FEBRUARY 2009

Translating Pain Into Action

A Study of Gender-based Violence and Minority Ethnic Women in Ireland

SUMMARY REPORT

The **Women's** Health Council
Comhairle Shláinte na mBan

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 full report, principles of best practice for service delivery, 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 and Law Reform.

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Contents

Introduction

This summary presents the findings of the first major study conducted in Ireland on gender-based violence (GBV) and minority ethnic women[2]. 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). Three factors formed the rationale for this focus on the needs and experiences of minority ethnic women. 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. According to Census 2006, 12 per cent (n. 246,441) of the female population in Ireland are members of minority ethnic groups.

The voices of minority ethnic women who experienced GBV play an essential role in this attempt to address the current knowledge gap. This 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 who facilitated their involvement. These interviews also provided invaluable additional insights into the findings of the quantitative aspects of the research, namely the surveys of GPs, other mainstream health and social services, GBV organisations and minority ethnic organisations.

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, it highlights the universal nature of this devastating social issue. 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 required services in Ireland. It is on the basis of this information that principles of best practice for service providers are provided as well as recommendations for national policy and legislation, service planning and service delivery.

2 The principles of best practice are published separately and can be downloaded from www.whc.ie.

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 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 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;
- To provide key principles of good practice for service providers.

3 http://www.cosc.ie/en/COSC/Pages/WP08000082, accessed August 2008.

Part: 1 Background Literature

1

Key Findings from the Literature Review

The United Nations Convention on the Elimination of All Forms of Discrimination (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)[4]. It includes any act which results in, or is likely to result in, physical, sexual or psychological harm. Domestic violence is the most common form of GBV among all women, including those from minority ethnic groups (Watts & Zimmerman, 2002; Heise et al, 1999; UN, 2006). Other forms of GBV include harmful traditional practices such as Female Genital Mutilation (FGM), conflict-based rape and sexual violence against women prisoners.

The ecological framework was adopted as the key analytical framework for this study as it is considered the most comprehensive explanation of VAW to have been developed to date (Heise, 1998). This framework conceptualises GBV as a multifaceted phenomenon grounded in an interplay of personal, situational, and socio-cultural factors. At an individual level, risk factors include the perpetrator witnessing domestic violence as a child and experiencing physical or sexual abuse as a child. At the level of family, they include marital conflict and patriarchal family structure. At a community level, they include unemployment, low socioeconomic status and social isolation.

A final, fourth level represents the general views and attitudes of a culture, including state structures and processes that legitimise and institutionalise gender inequalities. As GBV is a manifestation of gender inequality that serves to maintain an unequal balance of power, no act of GBV can be fully understood without consideration of this level (UN, 2006). Though some cultural contexts are more patriarchal than others, patriarchy exists in every culture in the world and should therefore never be confused with culture itself.

[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.

Figure 1: The Ecological Framework

Source: Heise, 1998.

Research literature identifies the following risks factors of domestic violence that can be faced by minority ethnic women:

- Endorsement of patriarchal views of marriage and women's sexual autonomy
- Members of a community or family not intervening in cases of domestic violence
- Isolation from the rest of their community
- Immigration and asylum legislation that increase dependence on their partner
- Changes in status, gender roles and traditional supports following migration.

In addition, low income has also been identified as a risk factor for GBV and minority ethnic women have a greater risk of living in poverty than majority ethnic women (Walby, 2004).

These risk factors also act as barriers to leaving a violent relationship and/or seeking support. Patriarchal norms lead to associations of stigma and shame with leaving a violent relationship. Restrictive immigration laws have been identified as a trap for immigrant women experiencing domestic violence; in response to this issue, many countries have adapted their immigration laws to include domestic violence concessions. Stringent social welfare policies can also act as barriers, by reducing income for migrant women and asylum seekers as well as those services trying to assist them.

Minority ethnic women can face discrimination from the majority culture, while simultaneously experiencing sexism against them from both the majority group and their own minority ethnic community. This intersectionality of racism and sexism can also make it more difficult to seek help. 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.

– Other Forms of GBV and Minority Ethnic Women

Though domestic violence is the most common form of GBV perpetrated against all women, minority ethnic women can also be at risk of other forms of GBV. Those fleeing conflict are vulnerable to conflict-based rape. During the migration journey, and while staying in refugee camps, migrant women and girls face an increased risk of sexual assault. Approximately 80 per cent of all refugees are women and children. Due to globalisation and migration, harmful traditional practices (HTP), such as FGM and forced marriage have become matters of concern within many destination countries for migrant workers, refugees and those seeking asylum. Even when GBV is experienced prior to migration, longstanding health consequences can lead to significant implications for health and social service delivery in host countries. Approximately two million women and girls every year are at risk of FGM and it has been estimated that more than 130 million girls and women alive today have undergone FGM. Recent research has shown that at least 2,584 women are currently living in Ireland who have undergone female genital mutilation (Patel, 2008).

Trafficking for the purposes of sexual exploitation is a phenomenon which has grown dramatically over the past ten years. 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. Studies conducted in Ireland over the last seven years have estimated between 76 and 150 cases of presumed trafficked women (Ruhama, 2007; Wylie & Ward, 2007). 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.

– Health Consequences of GBV

The health consequences of all forms of GBV are wide-ranging and severe[5]. 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 infections (STIs) (Sutherland, Sullivan & Bybee, 2001). Fatal consequences include murder, sometimes carried out in the name of 'honour', and suicide. A limited body of research suggests that the psychological consequences of GBV can be more severe for minority ethnic women than for majority ethnic women. Child and forced marriages have serious health consequences, including increased mortality risk due to pregnancy-related causes, increased risk of STIs, cervical cancer, and of domestic violence.

[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)*.

Physical and psychological health consequences of trafficking for the purposes of sexual exploitation are also wide-ranging and severe. During the transit journey they include illness, injury, trauma, risk of death due to dangerous modes of transport, food deprivation, solitary confinement and violent attacks perpetrated by the traffickers. Trafficked victims are also highly vulnerable to physical and sexual violent attacks by both traffickers and so-called clients.

– Resilience and Survival

Minority ethnic women display great resilience in facing these risk factors, overcoming barriers to accessing support, and 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.

Policy and Legislation: Towards A Human Rights Approach

The value of adopting a human rights approach to combating GBV has been highlighted both in international treaties and in national policies (Kelly & Regan, 2007; UN, 2006). 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" (UN, 2006: 18). In doing so, it empowers women as active rights-holders and enhances the participation of other advocates. Rather than precluding other approaches to the issue, such as a health focus, the human rights approach encourages a "holistic and multi-sectoral response that adds a human rights dimension to work in all sectors" (Ibid.: 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 & Phillips, 2001; Principe, 2004). For some, this highlights a tension between human rights and multiculturalism (Moller-Okin, 1999). Others however point to the dangers of narrow conceptions of what constitutes culture, noting that different cultures are not separate, clearly delineated 'packages' (Narayan, 1997). Noting that "the ways in which culture shapes violence against women are as varied as culture itself" (2006: 31), the UN emphasises

the dangers associated with narrow conceptions of what constitutes 'culture' when seeking to understand this complex relationship. 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).

This is not to deny the relationship between patriarchal values and GBV. 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. Nor is it to deny the fact that some cultural settings are more patriarchal than others. However, patriarchy is not culture. Policy on GBV would be strengthened by a conceptual framework that recognises the relationship between patriarchy and GBV and that identifies all forms of GBV as unacceptable infringements on women's human rights. In order to be interculturally competent, it should address the specific problems and challenges of minority groups without generalizing or stigmatizing those cultures (Langvasbraten, 2008).

The Report of the Task Force on Violence Against Women (1997) makes some recommendations which, if implemented, would play an important role in addressing the needs of minority ethnic women regarding GBV. These relate to staff training on inter-cultural issues, the training of women from all marginalised groups to deliver culturally appropriate responses within their own communities and the training and employment of Traveller women within refuges. More recent policy developments include the National Action Plan on Racism (NAPR) developed by the Department of Justice, Equality & 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 new Office of the Minister for Integration[6] in May 2008. Though these related 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. Finally, the National Strategic Plan on Domestic, Sexual, and Gender-based Violence currently being planned by Cosc presents an ideal opportunity to develop an interculturally competent strategy on this issue.

Asylum policy also has a role to play in protecting women from GBV. The new *Immigration, Residency and Protection Bill* (2008) was introduced by the Minister for Justice in January 2008 and provides an integrated statutory framework on immigration policy. At time of writing, this has not been enacted. 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 of persecution. These acts must fulfil particular requirements of severity and frequency of occurrence in order to constitute a "severe violation of basic human rights" (2008: 70), or must occur alongside other measures. Of relevance to the implementation of this and any other relevant immigration and asylum legislation are the guidelines on international protection for gender-related persecution regarding the 1951 Convention relating to the Status of Refugees, developed by the UNHCR.

6 This office excludes Travellers and asylum seekers from its remit.

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 seeking 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 (WHC, 2007)[7].

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. Advocates for the immigrant population in Ireland have also argued that any additional temporary residency provisions should be provided on a humanitarian basis only and should not depend on the victims' willingness to assist the Gardai in investigations regarding their case. Other relevant developments in Ireland regarding policy on combating trafficking include the establishment of a High Level Group on Combating Trafficking in Human Beings and a planned National Action Plan to Combat Trafficking in Human Beings.

[7] For a more in-depth exploration of this subject, see the Women's Health Council report *Female Genital Mutilation/Cutting. A Literature Review, (2008)*.

Part: 2
Research Design

2

A mixed method approach was adopted for this research. Two populations were identified as being relevant to this project: 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, as it can yield an in-depth understanding of the nature of an experience.

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.

– Ethical Issues

Due to the sensitive nature of the subject of this study, ethical considerations were a principle focus in the research design, particularly regarding the qualitative stage. Research guidelines were adhered to, namely those of the Social Research Association (SRA) and the Sociological Association of Ireland (SAI). This study also followed the ethical guidelines for conducting qualitative research with victims/survivors of GBV developed by the World Health Organization (2001). Service providers working with minority ethnic women acted as gatekeepers, in order to ensure that all interviewees had access to support and were at the time of interview living in a safe environment. Potential interviewees were invited to participate only if they were aged 18 years or over, their experience of GBV was in the past and they were in contact with a support service. Each participant was given the choice of being interviewed by the senior researcher/ project coordinator or by a trained interviewer closer to their own ethnic identity. Ethical approval was sought from and granted by the Research Ethics Committee of the Irish College of General Practitioners (ICGP).

– Qualitative Data

A total of 26 interviewees participated in the qualitative aspect of this research. The purpose of this stage of the research was to elicit in-depth, exploratory data on the experiences of GBV among ethnic minority women, their perceptions of service provision in Ireland and their views on barriers to accessing support services. A collaborative approach was adopted, whereby nine minority ethnic women completed a rigorous training programme to act as peer interviewers[7]. This approach ensured that interviews were conducted in a culturally sensitive way and facilitated inclusion of those who do not speak the English language (Crigger et al, 2001; Campbell and Dienneman, 2001; Atkin & Chattoo 2006)[8]. A thematic content approach was used to analyse the qualitative data, which comprised of verbatim transcriptions of each interview. The coding stage of this analysis process was aided by use of the software package nVIVO.

– Quantitative Data

The aim of the quantitative dimension of the research was to provide descriptive data on the scale and nature of service provision available in Ireland to minority ethnic women regarding their experience of GBV, 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. The same questionnaire was also sent to the directors of other mainstream health and social services, namely, 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). An average of 42 per cent of organisations in this category responded. In addition, postal surveys were conducted with GBV organisations and minority ethnic organisations within the voluntary sector. Regarding GBV organisations, a total number of 62 organisations[9] was identified and a response rate of 77 per cent was achieved. Regarding minority ethnic organisations, a response rate of 31 per cent was achieved of 178 identified organisations. All quantitative data were analysed using the statistical computer programme SPSS.

8 Further detail on this training programme can be found in Appendix C of the full report.
9 The trained peer interviewers spoke the following 9 languages apart from English: Polish, Russian, Ukrainian, Chinese, Urdu, Arabic, Lugandan, Romanian and Roma.
10 This included rape crisis centres and members of the National Network of Women's Refuges and Support Services.

Part: 3
Research Findings

3

This section considers the key findings from the qualitative and quantitative stages of this study. While the full report separates these findings by methodology, they are considered here together under key headings, for ease of readership.

– Research Finding 1: Increased Risk for Minority Ethnic Women in Ireland

Evidence from this study suggests that minority ethnic women are over-represented among women who access services for support regarding GBV in Ireland. 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, asylum seekers or 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 to these GPs was 3.6. 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. As research into GBV consistently suggests that many victims/ survivors never disclose to services, this finding is all the more significant.

Table 1. % of Minority Ethnic Women accessing GBV organisations

Population Category	% at GBV orgs.	% of Gen. Pop.
Traveller women aged 15 years and over	15	0.5%
Migrant workers, asylum seekers, refugees	13	(estimate) 5%[10]

[11] 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).

– Research Finding 2: Domestic Violence, Control and Unequal Power Relations

Domestic violence was the most common form of GBV experienced by the interviewees. An underlying theme running through interviews regarding domestic violence was the perpetrator's constant attempts to control the victim/survivor. 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 strong relationship between patriarchal social values and norms, the perpetrator's desire to control them and attacks of physical and sexual violence:

> 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 [out]look. That a husband may beat you or getting another woman, that kind of thing' (Kissa).

> '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).

> '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).

> '[He] 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).

It is important to note that patriarchy is a feature of all cultures, including Western society. In that sense, these findings are not unique to the experience of minority ethnic women. However, many interviewees were living in highly patriarchal communities. As noted in the review of literature, this has been associated with higher risk of GBV. This issue also emerged as a barrier to seeking help and/or leaving a violent relationship, as patriarchal values led to a high degree of stigma and shame attached to doing so. This made it difficult for victims/ survivors to reach out to friends or family or to access services, as doing so could lead to social isolation and condemnation:

> '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).

The surveys of service providers show that this is a common issue among minority ethnic women who have experienced GBV. Four fifths of mainstream health and social (MHS) services identified the patient's reluctance to disclose as a significant barrier to meeting their needs regarding GBV. Cultural issues posed as significant barriers for a majority of MHS services. Reasons included perceived acceptance of domestic violence among some minority communities, unequal power relations between men and women, perceived unwillingness to seek help due to fear of ostracisation, a sense of loyalty to that community and fear of reprisal.

– Research Finding 3: Domestic Violence and Social Isolation

Non-indigenous interviewees experienced social isolation on moving to Ireland, as family and friends were left behind. For some, this loss negated any positive impact of improved legal protection from GBV in Ireland:

> '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).

In relation to this point, one interviewee who got a barring order against her husband, initially feared she would not be able to use it. This was because the absence of a social support network in Ireland meant that she would have to present it to him alone:

> '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).

Interviewees described how many aspects of their migrant status were exploited by the perpetrator to enforce this isolation. Opportunities to form friendships and maintain existing friendships and family supports were strictly curtailed:

> When I call into my friends…He would make me feel guilty. '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).

One interviewee described how, in an attempt to isolate her, her abusive partner, who was 'white Irish', portrayed Ireland as a highly racist society, where relevant services were only provided to the majority ethnic population.

For Traveller interviewees, social isolation from family and friends was caused by a fear of reprisal on the part of the perpetrator and/or his family, if she sought support from them:

> '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).

> '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).

Social isolation also led to a very low level of awareness of services and entitlements among interviewees. Most interviewees had no information on available services in Ireland, which led to the important role played by acquaintances and even strangers in referring interviewees to GBV organisations.

– Research Finding 4: Domestic Violence, Migrant Status and Income

Perpetrators used many aspects of the victim/survivor's migrant status to maintain their control. Abusive acts included legal documents being destroyed and the security of the victim's/ survivor's legal status falsely being thrown into question.

> '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).

> '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).

One interviewee found herself being coerced by the perpetrator into providing false information to the Refugee Application Authority, against her own wishes:

> 'When we got here, he changed the baby's name. He said, when you go to Justice, 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. [He said] '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).

Others found themselves prohibited from attending further education:

> '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).

Some interviewees who had survived traumatic experiences prior to their arrival in Ireland found themselves in violent relationships with members of the majority ethnic group. In these cases, the emotional wounds from past traumatic events were exploited by the perpetrator to further undermine and weaken the personal strength of the victim/survivor.

> 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).

All of these migration related barriers were compounded for many by language difficulties:

> '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).

Interviewees who experienced domestic violence in Ireland described how lack of adequate income acted as a barrier to leaving 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).

Aspects of immigration policy impact on income opportunities of minority ethnic women. The Spouse Dependent Visa does so by not allowing many of the spouses of migrant workers to enter into paid employment. If a person on this visa leaves their partner, they lose their legal status. One interviewee noted that her husband did not become physically violent until they arrived in Ireland, which she attributed to her dependent legal and financial status:

> 'When he was returning from work [in home country], 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).

The Habitual Residence Condition (HRC) requires all social welfare applicants to have evidence of residence in Ireland for a minimum of two years prior to their application. The same interviewee quoted above described how she left her husband, following an extremely violent physical attack. The HRC curtailed her entitlements to any social welfare payment with the exception of an emergency payment. As a result, she and her daughter could only find accommodation in a direct provision centre for people seeking asylum. She described both the accommodation and food as highly substandard. During the year they stayed there both she and her daughter suffered negative health consequences:

> '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…My daughter fell sick. I start to get, you know, [pain] 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).

Findings from the surveys of GBV and minority ethnic organisations indicate that this story is not unusual. The HRC was identified as a barrier to meeting the needs of women who have experienced GBV by 56 per cent of GBV organisations and 34 per cent of minority ethnic organisations.

– Research Finding 5: Discrimination

Traveller interviewees experienced discrimination against them by wider society and by mainstream services. For some, this presented as a risk factor for domestic violence, as perpetrators felt that victims/survivors would face difficulty in accessing support from external services. Stigma surrounding domestic violence, which leads to the ostracisation of a victim/survivor for reporting abuse in some communities also made it easier for a perpetrator to carry out violence against them.

> '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).

It was also found that discrimination can pose as a barrier to seeking help. Traveller interviewees expressed a lack of trust in services, such as GPs and GBV organisations, fearing that disclosure of GBV would lead to their children being taken in care. This issue was raised specifically by Traveller interviewees:

> '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).

> '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… You'd just feel in your own mind, what are you doing here? You'd be better off to go home' (Brigid).

Among Traveller interviewees, there was also a perception that domestic violence was seen as a part of Traveller culture by the police, which reduced their motivation to enforce barring orders.

> 'Sometimes you don't get much help from them [Gardaí]…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).

> '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).

One positive finding from this research was that none of the non-indigenous minority ethnic interviewees recounted any experiences of racism from the wider public, or discrimination against them in accessing services; on the contrary, those who had accessed services regarding GBV spoke highly of the support they received. For those whose partner was 'white Irish' however, racism was sometimes a feature of verbally abusive attacks:

> '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).

– Research Finding 6: Acute Consequences of Domestic Violence

Physical and mental health consequences described by interviewees were wide-ranging, often serious and on some occasions chronic in nature. They included injuries such as open head wounds, fractured ribs, collapsed lung, teeth being knocked out and knife wounds. Chronic health consequences included hypertension, eyesight and gynaecological problems. Many interviewees were hospitalised due to physical attacks of violence.

Despite the acute nature of physical violence inflicted on them, there was a perception among interviewees that the psychological effects of domestic violence were much worse than physical ones. Interviewees spoke of a very poor sense of self worth, feeling loss of control over their own life, constant sense of fear and anxiety and depressed moods. Out of 22 interviewees who experienced domestic violence, seven had attempted suicide. This reflects international research findings that suggest that the psychological consequences of GBV can be more severe for minority ethnic women.

> '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).

– Research Finding 7: Pre-Migration Experience of GBV

Some interviewees experienced GBV in their country of origin. Among those seeking asylum and those with refugee status, experiences of GBV included domestic violence, conflict-based rape, rape during the migration journey and sexual violence in prison. Some interviewees experienced harmful traditional practices in their country of origin, namely forced marriage and female genital mutilation (FGM). For many, these experiences occurred alongside other traumatic events, such as bereavement, long-term captivity, forced labour, physical and psychological torture, widespread discrimination and separation from their family.

All of these experiences caused significant suffering and distress. Not only did they have negative health consequences, they also led to poor self-esteem and low emotional wellbeing. For those victims/survivors fleeing war, it was often just a matter of days between traumatic experiences and arrival in Ireland. Chance, courage and unexpected sources of help were common threads running through interviewees' narratives of their final escape from captivity. None was given the opportunity to return to their hometown or to say goodbye to their children. The journey of migration offered little opportunity to deal with trauma:

> '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).

The escape process was described as one that moved fast, leading directly to their journey of migration to Ireland, and their request for asylum.

> '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).

Among those who experienced harmful traditional practices, most experienced this alongside other forms of GBV and/or other traumatic experiences. Forced marriages typically took place when the interviewee was aged from 12 to 14 years. This was related to the importance placed on the virginity of the bride. Interviewees perceived a strong economic basis behind their experience of forced marriage. Tradition, duty and unequal power relations were also associated with it. Parents played a principal role. Forced marriages caused significant suffering and distress, leading to a severe reduction in the rights and level of respect afforded to victims/survivors. Others described feelings of helplessness. Forced marriages had long-term negative consequences on the self-esteem and emotional wellbeing of interviewees concerned.

> '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).

> '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).

One interviewee survived female genital mutilation (FGM). As with forced marriage, the interlinking of the notion of honour with a woman's virginity played a key role in its rationale. This interviewee's experience of FGM was entirely negative. She felt anger, a sense of betrayal towards her mother, and battled with 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:

> '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. Feelings of shame and embarrassment, caused by a perceived stigma regarding FGM prevented her from discussing the issue with her husband or from seeking such support.

> '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).

This also prevented her from discussing the issue with friends who have not gone through FGM:

> '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).

Interviewees with pre-migratory experience of GBV identified a range of ongoing needs. Some spoke of the therapeutic value of sharing their experience with others who have gone through similar trauma, such as FGM or forced marriage, in a caring environment like a support group. Other needs regarding FGM included information on care/treatment options and relationship counseling/sex therapy. Key features of service needs include person-centred care, holistic care, flexibility, availability of expertise on forms of GBV, and an inter-agency approach.

Being alone and without occupation were considered the greatest risk factors for emotional distress. Interviewees described how in such circumstances, traumatic memories would return. For these reasons, they emphasised the therapeutic value of keeping busy and social interaction:

> '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).

> '[You] 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).

Those seeking asylum engaged in voluntary work to this end, as they are not entitled to enter paid employment. Some found that its altruistic nature had an added therapeutic benefit.

> '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).

> '[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 ou there need my service. I feel good. Like I've done something to help other people out there who need a service' (Mangeni).

However, opportunities for those seeking asylum to remain busy were curtailed by the limited weekly allowance they received and a lack of information regarding relevant services and support groups. Barriers they faced were transport and childcare costs. Opportunities to seek relevant information were hampered by poor mental health and fear of jeopardising their asylum plea.

> I came to [name of service], 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).

Survey findings indicate that pre-migration experiences of GBV affect a considerable number of minority ethnic women. FGM was disclosed to over one quarter of those mainstream health and social (MHS) services to whom GBV was disclosed. It was also disclosed to 16 (33%) of GBV organisations and 16 per cent of minority ethnic organisations. Conflict-based rape was disclosed to one quarter of GPs, 16 per cent of other MHS service providers, 21 per cent of GBV organisations and 23 per cent of minority ethnic organisations. Forced marriage was disclosed to 48 per cent of GBV organisations and 30 per cent of minority ethnic organisations. Finally, trafficking for the purposes of sexual exploitation was disclosed to a small number of MHS services (n. 13), as well as 21 per cent of GBV organisations and 28 per cent of minority ethnic organisations.

– Research Finding 8: Resilience, Survival and Support that made a Difference

Interviewees showed great resilience in surviving violent relationships. Important factors included religious belief, love of children, and support from friends.

> '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).
>
> '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).

All interviewees for this research who were victims/survivors of domestic violence had left the abusive relationship. Many existing features of service provision proved invaluable to interviewees in enabling them to do so. Regarding GBV organisations, one of the most important aspects of the care was being listened to in a non-judgemental and empathetic way. It was found that this could overcome very strong barriers, such as stigma and shame associated with seeking help:

> '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 Citizen's Information, 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 [home country]. I don't think I would find good, would feel like this if I was in [home country]' (Riya).

The intimidating nature of appearing in court was heightened by language barriers and unfamiliarity with the Irish criminal justice system. In such cases, court accompaniment was invaluable.

> 'The difference when I got in contact with [service], 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).

As noted earlier, many found themselves reliant on the support of casual acquaintances or even complete strangers in being linked into a GBV organisation, highlighting the potential value of outreach work with minority ethnic women regarding GBV.

Non-indigenous interviewees who overcame barriers to seeking support from the Gardaí found that the experience helped them to gain a sense of control, and this was successfully used 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).

The value of being given private accommodation was also raised. One interviewee cited the point at which she and her children were given private housing in a transitional housing programme as a crucial point in her recovery:

> '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).

Other important features included help with practical issues such as childcare and provision of clear information on all options available. Survey findings highlighted a need for general advice and support, characterised as a person-centred, non-judgemental and flexible approach to meeting needs. This was identified by 94 per cent of GBV organisations and 89 per cent of minority ethnic organisations. Other common needs identified by these groups included information on GBV services and counselling services, accommodation options, legal aid, outreach/visiting support and court accompaniment.

Some interviewees who survived pre-migration experiences of GBV shared positive experiences regarding health and counseling services in Ireland. For those who were emotionally traumatised by past events, the reception of these women at frontline services such as the Refugee Application Commission played an very important role in allaying 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).

– Research Finding 9: Training and Resource Needs of Service Providers

The absence of necessary training to respond to the needs of these patients emerged as a barrier to providing services 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 inter-culturally competent care.

Language posed another serious barrier, identified as such by a high percentage of GPs and other MHS services. For GBV organisations, one of the needs frequently identified was availability of professional interpreters, who are trained in the subject of GBV. This need was identified both in relation to provision of their own services, and in linking women to relevant external services.

Among those GPs to whom GBV had been disclosed by a minority ethnic woman, sexual violence by an intimate partner was disclosed to 23 per cent by Traveller patients and 17 per cent by non-indigenous minority ethnic patients. These figures are substantially lower than the percentage to whom physical violence by an intimate partner was disclosed (see research finding 1). A lower disclose rate of sexual violence was also a finding of the survey of minority ethnic organisations. 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 indicate that any barriers regarding disclosure of this form of GBV are not unique to minority ethnic women. This finding highlights the need for training of MHS service providers on enabling and dealing with disclosures of sexual violence.

Both GBV and minority ethnic organisations identified the need for staff training, on inter-culturally competent service provision and on GBV, respectively. Inadequate resources were identified as a barrier to meeting needs by a majority of both sectors. Aspects of immigration policy were also identified as barriers by a high percentage of GBV organisations and minority ethnic organisations. Fifty two per cent of GBV organisations and 36 per cent of minority ethnic organisations identifying the Habitual Residence Condition as a barrier to meeting needs. Eighty one per cent of GBV organisations perceived the addition of a Domestic Violence Concession to the Habitual Residence Condition as a required measure towards meeting needs.

Part: 4 Conclusions and Recommendations

4

The results outlined here 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. Survey findings also showed 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 identified, 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.

The key findings of this research and arising recommendations are considered here in the context of the ecological framework presented in Part I. 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 arise at 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.

- **Policy and legislation**
- **Service planning and delivery**
- **Research**

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 that 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 on 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 recognizes 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 protect its victims/survivors, most notably the 1997 Report of the Task Force on Violence Against Women and the National Women's Strategy. 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 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. Crucially, 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 is required. This strategy should be underpinned by a conceptual framework that identifies GBV as a human rights abuse. Equally, it 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. 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. 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.

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 cause of 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 and Residence 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 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 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, 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 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 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 of 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 this 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 & 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 their literature review of FGM (WHC, 2007). Ongoing developments are occurring in this field, most notably the launch of the Irish National Plan of Action Against FGM 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 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 were 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. Patriarchal norms also lead to stigma and shame associated with leaving a violent partner, and can lead to the risk of being ostracised by the minority community for doing so. 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 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.**

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, 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 and have been shown in this study to be accessed for support 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.

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.**

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 leave a violent relationship. It stands to reason that isolation is an even greater issue for those who do not access such services.

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.**

Such 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 & Protection Bill to allow family reunification for those migrant women who are not asylum seekers, who have experienced 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 limit the opportunity to leave a violent relationship.

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.**

Such 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. 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.

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.**

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 are under-funded. 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 include 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 & Dupont, 2005). In this study, 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 service 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 pover and GBV. This should explore the feasibility of appropriate models for enabling victims survivors to leave a violent relationship.**

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, 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 (WHC, 2007). 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 in accessing health and social services regarding GBV. Almost four fifths of GPs felt that they lacked the necessary training to meeting the needs of those 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.

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.**

R13 **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.

R14 **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.

Criminal Justice System

The Gardaí play an important role in protecting all victims/survivors of GBV from violent attacks by the perpetrator. Migrant participants 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 experiences illuminated the potentially negative impact of unfamiliarity with the Irish court system, which for her was compounded by a language barrier.

R15 **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 interculturally competent training programmes 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 Gardai performance appraisals.

The important work of the Ethnic Liaison Unit of the Gardaí should be continued. Emphasis should be placed on establishing trustful relations with 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.

Level 2: The Family

Level two 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, 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 really 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, 5, 6 and 12.

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.**

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. Two qualitative interviewees for this study raised the issue of crisis pregnancy. 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.**

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The **Women's** Health Council
Comhairle Shláinte na mBan

Women's Health Council
Block D, Irish Life Centre, Abbey Street Lwr, Dublin 1

Telephone: 353 1 878 3777
Fax: 353 1 878 3710
Email: info@whc.ie

www.whc.ie