in order to meet the needs of all patients who are victims/survivors of GBV.

7.3 Key Points

- One third of GPs reported that at least one disclosure of GBV had been made to them by a minority ethnic woman at some stage in the past. For 93 per cent of these GPs, such disclosures had been made within the previous year.
- Disclosures of GBV were also made by minority ethnic women to hospital and community based social work departments, Public Health Nurses and Sexual Assault Treatment Units.
- Over one year, 544 minority ethnic women disclosed GBV to their GP, of whom 228 were Traveller women and 316 were non-indigenous minority ethnic women. The number of disclosures made to these GPs ranged from one to 20 and the average number of disclosures per GP was 3.6. These figures indicate a considerable population of minority ethnic women who are victims/survivors of GBV.
- Physical violence by an intimate partner was identified as the most common form of GBV disclosed by minority ethnic women to MHS services.
- Sexual violence by an intimate partner was disclosed to a substantially lower percentage of MHS services, particularly regarding GPs. As there is a high correlation between physical and sexual violence perpetrated by an intimate partner, this suggests that minority ethnic women are less likely to disclose sexual violence than physical violence to health and social service providers.
- Other forms of GBV were disclosed by non-indigenous minority ethnic women to a minority of MHS services, including FGM, conflict-based rape and trafficking for the purposes of sexual exploitation.
- Four fifths of MHS services identified the patient’s reluctance to disclose as a significant barrier to meeting their needs regarding GBV. This suggests that issues such as stigma, lack of trust in mainstream services and fear of ostracisation from their community are serious barriers to seeking help.
- Cultural issues also emerged as a significant barrier. Descriptions included perceived acceptance of domestic violence among some minority communities, unequal power relations between men and women, different perceptions of gender roles, a sense of loyalty to that community and fear of
reprisal. Others referred to challenges they themselves faced in conducting interculturally sensitive questioning with patients and lack of knowledge of different cultures.

- Language posed another serious barrier, identified as such by a high percentage of GPs and other MHS services.
- The absence of necessary training to respond to the needs of these patients emerged as a barrier for a substantial percentage of MHS services. Feeling powerless to help these patients also emerged as a barrier. These findings signify the need for the provision of guidelines and training for GPs and other MHS services on GBV and providing interculturally competent care.
8 GBV and Minority Ethnic Organisations

8.1 GBV Organisations and Minority Ethnic Women

A total of 62 voluntary organisations were identified throughout the country who provide dedicated services to victims/survivors of GBV. They include 16 Rape Crisis Centres, three Women’s Aid centres, 20 refuges and eight transitional housing units. Twelve are based in Dublin. Of the remaining 50, the majority are located in urban locations. This geographic breakdown is reflected in our survey findings, which had a response rate of 77 per cent.

Typical services provided by GBV organisations include emergency accommodation, confidential helpline, support and information on rights and entitlements, counselling, accompaniment to the courts, the Gardaí and health professionals, advocacy, support groups, outreach and aftercare and referral to other relevant services. Some services also provide medical care onsite. Capacity varies, with a higher level of service provision and resource allocation to be found in those centres in large urban settings, such as Dublin, Cork and Galway. Table 9 below presents an overview of GBV services in Ireland, by client group and survey response rates.

Table 9. GBV organisations in Ireland, by Client Group and Response Rates

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Total pop.</th>
<th>Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women victims/survivors of domestic violence and children</td>
<td>25 (40%)</td>
<td>21 (44%)</td>
</tr>
<tr>
<td>Women victims/survivors of domestic violence</td>
<td>16 (26%)</td>
<td>10 (21%)</td>
</tr>
<tr>
<td>Victims/survivors of domestic violence, including men</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Survivors of sexual abuse</td>
<td>17 (27%)</td>
<td>10 (21%)</td>
</tr>
<tr>
<td>Victims/survivors of prostitution and trafficking</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Missing data</td>
<td>N/a</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Total</td>
<td>62 (100%)</td>
<td>48 (100%)</td>
</tr>
</tbody>
</table>

Over the past two years, two Rape Crisis Centres in Galway and Dublin have developed dedicated services for specific groups of asylum seekers and refugees, in response to a growing number who were being referred to the RCCs, usually in relation to sexual violence they had experienced in their country of origin. In 2004, the Galway Rape Crisis Centre established an Asylum Seeker and Refugee Clinic. The aims of this clinic are to provide counselling and support and to create awareness of, and information about, the issue of sexual violence among asylum seekers and refugees living in Ireland (Galway Rape Crisis Centre, 2007). In 2006, the Dublin Rape Crisis Centre established an outreach programme for migrant communities, with the aim of raising awareness among them regarding sexual violence and abuse, entitlement to services and information on how to access them (Dublin Rape Crisis Centre, 2006). In 2008 information leaflets on sexual violence and service provision were published by this outreach programme in six languages. In additions, the DRCC published a handbook for community interpreters entitled *Interpreting in Situations of Sexual Violence and Other Trauma*.

8.1.1 Minority Ethnic Women Presenting to GBV Organisations

Eighty five per cent of GBV organisations reported having been accessed by one or more Traveller women. In total, Traveller women comprised an average of 15 per cent of service users. According to Census 2006, Traveller women represent 0.5 per cent of the total population of women aged 15 years and over. This suggests that Traveller women are over represented among service users of GBV organisations.

Ninety eight per cent of GBV organisations were accessed by at least one non-indigenous woman. In total, non-indigenous minority ethnic women comprised an average of 13 per cent of service users. According to Census 2006, non-indigenous minority ethnic women also represent 13 per cent of the total population of women aged 15 years and over. However, the vast majority of those accessing GBV organisations were asylum seekers, refugees, on a spouse dependent visa or a migrant worker visa. Only approximately five per cent of women aged 15 years and older fall into
these legal categories. This indicates that certain categories of non-indigenous minority ethnic women are over-represented among services users of GBV organisations.

Table 10. % of Minority Ethnic Women accessing GBV organisations

<table>
<thead>
<tr>
<th>Population Category</th>
<th>% at GBV orgs.</th>
<th>% of Gen. Pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traveller women aged 15 years and over</td>
<td>15</td>
<td>0.5%</td>
</tr>
<tr>
<td>Migrant workers, asylum seekers, refugees</td>
<td>13 (estimate)</td>
<td>5%</td>
</tr>
</tbody>
</table>

These data are limited by the absence of ethnic identifiers among service providers and varying record keeping methods across services. However, this finding is supported by international research that shows minority ethnic women face a higher risk of GBV. It is all the more significant when it is taken into account that the majority of minority ethnic women who experience GBV do not access services regarding it.

8.1.2 Forms of GBV Disclosed to GBV Organisations

Physical violence by an intimate partner was disclosed to 91 per cent of GBV organisations by minority ethnic women. This was followed closely by sexual violence by an intimate partner and emotional violence, both disclosed to 85 per cent of GBV organisations. Interestingly, only 58 per cent of mainstream health and social (MHS) services identified that emotional violence had been disclosed to them. This indicates that minority ethnic women may be less likely to disclose emotional violence to their GP or other MHS service provider than they are to a GBV organisation, or that MHS services are less likely to identify this as a form of GBV.

Almost half of GBV organisations had been accessed at some stage regarding forced marriage. Over two fifths reported having been accessed by minority ethnic women who had been trafficked to Ireland for the purposes of sexual exploitation. The same number identified the issue of conflict-based rape among this client group. Finally, 16 organisations referred to FGM in this context.

In addition, 28 GBV organisations provided statistical information on the number of disclosures of GBV by minority ethnic women over the previous year. The main reason for not providing these data was lack of adequate data records. For those who did provide it, some noted that they may not receive full information from clients, and that therefore under-estimation is a possibility. Others

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20 This figure comprises Census 2006 data on women from the following countries: Poland, Lithuania, Latvia, China, India, Malaysia, Philippines, Pakistan, other Asian countries, Canada, US, Ukraine, South Africa, Nigeria, other African countries, New Zealand, Brazil and Australia. These countries have been identified as the most common nationalities of migrant workers, asylum seekers and refugees (NCCRI, 2003, Dept of Enterprise Trade and Employment, 2008).
noted that the figures provided represented estimates only. This information is therefore best used to inform our understanding of the role of this sector in meeting the needs of minority ethnic women, and to provide an indication of the level of reported need.

In total, 1,485 incidences of GBV were disclosed by minority ethnic women over this period. The findings here confirmed that physical violence by an intimate partner and emotional violence are very commonly disclosed to GBV organisations by minority ethnic women. However, it also showed that a much smaller percentage disclosed sexual violence by an intimate partner. This suggests that even though sexual violence has been disclosed to the majority of GBV organisations by minority ethnic women, the number of minority ethnic women who makes such a disclosure is actually very low. This corresponds to data on the same issue among MHS services and shows that barriers to disclosure of this form of GBV are very significant. These data are presented in the chart below.

Chart 5. Number of Disclosures Over the Past Year, by Form of GBV

Despite limitations, these data show that GBV organisations play a very important role in meeting the needs of minority ethnic women in Ireland. They also indicate that GBV affects the lives of a significant number of minority ethnic women living in Ireland, particularly when it is considered that GBV is largely a hidden issue, and that disclosures represent only a fraction of actual cases.

8.2 Minority Ethnic Organisations and GBV

Minority ethnic organisations emerged as a highly diverse sector, with organisations varying substantially in terms of funding sources, capacity and resources. The nature of services provided by these organisations ranged from education and training courses to advocacy to providing legal advice. None was concerned specifically with the issue of GBV. They extend from small, ad hoc, local organisations with limited resources, to national organisations with a high number of staff. There was an average of nine voluntary workers per organisation, indicating a high level of voluntary activity in this sector.

A total of 173 minority ethnic organisations were identified. Relevant populations included asylum seekers and refugees, specific minority ethnic communities/ nationalities, the Traveller community

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21 This relates to the number of disclosures of each form of gender-based violence, rather than the number of individual women who have made such disclosures. Multiple forms of gender-based violence can be experienced by one woman. For example, emotional violence is commonly experienced in addition to other forms of GBV.
and migrant workers. Some organisations worked specifically with minority ethnic women. All were approached regarding this survey and 54 (31%) organisations responded. The varying capacity levels of this sector had an inevitable impact on response rates. However, in a specialist survey such as this, the low response rate among these organisations most probably also reflects the perceived degree of relevance to the service provider, based on whether or not the service in question has been accessed for support regarding GBV.

The most common services provided by minority ethnic organisations were advocacy (77%), information (76%), education and training (72%), referral (49%) and support groups (47%). 40 per cent provided services specifically for women. These included a health care programme, medical assessment, training courses and women’s groups.

8.2.1 Disclosures of GBV to Minority Ethnic Organisations
Among the 54 respondent organisations, 80 per cent (n. 43) had one or more female clients who had sought support regarding GBV. As with GBV organisations, physical violence by an intimate partner was disclosed to the vast majority of these organisations (88 per cent). Emotional violence was disclosed to over three quarters of them. Unlike GBV organisations, sexual violence by an intimate partner was only disclosed to 28 per cent, highlighting again the added difficulties faced by victims/survivors in disclosing this form of abuse.

Twenty eight per cent of organisations reported being accessed for support by victims/survivors of trafficking to Ireland for the purposes of sexual exploitation. Other identified forms of GBV included conflict based rape (23%), FGM (16%), forced marriage (30%), GBV perpetrated by family members (40%) and GBV carried out in the community (30%).

Twenty three of these organisations provided statistical information on the number of disclosures of GBV made by women accessing the organisation over the previous year. A total of 673 disclosures of GBV were made in this period, among which 417 regarded emotional violence and 150 regarded physical violence by an intimate partner. Regarding other forms of GBV, such as harmful traditional practices and trafficking for the purposes of sexual exploitation, most disclosures were made to a small number of organisations.

Data on the number of disclosures made over the past year are presented in the chart below.

Chart 6. Number of Disclosures Over the Past Year, by Form of GBV

22 The same limitations regarding this data from GBV organisations apply here.
8.3 Barriers to Meeting Needs

There was a large degree of consensus between GBV organisations and minority ethnic organisations regarding the needs of minority ethnic women who seek support regarding GBV. For example, 94 per cent of GBV organisations and 89 per cent of minority ethnic organisations perceived a need for general advice and support. Qualitative findings confirm the importance of this aspect of service provision, characterised as a person-centred, non-judgemental and flexible approach to meeting needs.

Information on GBV services and entitlements was another general service need that was identified by the majority of both sets of organisations. This finding was also validated by the qualitative stage of the research, which showed that lack of relevant information could seriously hamper victims/survivors' likelihood of receiving the support they needed.

Other, more specific needs were also identified by both cohorts. These included the need for counselling services, accommodation options, legal aid, outreach/visiting support and court accompaniment. GBV organisations were more likely to identify these needs than were minority ethnic organisations. This is not surprising, given the focus and expertise of GBV organisations.

Chart 7. % Organisations identifying different service needs, by organisation type

A degree of consensus was also found across GBV organisations and minority ethnic organisations regarding many of the barriers they face in responding to these needs. Inadequate resources were cited by 54 per cent of GBV organisations and 66 per cent of minority ethnic organisation. A related issue, absence of staff training, was identified as a barrier to meeting needs by over two fifths of both organisations. For GBV organisations, this question related to training on interculturally sensitive service provision, while for minority ethnic organisations, it concerned training on GBV.

The Habitual Residence Condition was identified as another barrier by a high proportion of GBV organisations (56%) and minority ethnic organisations (34%). Introduced in May 2004, this condition requires all social welfare applicants to have proof of residence in the state for the two years prior to their claim, in order to be eligible. This can pose a barrier for services which are

\(^{22}\) As more than one form of gender-based violence can be disclosed by one person, this figure does not comprise the total number of individuals who disclosed it.
partially reliant on social welfare payments, such as rent allowance, to provide their services. It can also lead to exclusion from external services, due to cost.

Finally, the vast majority of GBV organisations identified language, and the related absence of professional interpretation services, as barriers to meeting needs. This was identified both in relation to provision of their own services, and in linking women to relevant external services. Not surprisingly, this issue was identified by a smaller percentage of minority ethnic organisations. Chart 8 summarises the most commonly identified barriers to meeting needs by each organisation.

**Chart 8. Identified Barriers to Meeting Needs by GBV and Minority Ethnic Organisations (%)**

8.3.1 Measures to Overcome Barriers

One of the most commonly identified measure for tackling barriers was raising awareness and information among minority ethnic communities regarding GBV and service provision in Ireland. This was identified as a positive measure by 92 per cent of GBV organisations and 91 per cent of minority ethnic organisations. Other measures that emerged as particularly important, especially from the point of view of GBV organisations, included:

- Availability of professional interpretation facilities, which was identified by 92 per cent of GBV organisations and 65 per cent of minority ethnic organisations;
- Increasing resources for NGOs working in the field, which was identified by 88 per cent of GBV organisations and 62 per cent of minority ethnic organisations;
- Engaging community leaders in awareness raising work on GBV, which was identified by 83 per cent of GBV organisations and 68 per cent of minority ethnic organisations;
- Provision of accessible counselling and psychology services, which was identified by 83 per cent of GBV organisations and 59 per cent of minority ethnic organisations;
- Provision of independent residency status for those women on a Spouse Dependent Visa who are victims/survivors of GBV, which was identified by 81 per cent of GBV organisations and 53 per cent of minority ethnic organisations.
8.4 Key Points

- Among 48 GBV organisations, all except one had been accessed by a minority ethnic woman.
- Traveller women comprised an average of 15 per cent and non-indigenous minority ethnic women comprised an average of 13 per cent of service users of GBV organisations, figures that suggests that minority ethnic women are over represented among GBV organisations’ clients. While these data are limited by the absence of ethnic identifiers among service providers and varying record keeping methods across services, this finding is supported by international research.
- Physical violence by an intimate partner was disclosed to 91 per cent of GBV organisations by minority ethnic women. This was followed closely by sexual violence by an intimate partner and emotional violence, both disclosed to 85 per cent of GBV organisations.
- Other forms of disclosed GBV among minority ethnic women include forced marriage, trafficking for the purposes of sexual exploitation, conflict-based rape and FGM.
- Despite limitations, these data show that GBV organisations play a very important role in meeting the needs of minority ethnic women in Ireland. They also indicate that GBV affects the lives of a significant number of minority ethnic women living in Ireland.
- Regarding minority ethnic organisations, among 54 respondent organisations, 80 per cent had one or more female clients who had sought support regarding GBV. As with GBV organisations, physical violence by an intimate partner was disclosed to the vast majority of these organisations. Emotional violence was disclosed to over three quarters of them.
- Unlike GBV organisations, sexual violence by an intimate partner was only disclosed to 28 per cent, highlighting again the added difficulties faced by victims/survivors in disclosing this form of abuse.
- Minority ethnic organisations were also accessed regarding other forms of GBV, including trafficking to Ireland for the purposes of sexual exploitation, conflict-based rape, FGM, forced marriage and GBV perpetrated by family members.
- Among 23 minority ethnic organisations, 673 disclosures of GBV were made over the previous year, 417 of which were emotional violence and 150 were physical violence by an intimate partner. Most disclosures of other forms of GBV, such as harmful traditional practices and trafficking for the purposes of sexual exploitation were made to a small number of organisations.
- Ninety four per cent of GBV organisations and 89 per cent of minority ethnic organisations perceived a need for general advice and support, characterised as a person-centred, non-judgemental and flexible approach to meeting needs.
- Other commonly identified needs included information on GBV services and counselling services, accommodation options, legal aid, outreach/visiting support and court accompaniment.
- A degree of consensus was also found across GBV organisations and minority ethnic organisations regarding many barriers to responding to these needs. Commonly identified barriers included inadequate resources, absence of staff training and the Habitual Residence Condition.
- The vast majority of GBV organisations identified language, and the related absence of professional interpretation services, as barriers to meeting needs. This was identified both in relation to provision of their own services, and in linking women to relevant external services.
9 Referral Pathways

This chapter maps the main referral pathways experienced by minority ethnic women seeking support regarding gender-based violence (GBV). The surveys of service providers comprise the primary data sources for this purpose. Qualitative interviews with minority ethnic women and the consultation process with service providers are also employed as a secondary source.

9.1 First Contact: Self-Referral

The first point of disclosure of GBV can be a crucial point in successful intervention for victims/survivors. In this study, GPs emerged as a key self-referral service - for 94 per cent of GPs, self-referral was identified as one of the most common means of referral by minority ethnic women regarding GBV.

Many minority ethnic women also self-refer to GBV organisations, with 65 per cent of survey respondents citing this as a key means of referral to their organisation. An even higher proportion of minority ethnic organisations (81%) identified self-referral as a common means of referral to them regarding victims/survivors of GBV. In addition to these services, qualitative interviews with minority ethnic women found that other points of first contact include the Gardaí, the Family Courts, Legal Aid Centres and Citizen Information Centres. As noted in chapter five, some victims/survivors were linked to relevant services by acquaintances and even strangers.

9.2 Referral Pathways

Minority ethnic women who have experienced GBV are commonly referred to GBV organisations by just under two fifths (39%) of GPs and 88 per cent of other mainstream health and social (MHS) services. This is also a common onward referral pathways for those women who seek support regarding this issue from minority ethnic organisations, with 50 per cent of this sector identifying ‘women’s hostel or refuge’, and a further 21 per cent identifying ‘other women’s support service’ as a common onward referral route. These findings are corroborated by referral routes identified by GBV organisations themselves. According to GBV organisations, other common referral routes to them include social work departments and the Gardaí. A small number identified Public Health Nurses in this regard.

Legal aid centres are another common onward referral destination for minority ethnic women regarding GBV. This was identified by 56 per cent of GBV organisations and 33 per cent of minority ethnic organisations. Other common onward referral routes included GPs, counselling services, housing organisations and the Gardaí.

Finally, in some cases, GPs also refer these patients onto specialist physical and mental health services. The most commonly identified were Social Work Departments and counselling services. Others include maternity units, Sexual Assault Treatment Units (SATU) and psychologists/psychotherapists. Chart 9 overleaf shows the percentage of GPs who identified each of these services as common onward referral routes from them.
9.3 Key Points

- GPs emerged as a key service to which minority ethnic women self-refer regarding GBV.
- Many minority ethnic women also commonly self-refer to GBV organisations and minority ethnic organisations.
- Qualitative data suggests that other important points of first contact regarding this issue include the Gardaí, the Family Courts, Legal Aid Centres and Citizen Information Centres.
- Minority ethnic women who have experienced GBV are commonly referred to GBV organisations by GPs, other mainstream health and social (MHS) services, minority ethnic organisations and the Gardaí.
- Other common onward referral routes from GBV organisations and minority ethnic organisations include legal aid centres, GPs, counselling services, housing organisations and the Gardaí.
- In some cases, GPs also refer these patients onto specialist physical and mental health services, namely Social Work Departments, counselling services, maternity units, Sexual Assault Treatment Units (SATU), and psychologists/ psychotherapists.
Figure 4. Key Referral Pathways for Minority Ethnic Women regarding GBV

Gender-based Violence Organisations

- Psychologist/ Psychiatrist
- A&E
- Maternity Unit
- Counselling
- GPs
- SATU
- Social work
- PHN
- Gardaí
- Family Courts
- Minority ethnic organisations
- Housing support organisations
- Other women’s support orgs
- Legal Aid Centre
- Community Welfare Officer
- Citizen Information Centre
- Self-referral

Counselling
Gardaí
Maternity Unit
Counselling
Ministry ethnic organisations
Housing support organisations
Other women’s support orgs
Legal Aid Centre
Community Welfare Officer
Citizen Information Centre
Self-referral
10 Conclusions and Recommendations

This report presents the findings of the first major study conducted in Ireland on gender-based violence (GBV) and minority ethnic women. Three factors formed the rationale for this research. Firstly, international research literature shows that minority ethnic women are at increased risk of GBV, and that they face a range of barriers to accessing relevant services. Secondly, there is an internationally recognised paucity of research literature on GBV and minority ethnic women, of which Ireland is no exception. Thirdly, recent decades have seen a dramatic increase in the number of people migrating to Ireland. Ireland is now a more multicultural country than ever before.

Methodologies included 26 qualitative interviews with minority ethnic women who experienced GBV, three quantitative surveys of service providers, as well as a review of international research literature and policy analysis. The quantitative findings provided national data on the incidence of minority ethnic women who disclosed GBV to services, and the experiences of services in responding to their needs. The qualitative findings provided an important insight into the causes and nature of GBV as experienced by minority ethnic women. This crucial aspect of the study was only made possible by the brave and generous participation of victims/survivors of GBV to this research. Other important factors that made this section of the study possible included the collaborative approach which was adopted for this stage of the research, the commitment of peer interviewers, and the support of service providers who agreed to act as gatekeepers.

Results confirm that this study is both relevant and timely. One of the most significant findings is that Traveller women and certain categories of non-indigenous minority ethnic women in Ireland do face an increased risk of GBV. Thirteen per cent of service users of GBV organisations were non-indigenous minority ethnic women, the vast majority of whom were on a spouse dependent visa or a migrant worker visa, were seeking asylum, or were refugees. Yet these categories correspond to only an estimated 5 per cent of the total population of women aged 15 years and older in Ireland (CSO, 2006). Traveller women comprised an average of 15 per cent of service users, yet according to Census 2006, Traveller women represent 0.5 per cent of the total population of women aged 15 years and over. High representation of minority ethnic women was also found in the level of disclosure to GPs - among a sample of 498 GPs, one third had GBV disclosed to them by a minority ethnic woman, and the average number of disclosures per these GPs was 3.6.

Survey findings show GBV among minority ethnic women to be a multifaceted and complex issue. While domestic violence is the most common form of GBV experienced by minority ethnic women accessing GBV organisations in Ireland, services also reported disclosure of many other forms of GBV. For example, those services that provide support for asylum seekers and refugees identified conflict-based rape and sexual assault in prison. Harmful traditional practices were also highlighted, namely forced and child marriage and female genital mutilation. A small number of GBV organisations, GPs and other mainstream health service providers were also accessed by victims/survivors of sex trafficking. Experience of multiple forms of GBV was not uncommon.

Chapter three of this study presents the ecological framework as the most useful and comprehensive model for understanding the causes of GBV. Risk factors are identified across four levels, namely the individual (level 1), family (level 2), community (level 3), and society (level 4). The findings of all stages of this research confirm the value of this model in understanding the experiences and needs of minority ethnic women regarding GBV.

Figure 5: The Ecological Framework

The rest of this chapter considers the key findings of this study in the context of this framework and highlights any arising recommendations. These findings are drawn from all stages of the research study. The levels of the ecological framework are addressed in reverse order, commencing with level four, society, as the most important recommendations from this research apply to this level. In order to facilitate ease of readership, each recommendation is colour coded as it relates to policy and legislation, service planning and delivery, and research.

### 10.1 Level 4: Society

No act of GBV can be fully understood without consideration of level four which is concerned with the existence of patriarchal views and attitudes within a society (UN, 2006). It both informs and defines almost all of the risk factors present under the other three levels. Risk factors at this level relate to patriarchal norms in society and include any state structures and processes that legitimise and institutionalise gender inequalities and/or do not provide adequate protection for women against GBV (UN, 2006).

International recognition of GBV as a violation of human rights has raised awareness of the issue on a global level and has led to binding obligations to prevent, combat and eradicate it in States throughout the world. In 1995, Ireland signed up to the Platform for Action of the United Nations' Beijing World Conference on Women which explicitly recognises that violence against women creates an obstacle to the achievement of the objectives of equality, development, and peace at the national level and violates the human rights of women at the individual level (United Nations, 1995a). A range of national policies and legislation exist with the aim of preventing the occurrence of GBV and protecting its victims/survivors, most notably the 1997 Report of the Task Force on Violence Against Women and the National Women’s Strategy 2007-2016. The establishment of Cosc, the National Office for the Prevention of Domestic, Sexual and GBV, is a more recent and welcome development that also reflects a strong commitment to eradicating GBV in Ireland. In addition, the fact that Cosc supported the undertaking of this research study signals cognisance of the need for interculturally competent responses to tackling GBV.

An important finding of this study is that a human rights/gender equality approach and an interculturally competent approach to combating GBV are not mutually exclusive, nor are they irreconcilable. Importantly, both are concerned with achieving equality for those who suffer discrimination. As noted by the WHO, the right to participate in cultural life and freedom of religion are rightfully protected by international law (2008). However, international law also stipulates that freedom to manifest these values and beliefs might be subject to limitations necessary to protect the fundamental rights and freedoms of others (ibid.). It is patriarchy that presents one of the strongest risk factors for GBV, not a particular culture. While patriarchy can be stronger in some cultural contexts than others, it is a feature of all cultures and should not be confused with culture itself. The use of social and cultural claims to justify any form of GBV entails disregarding the human rights of the victim/survivor. It also entails a misrepresentation of what culture is and can never be justified.

A national strategy on GBV that is underpinned by a conceptual framework identifying GBV as a human rights abuse is therefore required. Equally, the strategy needs to be interculturally competent, addressing all forms of GBV, the universality of patriarchy as an underlying risk factor, as well as the particular risk factors and barriers experienced by minority ethnic women. In order to be interculturally competent, this strategy should address specific challenges faced by minority
ethnic groups regarding GBV. It should also address the implementation of those recommendations laid out in the 1997 Report of the Task Force on Violence Against Women relating to minority ethnic women. At the time of writing, Cosc is planning a National Strategic Plan on domestic, sexual and gender-based violence. This represents an ideal opportunity for these issues to be addressed. In turn, this will facilitate the delivery of standardised and equitable service delivery for all victims/survivors of GBV.

R1 An interculturally competent national strategy on all forms of GBV which is underpinned by a conceptual framework that recognises GBV as a human rights abuse should be developed.

Immigration is another area that has an important role to play in State protection for victims/survivors of GBV. Regarding the process of seeking asylum, it is clear from these interviews that gender can be a ground for persecution. Participants were victims/survivors of harmful traditional practices in their country of origin, namely forced marriage and FGM, with devastating consequences. For those captured by rebels in war-torn areas, gender had a critical impact on their experiences, with female captives being subjected to sexual assault and forced labour. Some participants survived conflict-based rape, both in their country of origin and during the migration journey. The UNHCR guidelines on international protection for gender-related persecution regarding the 1951 Convention relating to the Status of Refugees, to which Ireland is a signatory, show that the refugee definition, properly interpreted, covers gender-related claims, such as GBV. They also elucidate that women comprise a social group, which is an identified ground for persecution both in the 1951 Convention and in the new **Immigration, Residence and Protection Bill**. The UNHCR guidelines also address procedural issues that would facilitate women to raise gender-related refugee claims, such as domestic violence. The implementation of these guidelines in Ireland would ensure that all women who have migrated to Ireland due to gender-related persecution would be assured of an equitable and standardised experience with the process of seeking asylum.

R2 Training should be provided for all immigration officials on **UNHCR gender guidelines** for asylum law, in order to ensure that they are implemented in a consistent and standardised manner.

Another finding from this research was the effect the Spouse Dependent Visa (SDV) can have on the accessibility of required support for a victim/survivor of domestic violence. For those women on a SDV, their legal status is reliant on their continued relationship with their spouse. In January 2007, new arrangements were introduced by the Department of Enterprise, Trade and Employment, whereby, in certain circumstances, spouses and dependants of employment permit holders can apply for a permit to work. However, even if a woman on a SDV does gain access to a work permit, she loses her entitlement to work if she leaves her spouse/partner. Moreover, many other women on a spouse dependent visa are not entitled to access paid employment. Regardless of their employment status, all spouse dependent visa holders become legally undocumented once they leave their partner. Eighty one per cent of GBV organisations that participated in this research said that provision of independent residency status for those on a Spouse Dependent Visa is a required measure in addressing the needs of minority ethnic women who experience GBV. Migrant advocacy bodies, such as the Migrants Rights Centre Ireland (MRCI) and the Immigrant Council of Ireland (ICI), as well as Women's Aid, have also identified this as an issue of concern.

R3 A Domestic Violence Concession should be added to the Immigration and Residence Bill, whereby victims/survivors of domestic violence, whose legal status is dependent on their continued relationship with their spouse, should be given leave to remain.

The MRCI and ICI have also shown domestic workers to be a vulnerable group in this regard. Consideration should also be made for the provision of a similar concession for those migrant
women who are required to leave their employment due to domestic violence or GBV in their place of work, and in so doing, lose their work permit and legal status.

Applicants for the Jobseeker’s Allowance and Supplementary Welfare Allowances in Ireland must satisfy the Habitual Residence Condition (HRC). This requires all applicants, regardless of nationality, to provide evidence of being legally present in Ireland for two years or more prior to their application. Those women living in Ireland for less than two years who are not in paid employment can therefore be financially dependent on their partner. Furthermore, those on a spouse dependent visa have no entitlement to social welfare payments, no matter how long they have been living in Ireland. Victims/survivors of domestic violence who are affected by this condition could thereby find themselves trapped in a violent relationship. This has already been identified as deepening the vulnerability of minority ethnic women who experience domestic violence (Migrants Rights Centre Ireland, 2006, Women's Aid, 2008, Women's Health Council, 2006). The story of one participant in this study illuminates the highly negative effect the HRC can have. She and her daughter found themselves living in substandard accommodation and suffering from ill-health for a period of one year after they left the home they had shared with the perpetrator. Survey findings show that she is not alone in her experiences, with 56 per cent of GBV organisations identifying the HRC as a barrier to meeting the needs of minority ethnic women regarding GBV.

**R4**

A Domestic Violence concession should be added to the Habitual Residence Condition, so that victims/survivors of domestic violence are enabled to leave a violent relationship.

Trafficking for the purposes of sexual exploitation is another form of GBV affecting a small percentage of highly vulnerable women in Ireland (Wylie and Ward, 2007). The recently enacted Criminal Law (Human Trafficking) Act 2008 makes a welcome improvement on Irish legislation regarding this issue. However, research literature suggests that victims/survivors should be provided with a reflection period of 90 days, rather than the existing 45 days. It has also been pointed out that a humanitarian approach should inform any provisions to extend this period and victims/survivors should not have to testify to qualify for this (Amnesty International, 2007).

In relation to FGM, current legislation in Ireland provides scope for a cultural relativist approach to the issue. This opposes a human rights stance on the issue and does not protect victims/survivors. As we have seen, FGM clearly represents a human rights abuse. In the words of the study participant who experienced this, "no one can do that to my daughter. I believe it’s a right. That girl has a right." New legislation needs to be enacted, or at the least existing legislation should be amended so that women are protected against this form of GBV in Ireland and to enable the medical profession to provide necessary treatments. The WHC has already made this recommendation in its literature review on the topic (WHC, 2007). Ongoing developments are occurring in this field, most notably the development of the Irish National Plan of Action Against FGM which was launched in November 2008 (National Steering Committee to Address FGM, 2008).

Level four of the ecological framework also relates to patriarchal social norms and definitions of masculinity linked to dominance that exist in society generally. Qualitative findings of this research confirmed that patriarchal social norms within minority ethnic communities did comprise a risk factor for GBV and also acted as a barrier to seeking help. A strong relationship emerged between participants’ experience of GBV and patriarchal values and norms, such as traditional gender roles being associated with the concept of honour. Patriarchal norms also underlined the reasons provided regarding forced marriage and female genital mutilation, even when women are involved in their perpetration. These findings support those of the largest multi-country study ever conducted on the topic, which found a strong relationship between the extent to which patriarchy was reflected in social values and norms and domestic violence (Garcio-Moreno, 2005). It is important to note in this regard, that for many participants of the research, the perpetrator of violence fell into the majority ethnic category of ‘White Irish’. This issue is the focus of Level 1, and is addressed in recommendation 16.
Not only do patriarchal norms increase the vulnerability of minority ethnic women to experiencing GBV, they also translate into barriers to seeking and receiving support from relevant services. Highly patriarchal norms lead to stigma and shame associated with leaving a violent partner and can even lead to the risk of being ostracised by the minority community for doing so. These norms prevented some participants from accessing the Gardaí. Quantitative data showed that factors related to patriarchy were one of the highest barriers to accessing support from GPs, other mainstream health and social services, as well as GBV and minority ethnic organisations.

In Ireland, the most important existing documents in terms of addressing gender inequality are the National Women’s Strategy 2007-2016 (NWS) and the equality legislation. The stated vision of the National Women’s Strategy 2007-2016 aims to create an “Ireland where all women enjoy equality with men and can achieve their full potential while enjoying a safe and fulfilling life” (Government of Ireland, 2007: xv). The equality legislation addresses unequal treatment in the workplace and elsewhere on a range of grounds that include gender. Stated actions in the National Women’s Strategy and the equality legislation that address gender inequality in Irish society should be implemented as a matter of priority.

According to the United Nations,

“given the fluidity of culture, women’s agency in challenging oppressive cultural norms and articulating cultural values that respect their human rights is of central importance. Efforts to address the impact of culture on violence should therefore take direction from the women who are seeking to ensure their rights within the cultural communities concerned” (2006: 31).

This study is an example of the valuable insight to be gained from the voices of women themselves in tackling GBV. Participants spoke positively of their contribution to the research, both in terms of sharing their experiences with the outside world and with fellow victims/survivors. As one participant noted, “people…will know that some people are suffering. And…when you know that there is someone who suffers as you and is strong, who continued life, who continued to build something better, it’s better. It can give you hope, it can help you cope in your life.”

It is therefore important that steps are taken to empower minority ethnic women in Irish society generally and to enable them to address these barriers collectively, and from a grassroots level. This would be instrumental in removing certain risk factors for GBV. Action 9.2.2 under Objective 5 (Participation) of the National Action Plan Against Racism is to enhance the role of Oireachtas committees and subcommittees, in particular through the Joint Oireachtas Committee on Justice, Equality, Defence and Women’s Rights, to consider issues related to racism and cultural diversity. This represents an ideal channel through which the agency of minority ethnic women could be increased. Minority ethnic women should be represented on this committee. At a local level, minority ethnic women could be empowered through participation in community development work and support networks.

R5  Funders of the voluntary sector should provide additional resources to minority ethnic and other relevant organisations for the facilitation of minority ethnic women’s participation in the community.

10.2 Level 3: Community

Level three, the community, relates to formal and informal social structures that impact on the immediate context of the victim/survivor (Heise, 1998). Identified risk factors at this level include poverty and low socioeconomic status and the isolation of the woman and of the family. These issues emerged both as risk factors and as barriers for seeking help among participants of this research.
In terms of support structures, a very encouraging finding is that interviewees shared extremely positive experiences of GBV organisations. Factors such as being listened to in a non-judgemental way, service providers taking a person-centred approach, clear information on services, rights and entitlements and where relevant, provision of court accompaniment, all played hugely important roles in overcoming barriers and in enabling the victim/survivor to accept referrals, recover and move on. These findings support the literature that emphasises the importance of GBV services providing a tailored, flexible and non-judgemental service to minority ethnic women. They are evidence that certain good practice measures are already in place in many GBV organisations. In addition, many minority ethnic organisations provide support groups for women which have been shown in this study to be accessed by victims/survivors of GBV.

Notwithstanding this evidence of existing good practice, it is important that interculturally competent service delivery is standardised throughout all relevant services. GBV organisations identified a need for training and guidelines on providing an interculturally competent service. Other relevant measures would include the development of clear policy on the issue, inclusion of intercultural issues on staff guidelines and where possible, employment of staff from minority ethnic cultures. Minority ethnic led organisations, which were also accessed by a high number of women regarding GBV, identified the need for training on dealing with disclosure of GBV. Principles of good practice were developed from the findings of this research; their implementation should play an important role in addressing these issues.

GBV organisations and other relevant services should use the principles of best practice identified in this study in order to develop an interculturally competent service.

Isolation emerged as a strong risk factor and barrier to seeking help for minority ethnic women regarding GBV. While isolation is a risk factor for all women, particular circumstances linked to minority ethnic status can increase the ability of the perpetrators to create and maintain isolation. For example, it is much easier for a perpetrator to ensure the isolation of a migrant woman who has left behind family and friends in her country of origin. This risk was highlighted by one interviewee whose husband became physically violent towards her only after they moved to Ireland. In such contexts, perpetrators are in a position to exploit and maintain the isolation of the victim/survivor by destroying legal documentation, strictly curtailing opportunities to form new friendships and lying to the victim/survivor about their rights and entitlements. These barriers are compounded for those who do not speak English.

One positive experience shared by many participants was the instrumental role played by acquaintances and even total strangers in supporting them and providing a vital link to GBV organisations. However, this also highlights the level of isolation experienced by participants and the lack of information available to them on relevant services and entitlements among minority ethnic women. It is also important to note that for ethical reasons, study participants were limited to those women who did access services and left a violent relationship. It stands to reason that isolation is an even greater issue for those who do not access such services.

Measures should be taken to raise awareness among minority ethnic women of GBV organisations and other relevant services, and the rights and entitlements of women in Ireland regarding GBV.

Steps should include the development of outreach programmes for minority ethnic women and the wide dissemination of information on GBV rights and entitlements of victims/survivors in Ireland. Contact details of relevant services should be made available to minority ethnic organisations and other relevant service providers, such as Legal Aid Centres and Citizen Information Centres. Recommendation 2 would also address this issue, particularly in relation to the establishment of support groups for minority ethnic women. Information leaflets for all victims/survivors of GBV should be interculturally competent and should be available in different languages. Consideration should be made of providing leaflets in ‘palm card’ format to increase confidentiality. On a policy
level, consideration should be made under the *Immigration, Residence and Protection Bill* to allow family reunification for those migrant women who are not asylum seekers who experience domestic violence.

Many victims/survivors experience more than one form of GBV and it is also not uncommon for such experiences to occur alongside other traumatic events, such as bereavement, separation from family and illness. A strong finding from the qualitative stage of this research regarding such multiple traumas is the damaging effect of isolation and, conversely, the valuable role played by social interaction and occupation in the process of recovery. As one participant noted, “the moment you are alone, the whole thing just comes back”. However, for asylum seekers, their limited living allowance acted as a barrier to even engaging in voluntary work in the community. Absence of information on how to go about this was also a barrier, compounded by a fear that seeking such information may negatively impact on their asylum claim.

Findings from the review of literature, qualitative interviews and surveys also highlight the increased vulnerability of women seeking asylum should they become the victims/survivors of domestic violence. Very limited income restricts these women from accessing relevant services while living in direct provision accommodation. Restrictions on moving from one direct provision centre to another also severely limits the opportunity to leave a violent relationship.

Steps should be taken to protect women seeking asylum from the damaging effects of social isolation, and to ensure that those who experience GBV while living in direct provision accommodation are enabled to seek support and leave a violent relationship.

**Steps**

Steps include informing those seeking asylum of their rights and service entitlements, including their right to access community services such as Citizen Information Centres, proactively encouraging requests for information and addressing transport costs, through an increase in the weekly allowance made available to those seeking asylum. For those women who experience GBV while living in direct provision accommodation, relevant steps would include ensuring that they are enabled to access support and to change residence in order to leave a violent relationship.

For Traveller women, the main cause of isolation and exclusion from relevant services was discrimination. Discrimination did not emerge as a risk factor for other interviewees regarding their experience in Ireland. This reflects the findings of a study conducted in 2000, which indicated that the Traveller population are more discriminated against than any other sector of Irish society (Curry, 2000). Discrimination from general society led to social isolation, distrust of service providers and the fear of children being placed in care when disclosing abuse within the family. Implementation of the equality legislation has obvious relevance here too, in terms of tackling discrimination at a societal level. The use of ethnic identifiers would facilitate services to provide a service that is equally accessible to all women. This would facilitate a coherent collection and application of data around needs, outcomes, and the accessibility of services. Through this, specific health and support needs could be identified and addressed. Service planners should provide training for service providers on the implementation of this recommendation.

The ethnicity question in Census 2006 should be adopted as an **ethnic identifier** in all GBV organisations and relevant health and social services, to enable collection and application of ethnic equality monitoring.

Meeting the needs of minority ethnic women has significant resource implications for GBV and minority ethnic organisations. However, as the survey showed, despite their important role in meeting needs, they have varying capacity levels and many require increased funding to properly fulfill this role. Fifty four per cent of GBV organisations and 66 per cent of minority ethnic organisations cited inadequate resources as a barrier to meeting needs. Regarding minority ethnic organisations, the commitment made by the Office of the Minister for Integration (2008) to support
the services offered by ethnic-led non-Governmental organisations working with the immigrant community is to be welcomed.

**R10** Funders of GBV and minority ethnic organisations should provide additional resources for those organisations that take specific steps towards meeting the needs of minority ethnic women regarding GBV.

Desirable measures to improve current services include the provision of information in relevant languages, staff training on intercultural competence, long term commitment to individual cases, the establishment and support of support groups for victims/survivors of specific forms of GBV, the conduct of liaison and awareness raising initiatives with minority ethnic communities regarding GBV and related rights and entitlements in Ireland, and the organisation of information sharing and networking initiatives between GBV organisations and minority ethnic organisations.

Finally, the impact of poverty cannot be over-emphasised - one study found that increased rates of GBV among minority communities disappear when this factor is accounted for (Sokoloff and Dupont, 2005). In the current research project, many participants’ experiences of domestic violence were contextualised by financial strain and poverty. For Traveller women, this was caused by discrimination. It meant that perpetrators knew that outside support was not a viable option for the victim/survivor. For other participants, the process of migration and legal status that precluded the opportunity to earn an income led to financial strain. Living in poverty means that a victim/survivor of GBV is excluded from accessing services due to their cost or other associated expenses such as transport, childcare, etc. This issue is particularly acute for those women living in direct provision accommodation while awaiting the outcome of their asylum plea.

**R11** Research should be conducted on the relationship between poverty and GBV. This should explore the feasibility of appropriate models for enabling victims/survivors experiencing poverty to leave a violent relationship.

### 10.2.1 Health Sector Response

The devastating physical and mental health consequences of GBV have been well documented (WHC, 2007). Participants of this research sustained injuries that included open head wounds, fractured ribs, a collapsed lung, teeth being knocked out and knife wounds. Some interviewees suffered from long-term physical health problems which they attributed to domestic violence, such as hypertension, eyesight and gynaecological problems. As serious as such conditions are, there was a perception that the psychological effects of domestic violence were much worse than physical problems. Interviewees spoke of a very poor sense of self worth, feeling loss of control over their own life and constant sense of fear. Symptoms of anxiety and depression were described. Seven had attempted suicide. Research literature suggests that its mental health consequences are even more severe for minority ethnic women.

The WHC has already made a range of recommendations to maximise the health sector response to GBV, which if implemented, would be of benefit to all victims/survivors of GBV (see Appendix F for details). The findings of this study show that additional steps need to be taken in order to ensure that the health sector overcomes the barriers faced particularly by minority ethnic women who have experienced GBV in accessing health and social services. Almost four fifths of GPs in our survey felt that they lacked the necessary training to meeting the needs of the women who had disclosed to them. The same proportion of GPs felt that lack of information on community resources presented as a barrier to making appropriate referrals for these patients. The ICGP’s guidelines on domestic violence for GPs represent an important step in addressing this issue (Kenny and Ni Riain, 2008). Many of the GPs who identified culture as a barrier to meeting needs related this to their own lack of knowledge and training on providing and interculturally competent service. This points to the need for training on providing an interculturally competent service for GPs and other mainstream health and social services. This training should be informed by a human rights approach that emphasises the fact that all forms of GBV are an abuse of human rights.
Guidelines on GBV should be developed for healthcare professionals. These should address all forms of GBV, as well as the specific barriers and needs experienced by minority ethnic women.

An intercultural approach should also be adopted in the development of training/academic modules on the issue of GBV for relevant healthcare professionals, namely GPs, public health nurses, social workers and nursing staff in A&E and maternity hospital departments.

An unquantifiable number of minority ethnic women never disclose GBV to a mainstream health and social service. For some, leaving a violent relationship may not be a feasible option due to the stigma associated with such an action in their community and the very real threat of ostracisation. Traveller women shared a deep concern that disclosing GBV to a social worker would result in their children being placed in care. Yet those health and social service professionals who work with clients in the community have a potentially valuable role to play in supporting minority ethnic women who are victims/survivors of GBV.

Health Professionals whose role involves an outreach/community-based dimension, such as public health nurses and social workers, should liaise with relevant minority ethnic and GBV organisations in order to raise awareness of the support they can offer regarding GBV.

Social workers in particular should emphasise the confidential nature of their service and work with GBV and other relevant organisations in informing victims/survivors of the support they can provide.

10.2.2 Criminal Justice System
The Gardaí play an important role in protecting all victims/survivors of GBV from violent attacks by perpetrators. Migrant participants in this study described how simply knowing the Gardaí were accessible regarding domestic violence increased their sense of autonomy and control in a violent relationship; as one noted, “I always know information is power…So I say, I’m going to call the police. And I’m going to go to the court. So he would go”. Participants also shared some positive experiences of accessing Family Courts regarding domestic violence and applications for protection and barring orders.

Notwithstanding these positive findings, it emerged that trust was an essential prerequisite for seeking help from the Gardaí. Traveller women in particular recounted a lack of trust in the criminal justice system, caused mainly by a perception that the Gardaí viewed domestic violence as a part of Traveller culture and that their intervention in such cases was not appropriate. Regarding the Family Courts, one participant’s experience illuminated the potentially negative impact of unfamiliarity with the Irish court system, which for her was compounded by a language barrier.

The Criminal Justice System should be enabled to implement an interculturally competent approach to all aspects of their service that relate to GBV.

One important step in this regard is the development of an interculturally competent training programme on GBV for the Gardaí and other relevant Criminal Justice System departments, such as Family Courts officials. In order to ensure that this training is interculturally competent, all forms of GBV should be addressed. It should be emphasised that no form of GBV can ever be condoned by so-called cultural reasons. The fact that Garda intervention can play a valuable role in protecting victims/survivors of GBV, even when it does not result in the perpetrator being brought to court, should be addressed during Garda training on the issue. It should also be acknowledged in Gardaí performance appraisals.
The important work of the Ethnic Liaison Unit of the Gardaí should continue. Emphasis should be placed on establishing trustful relations with ethnic minority communities, and on ensuring confidentiality in dealing with any disclosures of GBV. Ethnic Liaison Officers should have regular contact with GBV organisations, as this has been shown to increase trust among minority ethnic victims/survivors of GBV.

10.3 Level 2: The Family

Level two of the ecological model relates to risk factors in the immediate context, such as the relationship or family, in which GBV takes place. Risk factors at this level are all manifestations of patriarchal norms at local level. They include male dominance in the family, male control of wealth in the family, marital conflict, such as that caused by disagreements over the division of labour and decision-making in the family (Heise et al., 1999). These factors are borne out by the findings of this study. In fact, an underlying theme running through all interviews with victims/survivors of domestic violence was the way in which the perpetrator’s constant desire to demonstrate the control he had over the victim/survivor was inextricably connected to marital conflict and refusal of the male to relinquish such control. This was manifested through irrational justifications for violent attacks, repeated infidelities, verbal attacks aimed at decreasing the victim/survivor’s self-esteem, financial abuse and forced labour. Interviewees perceived a clear relationship between the perpetrator’s desire to control them and patriarchal social values and norms, such as traditional gender roles being associated with the concept of honour. For some, sexual violence was contextualised in a sense of duty arising from such social norms.

Interviewees who had migrated to Ireland described how their migrant status was used as another tool of control by the perpetrator. Legal status that depends on the victim/survivor’s relationship with the perpetrator, increased financial dependency and social isolation caused by language barriers increased the level of control the perpetrator had over the victim/survivor. It also emerged that women who found themselves in a violent relationship with a member of the majority ethnic (‘white Irish’) group were also vulnerable to attacks that revealed how male dominance was furthered through their immigrant status. One participant described how her husband lied to her about the Irish legal system, with the aim of convincing her that her legal status was less secure than it actually was. Another participant who had survived traumatic experiences prior to her migration to Ireland found that the perpetrator exploited the emotional wounds of this past experience, in order to further undermine and weaken her position within their relationship. These risk factors are addressed in many of the recommendations outlined here, particularly recommendations 1, 3, 4 and 11.

10.4 Level 1: The Individual Perpetrator

Level 1 concerns the personal history of the perpetrator. Identified risk factors include the perpetrator witnessing domestic violence as a child and experiencing physical or sexual abuse as a child. These issues were not explored during interviews with victims/survivors for this study. Interviewees were not necessarily aware of any such past history of the perpetrator. More importantly, this issue did not relate to the focus of the research, which was the experiences and needs of interviewees. The existence of this risk factor however does point to the need for intervention work to be conducted with perpetrators of GBV against minority ethnic women. It has been found that “it is impossible to eliminate VAW if the attitudes and behaviour of violent men are not changed as a central part of this process” (Velzeboer et al, 2003: 89).

R16 A best practice model of intervention for perpetrators of GBV against minority ethnic women should be identified, adapted to the Irish context and implemented. This should address all perpetrators, including those belonging to the majority ethnic group.
10.5 Further Research

The need for research to be conducted on the relationship between poverty and GBV has already been noted. In addition to this, a number of other gaps in research were identified in this study. The issue of crisis pregnancy was raised by two qualitative interviewees for this study. One was an asylum seeker and the other was a migrant worker. Neither of these interviewees experienced this in the context of a violent relationship. However, both faced barriers to accessing required support. This study also highlights the mental health needs of migrant women in Ireland. Finally, the range of barriers experienced by minority ethnic women in accessing support for GBV highlights the vulnerability of children of minority ethnic victims/survivors of GBV.

| R17 | Research should be conducted on the experiences and needs of migrant women who experience crisis pregnancy in Ireland. |
| R18 | Research should be conducted on the mental health and related needs of migrant women in Ireland. |
| R19 | Research should be conducted on the needs of children of minority ethnic women who are victims/survivors of GBV in Ireland. |
### 10.6 List of Recommendations

#### Policy

| R1 | An interculturally competent national strategy on all forms of GBV should be developed, which is underpinned by a conceptual framework that recognises GBV as a human rights abuse. |
| R3 | A Domestic Violence Concession should be added to the Immigration and Residence Bill, whereby victims/survivors of domestic violence, whose legal status is dependent on their continued relationship with their spouse, should be given leave to remain. |
| R4 | A Domestic Violence concession should be added to the Habitual Residence Condition, so that victims/survivors of domestic violence are enabled to leave a violent relationship. |

#### Service Planning and Delivery

| R2 | Training should be provided for all immigration officials on UNHCR gender guidelines for asylum law, in order to ensure that they are implemented in a consistent and standardised manner. |
| R5 | Funders of the voluntary sector should provide additional resources to minority ethnic and other relevant organisations for the facilitation of minority ethnic women's participation in the community. |
| R6 | GBV organisations and other relevant services should use the principles of best practice identified in this study in order to develop an interculturally competent service. |
| R7 | Measures should be taken to raise awareness among minority ethnic women of GBV organisations and other relevant services, and the rights and entitlements of women in Ireland regarding GBV. |
| R8 | Steps should be taken to protect women seeking asylum from the damaging effects of social isolation, and to ensure that those who experience GBV while living in direct provision accommodation are enabled to seek support and leave a violent relationship. |
| R9 | The ethnicity question in Census 2006 should be adopted as an ethnic identifier in all GBV organisations and relevant health and social services, to enable collection and application of ethnic equality monitoring. |
| R10 | Funders of GBV and minority ethnic organisations should provide additional resources for those organisations that take specific steps towards meeting the needs of minority ethnic women regarding GBV. |
| R12 | Guidelines on GBV should be developed for healthcare professionals. All forms of GBV should be addressed, as well as the specific barriers and needs experienced by minority ethnic women. |
An intercultural approach should also be adopted in the development of training/academic modules on the issue of GBV for relevant healthcare professionals, namely GPs, public health nurses, social workers and nursing staff in A&E and maternity hospital departments.

Health Professionals whose role involves an outreach/community-based dimension, such as public health nurses and social workers, should liaise with relevant minority ethnic and GBV organisations in order to raise awareness of the support they can offer regarding GBV.

The Criminal Justice System should be enabled to implement an interculturally competent approach to all aspects of their service that relate to GBV.

A best practice model of intervention for perpetrators of GBV against minority ethnic women should be identified, adapted to the Irish context and implemented. This should address all perpetrators, including those belonging to the majority ethnic group.

Further Research

Research should be conducted on the relationship between poverty and GBV. This should explore the feasibility of appropriate models for enabling victims/survivors to leave a violent relationship.

Research should be conducted on the experiences and needs of migrant women who experience crisis pregnancy in Ireland.

Research should be conducted on the mental health and related needs of migrant women in Ireland.

Research should be conducted on the needs of children of minority ethnic women who are victims/survivors of GBV in Ireland.
11 Principles of Best Practice for Service Delivery

This chapter presents eleven principles of best practice for relevant service providers. The aim of these principles is to provide relevant services with a basis on which to develop policies, guidelines and training programmes in responding to the needs of minority ethnic women. These principles were developed primarily for GBV organisations. However, they are also relevant to any service that provides support for minority ethnic women who have experienced GBV. Fourteen principles of best practice are presented here. Their adoption will ensure that the needs of minority ethnic women who experience GBV are met in a way that is interculturally appropriate and sensitive to the range of inter-related factors. These principles are grounded in the primary research findings of this study. The UK Home Office paper, *Tackling Domestic Violence: Providing Advocacy and Support to Survivors from Black and Other Minority Ethnic Communities* was a useful secondary source of information (2005).

- **Be Interculturally Aware**
  In order to respond to the needs of minority ethnic women, services must be interculturally congruent, reflecting awareness and understanding of cultural issues that may affect the situation and needs of victims/survivors of GBV. Staff training should address issues around working with minority ethnic clients, such as intercultural and religious factors, immigration issues, multiple trauma, racism, and information on external relevant services. Where possible, minority ethnic women should also be trained and employed as staff in refuges and other dedicated GBV services. It is equally important that a human rights approach underpins service delivery for all victims/survivors of GBV. Every instance of GBV is a violation of the human rights of the victim/survivor. Social and/or cultural claims should never be perceived as justification of any form of GBV.

- **Recognise Racism as a Factor**
  Service providers should work with clients to explore any possible impact of racism regarding their experience of GBV and of accessing relevant services.

- **Recognise Social Exclusion and Poverty as a Factor**
  Service providers should be cognisant of and work with clients to explore any possible impact of social exclusion and poverty on their experience of GBV, options available to them and the accessibility of relevant services.

- **Recognise Complexity: A Person-Centred Approach**
  Minority ethnic women are not a homogenous group. A wide range of factors can impact on their experience of GBV and resultant needs, such as cultural factors, language barriers and immigration law to name but a few. The extent to which these issues are relevant and the way in which they inter-relate can vary from individual to individual. It has also been shown that intensive work with minority ethnic clients, over long periods of time results in a much higher satisfaction level among clients (Home Office, 2005). Such cases resulted in greater likelihood to report to the police and to pursue legal action. This principle is about providing a tailored, person centred approach to working with minority ethnic women, in which they play a proactive role in developing an assessment plan and identifying priority needs.

- **Be Proactive about Intercultural Issues**
  Service providers should also be able to identify issues such as culture, language and immigration surrounding a client and if required, sensitively help the client to perceive them too. It has been shown that a little goes a long way in terms of letting the client know of the service’s awareness of such issues and associated needs. One study found that practical gestures, such as buying culturally appropriate clothing for a client who left home without having time to pack, can be of great value to the victim/survivor (Home Office, 2005).

24 Level of intensity of work was measured by number of phone calls and meetings and concurrent assistance on a range of issues, as well as practical advice on a range of issues.
Develop Relationships Built on Trust
Trust is an essential element in providing support to any victim/survivor of GBV. Regarding minority ethnic clients, certain measures can facilitate this, such as matching clients with service providers who share their ethnic background whenever possible, providing long term support, and taking a person-centred, interculturally informed approach to meeting their needs, as outlined above.

Encourage rather than Push
Some minority ethnic women can be particularly vulnerable to barriers in taking legal action, such as fear of ostracisation from family and community, and fear of appearing disloyal, both to the perpetrator and to her community. For this reason, taking legal action and/or leaving a violent relationship may not be a viable option. Service providers should encourage these clients to take the steps they assess as being most beneficial to them, but should not push them to do so. Again, this relates to the person-centred approach, with the client being facilitated to recognise which support option is most appropriate to her and whether or not she is ready to take it. Pushing someone to take steps for which they are not ready could result in trust being lost.

Take an Inter-Agency Approach
Minority ethnic women can experience a range of problems such as legal status issues, separation from family, racism from the majority ethnic group and persecution in country of origin. For those women who are also victims/survivors of GBV a range of needs can present concurrently. These needs can include, but are not limited to, housing, employment, immigrant status and health service needs.

It has been shown that close links between VAW organisations and the police and other services can lead to higher levels of reporting to police among minority ethnic women who experience GBV. In a recent review of GBV organisations in the UK, it was found that those services that showed an understanding of the structures and policies of other organisations had more positive experiences in working together with statutory bodies to meet their clients’ needs, which, in turn, led to more positive outcomes for clients (Home Office, 2005). For this reason, an inter-agency approach should be adopted, whereby GBV organisations aim towards positive inter-agency working relationships with relevant agencies and government departments. In this process, the victim/survivor should play a central role in prioritising needs and identifying relevant services.

Confidentiality is Paramount
Confidentiality is a very important feature of support delivery to all victims/survivors of GBV. There can be further issues for minority ethnic women, of which services should be aware and act accordingly. For example, if a refuge responds to a specific minority ethnic group, its existence and location may become well known among that community, making it easier for perpetrators to trace women staying there. Again, this issue should be discussed with the client and any decisions made regarding referral should be informed by her views and wishes.

Involve the Community
For some minority ethnic women who experience domestic violence, the range of barriers to seeking help can be insurmountable. Insofar as it is possible, relevant services should reach out to minority ethnic communities in order to make contact with the most vulnerable and most isolated. Awareness raising exercises should focus on the fact that VAW is a crime and unacceptable, and secondly, that services are available which can help women. The value of word of mouth as a means of dissemination should be recognised and made use of. Women from minority communities could be employed to input in the development of such awareness raising strategies. As noted under the principle of providing an interculturally congruent service, minority ethnic women should also be trained and employed as staff in refuges and other GBV services, where possible. Finally, these services should also tap into local expertise regarding minority cultures to be found in local minority ethnic organisations. This could be a two-way process, with GBV organisations providing them with information and guidance regarding GBV.
- **Develop Clear Policies**
  Services should develop clear, written policies on providing support to all minority ethnic women. These should refer to specific issues regarding refugees, asylum seekers, migrant workers, and spouses of Irish citizens, as well as Traveller women. They should also relate to different forms of GBV, including intimate partner violence, conflict-based violence and harmful traditional practices such as FGM and forced marriages.

- **Provide Accessible and Interculturally Appropriate Information**
  Relevant services should ensure that the information they disseminate is accessible to all women, by making it available in different languages as well as using pictorial information when possible and appropriate. Services who disseminate information on GBV should consider providing relevant information on small 'palm cards' which women can take with minimum risk to their safety. Consideration should be made of local, alternative channels for the dissemination of information, such as minority ethnic newspapers. Service providers should not take for granted the level of knowledge of minority ethnic women, especially those who have only recently arrived in the country, regarding practical matters such as using public transport. Research in the UK found that provision of this sort of information can prove very valuable (Home Office, 2005).

- **Advocacy**
  Advocacy is a feature of many GBV services generally. Service providers should be aware that this may be even more important for minority ethnic women, who for a range of reasons may find themselves socially isolated. This issue should be explored with clients.

- **Monitor Intercultural Competence**
  Services should regularly monitor their performance regarding intercultural competence. Ethnic identifier information should be gathered from all service users for this purpose.
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Appendices

Appendix A  Glossary of Terms
Appendix B  Participant Information Sheet and Consent Form
Appendix C  Information Document for Service Providers
Appendix D  Training Programme for Peer Researchers
Appendix E  Questionnaires
Appendix F  Additional Quantitative Data
Appendix A

Glossary of Terms

Asylum seeker
“An asylum seeker is a person seeking to be recognised as a refugee in under the 1951 United Nations Convention Relating to the Status of Refugees, to which Ireland is a signatory. If someone is granted this recognition, they are granted refugee status and are no longer considered to be an asylum seeker”.\(^{25}\)

Black
“People can describe themselves as Black for a number of reasons, for example, in relation to their physical appearance, their ancestry, as a political term, or all of the above. Some people use the word Black to mean ‘of African origin’; whereas others mean ‘non-white’ and would include people from Asia for example. Black is not generally considered to be a derogatory term and in Ireland, the term ‘Black and minority ethnic group(s)’ is often used”.\(^{26}\)

Conflict-based rape
Conflict-based rape refers to that which occurs in conflict settings. Rape has been used as a strategy in many conflicts, throughout history and throughout the world. Rape and enforced impregnation are used as weapons of war, a means of ethnic cleansing, a means of humiliating men and their family honour. In turn, women are often ostracized from the family and the community because they have been raped. Conflict-based rape is an international crime against humanity in the Rome Statute of the International Criminal Court.\(^{27}\)

Culture
“Culture refers to the shared customs, values and beliefs which characterise a given social group, and which are passed down from generation to generation".\(^{28}\)

Discrimination against women
Discrimination against women has been defined as “any distinction, exclusion, or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field”.\(^{29}\)

Domestic Violence
The term domestic violence can be used interchangeably with intimate partner violence (IPV). Domestic violence is one of the most common forms of gender-based violence and is often characterized by long-term patterns of abusive behaviour and control.\(^{30}\) Domestic violence most usually refers to violence perpetrated by an intimate partner, though can also be used regarding violence perpetrated by other family members.

Early/child marriage
Early marriage is the marriage of girls below the age of 16 years, in some cases before the girl reaches sexual maturity.\(^{31}\)

Ethnicity
Ethnicity refers to the shared characteristics such as culture, language, religion and traditions, which contribute to a person or group’s identity. Ethnicity has been described as residing in:

\(^{25}\) NCCRI, 2007: 3.
\(^{26}\) NCCRI, 2007: 4.
\(^{27}\) Women’s UN Report Network, 2004; Krug et al, 2002
\(^{29}\) Article 1 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
\(^{30}\) Watts and Zimmerman, 2002.
\(^{31}\) Kelly and Regan, 2007
the belief by members of a social group that they are culturally distinctive and different to outsiders;
their willingness to find symbolic markers of that difference (food habits, religion, forms of dress, language) and to emphasise their significance; and
their willingness to organise relationships with outsiders so that a kind of ‘group boundary’ is preserved and reproduced.\textsuperscript{32}

Commentators also emphasise the fluid, ever-changing nature of ethnicity.\textsuperscript{33}

**Female Genital Mutilation**

FGM involves the removal of all, or parts, of the external female genitalia. It is generally performed on young girls, but is sometimes performed on infants, adolescents and women. It is normally performed without the use of anaesthetic or hygienic surgical tools.\textsuperscript{34}

**Forced Marriage**

Forced marriage is that which occurs without consent of both parties, and involves the use of coercion or force. In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangement remains with the young people. Arranged marriages therefore do not constitute a form of GBV, while forced marriages do.\textsuperscript{35}

**Gender**

Gender is the term used to denote the social characteristics assigned to men and women. These social characteristics are constructed on the basis of different factors, such as age, religion, national, ethnic and social origin. They differ both within and between cultures and define identities, status, roles, responsibilities and power relations among the members of any culture or society. Gender is learned through socialisation. It is not static or innate, but evolves to respond to changes in the social, political and cultural environment.\textsuperscript{36}

**GBV organisation**

For the purposes of this research study, the term GBV organisation refers to any organisation whose principal aim is to provide support to victims/survivors of any form of GBV, such as domestic violence and sexual violence outside the home. Most clients of these organisations in Ireland are women, however, some GBV organisations are accessed by men too.

**Gender-based violence**

An umbrella term for all forms of violence that are directed against a person on the basis of their gender or sex. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty. Examples of gender-based violence include sexual violence, domestic violence, emotional and psychological abuse, trafficking, forced prostitution, sexual exploitation, sexual harassment, and harmful traditional practices (such as female genital mutilation and forced marriage). The vast majority of cases of gender-based violence are perpetrated against women.\textsuperscript{37}

**Habitual Residence Condition (HRC)**

This was introduced by the Irish Government on 1\textsuperscript{st} May 2004 as an additional criterion for qualifying for social assistance payments, Child Benefit and access to emergency accommodation. To demonstrate that ‘habitual residence’ in Ireland in order to qualify for such payments, a person must provide evidence that they have been living in Ireland for approximately 2 years or more, and that they intend to settle here and make it their permanent home.\textsuperscript{38}

**Honour killing and maiming**

Maiming or murdering a woman or a girl as a punishment for acts considered inappropriate with regards
to her gender, and which are believed to bring shame on the family or community (e.g. pouring acid on a young woman’s face as punishment for bringing shame to the family for attempting to marry someone not chosen by the family), or to preserve the honour of the family (i.e. as a redemption for an offence committed by a male member of the family)/39

**Female infanticide and/or neglect**
Killing, withholding food from, and/or neglecting female children because they are considered to be of less value in a society than male children.40

**Intimate Partner Violence (IPV)**
Intimate partner violence is abuse that occurs between two people in a close relationship. The term “intimate partner” includes current and former partners. IPV exists along a continuum from a single episode of violence to ongoing abuse. It includes physical, sexual, financial and emotional violence.41

**IRIN**
IRIN is the UN Office for the Coordination of Humanitarian Affairs. Its key role is to provide news and analysis about sub-Saharan Africa, the Middle East and parts of Asia for the humanitarian community.42

**Migrant worker**
“The term migrant worker refers to a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national”.43

**Minority ethnic organisation**
For the purposes of this study, the term minority ethnic organisation refers to all organisations in Ireland for and/or coordinated by minority ethnic communities in Ireland. It includes those organisations working specifically with one minority ethnic community and those that provide services to all minority ethnic communities. It refers to both national and locally based organisations.

**Minority ethnic group**
“Sometimes referred to as ‘Black and minority ethnic group(s)’, this means a group whose ethnicity is distinct from that of the majority of the population. The term ‘ethnic minority’ is sometimes used, but the term ‘minority ethnic’ draws attention to the fact that there are majorities and minorities, all with their own ethnicity – white Irish people are the majority ethnic group”44

**Patriarchy**
The predominance of men in positions of power and influence in society, with cultural values and norms being seen as favouring men.45

**Refugee**
A refugee is "any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail her/himself of the protection of that country; or (any person) who, not having a nationality and being outside the country of her/his former habitual residence, is unable, or owing to such fear is unwilling to return to it".46

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40 Ibid.
41 Sources: Garcia-Moreno, 2005; Renzetti, 2000.
42 [www.irin.org](http://www.irin.org)
44 Ibid: 10.
45 OED, 2008.
46 UN Convention Relating to the Status of Refugees, 1951.
Sexual Exploitation
“Any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another”.47

Sexual Violence
Sexual violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work48. Coercion refers to physical force, psychological intimidation, blackmail or other threats. It may also occur when the person aggrieved is unable to give consent – for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation.49

Spouse Dependent Visa
Spouses of migrant workers have the right to reside in Ireland on what is called a ‘spouse dependent visa’. Since January 2007, those on a spouse-dependent visa have been permitted to seek and enter into paid employment50. However, those who are not in paid employment lose the legal right to remain in the state and become undocumented if they leave the relationship.

Trafficking in Persons
“Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs” 51

Victim/survivor
“The term victim(s)/survivor(s) refers to individuals who have experienced gender-based violence. While victims should be treated with compassion and sensitivity, referring to them as survivors recognises their strength and resilience”.52

Violence
“The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”.53

Violence against Women (VAW)
Violence against women is “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”.54 The term is often used interchangeably with GBV. The introduction of the Declaration on the Elimination of VAW states that VAW is “a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men”.55

49 Ibid.
54 UN Declaration on the Elimination of Violence against Women, 1993.
55 Ibid.
The United Nations (UN) is an international organisation which was founded following the Second World War to replace the League of Nations. Its purposes, as set forth in the UN Charter, are to maintain international peace and security; to develop friendly relations among nations; to cooperate in solving international economic, social, cultural and humanitarian problems and in promoting respect for human rights and fundamental freedoms; and to be a centre for harmonizing the actions of nations in attaining these ends.\textsuperscript{56}

The United Nations Population Fund (UNFPA) is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect\textsuperscript{57}

The Office of the United Nations High Commissioner for Refugees (UNHCR) is mandated with the protection and care of refugees.\textsuperscript{58}

The United Nations Development Fund for Women (UNIFEM) is the women's fund at the UN. It provides financial and technical assistance to innovative programmes and strategies to foster women's empowerment and gender equality. One of its four strategic areas is ending violence against women.\textsuperscript{59}

The United Nations Children Fund (UNICEF) is the children's fund at the UN. Its purpose is to work with others to overcome the obstacles experienced by children that are caused by poverty, violence, disease and discrimination.\textsuperscript{60}

The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.\textsuperscript{61}

\textsuperscript{56} \url{www.un.org}  
\textsuperscript{57} \url{www.unfpa.org}  
\textsuperscript{58} \url{www.unhcr.org}  
\textsuperscript{59} \url{www.unifem.org}  
\textsuperscript{60} \url{www.unicef.org}  
\textsuperscript{61} \url{www.who.int}
Appendix B

Participant Information Sheet and Consent Form

Information Sheet for Participants

You are invited to take part in a study that hopes to find out how the needs of minority ethnic women in Ireland who have experienced gender-based violence can best be met. This research is being conducted by myself, Liza Costello, a senior researcher with the Women’s Health Council. Below you will find some information about why the research is being done and what it will involve. Please read this information carefully to help you decide if you would like to take part.

- **What is the aim of the study?**
  The aim of this research is to find out how services in Ireland can best respond to the needs of women from minority ethnic backgrounds who experience gender-based violence.

- **What is gender-based violence?**
  Gender-based violence is a very broad concept and is also referred to as violence against women. It refers to violence that is carried out against women, because of their gender. Such violence results in, or is likely to result in, physical, sexual or psychological harm on the woman.

  Gender-based violence includes domestic violence, physical violence and sexual violence which can happen in the home or in the community, and emotional or psychological violence. It also includes forced prostitution and harmful traditional practices, such as female genital mutilation and forced marriages.

  Men can experience gender-based violence too, but for different reasons than women, and they are at a much lower risk of it. This study is focusing on violence against women.

- **What is a minority ethnic group?**
  A minority ethnic group is a group of people who share certain aspects of their identity, such as their culture, religion, the country they were born in or language, who live in a country where the majority of the population belong to a different race/religion/nationality. In this study, we are focusing on Irish Travellers, and members of any minority ethnic groups who are asylum seekers, refugees, students, migrant workers or are on a spouse dependent visa.

- **Who is being asked to participate?**
  We are asking minority ethnic woman, aged 18 and over, who are living in Ireland and have experienced gender-based violence to take part in this study. In order to ensure the wellbeing of all those who participate in the research, we wish to interview only those who have received support for their experience of gender-based violence, and who are currently living in a safe environment.

  Your experience of gender-based violence could have happened in your home country, on your way to Ireland, or in Ireland. We are particularly interested in finding out about your experiences in trying to access health and social care services in Ireland, your views on health and social services in Ireland, and any service needs you feel are not being met.

  By taking part, you will have the opportunity to discuss your experiences of this issue and play a role in helping to identify how services in this area can be improved.

- **What will I be required to do?**
  You will be asked to attend an interview that will last for about one hour. The interviewer will ask you about your experience of gender-based violence, your experiences in accessing related services for this in Ireland, and how you think services could be improved. After the interview, you will be given the opportunity to read the transcript of your interview, if you so wish.
Where will this take place?
Interviews will take place in a safe venue that is convenient for you. This might be in a private room in the service where you heard about this research. A private interview room is also available in a safe and confidential location in Dublin city, should you prefer this. The interview will only be held in a place with which you feel completely comfortable.

Who will do the interviews?
A team of interviewers from different minority ethnic groups have been trained to conduct these interviews. You can choose to be interviewed by myself or by someone closer to your own cultural background.

What if I find the interview upsetting or difficult?
All interviewers are trained in conducting these interviews in a sensitive way. In similar studies, it has been found that women often benefit from taking part. At any stage of the interview, you are free to end the interview. After the interview, the interviewer will provide you with a list of support services in your area that you can access if you wish.

Counselling Support
If you become distressed during the interview or feel that it has raised any unresolved issues for you, a counselling service will be available for you after the interview. Just let the interviewer or service provider know that you would like to avail of this and it will be arranged, without any cost to you. If required, will continue to provide you with support following study completion.

What will happen to the information gathered?
All information (data) will be entirely confidential and anonymous. To assist the research process, the interview will be taped, with your permission. Interviews conducted in English will be kept in a locked cupboard that only I can access. Interviews conducted in another language will also be kept in locked storage that only the interviewer can access. As soon as they are transcribed, all taped interviews will be erased immediately. No identifying information will be included on tapes or on transcripts.

I will transcribe all interviews conducted in English. Any interviews conducted in another language will be transcribed and translated by the interviewer who conducted the interview. All personal details will stay confidential. I will then write up the written information but any names or identifiable information will be changed or removed. The final results will appear in a report. No information included in any report or publication will identify you in any way.

Will anyone be able to connect me with what is recorded and reported?
No. Participation in this research is entirely confidential and anonymous. The only people who will be aware of your participation in this research will be the service provider who informed you of the research and the person who conducted the interview. No identifying information will be attached to the tape of the interview, or on transcripts of the interview.

How will you use what you find out?
Once the research is completed, a report will be prepared on the service needs of women from minority ethnic groups who experience gender-based violence. This report will make a number of recommendations to improve service delivery in this area. In addition, key principles for guidelines will be identified for service providers to support the needs of women from minority ethnic groups who experience gender-based violence.

How long is the whole study likely to last?
The entire study will last about one year.

How can I find out about the results of the study?
If you are interested in finding out about the results of the study, just let the interviewer or your service provider know. When the study is completed, we would be delighted to share its findings with you.
What if I do not wish to take part?
Participating in this study is totally voluntary. If you decide not to take part after reading this information, that is fine. If you don’t want to get involved at the moment but change your mind later on, don’t hesitate to ring us. We'll be pleased to hear from you.

What if I change my mind during the study?
You are free to withdraw at any stage, without giving a reason. You can withdraw before the interview takes place. During an interview you have the right to choose not to answer any question or to stop or pause the interview at any time. You can even change your mind about participation after the interview has taken place, if you decide you do not want your interview to be used in the research. If you do decide to get involved and later change you mind, that’s no problem: it would be helpful if you could let one of the interviewers know.

If I am interested in participating, who can I discuss this with?
If you are interested in taking part, please tell the person who told you about the research, or you can call this Free-Phone number: 1800 300 330.

A meeting will then be arranged for you to meet the member of the research team of your choice, who can then answer any questions you may have about the research. After this, you can decide whether or not you wish to participate.

Thank you for taking the time to read this information leaflet.
Participant Consent Form

Please answer the following questions by ticking the appropriate boxes

- Have you read and understood the information sheet about this study?
  YES ☐ NO ☐

- Have you been able to ask questions about this study?
  YES ☐ NO ☐

- Have you received enough information about this study?
  YES ☐ NO ☐

- Do you understand that you are free to withdraw from this study?
  YES ☐ NO ☐

  At any time?
  YES ☐ NO ☐

  Without giving a reason for your withdrawal?
  YES ☐ NO ☐

Your participation in this research study is completely confidential. Besides the person who told you about the research, and the person who will interview you, nobody will know of your participation in this research. The data from your interview will be anonymous.

- Do you give permission for the interviewer to tape your interview?
  YES ☐ NO ☐

- Do you give permission for the senior researcher to have access to this anonymous data from your interview?
  YES ☐ NO ☐

- Do you agree to take part in this study?
  YES ☐ NO ☐

Your signature will confirm that you have voluntarily decided to take part in this research study having read and understood the information in the sheet for participants. It will also confirm that you have had enough opportunity to discuss the study with a study interviewer and that all questions have been answered to your satisfaction.

Signature of participant: ______________________________  Date: ________________

Name (block letters): ________________________________

Signature of investigator: ___________________________  Date: ________________

Please keep your copy of the consent form and the information sheet together. Please note the service provider who informed you of this research can look after these forms for you, if you prefer.
Appendix C

Information Document for Service Providers

1. Research Overview

1.1 The Women’s Health Council
The Women’s Health Council (WHC) is a statutory agency established in 1997 to advise the Minister for Health and Children on all aspects of women’s health. In 2007, the WHC received funding from the Department of Justice, Equality and Law Reform to conduct research on gender-based violence and minority ethnic women.

1.2 Defining Gender-Based Violence
A broad definition of gender-based violence (GBV) has been adopted for this study, encompassing intimate partner violence, sexual violence, sexual exploitation, including forced prostitution, and traditional harmful practices, such as female genital mutilation/cutting and forced marriages.

1.3 Study Aim and Objectives
The aim of the research is to identify how services in Ireland can best respond to the needs of minority ethnic women who experience GBV. The research objectives are:

- To document the experiences of minority ethnic women in relation to various forms of GBV;
- To document the current level of service provision in the area;
- To identify existing barriers to the delivery of current services to minority ethnic women;
- To provide key principles of good practice for service providers

1.4 Methodology
A mixed method approach has been adopted. Key methods include:

- A review of national and international research literature;
- Qualitative interviews with minority ethnic women who have experienced gender-based violence;
- A survey of relevant service providers and healthcare professionals;
- A consultation process with key service providers.

1.5 Research Outputs
- Final report including: literature review, analysis of primary and secondary data and recommendations
  - Guiding Principles of good practice.

2 Ethical Considerations
Due to the sensitive nature of the subject of this research, ethical considerations have naturally been a principle focus in the development of the research strategy. This section outlines the key measures taken in this study in order to maximise benefit of participation and minimise the potential risk of harm.
2.1 An Ethical Framework

- The framework developed for this research adheres to social research guidelines of the Social Research Association (SRA) and the Sociological Association of Ireland (SAI). Key principles include avoiding undue intrusion, obtaining informed consent, ensuring participation is voluntary, protecting the interests of subjects, enabling participation and confidentiality.

2.2 Ensuring Cultural Sensitivity

- A collaborative approach has been adopted for this study. This has involved a rigorous training programme for nine women from minority ethnic groups, to be peer interviewers for this study. Each participant will be given the choice of being interviewed by the senior researcher or by a representative of their minority ethnic group, or one that at least shares some aspects of their cultural background. This approach contributes to ensuring that interviews are conducted in a culturally sensitive way (Crigger et al, 2001, Campbell and Dienneman, 2001, Atkin and Chattoo 2006). It also ensures inclusion of those who do not speak the English language.

- A three-day intensive training process has been conducted with interviewers. This addressed the concepts of GBV and gender inequality, challenging myths regarding GBV, qualitative research, in-depth interviewing skills, displaying sensitivity, ethical issues, confidentiality, ongoing consent, role play and safety issues. External expertise contributed to this training, with regard to the issue of GBV, from the Outreach Team of the Dublin Rape Crisis Centre, Equality Studies, UCD, Women’s Aid and Christian Aid, regarding the global nature of GBV.

2.3 Protecting Participants from Emotional Distress

- Informed and Ongoing Assent: Potential participants will be given an information leaflet on the research (see page 3). A pre-interview meeting will be arranged with those who express an interest in participating. At this meeting, the interviewer will answer any remaining questions the potential participant may have. If they decide they do wish to participate, a consent form will be signed by the interviewer and interviewee. Only at this point will arrangements be made for the interview to take place.

  In addition to receiving informed, voluntary consent from participants prior to the interview, ongoing assent will be requested from participants throughout the interview process, whereby at set stages of the interview, the interviewer will remind the interviewee of the voluntary nature of their participation, and ask them if they are happy with continuing. If a participant experiences distress at any stage of the interview, interviewers will reassure participants, reminding them again of the voluntary nature of their contribution. In this event, if the participant wishes to continue with the interview, they will be given the choice of exploring the issue that has caused distress or of moving to a different subject (Mauthner et al, 2002, WHO, 2001). If a participant wishes to terminate an interview before it is completed, the interviewer will ensure that they are aware that counselling support is available.

- Support after the Interview: All interviews will end in a positive manner, reinforcing participant’s own coping strategies and reminding them that their contribution is important and will be used to help other women (WHO, 2001). In order to provide further support to participants, at the end of interviews, interviewers will also inform each participant of her legal rights and entitlements and will provide information on support services that are available to them. Following interviews, counselling support will be available for all participants, to address any issues that may have arisen during the course of the interview.

- Reading Transcripts: Participants will be given the opportunity to review the transcripts of their interview. However, as there is some evidence in research literature on violence against women that this process can cause emotional distress, participants will be informed of this risk. They will be given the alternative choice of the interviewer summarising the main issues that arose during the interview.
2.4 Confidentiality

- Participants will be given the option of storing their information and consent form in a safe place away from their own home (WHO, 2001).
- All interviews will take place in a safe and neutral venue that is agreed by the participant and the interviewer. All interviews will take place at a time suitable to participants.
- The service provider to whom the participant has previously disclosed her experience of GBV, and the interviewer, will be the only people who will be aware of their participation in the research.
- Confidentiality has been treated as a paramount issue in training of interviewers.
- In the case of interviews being conducted in a community setting, only private rooms will be used for this purpose. For those who are not directly involved in the arrangement and conduct of the interview (i.e., the interviewer, the participant and the contact service provider), the study title will be framed as ‘Health services for minority ethnic women,’ in order to ensure confidentiality of participants.

2.5 Transcription, Translation and Data Storage

- Interviews conducted in another language, these will be transcribed and translated by the interviewer. All other interviews will be transcribed by the principal investigator.
- Following WHO guidelines, tapes of interviews with women who have experienced GBV will be kept in locked storage that is only accessible to the principal investigator.
- No identifying information will be included on tapes or on transcripts.
- Electronic transcripts will be password protected and printed transcriptions will be kept in locked storage. All taped interviews will be erased as soon as they are transcribed, which will take place within one month of the interview taking place. Electronic and printed transcripts will be destroyed following analysis.

2.6 Ethical Approval

- This study was submitted to the Research Ethics Committee of the Irish College of General Practitioners (ICGP). Ethical approval was given by the ICGP in September 2007.

3 Identifying Study Participants

Each participant will be given the choice of being interviewed by the senior researcher or by someone closer to their own cultural background. The table below summarises the ethnic backgrounds of peer interviewers.

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Additional languages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poland</td>
<td>Polish</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Russian, Ukrainian</td>
</tr>
<tr>
<td>China</td>
<td>Chinese</td>
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<tr>
<td>South Africa</td>
<td>Urdu</td>
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<tr>
<td>Libya</td>
<td>Arabic</td>
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<td>Uganda</td>
<td>Lugandan</td>
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<tr>
<td>Romanian</td>
<td>Romanian, Roma</td>
</tr>
<tr>
<td>Traveller community, Ireland</td>
<td></td>
</tr>
</tbody>
</table>
Participants will be accessed via service providers. Participants will:

- Be female;
- Be aged over 18 years;
- Have past experience of gender-based violence, based on the definition given above;
- Have experience in accessing Irish health and/or social services, and/or have a current or past service need in Ireland, in relation to their experience of gender-based violence;
- Be currently living in a safe environment;
- Have access to support.

Counselling will be arranged and provided after interviews at the request of participants. This will be provided by trained counsellors who have received accreditation from the Irish Association of Counsellors and Psychotherapists. A small token of appreciation (€40) will be given to participants.

3.1 Identifying Participants

Participants will be identified via the following process:

- Following receipt of this information pack, service providers are asked to consider whether any of their current or past service users who relate to the description outlined above may be interested in participating in this study.
- Service providers are then asked to tell those they identify about the research, and pass on a copy of the information sheet to anyone who expresses an interest in participating.
- Service providers can contact the senior researcher on the Free-phone number (1800 300 330) for additional copies of the information sheet if required. The information sheet is also available in all of the above languages.
- In order to protect the confidentiality of those who wish to read the information sheet, service providers are asked to offer them a safe place to store the information sheet.
- Service users who are interested in participating after reading the information sheet can then contact the senior researcher on the Free-phone number, or their service provider, as they prefer. If a service user tells the service provider they wish to participate, the service provider is asked to contact the senior researcher on the Free-phone number (1800 300 330).
- A pre-interview meeting is arranged between the service user and the interviewer. The contact service provider can attend this meeting, if requested by the participant.
- In the case that the service user agrees to participate in the research, a consent form will be signed by them and by the interviewer.
- A time and venue for the interview to take place will be agreed. The interview may take place there and then, or at a later point, depending on the preference of the participant.
4. References


Appendix D
Training Programme for Peer Researchers

Day 1: Gender Based Violence

9.30 – 10.00: Introductions, welcome

10.00 – 10.30: The Training
   Exercise 1: A Group Contract
   Issues for women in society
   Exercise 2: Binning Fears

10.30 – 12.30: Rape Crisis Centre
   Presentation and group work on:
   - Understanding the concept of gender-based violence: exploring attitudes and beliefs
   - The emotional, physical and psychological effects of experiencing gender-based violence
   - Dealing with disclosure of experiences of gender-based violence

12.30 – 13.00: Violence Against Women:
   Exercise 3: Myths and Facts Exercise

13.00 – 14.00: LUNCH

14.00 – 15.00: Exercise 4: Tree of Discrimination
   Small Groups

15.00 – 15.40: Gender inequality and gender-based violence
   Short presentation followed by group work:
   Teresa O’Keefe, Equality Studies, UCD

15.40 – 16.00: Gender-based violence as a human rights abuse
   Group discussion

16.00 – 16.40: Barriers to Help
   Exercise 5: Circles of Support Exercise.

16.40 – 17.00: Questions
Intimate Partner Violence
- Individual: Childhood abuse, alcohol dependency.
- Family: Male control in family, marital rape seen as male right, marital conflict, traditional roles challenged.
- Community: Poverty, isolation and acculturation.
- Society: Norms within cultures that lead to gender inequality such as rigid gender roles, male toughness.

Forced Marriage

Female Genital Mutilation/Cutting

Harmful Traditional Practices
- Dowry related violence
- Forced Marriage
- Female Genital Mutilation/Cutting (FGM/C)
- Trafficking, Domestic Work
- Substance abuse
- Violence against women who have experienced gender-based violence
- Violence against girls: 8-32%
- Prepetrator could be a relative, friend, acquaintance, neighbour, work colleague or stranger (almost always male);

Accessing Support and Services
- Positive features in minority community
- Family network and emotional support
- Elder respect stopping GBV
- Community: legal status, shared values can mean sense of connection
- Art and cultural celebrations
- Coping strategies
- Stress experienced by husbands
- Refusing to cook
- Coping strategies
- Keeping legal documents safe

Sexual Violence by a Non-Partner

Sexual Violence by Non-partners
- Individual: Alcohol and drug abuse, psychological factors
- Family and peers level:
  - Definition, norms, belief in family 'honour'
- Community level:
  - Poverty
  - Vulnerability as refugee: refugee camps, conflict-based topic, vulnerability during journey
- Individual level:
  - Alcohol and/or drug abuse, psychological factors
  - Stress experienced by husband
  - Keeping legal documents safe

Sexual Exploitation

Harmful Traditional Practices
- Forced sexual initiation

Forced sexual initiation

Coping strategies

Echoing the advice of experts, it is crucial to understand the context in which GBV occurs and the factors that contribute to it. It is also important to remember the resilience of survivors and the efforts they make to rebuild their lives. The training for interviewers aims to equip them with the skills necessary to conduct in-depth, qualitative interviews that respect the experiences and perspectives of survivors. The training will ensure that the research is conducted in a culturally sensitive way, facilitating inclusion and representation of diverse communities.
**Day 2: Qualitative Interviewing**

9.30 – 9.40:  **Quick Recap/Feedback on Day 1**

9.40-10.20:  **Introduction to Qualitative Research**
- Qualitative and quantitative research
- Methodology for this research study
- Methods in qualitative research

10.20-11.10:  **The Qualitative Interview**
- Features of the qualitative interview
  - Group work: identifying themes for exploration in qualitative interviews in this research.
  - Feedback and group discussion

11.10 – 11.20  **Break**

11.20 – 12.00  **The topic guide**
- Introduction to the topic guide
  - *Pair-work: read and discussion of study topic guide*
  - *Feedback and group discussion*

12.00 – 13.00  **Conducting a qualitative interview**
- Probing questions
- Interviewer requirements
- Further techniques
  - *Pair-work: application to topic guide.*

13.00 – 14.00:  **LUNCH**

14.00-15.00:  **Ethical Issues**
- Confidentiality and anonymity
- Informed consent and right to withdraw
- Avoiding undue harm: sensitivity and support
- SAI Guidelines

15.00 – 16.30:  **Role Play**
- Groups of 3, role play on conducting the interview
- Feedback, questions.

16.30 – 17.00:  **Sum up**
Gender-based Violence and Minority Ethnic Women

Interviewer Training
Day 2: Qualitative Interviewing

2 Kinds of Research
- Quantitative research:
  - The world is independent
  - Facts and values are solid and never change
  - Objective observation
  - The same methods from science used to study people.
- Qualitative research:
  - The researcher is part of the world
  - Impossible to do completely objective research
  - People are more complicated than science
  - The meaning people attach to something is important – beliefs, values, experiences

Qualitative Research
- Quality, not quantity
- In-depth understanding
- Lets the participant explain things in their own words
- Rich, detailed information, through quotes
- 20-50 interviews typical

Methods
- Quantitative Methods
  - Census
  - Survey – postal or telephone
  - Secondary analysis
- Qualitative Methods
  - In-depth interviews
  - Focus groups
  - Observation – participant and non-participant

Toolkit Approach
- Different methods answer different questions
- Qualitative and quantitative research can be complementary
- E.g. The aim of this study is to identify how health and social services can best meet the needs of minority ethnic women who experience gender-based violence.
- What questions need to be answered?

Study Objectives
1. Document experiences of minority ethnic women in relation to gender based violence
2. To document the current level of service provision in the area
3. To identify existing barriers to the delivery of current services to minority ethnic women.
4. To provide key principles of good practice for service providers

Features of a Qualitative Interview
- ‘Conversation with a purpose’
  - Many differences to an everyday conversation
  - Flexibility
  - Interaction
  - Exploration
  - Approx. 1 hour long

Qualitative Interviewing
- Interviewer Training
- Day 2: Qualitative Interviewing

Toolkit Approach
- Different methods answer different questions
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Features of a Qualitative Interview
- ‘Conversation with a purpose’
  - Many differences to an everyday conversation
  - Flexibility
  - Interaction
  - Exploration
  - Approx. 1 hour long

Qualitative interviews with minority ethnic women who have experienced GBV
- Experiences in country of origin
- Experiences during journey to Ireland
- Experiences in Ireland
- Remember study aim: to find out how Irish services can best meet needs
- Services: voluntary organisations, health services (hospitals, GPs), social services

Identifying themes and issues for the interview

Group work

The topic guide
- Purpose: to document the subjects that are to be explored in the interview
  - Aide memoir
  - Ensures consistency, while allowing for flexibility
  - Not a questionnaire!
  - Not necessarily the same order or same questions to every interviewee
Conducting a qualitative interview
- An interview in stages
- Role of the interviewer
- Characteristics of a good interviewer
- Asking questions
- Further techniques

Interview in stages
- Arrival
- Introducing the research
- Beginning the interview
- During the interview
- Ending the interview
- After the interview

Characteristics of a Good Interviewer
- The ability to listen
- Hearing, digesting, comprehending
- The use of logic
- Thinking about answers, judgement, remembering, next question
- Curiosity
- Creating the right rapport
- Trust, respect, sensitivity, humility
- Familiarity with research subject and topic guide
- Application of ethical considerations at all stages

Stages during the interview
1. Introduction
   - Surface level, background info, defining
2. Core part of the interview
   - From general to specific, experiences, attitudes, explanations. Telling their story
3. Winding down
   - Suggestions, looking to the future

Role of the Interviewer
- Initial response to questions: surface level
- Role of interviewer: to uncover fuller meaning, experience, feelings and attitudes, and to capture new knowledge.
- Capture data in natural form: interviews must be tape recorded.
- Qualitative interviewing is not counselling.

Asking questions 1: Content mapping questions
- Opening up the research area
  - General mapping questions: "Widely format, opens up a subject, e.g. "Have you ever stayed in a refuge in Ireland?"
- Dimension mapping questions: "Narrow focus to specific issues, e.g. "What happened next?"
- Perspective-widening questions: "Helping interviewee to look at issues from different perspectives, e.g. "People talk a lot about the role of the doctor in this. Do you see that as being relevant?"
- Ground mapping questions: "Prompting further consideration of an issue, checking all sides, e.g. "What do you mean when you say 'you managed?'; ongoing assent.

Asking questions 2: Content mining questions, or probing
- Tools for probing further
  - Probes to increase response: e.g. "When you say..."
  - Probes to identify underlying views and feelings to behaviour, events or experience, e.g. "How did you feel when...?" "What effect did that have on you...?"
  - Probes that clarify responses, e.g. "I just want to make sure I've understood. What exactly was it that...?"

Asking questions 3: In-depth probing
- Beyond normal conversation.
  - May feel obvious, but often required for full understanding
  - "This probably sounds like an obvious questions, but why...?"
  - "I just want to make sure I've understood. What exactly was it that...?"

Further techniques
- Expressing interest and attention
  - Eye contact, odd smile, nod
- No right and wrong answers
- Body language
  - "You look a little doubtful; 'Do you know what I mean?'" ongoing assent.
  - Time to reply
- Pacing the interview

SOME Don'ts
- Never assume understanding
- Never judge
- Avoid commenting on an answer
- Avoid summarising an answer
- Don't finish off an answer !!!
- Don't talk about yourself (this one within reason)

Ethical Issues
- Sociological Association of Ireland Guidelines:
  - Informed consent and right to withdraw
  - Avoiding undue harm
- Ensuring Confidentiality

Information Leaflet
- Pre-interview meeting
- Consent Form
- Ongoing assent

Avoiding Undue Harm
- Confidentiality, informed, voluntary consent, ongoing assent relevant
- Displaying sensitivity
- Responding to emotion
- Information on support, counselling
- Protecting interviewers: peer support, therapeutic support
139

### Sensitive interviews
- Ask questions in a matter of fact way.
- People pick up on embarrassment, discomfort.
- Acknowledging sensitivity of subject,
  - e.g. 'I know this may be difficult for you, but how did you feel when your husband first did this to you?'

### Responding to anxiety
- Spend more time on opening subjects.
- Spend more time on factual, concrete subjects.
- Use very open ended questions.
- Speak clearly and calmly.
- Show interest and attention.
- Acknowledge other people find the subject difficult to talk about.
- If required, refer to comments others made (while maintaining confidentiality) to spark discussion.

### Responding to emotion
- First signs of distress in facial expression, tone of voice, body language.
- Options include continuing interview, moving on to next topic, taking a break, ending interview.
- Let the interviewee guide outcome.
- Don't forget ongoing assent.
- Empathy through body language – eye contact, comments – 'It sounds as if that was a difficult time for you.
- Avoid displaying own emotions during interview.

### Anonymity and Confidentiality
- **Anonymity**: the identity of those taking part not being known outside the research team.
- **Confidentiality**: avoiding attribution of comments to identified participants.
- Both guaranteed to all participants.

### Guaranteeing Anonymity
- Who can know about a participant’s identity?
  - The interviewer
  - The service provider
  - The senior researcher (if required)
  - No one else.
- Implications:
  - Use of research team for support
  - Therapeutic support for interviewers
  - Ensuring safe venue for interviews
  - Disguise/generalise nature of research for outsiders.

### Guaranteeing Confidentiality
- Safe, locked storage of consent form.
- Safe, locked storage of tapes and transcripts.
- No names written on tapes.
- Change names when typing up transcripts.

### Sum - Up
- Qualitative Research
  - Difference from quantitative research, toolkit approach, qualitative interviews and questions for this study.
  - The topic guide.
  - Conducting a qualitative interview.
  - Interviewer requirements, asking questions.
  - Ethical issues.
  - Informed consent, avoiding harm, confidentiality.
Day 3: In The Field

9.30 - 10.00: Recap
Brief overview of Days 1 and 2
Group Exercise: Binning Fears Exercise, Stage 2
Circulation of Information Packs

10.00 – 10.20: Who will be interviewed?
Interviewer criteria
Capturing diversity

10.20 – 10.45: Accessing interviewees
Through service providers – the process
Through personal networks – the process
Problems that may arise

10.45 – 11.00: Break

11.00 – 11.40: Taping, transcription and translation
Using a Dictaphone
Good practice in transcribing and translating

11.40 – 12.00: After the interview
Support, Options, Payment

12.00 – 13.00: Gender-based Violence: A Global Perspective
Tendai Madondo, Christian Aid

13.00 – 14.00: LUNCH

14.00 – 14.30: Ethical Issues
Small Groups: identify ethical issues at each stage of the process (before interview, during interview, after interview)
Feedback and Group Discussion
Confidentiality Agreement

14.30 – 15.30: Role playing
using Dictaphones

15.30 – 16.15: Barriers to accessing services for migrant women survivors of domestic violence: some insights
Paula Fagan, Women’s Aid

16.15 – 17.00: Last issues
Payment and invoicing - timesheets
Final questions
Feedback
Gender-based Violence and Minority Ethnic Women

Recap
- Day 1: Gender-Based Violence
  - Understanding gender-based violence
  - Dealing with disclosure of gender-based violence
  - Exploring myths and facts
  - Gender inequality and gender-based violence
  - Barriers to support

Who will be interviewed?
- Interviewer criteria:
  - Female
  - Over 18
  - Experience of gender-based violence
  - Safe and supported
  - Service need/past use in Ireland
- Ethical principle: Protecting from harm

Who will be interviewed?
- Capturing diversity
  - Domestic violence, sexual violence, harmful traditional practices, sexual exploitation
  - Legal status
    - asylum seeker, refugee, leave to remain, spouse dependent visa, student, migrant worker
  - Urban/rural
  - Age
- Ethical principle: value of the research

Potential problems
- No show
  - Min. 20 minute wait (record in timesheet)
  - If possible, leave FreePhone with SP
- Ending interview/less time than planned
  - Try to reschedule
  - Decision on focus for shorter interview

Taping and transcribing
- Using a Dictaphone
  - Getting permission (on consent form)
  - Make sure it’s on!
- Transcribing
  - Do this first
    - Word for Word
  - Patience
  - 1 day

After the interview
- Support
  - Chat if desired (within reason!)
  - List of support services
  - Counselling option
  - Token of gratitude
  - Option to read transcript
- Ethical principle: protecting from undue harm, research value

Ethical Issues
- Before the interview takes place
  - (initial contact, pre-interview meeting, arrival)
- During the interview
- After the interview
  - (avoiding harm, confidentiality, informed and voluntary consent, research value)
Ethical Issues
- During the interview
  - Sensitivity (avoiding harm)
  - Responding to emotion (avoiding harm)
  - Ongoing assent (avoiding harm)
  - Taping (research value)

After the interview:
- List of support services (avoiding harm)
- Counselling support availability (avoiding harm)
- Option to read transcript (research value)
- Locked storage of tape (confidentiality)
- Prioritising transcription of interview (confidentiality)
- Changing names on transcript (confidentiality)
- Transcript to me (confidentiality)

Support for you (avoiding harm)
- Safe interview locations only
- Peer support
- Journal writing
- Counselling
- Free-Phone Number:

Role Play

Barriers to Accessing Services for Migrant Women who Experience Domestic Violence
Some Insights
Paula Fagan, Women's Aid

Final issues
- Feedback
- Final questions

Source for exercises:
Amnesty International Gender Awareness and Violence Against Women Workshops
http://www.amnesty.ie/amnesty/upload/images/attachdocuments/Making%20Rights%20A%20reality%20Gender%20Awareness%20Workshops.pdf
Appendix E
Questionnaires

Gender Based Violence and Minority Ethnic Women in Ireland
Survey of General Practitioners

INSTRUCTIONS

The aims of this survey are:
- to estimate the incidence of disclosure of gender-based violence made by female patients from minority ethnic groups to their GPs, and
- to identify barriers experienced by GPs in responding to the needs of these patients.

Note on Definitions
- Gender based violence includes domestic violence, sexual violence outside of the home, sexual exploitation and harmful traditional practices, such as female genital mutilation/cutting and forced marriage. For the purposes of this study we are focusing solely of the experiences of women.
- Minority ethnic groups includes the Traveller community and non-indigenous minority ethnic communities.

If an experience of gender-based violence has never been disclosed to you by a female patient from a minority ethnic group, please confirm this by ticking the box below, and return this uncompleted questionnaire in the enclosed Stamped Addressed Envelope.

☐ An experience of gender-based violence has never been disclosed to me by a female patient from a minority ethnic group

Please complete this questionnaire if one or more female patients from a minority ethnic background has ever disclosed to you an experience of gender-based violence. Please note:

Your responses will be confidential. The data will be used for statistical purposes only, and no individual participants will be identified.

To answer the questions, please put a tick-mark ✓ or number, for example (1) in the box by your chosen response. For open-ended questions, please give as full an answer as possible. Please answer each question.

Please give the response that best describes your opinion/experience. It should take no more than 10 minutes of your time to complete this questionnaire.

Completed questionnaires should be returned at your earliest convenience, and before Friday, 14th March 2008, to Liza Costello, Women’s Health Council, Irish Life Centre, Block D, Abbey St. Lwr, Dublin 1. A stamped addressed envelope has been enclosed for your convenience.

If you have any queries regarding this research, you can contact Liza Costello on (01) 878 3777, email: lcostello@whc.ie

62 Questionnaire sent to other mainstream health and social services was identical to this one.
### Gender-based violence among minority ethnic women presenting at your practice

#### 1. Please identify the forms of gender-based violence disclosed to you by female patients from:

<table>
<thead>
<tr>
<th>a) The Traveller community - Please tick all that apply -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse by intimate partner</td>
</tr>
<tr>
<td>Sexual abuse by intimate partner</td>
</tr>
<tr>
<td>Physical or sexual abuse by other family member</td>
</tr>
<tr>
<td>Physical or sexual abuse in the community</td>
</tr>
<tr>
<td>Emotional violence</td>
</tr>
<tr>
<td>Forced marriage</td>
</tr>
<tr>
<td>Other – please specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) Non-indigenous minority ethnic groups - Please tick all that apply -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse by intimate partner</td>
</tr>
<tr>
<td>Sexual abuse by intimate partner</td>
</tr>
<tr>
<td>Physical or sexual abuse by other family member</td>
</tr>
<tr>
<td>Physical or sexual abuse in the community</td>
</tr>
<tr>
<td>Trafficking for sexual abuse</td>
</tr>
<tr>
<td>Emotional violence</td>
</tr>
<tr>
<td>Forced marriage</td>
</tr>
<tr>
<td>Conflict-based rape</td>
</tr>
<tr>
<td>Other – please specify:</td>
</tr>
</tbody>
</table>

#### 2. Please identify the most common form of gender-based violence disclosed to you by female patients from:

<table>
<thead>
<tr>
<th>a) The Traveller community - Please tick one box only -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse by intimate partner</td>
</tr>
<tr>
<td>Sexual abuse by intimate partner</td>
</tr>
<tr>
<td>Physical or sexual abuse by other family member</td>
</tr>
<tr>
<td>Physical or sexual abuse in the community</td>
</tr>
<tr>
<td>Emotional violence</td>
</tr>
<tr>
<td>Forced marriage</td>
</tr>
<tr>
<td>Other – please specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) Non-indigenous minority ethnic groups - Please tick one box only -</th>
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<tr>
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</tr>
<tr>
<td>Physical or sexual abuse by other family member</td>
</tr>
<tr>
<td>Physical or sexual abuse in the community</td>
</tr>
<tr>
<td>Trafficking for sexual abuse</td>
</tr>
<tr>
<td>Emotional violence</td>
</tr>
<tr>
<td>Forced marriage</td>
</tr>
<tr>
<td>Conflict-based rape</td>
</tr>
<tr>
<td>Other – please specify:</td>
</tr>
</tbody>
</table>

#### 3. Please estimate the total number of female patients who have disclosed to you experience of gender-based violence over the past year, from:

- The Traveller community: Number
- Non-indigenous minority ethnic groups: Number
The Referral Process

4. Please identify the main pathway of referral to your clinic, for minority ethnic women who disclose experience of gender-based violence. **Please tick all that apply** -

- Self-referral (incl. referral by friend)
- Other health clinics (e.g. family planning)
- Direct provision centre
- Sexual Assault Treatment Unit
- Minority ethnic organisation
- Garda or immigration service
- Violence against women organisation (e.g. Rape Crisis Centre, Women’s Aid)
- Other women’s support service (e.g. local women’s support group)
- Accident and Emergency
- Counselling service
- Public Health Nurse
- Community Welfare Officer
- Social Worker
- Other – please specify: □

5. Please identify the most common services you refer these patients to. **Please tick all that apply** -

- Other health clinic (e.g. family planning).
- Gynaecology/maternity unit
- Sexual Assault Treatment Unit
- Minority ethnic organisation
- Garda or immigration service
- Free Legal Aid
- Violence against women organisation (such as Rape Crisis Centre, Women’s Aid)
- Other women’s support service (e.g. local women’s support group)
- Accident and Emergency
- Counselling service
- Public Health Nurse
- Community Welfare Officer
- Psychiatrist or psychologist
- Social Worker
- Other – please specify: □

6. According to your experiences as a GP, please rate how the following issues act as barriers in referring these patients to appropriate services. **Please tick one box for each statement** -

a. **Waiting lists in referral services:**
   - Not a barrier □
   - Minor barrier □
   - Moderate barrier □
   - Major barrier □

b. **Absence of culturally appropriate referral services:**
   - Not a barrier □
   - Minor barrier □
   - Moderate barrier □
   - Major barrier □

c. **Reluctance of patient to use referral service:**
   - Not a barrier □
   - Minor barrier □
   - Moderate barrier □
   - Major barrier □

d. **Unsure of patient’s entitlement to relevant services:**
   - Not a barrier □
   - Minor barrier □
   - Moderate barrier □
   - Major barrier □

e. **Cost of relevant services:**
   - Not a barrier □
   - Minor barrier □
   - Moderate barrier □
   - Major barrier □

f. **Lack of information about of community resources to which patients could be referred:**
   - Not a barrier □
   - Minor barrier □
   - Moderate barrier □
   - Major barrier □

g. **Other:**
   - Not a barrier □
   - Minor barrier □
   - Moderate barrier □
   - Major barrier □
   - Please specify: □
Responding to Needs of Minority Ethnic women who experience GBV

6. According to your experiences as a GP, please rate the following issues as barriers in providing care for minority ethnic female patients who experience GBV
- Please tick one box for each statement -

<table>
<thead>
<tr>
<th>a. Patient’s reluctance to disclose experience of gender-based violence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. Unresponsiveness of patients to questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. Cultural barriers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
<tr>
<td>If you have identified cultural barriers as a barrier, please specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d. Infrequent patient visits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>e. Language barrier:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>f. Feeling powerless to help her:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>g. Fear of offending the woman and jeopardising the doctor-patient relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>h. Do not have sufficient time to respond adequately to patients needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>i. Do not feel I have the necessary training to respond to needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>j. Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a barrier □1 Minor barrier □2 Moderate barrier □3 Major barrier □4</td>
</tr>
<tr>
<td>Please specify:</td>
</tr>
</tbody>
</table>

**Your details**

7. How long have you been in practice as a GP?  

8. What is your gender?  
   - Male □  Female □

9. Are you a member of a minority ethnic group?  
   - Yes □  No □

10. From the following options, please identify where your practice is based:  
    - Dublin city □  Rest of country (urban) □  Rest of country (rural) □

11. Do you have any final comment you wish to add regarding this research subject?  
    

12. Would you be interested in participating in a short (30 minute) interview on this subject?  
    - Yes □  No □
    - If yes, telephone number:  
    

*Thank you for your valuable contribution to this survey. Please enclose in the attached SAE and return.*
Questionnaire for GBV Organisations

INSTRUCTIONS

The aims of this survey are:

- to document the current level of service provision in Ireland for women from minority ethnic groups who experience gender-based violence, and
- to identify barriers experienced by service providers in responding to the needs of these service users.

Note on Definitions

- Gender based violence includes domestic violence, sexual violence outside of the home, sexual exploitation and harmful traditional practices, such as female genital mutilation/cutting and forced marriage. For the purposes of this study we are focusing solely on the experience of women.
- Minority ethnic groups includes the Traveller community and non-indigenous minority ethnic communities.

Your responses will be confidential. The data will be used for statistical purposes only, and no individual participants will be identified.

To answer the questions, please put a tick-mark ✓, rank letter, for example (a), or rank number, for example (1) in the box by your chosen response. For open-ended questions, please give as full an answer as possible. Please answer each question.

In the questionnaire, VAW refers to ‘violence against women.’

If you do not have access to statistical information required for question 11, please still complete the rest of the questionnaire and return.

Please give the response that best describes the experiences and views of your organisation. It should take between 10 and 20 minutes of your time to complete this questionnaire.

Completed questionnaires should be returned at your earliest convenience, preferably before Friday, 7th March 2008, to Liza Costello, Women’s Health Council. A stamped addressed envelope has been enclosed for your convenience.

If you have any queries regarding this research, you can contact Liza at 01-878 3777, email: lcostello@whc.ie
Your Organisation

1. From the following options, please identify where your organisation is based:
   - Dublin city
   - Rest of country (urban)
   - Rest of country (rural)

2. Please briefly describe your client group:

3. Please state the number of people who work for your organisation who are
   - Fulltime: 
   - Part-time: 
   - Voluntary: 

4. What is the principal source of funding for your organisation?

5. From the following list, please identify services your organisation provides. Please tick all that apply
   - Advocacy
   - Accommodation
   - Legal advice
   - Court accompaniment
   - Health services
   - Interpreter
   - Information
   - Education/Training
   - Counselling
   - Medical accompaniment
   - Services for minority ethnic women – please specify:
   - Helpline
   - Referral
   - Support groups
   - Interpretation
   - Other – please specify:

6. Approximately what proportion of people who access your organisation/service are:
   - Women?
   - Women from the Traveller community?
   - Women from other minority ethnic communities?

7. Approximately what proportion of minority ethnic women who access your organisation/service are:
   - Asylum seekers
   - Refugees
   - Undocumented
   - Irish citizen
   - Spouse Dependent Visa
   - EU migrant worker
   - Non-EU migrant worker
   - Student
   - Leave to remain
   - Other:
   - Unknown

Your organisation and gender based violence

8 a) Does your organisation have guidelines for dealing with disclosure of gender based violence?
   - Yes, written
   - Yes, unwritten
   - No

b) Does your organisation have guidelines for providing support regarding gender based violence?
   - Yes, written
   - Yes, unwritten
   - No

If you answered no to either of the above, would written guidelines on disclosure and providing support be useful to your organisation?
   - Yes
   - No

9. From the following list, please identify whether your service has ever been accessed by a minority ethnic woman, regarding any of these forms of gender based violence
   - Physical violence by partner/husband
   - Sexual violence by partner/husband
   - Physical/sexual violence by other family member
   - Trafficking for sexual exploitation
   - Physical or sexual violence in the community
   - Emotional violence
   - Forced marriage
   - Female genital mutilation
   - Conflict based rape
   - Other – please specify

If your organisation has never been accessed by a woman from a minority ethnic group who has disclosed an experience of gender-based violence, you are now finished this questionnaire. Please enclose in the attached SAE and return. Thank you for participating in this survey.
**Statistical Information**

10. Firstly, please give details as to the nature and format of records (i.e. manual/electronic) you keep on clients e.g. family details, type(s) of abuse experienced, referral, support sought, needs met etc.

11. Please state the number of minority ethnic women who accessed your service for support regarding each of the following forms of gender-based violence, over the past year:

<table>
<thead>
<tr>
<th>Numbers:</th>
<th>Numbers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical violence by partner/husband</td>
<td>Forced marriage</td>
</tr>
<tr>
<td>Sexual violence by partner/husband</td>
<td>Female genital mutilation</td>
</tr>
<tr>
<td>Physical/sexual violence by other family member</td>
<td>Conflict based rape</td>
</tr>
<tr>
<td>Trafficking for sexual exploitation</td>
<td>Other – please specify:</td>
</tr>
<tr>
<td>Physical or sexual violence in community</td>
<td></td>
</tr>
<tr>
<td>Emotional violence</td>
<td></td>
</tr>
</tbody>
</table>

a) If you have any concerns regarding the accuracy of any of the data provided in question 11 above, please briefly outline them here:

12. From the following list, please identify the main needs of minority ethnic women who have accessed your organisation regarding gender-based violence. - Please tick all that apply -

<table>
<thead>
<tr>
<th>General advice and support</th>
<th>Court accompaniment</th>
<th>Medical care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information on services and entitlements</td>
<td>Legal advice</td>
<td>Medical accompaniment</td>
</tr>
<tr>
<td>Accommodation</td>
<td>Outreach/visiting support</td>
<td>Medical accompaniment</td>
</tr>
<tr>
<td>Counselling</td>
<td>Other – Please specify:</td>
<td>Medical accompaniment</td>
</tr>
</tbody>
</table>

a) If you identified more than one main need, please rank your answers to this question in order of importance, by writing the identifying letters in the boxes below.

Highest need:  Letter: Second highest need:  Letter: Third highest need:  Letter:

**Referral Pathways**

13. From the following list, please identify the 3 most common referral pathways to your organisation/service, for minority ethnic women who have disclosed experience of gender-based violence. - Please tick 3 only -

<table>
<thead>
<tr>
<th>Public Health Nurse</th>
<th>Self referral (incl. referral by friend)</th>
<th>Women’s refuge or hostel</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>Other women’s support group/service</td>
<td></td>
</tr>
<tr>
<td>AandE</td>
<td>Refugee/asylum seeker service</td>
<td></td>
</tr>
<tr>
<td>Other minority ethnic organisation</td>
<td>Counselling service</td>
<td></td>
</tr>
<tr>
<td>Legal aid service</td>
<td>Other please specify:</td>
<td></td>
</tr>
<tr>
<td>Garda</td>
<td>Housing support organisation</td>
<td></td>
</tr>
<tr>
<td>STI clinic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. From the following list, please identify the 3 most common services your organisation refers these women to. Please tick 3 only:

<table>
<thead>
<tr>
<th>Public Health Nurse</th>
<th>Women’s refuge or hostel</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>Other women’s support group/service</td>
</tr>
<tr>
<td>AandE</td>
<td>Refugee/asylum seeker service</td>
</tr>
<tr>
<td>Other minority ethnic organisation</td>
<td>Social worker</td>
</tr>
<tr>
<td>Counselling service</td>
<td>Legal aid service</td>
</tr>
<tr>
<td>Garda</td>
<td>Other please specify:</td>
</tr>
<tr>
<td>Housing support organisation</td>
<td>STI clinic</td>
</tr>
</tbody>
</table>
### Needs and Barriers to Meeting Needs

15. From the following lists, please identify barriers faced in responding to the needs of minority ethnic women who have experienced gender-based violence. — *Please tick all that apply* —

<table>
<thead>
<tr>
<th>Within own organisation:</th>
<th>External issues/services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of guidelines for staff</td>
<td>a</td>
</tr>
<tr>
<td>Lack of information on services</td>
<td>b</td>
</tr>
<tr>
<td>Inadequate resources</td>
<td>c</td>
</tr>
<tr>
<td>Need for staff training</td>
<td>d</td>
</tr>
<tr>
<td>Language barrier</td>
<td>e</td>
</tr>
<tr>
<td>Absence of childcare facilities</td>
<td>f</td>
</tr>
<tr>
<td>Other — please specify:</td>
<td>g</td>
</tr>
</tbody>
</table>

a) If you identified more than one barrier, please rank your answers to this question in order of importance, by writing the identifying letters in the boxes below.

Greatest barrier: 
Second greatest barrier: 
Third greatest barrier: 

16. From the following list, please identify measures you feel would help minority ethnic women who have experienced gender-based violence. — *Please tick all that apply.*

| VAW Guidelines and training for support organisations for minority ethnic groups | □ a |
| Guidelines and training for VAW organisations regarding provision of culturally sensitive services | □ b |
| Guidelines and training for health and social services regarding provision of culturally sensitive services | □ c |
| Raising awareness and information among minority ethnic communities regarding VAW and service provision in Ireland | □ d |
| Engaging community leaders in awareness raising exercises on VAW | □ e |
| Dedicated VAW services for minority ethnic women | □ f |
| Employment of minority ethnic women in relevant mainstream services | □ g |
| Support development of grassroots organisations for minority ethnic women | □ h |
| Increase resources for NGOs working in this field | □ i |
| Independent residency status for women on spouse dependent visa who experience domestic violence | □ j |
| Availability of female Garda, if required | □ k |
| Availability of female health workers in mainstream services, if required | □ l |
| Accessible counselling/psychology services | □ m |
| Professional interpretation facilities to relevant services | □ n |
| Availability of childcare facilities in mainstream services | □ o |
| Visiting/outreach work with minority ethnic women | □ p |
| Other — Please specify: | □ q |

a) If you identified more than one measure, please rank your answers to this question in order of importance, by writing the identifying letters in the boxes below.

First measure: 
Second measure: 
Third measure: 

17. If there is anything that has not been addressed in this questionnaire which you feel is relevant, please do so here:

Your Details (optional)

18. Job Title

19. Gender
   - Male □
   - Female □

20. Are you a member of a minority ethnic group?
   - Yes □
   - No □

Thank you for your valuable contribution to this research study. Please enclose in the attached SAE and return.
Survey of Service Provision
Questionnaire for Non Governmental Organisations
Minority Ethnic Organisations

INSTRUCTIONS

The aims of this survey are:

- to document the current level of service provision in Ireland for women from minority ethnic groups who experience gender-based violence, and
- to identify barriers experienced by service providers in responding to the needs of these service users.

Your responses will be confidential. The data will be used for statistical purposes only, and no individual participants will be identified.

To answer the questions, please put a tick-mark ✓ or rank letter, for example, (a), in the box by your chosen response. For open-ended questions, please give as full an answer as possible. Please answer each question.

In the questionnaire, VAW refers to ‘violence against women.’

If you do not have access to statistical information required for question 11, please still complete the rest of the questionnaire and return.

Please give the response that best describes the experiences and views of your organisation. It should take no more than 10-15 minutes of your time to complete this questionnaire.

Completed questionnaires should be returned at your earliest convenience, preferably before Friday, 7th March 2008, to Liza Costello, Women’s Health Council. A stamped addressed envelope has been enclosed for your convenience.

If you have any queries regarding this research, you can contact Liza at Free-phone 01-878 3777, email: lcostello@whc.ie

Note on Definitions

- Gender based violence includes domestic violence, sexual violence outside of the home, sexual exploitation and harmful traditional practices, such as female genital mutilation/cutting and forced marriage. For the purposes of this study we are focusing solely of the experience of women.
- ‘Minority ethnic groups’ includes the Traveller community and non-indigenous minority ethnic communities.
Your Organisation

1. From the following options, please identify where your organisation is based:
   - Dublin city  
   - Rest of country (urban)  
   - Rest of country (rural)  

2. Please describe your client group:

3. Please state the number of people who work for your organisation who are
   - Fulltime:  
   - Part-time:  
   - Voluntary:  

4. What is the principal source of funding for your organisation?

5. From the following list, please identify services your organisation provides. Please tick all that apply
   - Advocacy  
   - Information  
   - Helpline  
   - Accommodation  
   - Education/Training  
   - Referral  
   - Legal advice  
   - Counselling  
   - Support groups  
   - Health services  
   - Services for women:  
   - Other:  
   - Interpreter  

6. Approximately what proportion of people who access your organisation/service are women?
   - None  
   - Less than 33%  
   - 33-66%  
   - 67-99%  
   - 100%  
   - Don’t know  

7. Approximately what proportion of minority ethnic women who access your organisation/service are:
   - a) Asylum seekers  
   - b) Refugees  
   - c) Undocumented  
   - d) Irish citizen  
   - e) Spouse Dependent Visa  
   - f) EU migrant worker  
   - g) Non-EU migrant worker  
   - h) Student  
   - i) Unknown  
   - j) Leave to remain  
   - k) Other:  
   - Percentage:  

Your organisation and gender based violence

8. From the following list, please identify the services your organisation could offer to a minority ethnic woman who has experienced gender-based violence. Please tick all that apply
   - Advocacy  
   - Information  
   - Helpline  
   - Accommodation  
   - Education/Training  
   - Referral  
   - Legal advice  
   - Counselling  
   - Support groups  
   - Health services  
   - Services for women:  
   - Other:  
   - Interpreter  

9. Does your organisation have guidelines for dealing with disclosure of gender based violence?
   - a) Yes, written  
   - b) Yes, unwritten  
   - c) No  
   - d) Yes, unwritten  
   - e) No  

9. Does your organisation have guidelines for providing support regarding gender based violence?
   - Yes, written  
   - Yes, unwritten  
   - No  
   - Yes, written  
   - Yes, unwritten  
   - No  

9. If you answered no to either of the above, would written guidelines on disclosure and providing support be useful to your organisation?
   - Yes  
   - No  

9. From the following list, please identify if your service has ever been accessed by a minority ethnic woman, regarding any of these forms of gender based violence
   - Physical violence by partner/husband  
   - Emotional violence  
   - Forced marriage  
   - Sexual violence by partner/husband  
   - Female genital mutilation  
   - Any violence by other family member  
   - Conflict based rape  
   - Trafficking for sexual exploitation  
   - Physical or sexual violence in the community  
   - Other – please specify  

If your organisation has never been accessed by a woman from a minority ethnic group who has disclosed an experience of gender-based violence, you are now finished this questionnaire. Please enclose in the attached SAE and return. Thank you for participating in this survey.
### Statistical Information

10. Firstly, please give details as to the nature and format of records (i.e. manual /electronic) you keep on clients e.g. family details, type(s) of abuse experienced, referral, support sought, needs met etc.

11. Please state the number of minority ethnic women who accessed your service for support regarding each of the following forms of gender-based violence, over the past year:

<table>
<thead>
<tr>
<th>Type of Violence</th>
<th>Numbers:</th>
<th>Numbers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical violence by partner/husband</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual violence by partner/husband</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/sexual violence by other family member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trafficking for sexual exploitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical or sexual violence in community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced marriage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female genital mutilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict based rape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – please specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a) If you have any concerns regarding the accuracy of any of the data provided in question 11 above, please briefly outline them here:

12. Please identify the main needs of minority ethnic women who have accessed your organisation regarding gender-based violence. Please tick all that apply

- General advice and support
- Information on services and entitlements
- Accommodation
- Counselling
- Medical accompaniment
- Medical care

a) If you identified more than one main need, please rank your answers to this question in order of importance, by writing the identifying letters in the boxes below.

<table>
<thead>
<tr>
<th>Highest need:</th>
<th>Second highest need:</th>
<th>Third highest need:</th>
</tr>
</thead>
</table>

### Referral Pathways

13. From the following list, please identify the 3 most common referral pathways to your organisation, for minority ethnic women who have experienced gender-based violence. - Please tick 3 only -

- Self referral (incl. referral by friend)
- Women's refuge or hostel
- Other women's support group/service (e.g. local women's support group)
- Refugee/asylum seeker service
- Other minority ethnic organisation
- Legal aid service
- Garda
- Housing support organisation
- STI clinic

14. From the following list, please identify the 3 most common services your organisation refers these women to. - Please tick 3 only -

- Women's refuge or hostel
- Other women's support group/service
- Refugee/asylum seeker service
- Other minority ethnic organisation
- Legal aid service
- Garda
- Housing support organisation
- STI clinic
15. From the following lists, please identify barriers faced in responding to the needs of minority ethnic women who have experienced gender-based violence. – Please tick all that apply –

Within own organisation:  
Absence of guidelines for staff ☐  
Lack of information on services ☐  
Inadequate resources ☐  
Need for staff training ☐  
Absence of childcare facilities ☐  
Other – please specify: ☐

External issues/services:  
Stigma attached to relevant services ☐  
Need for female health workers ☐  
Cost of external services ☐  
Habitual Residence Condition ☐  
Language barrier in mainstream services ☐  
Exclusion from services due to legal status ☐  
Other – please specify: ☐

a) If you identified more than one barrier, please rank your answers to this question in order of importance, by writing the identifying letters in the boxes below.

Greatest barrier  
Second greatest barrier  
Third greatest barrier

16. From the following list, please identify measures you feel would help minority ethnic women who have experienced gender-based violence. Please tick all that apply.

VAW Guidelines and training for support organisations for minority ethnic groups ☐ a  
Guidelines and training for VAW organisations regarding provision of culturally sensitive services ☐ b  
Guidelines and training for health and social services regarding provision of culturally sensitive services ☐ c  
Raising awareness and information among minority ethnic communities regarding VAW and service provision in Ireland ☐ d  
Engaging community leaders in awareness raising exercises on VAW ☐ e  
Dedicated VAW services for minority ethnic women ☐ f  
Employment of minority ethnic women in relevant mainstream services ☐ g  
Support development of grassroots organisations for minority ethnic women ☐ h  
Increase resources for NGOs working in this field ☐ i  
Independent residency status for women on spouse dependent visa who experience domestic violence ☐ k  
Availability of female Garda, if required ☐ l  
Availability of female health workers in mainstream services, if required ☐ m  
Accessible counselling/psychology services ☐ n  
Professional interpretation facilities to relevant services ☐ o  
Availability of childcare facilities in mainstream services ☐ p  
Visiting/outreach work with minority ethnic women ☐ q  
Other – Please specify: ☐

a) If you identified more than one measure, please rank your answers to this question in order of importance, by writing the identifying letters in the boxes below.

First measure  
Second measure  
Third measure

17. If there is anything that has not been addressed in this questionnaire which you feel is relevant, please do so here:

Your Details (optional)

18. Job Title

19. Gender  
   Male ☐  
   Female ☐

20. Are you a member of a minority ethnic group?  
   Yes ☐  
   No ☐

Thank you for your valuable contribution to this research study. Please enclose in the attached SAE and return.
## Percentage of GPs to whom a minority ethnic woman has disclosed GBV

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid yes</td>
<td>163</td>
<td>32.7</td>
<td>32.7</td>
<td>32.7</td>
</tr>
<tr>
<td>no</td>
<td>335</td>
<td>67.3</td>
<td>67.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>498</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

### Of whom a disclosure was made within previous year

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid yes</td>
<td>149</td>
<td>91.4</td>
<td>92.5</td>
<td>92.5</td>
</tr>
<tr>
<td>no</td>
<td>12</td>
<td>7.4</td>
<td>7.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>98.8</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>System</td>
<td>2</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>163</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

## Other MHS Services participating in survey

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Social Work</td>
<td>21</td>
<td>47.7</td>
<td>47.7</td>
<td>47.7</td>
</tr>
<tr>
<td>Departments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Social Work</td>
<td>12</td>
<td>27.3</td>
<td>27.3</td>
<td>75.0</td>
</tr>
<tr>
<td>Departments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>9</td>
<td>20.5</td>
<td>20.5</td>
<td>95.5</td>
</tr>
<tr>
<td>SATU</td>
<td>2</td>
<td>4.5</td>
<td>4.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

## Forms of GBV disclosed by Traveller Women to MHS Services

<table>
<thead>
<tr>
<th>Form of GBV</th>
<th>GP</th>
<th>Other MHS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse by intimate partner</td>
<td>114 (70%)</td>
<td>35 (90%)</td>
<td>149 (74%)</td>
</tr>
<tr>
<td>Sexual abuse by intimate partner</td>
<td>37 (23%)</td>
<td>8 (21%)</td>
<td>45 (23%)</td>
</tr>
<tr>
<td>Perpetrated by other family member</td>
<td>30 (18%)</td>
<td>12 (31%)</td>
<td>42 (21%)</td>
</tr>
<tr>
<td>Perpetrated outside the home</td>
<td>14 (9%)</td>
<td>7 (18%)</td>
<td>21 (10%)</td>
</tr>
<tr>
<td>Emotional violence</td>
<td>65 (40%)</td>
<td>18 (46%)</td>
<td>83 (41%)</td>
</tr>
<tr>
<td>Forceld marriage</td>
<td>14 (9%)</td>
<td>2 (5%)</td>
<td>16 (8%)</td>
</tr>
</tbody>
</table>

## Forms of GBV disclosed by Non-Indigenous minority ethnic women to MHS services

<table>
<thead>
<tr>
<th>Form of GBV</th>
<th>GP</th>
<th>Other MHS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse by intimate partner</td>
<td>111 (68%)</td>
<td>31 (80%)</td>
<td>142 (70%)</td>
</tr>
<tr>
<td>Sexual abuse by intimate partner</td>
<td>27 (17%)</td>
<td>17 (44%)</td>
<td>44 (22%)</td>
</tr>
<tr>
<td>Perpetrated by other family member</td>
<td>15 (9%)</td>
<td>6 (15%)</td>
<td>21 (10%)</td>
</tr>
<tr>
<td>Perpetrated outside the home</td>
<td>19 (12%)</td>
<td>2 (5%)</td>
<td>21 (10%)</td>
</tr>
<tr>
<td>Emotional violence</td>
<td>52 (32%)</td>
<td>22 (56%)</td>
<td>74 (37%)</td>
</tr>
<tr>
<td>Forced marriage</td>
<td>17 (10%)</td>
<td>5 (13%)</td>
<td>22 (11%)</td>
</tr>
<tr>
<td>FGM</td>
<td>43 (26%)</td>
<td>10 (26%)</td>
<td>53 (26%)</td>
</tr>
<tr>
<td>Conflict-based rape</td>
<td>41 (25%)</td>
<td>6 (16%)</td>
<td>47 (23%)</td>
</tr>
<tr>
<td>Sex trafficking</td>
<td>7 (4%)</td>
<td>6 (15%)</td>
<td>13 (6%)</td>
</tr>
</tbody>
</table>

## Most Commonly Identified Barriers to Meeting Needs

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Not a barrier</th>
<th>Minor barrier</th>
<th>Moderate</th>
<th>Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s reluctance to disclose</td>
<td>14 (7%)</td>
<td>26 (13%)</td>
<td>73 (37%)</td>
<td>85 (43%)</td>
</tr>
<tr>
<td>'Cultural’ barriers</td>
<td>28 (15%)</td>
<td>52 (27%)</td>
<td>68 (36%)</td>
<td>43 (23%)</td>
</tr>
<tr>
<td>Language</td>
<td>40 (20%)</td>
<td>45 (23%)</td>
<td>66 (34%)</td>
<td>45 (23%)</td>
</tr>
</tbody>
</table>
Survey of Voluntary Organisations

GBV Organisations

### Percentage of clients who are Traveller women

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid - None</td>
<td>6</td>
<td>12.5</td>
<td>15.0</td>
<td>15.0</td>
</tr>
<tr>
<td>1-5%</td>
<td>18</td>
<td>37.5</td>
<td>45.0</td>
<td>60.0</td>
</tr>
<tr>
<td>6-20%</td>
<td>8</td>
<td>16.7</td>
<td>20.0</td>
<td>80.0</td>
</tr>
<tr>
<td>21+ %</td>
<td>8</td>
<td>16.7</td>
<td>20.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
<td><strong>83.3</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Missing System**
- 8 clients (16.7%)

**Total**
- 48 clients (100.0%)

### Descriptive statistics on above data

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Service Users who are Traveller Women</td>
<td>41</td>
<td>80.00</td>
<td>.00</td>
<td>80.00</td>
<td>15.07</td>
<td>22.75210</td>
</tr>
</tbody>
</table>

### Percentage of clients who are non-indigenous minority ethnic women

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid - None</td>
<td>1</td>
<td>2.1</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>1-5%</td>
<td>16</td>
<td>33.3</td>
<td>38.1</td>
<td>40.5</td>
</tr>
<tr>
<td>6-20%</td>
<td>19</td>
<td>39.6</td>
<td>45.2</td>
<td>85.7</td>
</tr>
<tr>
<td>21+ %</td>
<td>6</td>
<td>12.5</td>
<td>14.3</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td><strong>87.5</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Missing System**
- 6 clients (12.5%)

**Total**
- 48 clients (100.0%)

### Descriptive Statistics on above data

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>42</td>
<td>100.0</td>
<td>.00</td>
<td>100.00</td>
<td>13.101</td>
<td>18.09643</td>
</tr>
</tbody>
</table>

### Legal statuses represented among clients

<table>
<thead>
<tr>
<th>Status</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>System</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum Seeker</td>
<td>20</td>
<td>65</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Refugees</td>
<td>13</td>
<td>45</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Undocumented</td>
<td>5</td>
<td>17</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Spouse Dependent Visa</td>
<td>13</td>
<td>45</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>EU migrant workers</td>
<td>16</td>
<td>53</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Non-EU migrant workers</td>
<td>9</td>
<td>31</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>4</td>
<td>13</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Leave to Remain</td>
<td>5</td>
<td>17</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>5</td>
<td>17</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>
### Percentage of GBV organisations to which forms of GBV have been disclosed

<table>
<thead>
<tr>
<th>Form of GBV</th>
<th>Frequency</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPV Physical</td>
<td>42</td>
<td>91%</td>
</tr>
<tr>
<td>IPV Sexual</td>
<td>39</td>
<td>85%</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>40</td>
<td>85%</td>
</tr>
<tr>
<td>Other family member</td>
<td>31</td>
<td>67%</td>
</tr>
<tr>
<td>GBV outside the home</td>
<td>24</td>
<td>51%</td>
</tr>
<tr>
<td>Forced marriage</td>
<td>22</td>
<td>47%</td>
</tr>
<tr>
<td>Sex trafficking</td>
<td>19</td>
<td>40%</td>
</tr>
<tr>
<td>Conflict-based Rape</td>
<td>19</td>
<td>40%</td>
</tr>
<tr>
<td>FGM</td>
<td>16</td>
<td>34%</td>
</tr>
</tbody>
</table>

### Number of disclosures over one year period, by form of GBV

<table>
<thead>
<tr>
<th>Forms of GBV</th>
<th>Frequency</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional abuse</td>
<td>599</td>
<td>40%</td>
</tr>
<tr>
<td>Physical Intimate Partner Violence</td>
<td>557</td>
<td>37%</td>
</tr>
<tr>
<td>Sexual Intimate Partner Violence</td>
<td>126</td>
<td>9%</td>
</tr>
<tr>
<td>Trafficking for Sexual Exploitation</td>
<td>61</td>
<td>4%</td>
</tr>
<tr>
<td>GBV perpetrated by Family</td>
<td>48</td>
<td>3%</td>
</tr>
<tr>
<td>Conflict-based Rape (CBR)</td>
<td>45</td>
<td>3%</td>
</tr>
<tr>
<td>GBV in community</td>
<td>29</td>
<td>2%</td>
</tr>
<tr>
<td>Forced Marriage</td>
<td>13</td>
<td>1%</td>
</tr>
<tr>
<td>FGM</td>
<td>7</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,485</td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Minority Ethnic Organisations

#### Percentage of minority ethnic organisations to which minority ethnic women have disclosed GBV

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>43</td>
<td>79.6</td>
<td>81.1</td>
<td>81.1</td>
</tr>
<tr>
<td>no</td>
<td>10</td>
<td>18.5</td>
<td>19.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>98.1</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>1</td>
<td>1.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Percentage of minority ethnic organisations to whom forms of GBV have been disclosed

<table>
<thead>
<tr>
<th>Form of GBV</th>
<th>Frequency</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPV Physical</td>
<td>46</td>
<td>88</td>
</tr>
<tr>
<td>IPV Sexual</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>40</td>
<td>76</td>
</tr>
<tr>
<td>Other family member</td>
<td>21</td>
<td>40</td>
</tr>
<tr>
<td>GBV outside the home</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>Forced marriage</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>Sex trafficking</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Conflict-based Rape</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>FGM</td>
<td>8</td>
<td>16</td>
</tr>
</tbody>
</table>
### Barriers to Meeting Needs for the Voluntary Sector

#### Needs of minority ethnic women regarding GBV

<table>
<thead>
<tr>
<th>Need</th>
<th>GBV organisations</th>
<th>ME organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice and support</td>
<td>45 (94%)</td>
<td>32 (89%)</td>
</tr>
<tr>
<td>Information on services and entitlements</td>
<td>42 (88%)</td>
<td>25 (71%)</td>
</tr>
<tr>
<td>Counselling</td>
<td>37 (77%)</td>
<td>14 (40%)</td>
</tr>
<tr>
<td>Legal aid</td>
<td>35 (73%)</td>
<td>19 (54%)</td>
</tr>
<tr>
<td>Outreach/visiting support</td>
<td>32 (67%)</td>
<td>16 (46%)</td>
</tr>
<tr>
<td>Court accompaniment</td>
<td>29 (60%)</td>
<td>9 (26%)</td>
</tr>
<tr>
<td>Accommodation</td>
<td>28 (58%)</td>
<td>16 (46%)</td>
</tr>
<tr>
<td>Medical accompaniment</td>
<td>19 (40%)</td>
<td>6 (17%)</td>
</tr>
<tr>
<td>Medical care</td>
<td>19 (40%)</td>
<td>9 (26%)</td>
</tr>
</tbody>
</table>

#### Barriers faced in responding to needs

<table>
<thead>
<tr>
<th>Barrier</th>
<th>GBV organisations</th>
<th>Minority ethnic organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>41 (85%)</td>
<td>7 (21%)</td>
</tr>
<tr>
<td>Absence of childcare facilities</td>
<td>20 (42%)</td>
<td>11 (33%)</td>
</tr>
<tr>
<td>Absence of guidelines</td>
<td>9 (19%)</td>
<td>10 (30%)</td>
</tr>
<tr>
<td>Lack of information on services</td>
<td>12 (25%)</td>
<td>8 (24%)</td>
</tr>
<tr>
<td>Inadequate resources</td>
<td>27 (56%)</td>
<td>21 (64%)</td>
</tr>
<tr>
<td>Need for staff training</td>
<td>21 (44%)</td>
<td>13 (39%)</td>
</tr>
<tr>
<td>Habitual Residency Condition</td>
<td>25 (52%)</td>
<td>12 (36%)</td>
</tr>
<tr>
<td>Legal Status</td>
<td>28 (58%)</td>
<td>11 (33%)</td>
</tr>
</tbody>
</table>

#### Identified measures to overcome barriers

<table>
<thead>
<tr>
<th>Measures</th>
<th>GBV</th>
<th>ME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raising awareness and information among ME communities regarding VAW and service provision in Ireland</td>
<td>43 (92%)</td>
<td>31 (91%)</td>
</tr>
<tr>
<td>Professional interpretation facilities to relevant services</td>
<td>44 (92%)</td>
<td>22 (65%)</td>
</tr>
<tr>
<td>Increase resources for NGOs working in this field</td>
<td>42 (88%)</td>
<td>21 (62%)</td>
</tr>
<tr>
<td>Engaging community leaders in awareness raising exercises on VAW</td>
<td>39 (83%)</td>
<td>23 (68%)</td>
</tr>
<tr>
<td>Accessible counselling/psychology services</td>
<td>38 (83%)</td>
<td>20 (59%)</td>
</tr>
<tr>
<td>Independent residency status for women on spouse dependent visa who experience domestic violence</td>
<td>39 (81%)</td>
<td>18 (53%)</td>
</tr>
<tr>
<td>Support development of grassroots organisations for minority ethnic women</td>
<td>32 (73%)</td>
<td>21 (64%)</td>
</tr>
<tr>
<td>Dedicated VAW services for minority ethnic women</td>
<td>28 (58%)</td>
<td>16 (47%)</td>
</tr>
</tbody>
</table>