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# Preventing and addressing intimate partner violence against migrant and ethnic minority women: the role of the health sector

POLICY BRIEF

# Preventing and addressing intimate partner violence against migrant and ethnic minority women: the role of the health sector

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**ABSTRACT**
Violence against women is an extreme manifestation of gender inequality in society and a serious violation of fundamental human rights. Intimate partner violence (IPV) is the most common type of such violence and takes place within couples. IPV can lead to death, physical injury, functional impairment, mental health problems, negative health behaviour, chronic conditions and reproductive health problems. Institutional discrimination, lack of access to or knowledge of services, and cultural differences can prevent women who are not only experiencing IPV but also migrants or members of ethnic minorities from seeking help. This policy brief aims to provide input into the role of the health sector in preventing and addressing IPV among migrant women and those of ethnic minorities. It describes the scope of the problem, presenting key evidence, and makes recommendations for health policy and health systems, health facilities and health service providers.

**KEYWORDS**
BATTERED WOMEN, DOMESTIC VIOLENCE, ETHNIC GROUPS, HEALTH POLICY, MIGRANTS

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**Background**
This brief was produced by the WHO Collaborating Centre on Social Inclusion and Health (Interuniversity Institute of Social Development and Peace, University of Alicante, Spain), in cooperation with the WHO Regional Office for Europe, which was responsible for the design and preparation of this policy brief.

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# Aim of this policy brief

This policy brief aims to provide input into the role of the health sector in **preventing and addressing intimate partner violence among migrant women and those of ethnic minorities**. It intends to do so by describing the scope of the problem, presenting key evidence, and making recommendations to health sector stakeholders in response to the WHO clinical and policy guidelines relating to violence against women (WHO 2013b). The European policy framework and strategy of the WHO Regional Office for Europe, Health 2020, recommends actions for improving health for all and reducing social inequalities by developing universal policies, targeting interventions to focus on those most affected, and addressing the social gradient in health. The strategy promotes a rights-based approach and gender mainstreaming in fulfilment of the principles of non-discrimination, equality and participation (WHO Regional Office for Europe 2013). This publication aims to highlight intimate partner violence among migrant and ethnic minority women as a public health priority and does not specifically focus on other forms of gender-based violence. However, many of the recommendations included here could also benefit all women experiencing gender-based violence, regardless of ethnicity and migrant status.

# Introduction

Violence against women is an extreme manifestation of gender inequality in society and a serious violation of fundamental human rights. The United Nations Declaration on the Elimination of Violence against Women defines it as any act of gender-based violence (GBV) that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of acts such as coercion or arbitrary deprivation of liberty, whether occurring in public or private life (United Nations 1993). Intimate partner violence (IPV) against women is the most common type of violence against women. It takes place within couples, and the perpetrators are almost exclusively men who are or have been in an intimate relationship with the woman (WHO 2013a).

IPV against women occurs in all countries, all cultures and at every level of society (Garcia-Moreno et al. 2006). It varies by region. In 2010, lifetime IPV was at 16.30% in East Asia while it was 65.64% in sub-Saharan Central Africa (WHO 2013b). In the countries comprising the 27 Member States of the European Union (EU),[1] it affects between 20% and 25% of adult women who have ever had an intimate partner (European Institute for Gender Equality 2012).

While limited evidence is currently available, it is possible that some populations of women may be at greater risk, such as migrant and ethnic minority women. The stresses of culturization and changes in family or gender roles that often accompany migration or belonging to an ethnic minority group can trigger or intensify IPV (Jampaklay et al. 2009). For both migrant and ethnic minority women, institutional discrimination, lack of access to or knowledge of services, and cultural differences can prevent women experiencing IPV from seeking help (PACE 2009).

In addition to the risk of death, IPV is related to physical and psychological injury, functional impairment, and negative health behaviours (such as smoking, and drug and alcohol abuse), chronic conditions, reproductive health problems, and mental health problems (WHO 2013b). Consequently, women affected by IPV may visit the doctor more frequently, if they are not prevented from doing so by their partners, and require more frequent use of health services, such as primary and specialist care, mental health care and inpatient services (hospitalization) (WHO 2013a). Health professionals are directly involved in treating the health effects of IPV. The health sector is thus in a key position, not only to detect and report IPV cases, but also to help coordinate and implement the tools to address and prevent such violence. Interventions to prevent IPV and respond to the needs of women affected by it will ideally involve a range of stakeholders, from legal services to social and health care institutions, along with civil society.

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[1] All 27 EU Member States prior to January 2013.

# A global epidemic unequally distributed among groups of women

Although IPV occurs across all social groups, migrant and ethnic minority women are in a more vulnerable situation that demands special attention from the health system. In Spain, a cross-sectional study of 10 202 women attending primary care centres showed an IPV prevalence of 27.9% in migrants, compared to 14.3% in Spanish women (Vives-Cases et. al. 2009). Prevalence rates may differ by country and by the characteristics of migrant status, such as country of origin, administrative status and length of stay in the host country (Hyman et al. 2006; Gupta et al. 2010; Anitha 2011). Lack of social or family support, frequent difficulties dealing with administrative procedures, language and cultural barriers faced by women in their interactions with health systems all help to explain the special vulnerabilities of migrant women who suffer from IPV (Raj & Silverman 2003).

Female members of ethnic minorities such as Roma are often invisible, in terms of their contact with the health system, which presents challenges with respect to efforts to measure and address the problem. IPV data relating to Roma women are lacking. At least 43% of Roma women have suffered from physical violence and 36% from psychological violence at the hands of their partners, according to one of the few studies about IPV among Roma women carried out in Bosnia and Herzegovina by nongovernmental organizations (NGOs) in 2011 (Prava za sve 2011). In a study in Turkey, it was estimated that the likelihood of Roma women suffering from IPV is three times greater than that of the native Turkish female population (Tokuç, Ekuklu & Avcioglu 2010). Further research is needed to fill this information gap.

# Barriers to access to health services for migrant and ethnic minority women experiencing IPV

Accessibility refers to the ease with which women can make use of health services in general and, in this context, in seeking help for IPV in particular (WHO Regional Office for Europe 2010). For migrant and Roma women, gender and ethnicity may be barriers to access to services (Kocze & Popa 2009). Health services also display gender regimes[2] that might inadvertently contribute to the discrimination of women, especially those belonging to certain groups (Sen & Östlin 2007). In countries without universal access to health care, lack of health insurance and difficulties in paying for health services – along with legal restrictions applied to asylum seekers or undocumented migrants – are frequent barriers to receiving health services related to IPV (Lawson, Laughon & Gonzalez-Guarda 2012). Access to care is not always dependent on administrative or citizenship concerns alone; in some IPV cases, abusers retain control of all of the family finances and health insurance details (Wilson et al. 2007), resulting in restricted access.

In addition to accessibility, underuse of health services on the part of migrant and ethnic minority women experiencing IPV is related to lack of knowledge about women's support programmes for those experiencing IPV and how to use them. This is a common problem among migrant women that have recently arrived in the host country and those who are not fluent in the language (WHO & London School of Hygiene & Tropical Medicine 2010b). Linguistic and cultural differences also contribute to misunderstanding between women and health care professionals and may generate confidentiality problems if women must communicate with health providers through a relative or a friend. This can prevent women from using health services as a first means of support in cases of IPV (Guruge & Humphreys 2009). For undocumented migrants, social stigmatization and fear of deportation can also serve as barriers to accessing health services (Larchanché 2012).

The health sector faces special difficulties in serving Roma women suffering from IPV. In the 2011 study by Prava za sve, nearly 70% of the women that survived IPV failed to report to health care institutions the injuries they suffered (Prava za sve 2011). Roma communities also face barriers related to reduced access to information (especially for those in isolated locations), lack of trust in professional health services, difficulty discussing health problems with strangers (especially if they are men), and difficulties with language, resulting in cultural barriers to understanding some medical concepts (Corsi et al. 2008). According to the European Union Minorities and Discrimination Survey (EU-MIDIS) (FRA 2009), between 11% and 23% of the Roma respondents in the surveyed countries (Bulgaria, Czech Republic, Greece, Hungary, Poland, Romania and Slovakia) indicated that they had experienced discrimination in an encounter with a health care professional in the previous 12 months. Fear of losing children in cases of separation and/or divorce, and feelings of shame are the most important factors that prevent Roma women from seeking help (both informally, such as seeking help through relatives or community leaders, and formally, through health or social care services) (Ceneda 2002).

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[2] Gender regimes refers to the configuration of gender relations within a particular setting, such as a school, a family or a neighbourhood (Sen & Östlin 2007).

# Recommendations for improving the response of the health sector to IPV among migrant and ethnic minority women

Health professionals and services are an important resource for helping **all** women experiencing IPV, and potentially even more so for migrant and ethnic minority women. Even in countries without universal health care, for some women, contact with the health system may be the only contact they have with public services over the course of their lives. Health professionals and service providers are in a key position to take action towards dealing with the short- and long-term health consequences of IPV.

According to the WHO clinical and policy guidelines relating to violence against women (WHO 2013b) and other sources on addressing health inequities linked to migration and ethnicity, effective development of this response requires a multi-level approach to the problem, as discussed in the following subsections (United Nations OHCHR 2012, WHO 2009, 2010, WHO Regional Office for Europe 2010, WHO & London School of Hygiene & Tropical Medicine 2010).

### At the health policy and health system levels

Inadequate entitlement to health services can make accessing health care difficult for migrant and ethnic minority women experiencing IPV. To protect and empower women, it is first necessary to ensure the right to health of these groups. Women must have the legal right to health services and they must be informed about and able to access them. Once formal access is secured, outreach and education are essential so that these women know their rights and know how and where to access care. It is also important to ensure that health and gender perspectives are included in all policies that affect migrant and ethnic minority women (for example, housing, immigration, labour, education, and so on). It is well documented that migrant and ethnic minority women (and Roma women in particular) may face discrimination in the health system. Policies must be put into place to protect these women from discriminatory practices both at institutional and provider levels.

The policy environment should enable the health rights of migrant and ethnic minority women, as well as their right not to suffer violence at the hands of their partners. An enabling policy environment includes an array of supportive policies, engaging stakeholders, and the appropriate allocation of resources to ensure that policies are implemented and programmes are funded. Policies must translate into effective programmes for training, education and research through a participatory process that involves all relevant stakeholders. Policies should also serve to reduce financial barriers for women by limiting out-of-pocket costs and co-payments, to promote universal coverage. Migrant and ethnic minority status should be mainstreamed into existing health programmes that deal with IPV.

#### *Promote social participation in the design of health policy*

Social participation must be promoted to ensure an integrated response to IPV and to empower migrant and minority communities. This participation is defined as the active involvement of individuals, communities or community-based organizations in the design, implementation, management or evaluation of community health services or systems. Educating or informing individuals or groups or consulting them to gain support for actions already decided by governments or organizations could not be considered social participation, in this context (Ferguson & Halliday 2013). Social participation includes promoting networks between the health sector and civil society (migrant, women's and Roma organizations, among others) and developing channels to foster the involvement of migrant and ethnic minority communities – and particularly women – into the design, implementation and evaluation of health services. Examples of IPV policies involving social participation include the Strategy for Protection from Domestic and Other Forms of Gender-based Violence in the Autonomous Province of Vojvodina for the Period 2008–2012. This strategy, developed under the legislative framework of the National Strategy for the Prevention and Elimination of Violence against Women in the Family and in Intimate Partner Relationships was designed by a working group made up of experts from civil society organizations, networks of organizations and institutions engaged in protecting women affected by sexual violence and other forms of GBV (Official Gazette of the Republic of Serbia 2011). Empowering participants through social participatory processes is an effective mechanism for project success (Ilika & Ilika 2005).

### *Strengthen coordination between the health system and other sectors*

The health sector can benefit from the experience of other services responsible for preventing and attending to IPV in migrants and ethnic minorities (such as social services, the police, and the judicial system). Alternatives to violence require intervention and support by non-medical agencies, at the community level in particular. In order to strengthen cooperation between the health system and other sectors, mechanisms should be put in place to enable this coordination and make it binding, thus promoting ownership. An example of this is joint intersectoral coordination and policy at the country level.

Social services can often serve as a point of entry into a community. Since 2003 in the Mures district of Romania, local NGOs have run a crisis centre that coordinates with local police and emergency medical units to support women and hold perpetrators accountable. The district began using an integrated information system for reporting, screening and referring cases of IPV. Building on the partnership, NGO workers, health providers and police began a dialogue about how to encourage women to file complaints (UNFPA 2005). Coordination with police must guarantee confidentiality and safety, as well as continued access to services. It also must not affect women's legal status, for example in the case of migrants in irregular situations.[3] This coordination effort may also include other sectors (such as urban planning, housing or employment agencies, among others). Coordination networks can also offer health providers information on specific agencies to which they can refer aggressors who ask for support (WHO 2009).

### *Develop a multisectoral approach*

A multisectoral approach aims to address the social determinants of GBV and IPV among migrants and ethnic minorities. This approach is based on the principle of equity and

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[3] Irregular migration refers to "someone who, owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorized to remain in the host country (also called clandestine/ illegal/undocumented migrant or migrant in an irregular situation)" (IOM 2004).

health in all policies, and it includes the health protection of migrant and ethnic minority women by addressing socioeconomic, cultural and environmental conditions. It also implies the integration of services to combat IPV among migrant and ethnic minority women at all levels of health policy: legislation, health plans, and other structures that facilitate implementation within health systems, such as protocols for a health care response to IPV, intersectoral committees and/or primary health care portfolios.

#### *Promote evidence-based policy-making*

Evidence on IPV among migrants and ethnic minorities is limited; more research at population level is needed. In particular in the case of Roma women, there is a lack of studies in areas such as GBV (all forms) and sexual violence, sexual exploitation and trafficking of women. Such research can be promoted through improvements in health system data-collection procedures. Monitoring and evaluation data should be disaggregated by ethnic group and migrant status. Measures to ensure confidentiality, safety and to avoid further stigmatization should be implemented within such systems. Health systems should also encourage partnerships between health workers and researchers, with a view to strengthening and consolidating the expertise of both researchers and health workers by improving cooperation between disciplines and professions and producing an appropriate evidence base for policy-makers in relation to IPV.

#### *Identify objectives and indicators for monitoring and evaluation*

The health system must define process, outcome and impact indicators related to IPV among migrant and ethnic minority women. These indicators should be agreed upon across different sectors within the health system and relevant to all stakeholders. They should be developed with the full participation of civil society groups, such as Roma and migrant associations that work with women and will serve to evaluate the relative success of IPV programmes accordingly.

### At the health facility level

Health facilities are more effective in providing services when they know the population they are serving. The first recommendation of the 2013 WHO clinical and policy guidelines relating to IPV is to ensure women-centred care, highlighting the importance of health care services adapted to women's circumstances (WHO 2013b). The guidelines state that health facilities should document effectively the concerns of women exposed to IPV, validate their experiences, offer short-term psychosocial support at first contact, be able to offer medical treatment, support special safety planning measures, recommend crisis and support services, and ensure appropriate follow-up.

#### *Address and prevent institutional discrimination*

Institutional discrimination occurs when a group is disadvantaged by the practices, procedures, and unwritten rules of an organization. Health systems have institutional gender regimes that might make access to some services more difficult for certain groups of women (Sen & Östlin 2007). When gender intersects with ethnicity, some women might face further discrimination. Options for reducing institutional discrimination include integrating health services for migrants and ethnic minorities as completely as possible into mainstream care and taking their needs into account in the practices and procedures of the organization.

### *Identify and address access barriers*

In order to ensure that health services are accessible to and acceptable for migrant and ethnic minority women, the barriers that hinder equal access to those services for all groups of women must be identified and tackled. Research that helps to identify such barriers in specific settings should be implemented, along with monitoring systems to evaluate progress.

### *Address language and cultural barriers to health services*

Language and culture present key barriers to access to health care for migrant and ethnic minority women. Language and cultural barriers can often be addressed by providing translation or interpreting services, or by incorporating cultural mediators, health interpreters or community outreach workers into the health workforce, including individuals from the same migrant or ethnic minority background. Specific training on culturally sensitive communication can be of great use to health professionals and should be provided to complement other training and education. In any health setting, women at risk should be able to find information in their first language about local or national services. If general information is routinely given to patients, this could also be an opportunity to include information on domestic violence services (EACH 2009).

### *Address administrative and practical barriers*

Administrative barriers can include challenges relating to documentation, and practical barriers include access to transport, or getting time out from work and home life to attend to health or IPV concerns. The health facility should identify these types of barriers and develop plans to reduce them. Such plans should be relevant to the needs of migrant and ethnic minority women that may be experiencing IPV.

### *Identify relevant programme adaptations that respond to the health needs of migrant and ethnic minority women facing IPV*

Attending to the specific health needs of migrant and ethnic minority women experiencing IPV should take place in any health care setting. However, sometimes effective service provision does not mean simply being granted access to the same services as others. Service delivery can be adapted to the cultural and social differences among the population, as well as differences in living and working situations. For example, a health programme or service could be provided in a community or other setting that is familiar to women seeking services.

### *Develop systems for organizational learning relating to IPV among migrant and ethnic minority women*

It is necessary to establish systems for generating and disseminating knowledge about migrant and ethnic minority health within the health facility and among stakeholders. This must be based on adequate basic information about these groups and their social characteristics. Organizational learning also takes place when an effective system is in place at the health facility, whereby health care, administrative and management personnel can share experiences relating to IPV services and programmes; this could be operationalized through courses, seminars, exchange visits.

### *Explore opportunities for prevention activities within primary care*

Prevention activities constitute a key element of the primary health care approach. In terms of IPV, this means promoting gender-equal and non-violent intimate relationships. It is possible to integrate messages about IPV into routine health-promotion activities, such as antenatal care groups or positive parenting groups. Health services can also coordinate with other institutions and organizations working with migrant and Roma populations in order to implement IPV prevention activities within primary care at several levels. Exploring strategies to implement such prevention activities with adolescents and young people of both genders is very important for preventing IPV in the future.

## At the health provider level

It is essential to ensure that providers are aware of IPV among migrant and ethnic minority women and are properly trained and able to: listen to women in a non-judgemental way; conduct appropriate clinical inquiry; support and validate disclosure; assess the woman's and her children's risks, intentions and expectations; and document and keep record of what a woman says.

### *Engage in training to better understand the IPV vulnerability of migrant and ethnic minority women*

Health care providers must be equipped with knowledge, tools and skills to identify and understand the vulnerable nature of women experiencing IPV. Health providers should also be trained in how to manage social and cultural issues that may arise as part of the medical encounter. The curricula may be focused on identifying and negotiating different styles of communication, decision-making preferences, family roles, sexual and gender issues, and issues of mistrust, prejudice and racism, among others. Health care workers dealing with IPV cases among migrant and ethnic minority women could benefit from instruction on the provision of services in non-traditional settings, such as women's associations or community centres, and from knowledge of innovative health care delivery programmes.

### *Know the legal implications of health service work with regard to IPV*

In the context of IPV the health provider must know the legal implications of their work, such as the fact that medical reports could be used in legal proceedings or the ways in which the possibility of male deportation may affect women's decisions. This is especially important for irregular migrants.

### *Become familiar with research literature on health provider bias and discrimination in medical decision-making with respect to migrant and ethnic minority women*

Documentation exists on health provider bias and discrimination in medical decision-making with respect to migrant and ethnic minority women. It can be especially useful to raise awareness through sharing experiences about unintentional behaviour. This could also be applied to the critical appraisal of monitoring and evaluation reports.

### *Create and participate in networks of health care professionals to address IPV among migrant and ethnic minority women within medical encounters*

Networks of health professionals can be organized at the health facility or health system levels, in cooperation with professional bodies (for example, medical associations, community nurses, social services and outreach workers, migrant associations, and so on) and educational centres (such as universities). A case in point is the Collaborative for Abuse Prevention in Racial and Ethnic Minority Communities (CARE) project – a network model for organizations serving victims and perpetrators of violence against women. The network brought together existing organizations and agencies for cultural competence training, development of referral protocols and implementation of joint outreach activities (Whitaker & Baker 2007).

### *Share best practices and engage in programme coordination with organizations that work directly with migrant and ethnic minority women experiencing IPV*

It is essential to engage with community groups, consulates, NGOs, and so on. Organizations that work directly with migrant and ethnic minority women experiencing IPV should gain knowledge of available health services and support provided by health care workers, so that they can pass information on to women, encouraging them to seek services. The sharing of effective practices and programmes and of experiences helping women can promote appropriate institutional response in other sectors that serve migrant and ethnic minority communities (employment market, judicial system, and so on).

The case studies that follow to conclude this policy brief provide examples of various practices being employed by organizations attending to the health needs of migrant and ethnic minority women experiencing IPV. These cases are contemporary examples that put into practice one or more of the above-mentioned recommendations at the health system, health facility and/or health provider levels.

# Conclusion

Preventing IPV is a challenge and a public health priority. Multiple sectors must be involved in order to address the issue appropriately. This policy brief highlights the potential role of health systems, services and professionals in responding to women affected by IPV, specifically migrants or those belonging to an ethnic minority group, such as Roma women. The evidence-based recommendations included in this brief can be of help to the health sector in fully realizing its capacity to respond effectively to the needs of migrant and ethnic minority women experiencing IPV.

# Case studies of health sector responses to IPV among migrant and ethnic minority women

### Case study 1. The Riu Violeta project, Spain, 2010[4]

#### *Description*

RIU VIOLETA is a community-based intervention that aims to promote gender equality and prevent GBV in vulnerable population groups, such as those belonging to Roma and migrant communities. The intervention was supported by the Health Council of the Valencia autonomous community government and the Spanish Ministry of Health, Social Policy and Equality.

#### *General aim*

The intervention provides training to health personnel on improving access to and use of health services for vulnerable population groups.

#### *Activities*

The intervention:

1. identifies neighbourhoods, creating a social and institutional support network (health, education, social and political institutions, and neighbourhood and civil society groups) and identifying key project contacts;
2. trains a community group to serve as health agents, to provide health promotion among women and draw attention to situations of violence they experience;
3. completes the intervention cycle by means of participatory action, through a series of steps: the community group comprises health professionals and community workers; they receive training on GBV; a so-called diagnosis of the neighbourhood is conducted, in terms of the degree of awareness of violence and the resources available to tackle it; an action plan is introduced with the help of the support network; and results are evaluated with suggestions for future improvements;
4. carries out an evaluation and follow-up of the process and results.

#### *Recommendations addressed by this case study*

1. Promote social participation in the design of health policy.
2. Strengthen coordination between the health system and other sectors.
12. Explore opportunities for prevention activities within primary care.
16. Create and participate in networks of health care professionals to address IPV among migrant and ethnic minority women within medical encounters.

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[4] Soler & Marín (2013).

## Case study 2. Asian women, domestic violence and mental health: a toolkit for health professionals, United Kingdom, 2009[5]

### *Description*

The toolkit is an initiative of the Department of Health, Government Office for London, Department of Health Victims of Violence and Abuse Prevention Programme (VVAPP) and Enabling Change, Rebuilding Lives (EACH). It is a resource to assist health practitioners in recognizing the links between Asian women with mental health issues and their experiences of domestic violence, thus making them able to respond more appropriately.

The toolkit is designed to be used by primary care health professionals and mental health personnel. It provides background information on Asian women's experiences of domestic violence and its impact on their health, and provides tools for health professionals to respond to these issues within their professional practice.

### *General aim*

The toolkit was developed to disseminate culturally appropriate best practices and to enable better care of Asian women with physical and mental health consequences of living with domestic violence and abuse.

### *Activities*

1. A total of 206 health professionals (general practitioners and practice nurses), social workers and professionals working within the mental health sector received training. Focus groups with service users were established in order to obtain feedback.
2. Good practice guidelines for health professionals were formulated, in order to make referrals to appropriate services and provide resources, to provide first language services where possible (posters are available in Arabic, Bengali, Chinese, Gujerati, Punjabi, Somali and Urdu), and to provide a safe environment in which Asian women feel they can disclose information and receive support.

### *Recommendations addressed by this case study*

2. Strengthen coordination between the health system and other sectors (namely, social services, NGOs and civil society organizations).
10. Identify relevant programme adaptations that respond to the health needs of migrant and ethnic minority women facing IPV.
11. Develop systems for organizational learning relating to IPV among migrant and ethnic minority women.
15. Become familiar with research literature on health provider bias and discrimination in medical decision-making with respect to migrant and ethnic minority women.

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[5] EACH (2009).

## Case study 3. Professional training courses on violence against women and girls, France, 2010–2011[6]

### *Description*

Professional training courses on violence against women and girls are offered by Migrations santé, a French NGO. The courses began in 2010 and are offered to medical, education and social services professionals.

### *General aim*

The objectives of the training initiative were to: identify and highlight different types of violence; share knowledge about situations in general involving violence and within the migrant population in particular; share knowledge about laws on violence; and provide support and networking opportunities. The training aims to help professionals to become aware of the situations of women and young immigrants who are particularly affected by violence and its impact on their life course and health.

### *Activities*

1. Methods were developed to identify research, knowledge and experience exchanges, analyses and comparisons of professional practices; with presentations from representatives of various associations, as well as psychologists and sociologists.
2. A total of four days of training each year are provided to professionals in order to familiarize them with various topics, including: the status of girls/women in different cultures; their beliefs, religion and education; the relationship with the family culture and country of origin; intra-family violence perpetrated against girls; access to legal support and relevant institutions; identification of risks; mediation and prevention activities; housing, social and health care; how victims of violence are or should be treated throughout their interaction with health services and how health professionals should work together as a team to provide those services.

### *Recommendations addressed by this case study*

13. Engage in training to better understand the IPV vulnerability of migrant and ethnic minority women.
14. Know the legal implications of health service work with regard to IPV.
15. Become familiar with research literature on health provider bias and discrimination in medical decision-making with respect to migrant and ethnic minority women.

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[6] The contents of the courses held in 2013 are available at the Migrations santé website (Migrations santé 2013).

## Case study 4. Roma women for life without violence: educational community meetings with Roma women's organizations in Bosnia and Herzegovina, 2010[7]

### *Description*

In February 2010 a community meetings programme was established in Roma communities in Bosnia and Herzegovina, namely in Sarajevo, Visoko, Kakanj, Banja Luka, Ključ, Prnjavor, Srebrenica, Tuzla and Zenica. As part of the project, Roma leaders and Roma women's organizations carry out educational community meetings on women's rights, with the support of project partners. During the nine months that the programme ran, Roma leaders and organizations held 90 meetings within the communities, with 1350 participants. These were mostly women, although a number of men also participated in the meetings. This community education was designed to respond to the results of an analysis of the factors that prevent female victims of violence from seeking assistance.

### *General aim*

The programme was intended to raise awareness and prevent violence by working with and educating communities.

### *Activities*

1. The programme initiated conversations in communities about domestic violence and the rights of women in the context of the Law on protection from domestic violence.
2. Representatives of the police and social welfare centres were invited to talk about their roles in protection against domestic violence. There was a forum for women to ask questions about the policies and procedures of institutions and to share their experiences in interacting with these institutions.
3. Women learned about how NGOs help domestic violence victims, particularly in relation to safe houses, free legal aid centres and psychological assistance counselling centres.
4. Roma leaders provided information to victims and conducted individual interviews with women who directly sought assistance. Since the programme's inception, 180 women have received information and assistance in individual domestic violence cases.

### *Recommendations addressed by this case study*

2. Strengthen coordination between the health system and other sectors.
3. Develop a multisectoral approach.
13. Engage in training to better understand the IPV vulnerability of migrant and ethnic minority women.

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[7] Prava za sve (2011).

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