TRAINING RESOURCE PACKAGE

INTRODUCTION INTO GBV CORE CONCEPTS, PRINCIPLES AND APPROACHES FOR NON SPECIALIZED PROFESSIONALS

ΚΕΝΤΡΟ ΓΥΝΑΙΚΕΙΩΝ ΜΕΛΕΤΩΝ ΚΑΙ ΕΡΕΥΝΩΝ
ΔΙΟΤΙΜΑ

TRANSNATIONAL PROJECT

BUILDING A SAFETY NET FOR REFUGEE AND MIGRANT WOMEN

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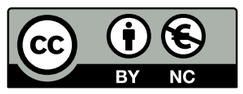


INTRO

Welcome to the "Training Resource Package: Introduction into GBV Core Concepts, Principles and Approaches for Non Specialized Professionals". This package is a result of the "Building a Safety Net for Refugee and Migrant Women" a project which is funded by the European Union – Daphne Strand and implemented in 2017-2018 through 5 partners in 3 different countries.

Gender power imbalances lie at the heart of the lived experiences of women and girls worldwide, at their home communities but also during the migratory routes they might have to take. In light of the so called "refugee crisis" since early 2015, Greece, Italy and Spain have continued to be entry gated to Europe for millions of persons, a significant number of whom women and girls. For them, Gender Based Violence (GBV) remains a major concern. Prevention of and response to GBV is one step towards every person's right to an independent and autonomous life, the right to their body and the right to self-determination and self-fulfillment.

GBV happens everywhere and at all times. GBV happens next to us. By creating this training resource package, our aim is to move one step closer to meeting the protection needs of female survivors. We also hope to promote preventative measures directly or indirectly, by adding to the ever-growing body of literature on the topic of gender inequality and GBV. Our ultimate goal is to enhance the guarantees that the EU and national legal frameworks which provide the full respect of the rights of migrant and refugee women who have survived or are experiencing GBV of all kinds (physical, psychological, financial) will be implemented ensuring the avoidance of their re-victimization.

PURPOSE AND AUDIENCE

This package was designed to be used as non-formal learning tool. Non-formal learning places the trainer/educator and the learner on a more equal level, moving the trainer/educator from the center and perceiving the learner as the main reference point. We also want to encourage trainers/facilitators that will use this material to structure future trainings to use personal reflections, recreational activities, role plays, case studies and media as a means of acquiring and practicing new skills and knowledge with the trainees. These will increase engagement of the participants and will make learning more personal, which is crucial to achieve the full potential of gender and GBV related training.

The package is intended to serve as a reference material, as it proposes a structured way of introducing Gender Based Violence in the context of migration to professionals and agencies not specialized in the field. It is drafted along international guidelines and standards and corresponds to the needs expressed in the context of what has been described as a "refugee crisis" in the Mediterranean region. The selected topics have being developed based on feedback from organizations and actors in Greece, Spain and Italy, over the course of 9 seminars delivered in 2017 and 2018, with the aim to enhance their response capacity; the modules and sessions were tailored in line with their training needs, as identified through their work with migrants and refugees. Some of these are: GBV Core Concepts, Types of GBV, Identification of GBV, Safe Referrals, Guiding Principles, and some special focuses on working with victims of Trafficking and children survivors.

Topics included serve to provide a solid introduction into GBV as well as the effects it has on persons and societies and the importance of tackling it, regardless of the context. The resources provided are strictly introductory and users are strongly encouraged to seek additional information referring to the sources listed at the end of this package. Offering quality services to refugee and migrant women require adequate theoretical knowledge, practical skills and sometimes also a change in attitude and behavior. The materials in this guide can be used to promote the acquisition of these skills and tools.

THE MAIN OBJECTIVES OF THE GUIDE ARE:

I **To improve understanding of GBV contextual circumstances and the diversification of GBV survivors' needs**

II **To improve knowledge on gender equality issues, guiding principles and international legal standards related to GBV**

III **To share a culturally sensitive approach to protection of GBV survivors or of women at risk**

GLOSSARY

OF TERMS

Adolescence: defined as the period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioral and psychosocial sphere.

Attitude: Opinion, feeling or position about people, events, and/or things that is formed as a result of one's beliefs. Attitudes influence behavior.

Belief: An idea that is accepted as true. It may or may not be supported by facts. Beliefs may stem from or be influenced by religion, education, culture and personal experience.

Child: Any person under the age of 18. Children have evolving capacities depending on their age and developmental stage. The following definitions clarify the term "child" with regards to age/developmental stages for guiding interventions and treatment:

Children = 0–18, as per the CRC
Young children = 0–9
Early adolescents = 10–14
Later adolescents = 15–19

Child Survivor: A person under the age of 18 who has experienced any form of gender-based violence.

Child Survivor of Sexual Abuse: A person under the age of 18 who has experienced an act of sexual abuse.

Consent: approval or assent after throughout consideration. The consenting person understands fully the consequences of consent and agrees freely, without any force or coercion.

Disclosure: The process of revealing information. Disclosure in the context of sexual abuse refers specifically to how a non-offending person (for example, a caregiver, teacher or helper) learns about a person's experience with sexual abuse.

Gender-based Violence: An umbrella term for any harmful act that is perpetrated against a person's will; it is based on socially ascribed (gender) differences between males and females. Gender-based violence encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices, including forced, early marriage.

Informed Consent: Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.

Perpetrator: A person who directly inflicts or supports violence or other abuse inflicted on another against his/her will.

Sexual Exploitation: Any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes. This includes profiting monetarily, socially or politically from the sexual exploitation of another (see also sexual abuse).

Survivor/Victim: A person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably, although "victim" is generally preferred in the legal and medical sectors, whereas "survivor" in the psychological and social support sectors.

LIST OF ABBREVIATIONS

FGM →	Female Genital Mutilation	*SGBV* →	Sexual and Gender-Based Violence
GBV →	Gender-Based Violence	*STI* →	Sexually Transmitted Infection
LGBTQI →	Lesbian Gay Bisexual Transgender Queer Intersex	*SOP* →	Standard Operating Procedure
NGO →	Non-Governmental Organisation	*VAW* →	Violence Against Women
PEP →	Post Exposure Prophylaxis	*UASC* →	Unaccompanied and Separated Child

CHAPTER ONE

CORE CONCEPTS OF GENDER BASED VIOLENCE

This chapter outlines the Core Concepts related to GBV that service providers must understand in order to work with female survivors. The objective of this chapter is to familiarise the trainees with GBV through providing fundamental understanding of "what do we talk about when we address GBV?''. The chapter walks the readers through this core knowledge, including the concept of gender, while also addressing stereotypical beliefs often expressed in this context. It also explains where and how GBV prevention and response fit in the overall protection of beneficiaries, regardless of the context (peace or conflict; in working with refugees, internally displaced persons or with host population). We are also proposing exercises and activities that can be used by facilitators if they choose to develop seminars and workshops using this Training Package.

During this chapter we will aim to explain terms and terminology used for building the understanding of GBV within the system of protection; explain the root-causes of GBV; define the concept of GBV; address some attitudes surrounding GBV and list the most common types of GBV.

When using this package to design a training, you are encouraged to first define the specific objectives of the course based on the trainees identified needs and then, at the beginning of the training adapt them or set additional objectives through participants' self-reflection.

1.1 KEY TERMS AND CORE CONCEPTS OF GBV

Prior to any in depth discussion around gender and GBV, it is important to share a common language and to identify key areas of interest that we will further pursue. In the context of training, this section aims at setting the scene within which participants will operate and at familiarising them with the roles and concepts most commonly involved in GBV.

I SEX AND GENDER

The first concept to be addressed is that of Gender. Users of this package as well as participants in any seminars designed with its assistance will be advised to initiate a discussion about the differences between Sex and Gender. This gives them the space to explore social and cultural expectations for males and females and illustrate the difference between those based on sex and those based on gender. According to this distinction, sex is connected with biology, whereas the gender identity of men and women in any given society is socially, historically and culturally determined. Biological and physical conditions (chromosomes, external and internal genitalia, hormonal states and secondary sex characteristics) are most commonly used to determine a person male, female or intersex at birth. However, to determine gender, social and cultural perceptions of masculine and feminine traits and roles must be taken into account.

Understanding that learning to be male or female is a process that takes place through socialisation and culture is central at this part of the discussion. Messages about gender are taught, displayed and reinforced by society and by both men and women from a very young age. Humans learn how they should behave in order to be perceived by others, and themselves, as either masculine or feminine. This learned behavior is what makes up gender identity, and determines gender roles and responsibilities. It is also consistently communicated that persons who act outside their gender roles may face disapproval.

This process takes place primarily through the institutions of Family, School and Education and Religion, while other institutions, such as the Media and Labor, play a central role too. In the context of a seminar, participants should be invited to identify the ways each of the above mentioned institutions participate in instilling gender roles and gender identities to persons throughout their lives and to also recall personal experiences of how they were taught to become men or women. Gender norms serve the purpose of determining girls' and boys' roles, responsibilities, opportunities, privileges and limitations. These factors affect power relationships between women and men later on in life. It should be noted that in most cultures, areas and situations males tend to yield more power than women.

PROPOSED ACTIVITIES

Sex vs. Gender: What is the Difference? - Facilitator's Guide For Media Reporting on Gender-Based Violence (UNFPA, 2016, can be found https://www.unfpa.org/sites/default/files/pub-pdf/-Facilitator1s_Guide_English_InDesign_Version.pdf

Act Like a Man, Act Like a Woman – The exercise is listed under several training manuals. An online version can be found at https://www.engenderhealth.org/pubs/gender/gender-toolkit/act-like-a-man-act-like-a-woman.html#

Gender Box – A variation of this exercise can be found at http://www.makeitwork-campaign.org/wp-content/uploads/2016/02/Gender-Box.pdf

II GENDER BASED VIOLENCE

Having introduced the concepts of gender and gender roles, the discussion can be shifted to Gender Based Violence. Professionals working with refugee and migrant women should reflect on what they already know with regards to GBV and how they come to possess that knowledge. Some key terms can be used to facilitate the exploration of the concept of GBV. In the context of workshops or seminars, participants might be encouraged to describe what the terms Survivor and Perpetrator mean, as a first step. Identifying the Survivor as the person who has experienced GBV and the Perpetrator as the "person, group, or institution that directly inflict or otherwise supports violence or other abuse inflicted on another against her/his will", it is then advised to progress to an interpretation of the concept of Disclosure.
Related questions can be:

I. Who can be a perpetrator?

II. Can a child or a woman be a perpetrator in the context of GBV?

III. What are possible obstacles to disclosing GBV?

An important milestone for persons acquiring knowledge on GBV is clearly defining Consent. During a seminar/workshop it is advised for facilitators to ask participants to explain what their prior knowledge of consent is and when they believe it becomes relevant to GBV. Facilitators are also advised to highlight the meaning of Informed Consent as the following:

Informed Consents is:

- A freely and voluntarily provided agreement to an action,
- By persons of equal power,
- Who possess all the information about the proposed action and understand the consequences of participating in it.
- There is no consent when agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, deception, or misrepresentation.
- Any agreement obtained from a person who is below the legal (statutory) age of consent, or is defined as a child under applicable laws is not considered to be consensual.

Note: As the concept of Consent often appears complicated for persons first coming in contact with it, it is advised for users of this training package or participants at seminars and workshops to try and write down instances they have been aware of when informed consent has or has not been provided.

There is no consent when agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, deception, or misrepresentation.

In addition to clarifying the meaning of consent in the context of personal relationship, the importance of consent for working with GBV survivors should be further highlighted to survivors, as they must be the decision makers in the management of their case and provision of services. Informed consent should be repeatedly requested, as survivors may choose to reject specific parts or even services as a whole.

The final part of this discussion will lead to the clear definition of GBV. Taking into account the power imbalance related to the socially ascribed characteristics of gender, we can define GBV as followed: "Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.[1]"

It should become clear that GBV is a form of violence that is related to maintaining the gender power imbalance and is directly related to "transgressions" from gender roles, therefore it can also happen to men and boys; it can also affect persons identifying as male or female and also possessing any sexual identity (lesbian, gay, straight, bisexual, asexual etc) or it can affect persons who do not identify as male or female at all (transsexual, queer, genderfluid etc).

Overall, GBV has affects significantly more women and girls than men and boys. But men and boys can also be survivors of GBV, especially sexual violence.

[1] Source: Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, P:5, available at: http://gbvguidelines.org/en/home/

PROPOSED ACTIVITIES

When defining GBV and all related concepts, it is proposed to also explore beliefs individuals have around these topics, as they can highlight the pervasive nature of socially constructed stereotypes and stances. The following statements[2] can be explored, either through self reflection or in discussion in the context of a seminar /workshop

I. Women allow intimate partner violence to happen to them and if they really want to, they can leave their abusive partners.
◇ true ◇ false

II. Conflicts and discord are a normal part of any relationship.
◇ true ◇ false

III. Men and women are equally violent to each other.
◇ true ◇ false

IV. Domestic violence happens only to a certain type of person.
◇ true ◇ false

V. GBV only includes physical abuse (hitting, punching, biting, slapping, pushing, etc).
◇ true ◇ false

VI. GBV is caused by substance abuse such as alcohol and/or drugs.
◇ true ◇ false

VII. Women should tolerate violence to keep the family together.
◇ true ◇ false

VIII. Domestic violence is a private family matter, in which the state has no right to intervene. How a man treats his wife is a private matter.
◇ true ◇ false

IX. Sex workers cannot experience rape.
◇ true ◇ false

X. A man cannot rape his wife.
◇ true ◇ false

XI. Most GBV is perpetrated by strangers.
◇ true ◇ false

[2] Sample statements can be found at http://www.health-genderviolence.org/sites/default/files/download/handout_5_en.pdf

1.2 INTERSECTIONALITY: UNDERSTANDING HOW SOCIAL INEQUALITY SHOULD BE EXPLAINED BY TAKING INTO ACCOUNT THE VARIOUS FORMS OF OPPRESSION

Having understood basic concepts on gender and GBV, users of this guide are advised to focus on the concept of intersectionality. While more theoretical, it can be a useful tool for professionals who want to understand underlying aspects of GBV. Intersectionality is a complex term that appears as a tool to identify how multiple factors and identities relate with each other to explain social oppression, and also to understand how these sets of identities cross and influence access to rights and opportunities or deny them, as they cannot be examined separately.

The origins of the term can be traced back to 1977. The Combahee River Collective was pioneer on using the term “simultaneity of oppressions” in their feminist manifesto of that year, as they challenged the fight based on excluding identity so deeply rooted in the black and feminist movement of the moment.

On the same path, Kimberlé Williams Crenshaw, professor at Columbia University, UCLA School of Law and black lawyer, was the person responsible for creating the term “intersectionality”, in 1989. She began to theorize about intersectionality when in 1976 a group of black women decided to sue the General Motors Corporation.

The dispute was as follows: General Motors had been hiring white women to hold administrative positions, while the black men hired were directed to the industrial sector, leaving black women out of all places. The group sued General Motors based on Title VII of the Civil Rights Act of 1964, alleging that they were being discriminated against on grounds of gender or ethnicity. Incredibly, they lost the case. The Court of First Instance ruled that, since General Motors already hired (white) women, the company did not discriminate on the basis of gender, and since the same company already hired blacks (men), neither did it for reasons of ethnicity, without taking into account the transversal forms of discrimination.

The analogy of the transit of cars in an intersection is presented as a good metaphor by Crenshaw and can help users of this guide grasp the concept. If we consider an analogy of traffic at a junction, we see cars coming and going in all four directions. Discrimination, like traffic at an intersection, can go in one direction or another. If an accident occurs at a crossing, it may have been caused by cars coming from any or all of the directions. Similarly, if a black woman is harmed by being at the intersection, her injury could be the result of gender discrimination or racial discrimination. Situations like this cannot be determined or addressed from a mono-focal point of view: we have to consider the simultaneous imbrications as the intersectional experience is greater than the sum of racism and sexism.

Crenshaw also identifies three aspects of intersectionality that affect the visibility of women of color[1] : structural, political and representational. Structural intersectionality deals with systems of oppression, such as gender discrimination, race and social class that have specific repercussions on the lives of people and social groups. Political intersectionality examines the different needs of an individual's group, such as how feminist and anti-racist laws and policies have paradoxically decreased the visibility of violence against women of color, calling the attention to the double discrimination. Finally, representational intersectionality refers to the cultural construction of the identity, including the production and the contemporary critiques of the identity.

Following the same pattern, Hill Collins contributes to this matter affirming that the matrix of domination that refers to how power is organized within the society is divided not into three, but four elements: structural, disciplinary, hegemonic and interpersonal. The intersection of the vectors of oppression and privilege creates variations, both in the forms and in the intensity within which people experience oppression. These dynamics are more complex than simply recognising either race or economic status alone as a contributing factor for inequality or discrimination; it is where intersectionality works to identify how multiple factors and identities relate with each other to create social oppression.

Nowadays, intersectionality has been welcomed by feminist studies globally and contributes to the understanding of the ways in which gender interacts with other identities and how these interbreeding contributes to unique experiences of oppression, including more various forms of social stratification such as social class, race, sexual orientation, age, disability, ethnicity, ancestry, religion, skin color, culture, geographic location and status as indigenous, refugee or migrant, as to questioning power relations and how privilege is articulated. When feminists finally recognized that the forms of oppression experienced by white women were different from the ones that non-white women experienced, they were able to understand how intersected forms of abuse were able to determine the course of their own lives.

To summarize, intersectionality has been used for decades as a conceptual framework; as said before, it emerged from the attempts to understand the experiences of black women in the United States and, more recently, it has been adopted by feminists from developing countries. The term and the conceptual framework are now widely used in the fields of gender, development and human rights, as tools for advocacy, program planning and research.

[3] The term "women of color" is mainly used in the USA and aims to describe non white females. The term encompasses all non-white people, emphasizing common experiences of systemic racism

WHY IS THE INTERSECTIONAL FRAMEWORK IMPORTANT FOR PROFESSIONALS IN HUMANITARIAN AND INTEGRATION PROGRAMMES?

Having presented the theoretical background of intersectionality, there is an obvious distance between theory and practice. Since the intersectional perspective has become more known and has attracted different kinds of professionals in the social field, many have faced the challenges of putting intersectionality to practice. Social reality is complex but, as many researchers have shown, policies and services are still mostly single sided.

An intersectional view is important, not only because it would help the professionals to address the different realities in a more comprehensive way, but also because it would help visualising power relations that would otherwise stay hidden. Intersectionality is a comprehensive framework – which actually includes many authors with different views – of which professionals can take advantage. Unfortunately, there are no magical tools for an ideal intersectional practice, but in what follows three considerations are described in order to help professionals develop an intersectional view.

PUTTING INTERSECTIONALITY IN PRACTICE

The following interactive exercise is designed to develop a critical thinking froman intersectional view rooted in professional direct practice. Ideally, groups of 5-7 people from the same professional field discuss together over a case which can be real or fictional. During 20-25 minutes they complete the following table, which will share later with the rest of the groups:

BRIEF CASE DESCRIPTION:	CONTEXT ANALYSIS:	DESCRIPTION OF THE INTERVENTION:	IMPROVEMENT PROPOSALS:
	Which are the oppressions in play at this given situation? *How are they affecting the situation?*		

When each group shares their analysis, the others give feedback and so on until every group is finished.

First of all, putting the intersectional perspective to practice, requires specific attention towards diagnosis, meaning towards reflexivity. To get started it is essential to critically reflect on how stereotypes and prejudices influence our way of looking at «the others» and also to question dominant imaginaries. It urges the professional to put her/his objectivity under question and to acknowledge that we are crosscut in unequal power relations. This reflexivity exercise aims to acknowledge our position as professionals, thus to identify how sexism, racism, classism, LGTBIphobia, islamophobia, anti-gypsyism, etc. are articulated in our actions, both at institutional and individual levels.
Secondly, power relations should be contextualized. As complex as the social world is, intersectionality does not refer to oppressions as fixed social categories, but rather highlights how different elements are intertwined and generate multiple oppressions in a given situation.

CONTEXT IS CRUCIAL AND IN EACH SITUATION THE FOLLOWING QUESTIONS SHOULD BE CONSIDERED:

I. Which are the oppressions that are activated at a given situation?

II. Can we identify them? How are they working together and what do they generate?

III. What role do laws, policy, services and resources play in this relation?

Finally, we should take into consideration the importance of listening, asking questions, and recognizing the people we work with. An essential part of working with people in situations of discriminations is to truly recognize them. On one hand, to understand how their experience of discrimination and privilege is configured and on the other hand, to acknowledge the multiplicity of voices and agencies that are involved. What are the needs and interests of the people we assist? Are we really attentive to these needs? How can we promote them? Who participates in the decisions?

Intersectionality recognises today the failure to address these issues individually in early social justice movements, and exists as a tool to understand the experiences of people who are subjected to multiple forms of subordination within society and should be applied to all fields of politics, health care, education, etc., as well as to create spaces so that legal and legislative bodies can address these layers of discrimination.

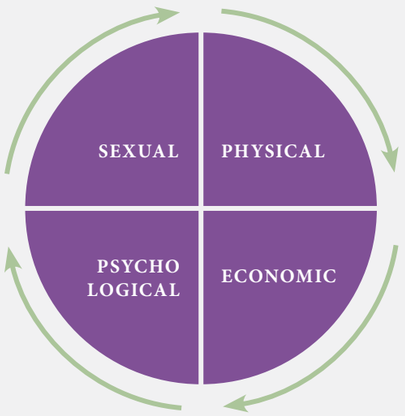
This is a crucial task for refugee and migrant women related interventions at the detection of GBV. GBV policies and services have mostly focused on gender as the category which explains discrimination, while forgetting or concealing others. As the black women Crenshaw referred to, migrant and refugee women are imbricated in different power relations where race, country of origin, nationality or resident status become essential elements. Also, as a heterogeneous group, the different voices and agencies of these women should be taken in consideration to avoid victimization and other forms of symbolic violence.

PROPOSED ACCOMPANYING MATERIALS

Users of the guide can also watch the "What is privilege?" video, available at
https://www.youtube.com/watch?v=hD5f8GuNuGQ

1.3 TYPES OF GENDER BASED VIOLENCE

There are four core types of GBV that apply in all GBV programming and responses/in all contexts. The four types are a basic classification, while in some other sources the Harmful Practices is recognized as a fifth form/type of GBV.



USERS OF THIS TRAINING PACKAGE WOULD BENEFIT FROM FAMILIARISING THEMSELVES WITH THE MOST COMMONLY IDENTIFIED SUB-TYPES OF GBV, PRESENTED IN THE LIST BELOW:

I. Rape: Non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.

Sexual Assault: Any form of non-consensual sexual contact other than penetration.

II. Physical Assault: Physical violence not sexual in nature

III. Forced Marriage: Any marriage conducted without the full consent of both parties and
IV. where duress is a factor. Early marriages often include some element of force.

Denial of Resources, Opportunities or Services

V. Psychological/Emotional Abuse: Infliction of mental or emotional pain or injury.
VI. Examples include threats of physical or sexual violence intimidation humiliation forced isolation stalking harassment unwanted attention remarks gestures or written words of a sexual and/or menacing nature destruction of cherished things etc.

VII. Sexual Exploitation: Any abuse of a position of vulnerability differential power or trust for sexual purposes; this includes profiting monetarily socially or politically from the sexual exploitation of another.

VIII. Human Trafficking: The recruitment, transportation, harboring or receipt of people for the purposes of slavery, forced labor (including bonded labor or debt bondage) and servitude

THE FOLLOWING TABLE CAN ALSO BE USED AS A REFERENCE FOR PROFESSIONALS WHO MIGHT COME INTO CONTACT WITH SURVIVORS OF ALL AGES.

Women and girls are at high risk of GBV at all stages of their lives.

PRE-BIRTH	Sex-selective abortions, battering during pregnancy (emotional and physical effects on the woman; effects on birth outcome); coerced pregnacy (for example, mass rape from war).
INFANCY	Female infanticide; emotional and physical abuse; differential access to food and medical care for girl infants.
GIRLHOOD	Child marriage; genital mutilation; sexual abuse by family members and strangers; differential access to food and medical care; child prostitution; child labour; neglect of girl child.
ADOLESCENCE	Early and forced marriage; dating and courtship violence (e.g. date rape); economically coerced sex; sexual abuse in the workplace; rape; sexual harassment; forced prostitution; trafficking in women; limitations in access to education; dowry/kalim* and other marriage related practices.
REPRODUCTIVE AGE	Marital rape, partner femicide, psychological abuse, battering during pregnancy and other forms of intimate partner violence; abuse by in-laws and other relatives; dowry abuse and age murders; sexual abuse or harassment at the workplace; rape; extreme exploitation of household labour; kidnapping; forced abortion.
OLD AGE	Abuse of widows; against older women.

As seen in the slide, some types are risk in many stages of life;
it is important to note that this is a guidance, not a rule as different types can happen across different life stages and are not strictly ties to it
(of course except in case pre-birth, infancy).

CHAPTER TWO

SIGNS AND SYMPTOMS OF GENDER BASED VIOLENCE

The presentation on signs and symptoms of GBV includes an overview of most commonly identified symptoms of GBV, as well as the risk categories indicating the high risk of GBV. The list is not exhaustive and serves rather as a general frame of indicators that may help front line workers to identify potential survivors.

For professionals who might come in contact with survivors without having knowledge of the incidents they have survived (i.e. when the disclosure is missing), it is important to be aware of some of the basic and most common signs and symptoms associated with GBV. The list of symptoms provided bellow is structured according to age, yet it is not exhaustive. Users of this guide need to always remember that every person is unique and that it is possible that experiences of GBV might not manifest through these particular symptoms for some people while others might exhibit a constellation of signs. It should also be noted that the coping mechanisms are diverse and some types of GBV are very difficult to identify. It is important to keep an open mind and look also beyond this list, especially in cases of survivors who faced the incident(s) some time ago.

INFANTS AND TODDLERS (0-5 YEARS):

- Crying, whimpering, screaming more than usual
- Clinging or unusually attaching themselves to caregivers
- Refusing to leave ''safe'' places
- Difficulty sleeping or sleeping constantly
- Losing the ability to converse, losing bladder control, other developmental regression
- Displaying knowledge or interest in sexual acts inappropriate to their age

YOUNGER CHILDREN (6-9 YEARS):

- Similar reactions to children 0-5, and additionally:
- Fear of particular people, places or activities, or of being attacked
- Behaving like a baby (wetting the bed or wanting the parents to dress them)
- Suddenly refusing to go to school
- Touching their private parts a lot
- Avoiding family or friends, or generally withdrawing to themselves
- Refusing to eat or wanting to eat all the time

ADOLESCENTS (10-18 YEARS)

- Depression (chronic sadness), crying or emotional numbness
- Nightmares or sleep disorders
- Problems in school or avoidance of school
- Displaying avoidance behaviour, including withdrawals from family and friends
- Self-destructive behaviour (drugs, alcohol, self-inflicted injuries)
- Changes in school performance
- Exhibiting eating problems
- Suicidal thoughts or tendencies
- Talking about abuse, experiencing the flashbacks

ADULTS:

- Flashbacks
- Nightmares
- Emotional numbing
- Avoidance of reminders of the trauma
- Depression, suicidal thoughts
- Difficulties with peer relationships
- Self-destructive behaviour (ex. changes in work performance, abandonment of friendships, neglecting caretaking responsibilities, self-harm)

ADDITIONAL MATERIAL

During workshops/seminars, facilitators can share the following handout with the participating professionals.

HANDOUT 19: UNDERSTANDING THE SIGNS OF GENDER-BASED VIOLENCE

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

Examples of clinical conditions associated with intimate partner violence

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

Source: adapted from Black 2011, cited in WHO 2013

Examples of behaviour that may indicate intimate partner violence

- Frequent appointments for vague symptoms
- Injuries inconsistent with explanation of cause
- Woman tries to hide injuries or minimize their extent
- Partner always attends unnecessarily
- Woman is reluctant to speak in front of partner
- Non-compliance with treatment
- Frequently missed appointments
- Multiple injuries at different stages of healing
- Patient appears frightened, overly anxious or depressed
- Woman is submissive or afraid to speak in front of her partner
- Partner is aggressive or dominant, talks for the woman or refuses to leave the room
- Poor or non-attendance at antenatal clinics
- Early self-discharge from hospital

Source: Department of Health 2005

CHAPTER THREE

GUIDING PRINCIPLES

FOR PROFESSIONALS WORKING WITH GBV SURVIVORS

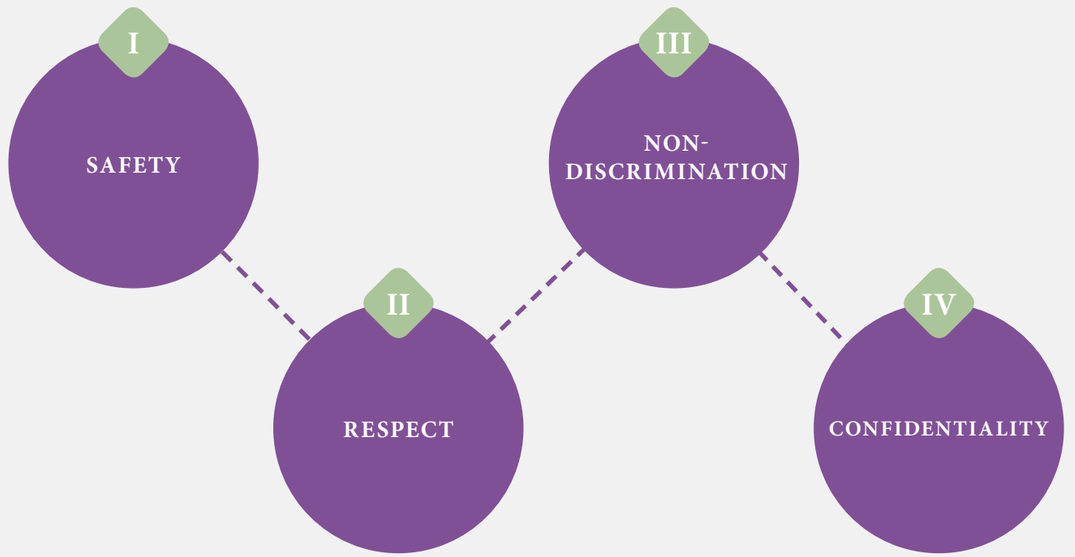
The guiding principles for working with GBV survivors are the core rules all relevant? professionals must know and implement at all times and stages of their work.

THE GOALS OF THIS CHAPTER OF THE TRAINING PACKAGE ARE:

- **Understand the essence of the guiding principles;**
- **Highlight the importance of the principles in working with GBV survivors;**
- **Understand their application in different stages of responding to GBV;**

FOUR PRINCIPLES OF WORKING WITH GBV SURVIVORS ARE THOSE GUIDING ANY PROFESSIONALS' APPROACH:

Users of this package or facilitators preparing the delivery of a GBV related seminar/ workshop are advised to revise these four concepts in depth.



I SAFETY

When working with GBV survivors, one of the most important principles to guide a professional's work is that of Safety and Security. Though there is a difference between the terms safety and security, when working with survivors an effort must be made so that they are both applied.

Safety is best described as having the awareness of potential risks that might affect the survivor following a GBV incident while also being prepared to address said risk, if/when it appears.

Security is basic entitlement, a right guaranteed by art.3 of UDHR 1948 and is associated with exercise of liberties, accessing rights (services) without any threat as well as having protection against harm (including arbitrary arrest or detention).

Service providers should remember that the survivor might be frightened and need assurance of her individual safety. In all cases, insurances must be made that she is not at risk of further harm by the assailant or by other members of the community. Professionals should also be aware of the safety and security of the people who are helping the survivor, such as family, friends, community service or sexual and gender-based violence workers, and health care workers.

II RESPECT

Respect is a human right. The dignity and respect of all survivors must be maintained by professionals/service providers at all times. This includes respecting ones choices, as long as they don't pause a threat to theirs or other persons' lives. It is also essential that all disclosures are received from a point of trust and that the service providers refrain from judging the person doing the disclosure, or their culture, religion, personality etc. Moreover, professionals working with GBV survivors should remain patient and not press for more information if the survivor is not ready to speak about her experience. The focus of all incident related discussions need to be on the relevant information and the rhythms of the survivor should be respected.

III NON-DISCRIMINATION

Every adult or a child, regardless of her/his sex, should be accorded equal care and support. Survivors of violence should receive equal and fair treatment regardless of their race, religion, nationality or sexual orientation.

IV CONFIDENTIALITY

Confidentiality is an ethical principle. Maintaining confidentiality requires that service providers protect information gathered about clients and agree to share information about a beneficiary's case only with their explicit permission. All written information is maintained in a confidential place in locked files and only non-identifying information is written down on case files. Maintaining confidentiality means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children. Information is to be shared, as requested and as agreed by the survivor, with those actors involved in providing assistance. The confidentiality of the perpetrator should also be respected.
Users of this package are strongly encouraged to always explain confidentiality and its limits to the persons they work with. This means utilizing the age and intellect appropriate language to make sure that the beneficiary knows the information they provide will be kept confidential, unless:

- **Their life is in immediate danger**
- **They share that they have made plans to seriously hurt themselves**
- **They share that they have made plans to seriously hurt someone else**

An additional, important exception to the confidentiality rules should always be clear to professionals. This exception applies to situations where there are threats of ongoing violence or harm to a child. In these cases, protection of the child overrides confidentiality restrictions. Service providers should always be aware of the legislation in their country of operation with regards to confidentiality and to its limits as well as the appropriate reporting pathway they should follow in case they have to.

PROPOSED ACTIVITY

When using this package to design a seminar/workshop, you can choose at this point to introduce a small case study for the participants to work on. You can either use a story that applies to the specific context that the participants are working at or you can use the following, more generic story:

A young woman arrives at the place you work.Together with her there are her 3 children. She is obviously scared and distressed and there are some visible cuts and bruises on her arms and face. She shares with you that her husband beat her up the previous night, while drunk. She also shares that she rarely has access to the family money, as he usually keep it so he can drink and go out with his friends. She and her children are malnourished and subjected to daily beating and humiliation. She cannot appeal to her community, as her husband is considered an influential person. You indeed notice that the mother and the children are in great shock and in need of immediate medical assistance.

QUESTIONS THAT CAN BE ASKED:

What actions are needed to ensure confidentiality?
How to ensure respect while assessing this case?
What actions are needed to ensure safety and security?
How to ensure non-discrimination in managing this case?

CHAPTER FOUR

SPECIAL CONSIDERATIONS

WHEN WORKING WITH VULNERABLE POPULATIONS

When working with survivors of GBV or persons at risk it is important to keep some special considerations in mind. This training package focuses on post populations post displacement and includes the care of child survivors. This forth chapter of the package aims at providing basic information and guidance when working with vulnerable populations or persons who belong in a specific sub-category of survivors (i.e. rape survivors, asylum seekers, children).
Users of this package can read the whole content of this chapter or choose the parts that are more relevant to their work. It is, though, highly recommended that all persons working on care related professions become aware of protocols available to them to respond to incidents of rape, as in those timely and coordinated response is crucial.

4.1. CLINICAL MANAGEMENT OF RAPE

The goal of this section is to facilitate the delivery of standardised and comprehensive post-rape care services to survivors through sensitisation of the professionals they might come in contact with or from whom they might ask for help. Moreover, through this, users of this package can better understand the clinical service providers' role in the care of rape survivors as well as how SOPs can improve access to care.

Following a rape, medical professionals can provide three emergency services to survivors: Emergency Contraception, Prevention of STDs and Wound Care.

EMERGENCY CONTRACEPTION

Emergency contraception refers to methods of contraception that can be used to prevent pregnancy after sexual intercourse. These are recommended for use within 5 days but are more effective the sooner they are used after the act of intercourse. Emergency contraceptive pills prevent pregnancy by preventing or delaying ovulation and they do not induce an abortion. Emergency contraception cannot interrupt an established pregnancy or harm a developing embryo. Usually two pills are given with a 12 hour break period between them. Side effects from the use of ECPs are similar to those of oral contraceptive pills, such as nausea and vomiting, slight irregular vaginal bleeding, and fatigue. Side effects are not common, they are mild, and will normally resolve without further medications.

Taking emergency contraceptive pills can reduce the chance of a pregnancy by between 56% and 93%, depending on the regimen and the timing of taking the medication. The use of emergency contraception is a personal choice that can only be made by the woman herself.

Women should be offered objective counseling on this method so as to reach an informed decision. A health worker who is willing to prescribe ECPs should always be available to prescribe them to rape survivors who wish to use them.

PREVENTION OF STIs

Survivors of rape should be given antibiotics to treat gonorrhoea, chlamydial infection and syphilis. If any other STIs are known to be prevalent in the area (such as trichomoniasis or chancroid), give preventive treatment for these infections as well.

Post-exposureprophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure. PEP should be offered, and initiated as early as possible, for all individuals with an exposure that has the potential for HIV transmission, and ideally within 72 hours. If started soon after exposure, PEP can reduce the risk of HIV infection by over 80%. Adherence to a full 28-day course treatment (received once or twice daily) is critical to the effectiveness of the intervention.

WOUND CARE

Any tears, cuts and abrasions need to be cleaned and dirt, faeces, and dead or damaged tissue should be removed. A medical professional should decide if any wounds need suturing. If there are major contaminated wounds, provision of appropriate antibiotics and pain relief should be considered.

It needs to be highlighted that all medical provisions for rape survivors remain personal choices and no one should be forced to a course of action they don't agree with. Exceptions exist for persons whose lives are in immediate danger. All women need to be provided with detailed information about their options as well as with the consequences these options have, so they can make an informed decision.

4.2. WORKING WITH CHILD SURVIVORS

While the principles and guidelines discussed in other chapters also apply to refugee children, there are other specific issues that should be considered when working with refugee children. This chapter addresses professionals who are not specialised at child protection and aims to offer a basic introduction of child protection as applied to minors who have survived GBV.
Refugee children face specific forms of sexual and gender-based violence: harmful traditional practices, trafficking, child prostitution, sexual violence within the family and sexual exploitation, abuse and violence by persons having unhindered access to children.

A starting point for professionals when working with refugee children is to become familiar with the Convention on the Rights of the Child (1989), which sets comprehensive standards for the protection of the rights of all children.
In addition to the Guiding Principles with which users of this package became familiar earlier, three other principles should be taken into account when working with refugee children: the right to life, survival and development; the best interests of the child; and participation.

Refugee children and/or children on the move are often exposed at particular risks of sexual and GBV because of their increased level of dependence, their limited ability to protect themselves, as well as their limited power and participation in decision-making processes. It is not possible for children to provide informed consent and they might also, depending on their level of development, not fully comprehend the sexual nature of certain behaviours. Additional ethnic, gender, cultural, economic and social factors may also increase refugee children's risk of experiencing sexual and gender-based violence.

GUIDING PRINCIPLES WHEN WORKING WITH CHILDREN

The right to life, survival and development: The "survival and development" principle applies not only to a child's physical survival and development, but also to a child's mental and emotional development. Measures need to be put to place to safeguard life.

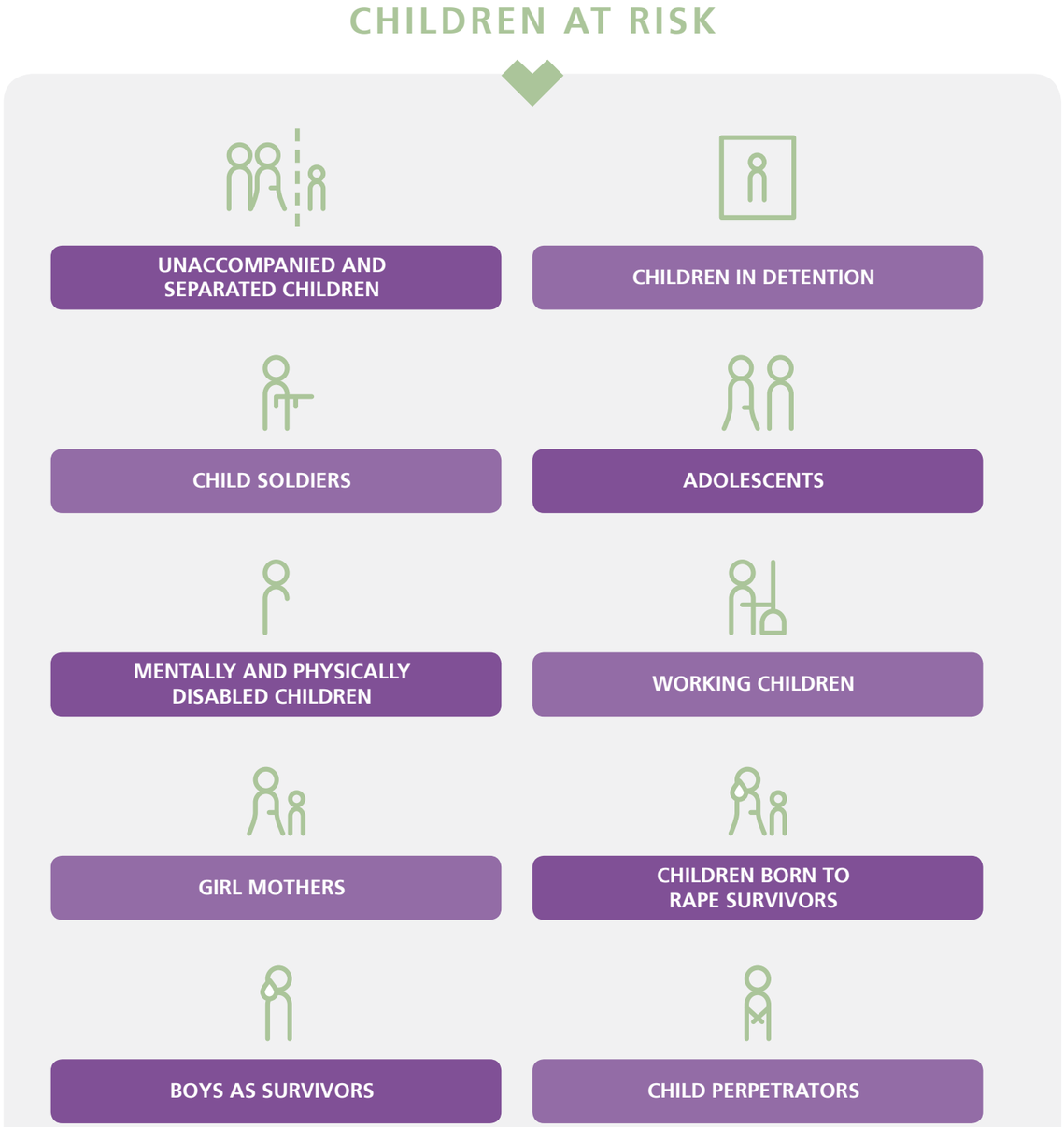
The best interests of the child: In each and every decision affecting children, the various possible solutions must be considered and due weight given to the child's best interests (Art.3, CRC). Service providers must evaluate the positive and negative consequences of actions with participation from the child and his/her caregivers (as appropriate). The least harmful course of action is always preferred. All actions should ensure that children's rights to safety and ongoing development are never compromised.

During the process of determining what is in the child's best interest, decision-makers need to take into account both the objective standards deemed to be in the child's best interests and subjective opinions, without leaving out the child's own views. There are many factors that have to be considered, such as age, sex, cultural background, general environment and past experiences of the child. On several occasions, it can be expected that determining a child's best interests can be difficult, and no single answer may be obviously and indisputably correct.

Participation: Service providers are expected to maintain that children have the right to influence decisions that will affect their lives, and that their views must be given "due weight". The level of a child's participation in decision-making should be appropriate to the child's level of maturity and age

GROUPS OF REFUGEE CHILDREN AT PARTICULAR RISK OF SEXUAL AND GENDER-BASED VIOLENCE

While all children and young persons are in greater danger of experiencing GBV, some groups might come in contact with more adverse conditions or might become targets more often. Below, professionals can find a table that can be used as an indicative guide, as it includes the categories of minors that are most commonly identified as "at risk":



CHAPTER FIVE

REFERRING CASES OF GBV

BASIC COMPETENCES

When responding to incidents of GBV, interagency cooperation is key. Several different service providers need to coordinate to achieve the comprehensive support of the survivor.

This section of the package aims at providing professionals with the basic competences required for the first step of this coordination process: the referral. It is intended to give them a general guidance and understanding of what to do when faced with the potential GBV case.

ROLES AND RESPONSIBILITIES OF GENERAL SERVICE PROVIDERS

GBV cases should be handled, when possible, by specialised personnel, as they often require delicate and specific actions. Yet, all actors coming into contact with GBV survivors are responsible for knowing the referral pathways and the forms of assistance available for the survivors and should be ready to share this information with the survivor. Professionals are under the obligation to know, be prepared, and understand their surrounding environment as well as what organisations and services exist.

When a case is disclosed to non specialized professionals, they should refrain from interviewing the survivor or from responding directly, unless a specialized professional or actor is not available. After informing the survivor at the right moment about one's limited capacity to respond to GBV, the field professional should ask the survivor's consent to contact professionals acting as focal persons across the GBV referral pathway, to facilitate the contact between service provider and survivor. As mentioned before, the wishes of the survivor must always be respected as to where or with whom to seek help. She should not be urged into a particular course of action.

CONDUCTING A REFERRAL

The following steps are advisable when referring a GBV survivor.

I. Comfort and reassure the survivor: Whoever is the direct recipient of a disclosure should make sure to provide comfort to the survivor. A series of small phrases can be used to achieve this. Some of them are: "I believe you", "I am sorry this happened to you", "You are very brave to talk to me ".

COMFORT AND REASSURE THE SURVIVOR - STEP 1

"I believe you.
→ **BUILDS TRUST**

"I am glad that you told me.
→ **BUILDS A RELATIONSHIP**

"I am sorry this happened to you.
→ **EXPRESSES EMPATHY**

"This is not your fault.
→ **NON BLAMING**

"You are very brave to talk with me.
→ **REASSURING AND EMPOWERING**

II. Explain Confidentiality: As discussed before, in the context of the guiding principles, confidentiality is a responsibility and obligation of all professionals. Even in the cases were not specialised service providers are involved, they should be able to assure the survivor that information shared with them, no matter how little it may appear - will be kept confidential. As a specialised service provider, explaining confidentiality must be part of the introductory talk with the survivor.

III. Receive Informed Consent: Consent should be given in a written form, in the language that the survivor understands. In case the survivor is in too much distress, time is required for them to calm down so that the specifics and the consequences of a referral are understood. In obvious situations of medical emergency, and acting in good faith, medical care should be provided, even if it was not possible to obtain consent in advance (for an example – survivor is unconscious).

IV Understand What Happened: When recording the incident, professionals should avoid going into details that are not useful at that given moment, while also making sure that the sayings of the survivor are clearly recorded. Any beliefs or assessments the

V Share Information About Services: Following obtaining an informed consent to proceed, all available services should be communicated to the survivor. The information shared should include how the services are provided and what are their consequences.

VI Ask About Immediate Safety Needs: This is a particularly important step in the referral process. Service providers need to take this into account, even when they are not specialised in GBV. Questions one can use to evaluate safety and security for a survivor can be: Is it safe for a survivor to go home? Where do they feel safe? Are the children safe?

PROPOSED ACTIVITIES

If using this material to prepare a workshop, facilitators/trainers can consider using the following scenarios so that participants can assess how well they have understood the process of referring a GBV survivor.

SCENARIO 1: Family members disclose an incident to you without the knowledge of the adult survivor.

Question: How could this put the safety of the survivor at risk? What should you do in this situation?

SCENARIO 2: An adult survivor declines medical referral even though she was within the timeframe to receive PEP.

Question: How should the assisting professional proceed?

SCENARIO 3: An adult survivor comes to you, but tells you she fears telling you about what has happened to her because she doesn't want her relatives to find out.

Question: How should the assisting professional proceed?

CHAPTER SIX

BURNOUT

CHALLENGES AND SELF CARE

When working with survivors of GBV, professionals might often experience secondary trauma and run the risk of experiencing burnout as well. The purpose of this part of the Training Package is to:

I **Increase awareness about what the experience of Burn Out and Secondary Trauma is and what happens when they occur**

II **Introduce a practical guide on dealing with Burn Out**

III **Introduce the training package users to Field Theory**

BURNOUT/SECONDARY TRAUMA

Professionals should be made aware of types of experiences that are commonly associated with Burn Out. It needs to be noted that most persons live within systems that are experienced as oppressive. Their exposure to other persons' traumatic experiences is likely to bring personal experiences of oppression and violation to the surface.

- **Professionals might enter into various moods, frustration, anxiety, sadness, fear, pain, guilt, shame, destabilization, or even feel as if their existence is in chaos**
- **One might feel unworthy or incapable to offer something useful to the community**
- **Conflicts with colleagues or with persons of one's close environment tend to occur more often**
- **There is a lack of appetite for work**
- **Feeling of isolation emerge, without the professional having a clear understanding why**
- **Feelings of being stuck or numb as well as apathy might be experienced.**
- **Strong physical symptoms from light to heavier, sleeping disorders, eating disorders**
- **Some individuals feel as if life stops making sense, and no point can be found in doing anything**

CREATING A FRAMEWORK OF SUPPORT
TO AVOID OR RECUPERATE FROM BURN OUT

- **Participation in supervision meeting provided by the actor employing the professional**
- **Personal Therapy**
- **Close contact with family, friends, significant others**
- **Establishing space for expression**
- **Change of environment, time away from the workspace**
- **Re-inventing what brings joy within the workplaces**
- **Focusing some of the energy provided to beneficiaries to the love of self**
- **Change position**

FIELD THEORY

One of the theories available for professionals to use in understanding burnout is Field Theory. Field Theory states that the fields within which individuals work exert forces on them and tend to «pull» them into specific roles .Professionals very often identify with these roles and begin to feel, think and behave like them. This might also be the case for professionals working with GBV survivors.
In some cases professionals freeze in these roles and without accepting them, do not explore them because they are afraid.

Filed Theory proposes that embracing these roles, acting them out, even if they are not roles that the individuals like, will allow them to shape the roles or even discard them. Even the awareness that what is experienced is not just personal but primarily a role that corresponds to the current field can become comforting. The less that is known about oneself or the roles they might be trapped in the easier it can become for someone to experience burnout through these roles. Through field theory professionals can also appreciate that they are larger than any role they play.

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ANNEXES

ANNEX 1: SAMPLE WORKSHOP AGENDA

DAY 1

Timing	*Topics*
09:00 – 09:30	Welcome and introduction
09:30 – 11:30	Sex, Gender and Gender Roles
11:30 – 13:00	Core Concepts of GBV - Exploring prevalent beliefs about GBV
13:00 – 14:00	Lunch
14:00 – 15:30	Guiding principles for working with survivors of GBV - National SOPs
15:30 – 17:00	Signs and symptoms of GBV -Risk Categories and Vulnerabilities

DAY 2

Timing	*Topics*
09:30-11:00	Basic principles on medical treatment of GBV
11:00-11:15	Coffee Break
11:15-13:30	The Referral System: Challenges, Dysfunctions and Good Practices
13:30-14:00	Light Lunch
14:00-15:30	Communication skills when working with GBV survivors
15:30-17:00	Avoiding Burnout

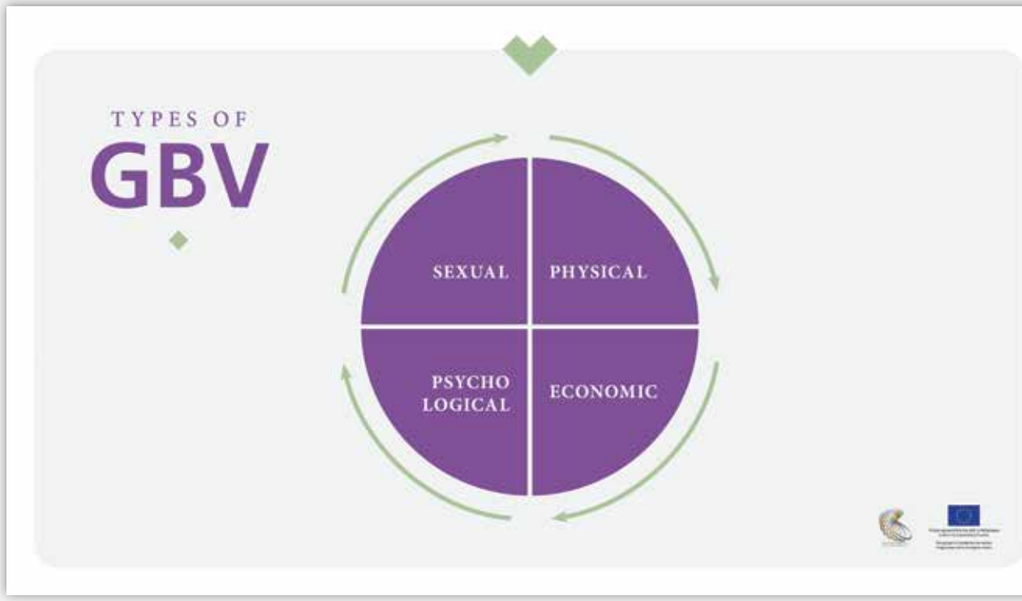
DAY 3

Timing	*Topics*
09:30-12:00	Asylum and international protection – GBV as a cause of displacement
12:00-12:30	Light Lunch
12:30-14:30	Local/National Legislation on GBV
14:30-14:45	Coffee Break
14:45-17:00	Issues of cultural diversification

DAY 4

Timing	*Topics*
09:30-10:30	Introduction to child protection: The gender dimension
10:30-12:30	Legislative Framework on the Protection of Children from GBV
12:30-13:00	Light Lunch
13:00-17:00	Working with child survivors of GBV – Guiding Principles

ANNEX 2: SAMPLE PRESENTATION



GBV ACROSS LIFE STAGES

PRE-BIRTH	Sex-selective abortions, battering during pregnancy (emotional and physical effects on the woman; effects on birth outcome); coerced pregnacy (for example, mass rape from war).
INFANCY	Female infanticide; emotional and physical abuse; differential access to food and medical care for girl infants.
GIRLHOOD	Child marriage; genital mutilation; sexual abuse by family members and strangers; differential access to food and medical care; child prostitution; child labour; neglect of girl child.
ADOLESCENCE	Early and forced marriage; dating and courtship violence (e.g. date rape); economically coerced sex; sexual abuse in the workplace; rape; sexual harassment; forced prostitution; trafficking in women; limitations in access to education; dowry/kalim* and other marriage related practices.
REPRODUCTIVE AGE	Marital rape, partner femicide, psychological abuse, battering during pregnancy and other forms of intimate partner violence; abuse by in-laws and other relatives; dowry abuse and age murders; sexual abuse or harassment at the workplace; rape; extreme exploitation of household labour; kidnapping; forced abortion.
OLD AGE	Abuse of widows; against older women.

I RAPE

Non-consensual, physically forced penetration of the vulva, anus or mouth, including with an object.

MAIN ELEMENTS:

1. **Power (exercised through force or threat);**
2. **Lack of consent;**
3. **Inflicting harm;**
4. **Penetration.**

TYPES OF GBV

Q: What types of (S)GBV are you familiar with?
What types you identify most often?
How do you identify them?

ACCORDING TO NATIONAL GBV SOPs:

- **Rape;**
- **Sexual Assault;**
- **Physical Assault;**
- **Forced Marriage;**
- **Denial of Resources, Opportunities or Services;**
- **Psychological/Emotional Abuse;**
- **Survival Sex/Sexual Exploitation;**
- **Human Trafficking.**

II SEXUAL ASSAULT

Any form of non-consensual sexual contact other than penetration.

EXAMPLES:

- **Unwanted kissing;**
- **Touching of genitalia and other private areas;**
- **Attempted rape;**
- **FGM.**

MAIN ELEMENTS:

- **Power**
- **Lack of consent**
- **Inflicting Harm**
- **Sexual in nature**

III PHYSICAL ASSAULT

Why and when do we consider it to be GBV?

Physical violence not sexual in nature;
Results in pain, discomfort or injury:

- hitting;
- Slapping;
- Choking;
- Cutting, burning, shooting;
- Acid attacks

IV FORCED MARRIAGE

- ***A marriage of an individual against his/her will***
- ***Child marriage (formal or informal union before 18)***

V DENIAL OF RESOURCES, OPPORTUNITIES OR SERVICES

- Widow prevented from receiving inheritance;
- Earnings forcibly taken by family member or intimate partner;
- Prevention to use contraceptives;
- A girl prevented to attend school, etc.

VI PSYCHOLOGICAL / EMOTIONAL ABUSE

Infliction of mental or emotional pain or injury:

- Threats of physical or sexual violence;
- Intimidation;
- Humiliation;
- Forced isolation;
- Stalking;
- Destruction of cherished things etc.

It is one of the GBV myths that GBV can only be physical.

VII SURVIVAL SEX/SEXUAL EXPLOITATION

FORCED prostitution or exchange of sexual favours for material resources, services and support;

- Usually targeting women and girls who cannot meet their or their children's basic needs;
- Male adolescents also targeted.

VIII HUMAN TRAFFICKING

"…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, deception…for the purpose of exploitation."
Protocol to Prevent, Suppress and Punish Trafficking in Persons

The General Secretariat for Gender Equality (GSGE) of the Greek Ministry of Interior is the governmental agency competent to plan, implement, and monitor gender equality and GBV policies.
It has developed an integrated Network of 61 Units for preventing and combating violence against women and has placed GBV high in its agenda.

The Research Centre for Gender Equality (KETHI) was founded in 1994, having a dual focus both on conducting social research on gender equality issues and also using this knowledge, to propose and implement specific policies, practices and actions to promote gender equality.

CRWI Diotima is a GBV-specialized NGO, national stakeholder expert in EIGE's database, with a long experience in gender equality and GBV field and in migrant women's integration and rights protection.

Differenza Donna is an ever growing women's NGO, active in the implementation of specific interventions in safeguarding migrant women's rights and especially GBV protection and previous transnational project experience.

Surt is a well established women's NGO with an excellent record of previous work with gender equality, GBV and also migrant integration experience. It has a wide regional network of collaborations, a great experience in transnational projects and a good capacity in service provision.