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Introduction

Definition of Sexual and Gender Based Violence - SGBV:

In line with the Research Protocol for the implementation of the National Reports (2.1), the WeToo Project relays on the definition of SGBV proposed by the United Nations High Commissioner for Refugees (UNHCR) which considers Sexual and gender-based violence as any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It includes physical, emotional, or psychological and sexual violence, and denial of resources or access to services. Violence includes threats of violence and coercion. SGBV inflicts harm on women, girls, men, and boys and is a severe violation of several human rights.[1]

In this report, the definition proposed by UNHCR will be taken as a reference.

Definition of SGBV Survivors and Victims:

Both words – *victim* and *survivor* – have their place in the research context and can have different meaning. In this report, victim is used mostly to express the concept that an individual has suffered from an act of violence. Also, it is a legal term used referring to the criminal justice system and legal prosecution in SGBV cases: to classify an individual as having suffered from SGBV and thus claiming the right to justice, protection, support and compensation in courts and legal procedures.

The term survivors is promoted by feminist movements and it is used to empower women to perceive themselves as agents of change, not as mere object of a process. Moreover, at social level, this term can also have an impact by promoting behavioural changes: for instance the way, women who have suffered from intimate partner violence are seen at social and community level. While survivor is already common in English-speaking countries, this may

[1] UNHCR , Sexual and gender based violence (SGBV) prevention and response, https://emergency.unhcr.org/entry/60283/sexual-and-gender-based-violence-sgbv-prevention-and-response#:~:text=Sexual%20and%20gender%2Dbased%20violence,resources%20or%20access%20to%20services.

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not be the case in other languages. In a day-to-day work, the choice of which term fits best will depend on the specialist, their role and on the victim/survivor willing and expression.
The combined term “victim/survivor” is used in this Report to promote an ongoing reflection about the use of language.

Aims of the Transnational report

The WeToo project was developed thanks to the experiences of partner organizations working in direct contact with women and minors who survived forms of gender-based violence (considering the special needs of migrants and refugees in the countries involved in the action). In implementing victim support and support programs, it emerged that front line staff (both staff from the WeToo Consortium organizations, but also front-line workers from other public and private services) are influenced by different level of care work related stress. This type of fatigue, called "compassion fatigue", can be exacerbated by the working conditions in which front line workers operate high bureaucratic demand and stringent rules (see in the legal, health and social sectors), low level of funds for services which turns in few resources for the well-being of workers and high staff turnover. In addition, in several EU countries, volunteer front line workers contribute to services offered by NGOs and private services. Often these volunteer front line workers have lower (or none) professional competences and no access to continuing training and acquisition of qualifications as compared to fully employed professional contractual front-line workers.
These elements affect the quality of public and private services aimed at supporting women victims of violence. High level of stress experienced by front line workers can have an impact on the relationship of help they have with survivors and, moreover, can make networking among different services more difficult.
To better understand this phenomenon, WeToo partner organizations carried out a field and desk research from April 2021 to August 2021 to analyse how the mental health of frontline workers was considered at legal, institutional, and organizational level in each partner country.

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The topic of mental health support and protection concerns in a different and very significant way also victims of gender-based violence, to understand how trauma and psychological distress caused by SGBV affect the health and the level of social inclusion of women and minors' victims of gender-based violence (both local people and migrants). Violence perpetrated by men and/or other persons on women and girls on the base of their gender identity causes serious damages to the mental and physical health of women as reported by WHO and other international sources. These damages are partially taken into consideration by social/legal/health service providers that deal with the protection of victims due to a difficulty in identifying and treating traumas and related symptoms (as emerged from the field research). This report intends to compare the data collected from the research experiences of WeToo partners in order to summarize the findings of five National reports developed (D.2.1, 2.2, 2.3, 2.4, 2.5).

The comparative methodology applied is based on the fact that every social phenomenon (and related legal, health and social systems) is organized in different forms and structures in the five WeToo partner countries. The aim of the comparative analysis was to explain in a systematic way - following the standards of qualitative observations, measurement, and inference - the variants of social phenomena developed in different countries, analysing the specific, contextual and common gaps, opportunities and practices of these social systems. Social systems are analysed considering how front-line workers and victims of gender-based violence are protected and supported in relation to their mental health well-being.

This report also includes recommendations for developing two assessment tools to monitor the mental distress of front-line operators and SGBV survivors. Training activities for professionals will be organized in the next phase of the action to upgrade protection services and front-line workers skills on stress management and improving their relation of trust with SGBV survivors (among local and migrant population).

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1. Legal Framework on Gender Based violence and protection of Mental Health at European level

All Countries' Partners of the WeToo Project have ratified the **UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)** as the most relevant legislative instrument for the prevention of and the response against sexual and gender-based violence (SGBV from now on). CEDAW itself does not explicitly mention the need to protect the mental health of women, but its General Recommendation n.35 emphasises the importance of supporting women victims and witnesses before, during, and after the legal proceeding.

Another important source for further development of the normative framework in the area of prevention of SGBV as well as the Mental Health and the psychosocial sphere of women victims is the Council of Europe Convention on preventing and combating violence against women and domestic violence, also known as **Istanbul Convention**. All Partners' Countries ratified the Convention except the Bulgarian Parliament: although the Convention was signed by ***Bulgaria*** in 2016 and despite its intent to ratify the Convention by the end of its EU Presidency on the 30th of June 2018, the 27th of June 2018 the Bulgaria Parliament considered the documents incompatible with the Bulgarian Constitution. This led to a misalignment of laws and national policy framework on SGBV prevention and response in the country compared to other EU countries. National CSOs working on this issue are facing several impediments to protects SGBV survivors among national and migrant population.

Historically, the first international sources that included the right to health among human rights were the **Universal Declaration of Human Rights and the Constitution** of the WHO (World Health Organization), both stipulated in 1948. The latter is particularly relevant as it gives a more precise definition of what is meant by the concept of health. Health, according to the WHO, is an overall state of physical, mental, and social well-being and not the mere absence of disease or infirmity. In this sense it also refers to mental health.

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Many subsequent conventions contain an article or a clause relating to the right to health, such as the **European Social Charter**, in article 11[2], and **the International Convention on Economic, Social and Cultural Rights (ICESCR)**, in article 12.[3] For many years, however, mental health was neglected, and little considered.

Being a socio-cultural right, the right to health is considered a progressive right, therefore not of immediate realization. The realization of this right therefore requires a longer action plan. The State does not have the obligation to immediately implement the law in its most complete form but reaches its completeness precisely in a progressive way. This means that states do not have any kind of obligation towards individuals. In the same way, however, the State cannot discriminate against individuals or guarantee access to the right to health only for certain categories. This is also found when analysing the national policy frameworks.

In 2006, the international community provided a more comprehensive picture on the right to mental health, with the **Convention on the Rights of Persons with Disabilities** (CRPD). The CRPD is the first legally binding instrument that establishes international standards and imposes precise obligations on States for the protection of persons with disabilities, defining them as a vulnerable group[4]. The Declaration is important because for the first-time mental health is included in the various specificities belonging to a vulnerable group in a document that is legally binding.

With the Mental Health Action Plan 2013-2020, adopted by the WHO, it is clarified that the right to mental health aims to facilitate the participation of the individual in their own health

[2] European Council, (1999), The European Social Charter, article 11. https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168048b059

[3] International Covenant on Economic, Social and Cultural Rights (1976), article 12.1. https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

[4] UN, (2006), Convention on the Rights of Persons with Disabilities, https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

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and thus allow them to exercise their autonomy and in a certain sense, one is right to self-determination[5].

1.2 The National legal framework: a comparison of the national policies

All the normative and laws related to the prevention of GBV and the protection of mental health from each country partner have been collected by partner organizations in order to comprehend how the protection system (intersecting mental health protection measures with SGBV protection measures) is intended and subsequently implemented by public authorities in the context of the intervention. The presence, the lack, the inadequacy or update of laws and policies make possible to understand the relevance of the issues for Public Authorities. In some cases, even if laws are present the fact that are quite recent make their application still difficult and delayed since a cultural change at social level has first to occur.

1.2.1 SGBV protection and mental health in Bulgaria

In Bulgarian law the term “gender” does not exist, furthermore, there is no equivalent in the Bulgarian language and for many years the used term was “sex”.

As aforementioned, the Bulgarian Parliament withdrew from the Istanbul Convention, before ratifying it, in June 2018, because it was considered unconstitutional. There is no formal definition of gender-based violence under the Bulgarian Law; there are only definitions for domestic violence. Defining only domestic violence implies leaving other forms of violence (such as bullying, transphobia, homophobia and all those forms of violence on a racial and religious basis) undefined and not considered. Not codifying certain crimes implies more difficulties in effectively protecting and supporting victims at legal level and more difficult for CSOs to advocate for their rights.

[5] Cardamone, G., & Facchi, E., (2016).Prospettive teoriche e operative della psichiatria italiana negli scenari geopolitici contemporanei. *Nuova Rassegna di Studi Psichiatrici, 13*... http://www.nuovarassegnastudipsichiatrici.it/index.php/volume-13/prospettive-teoriche-e-operative-della-psichiatria-italiana-negli-scenari-geopolitici-contemporanei

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In March 2005 was adopted the *Protection against Domestic Violence Act* (PADVA), the document that regulates the rights of those who have suffered from domestic violence, the protection measures and the procedure for the application of the survivor. Protection against domestic violence is granted upon complaint of the victim or a certain set of related people.
According to the Protection Against Domestic Violence Act domestic abuse is not gendered differentiated, which doesn't focus on the particular vulnerability of women when it comes to domestic abuse, therefore they do not receive sufficient protection. The single act of domestic violence per se is not criminalized, but only the systematic abuse is (3 or more times); this happened after the changes in the Penal Code that came into effect on February 25, 2019.

In Bulgaria, there is a wide *Roma Community* that applies traditional codes strongly rooted within the community. A common practice in the Roma Community is older men's cohabitation with young girls (between the ages of 11 and 18). This is considered the norm and parents are often encouraged to give their daughters to older men. Rarely there are criminal cases opened in these occurrences. Cohabitation from an early age is an ipso facto form of sexual misconduct because a sexual act with a child under 14 is a crime according to the Penal Code (irrelevant of whether it is consensual or not).

There is no national or subnational legal framework for the protection of mental health. In Bulgaria the care for the mental health is mainly psychiatric and focused on treating psychiatric conditions. There is no developed or applied national policy for prevention. There is no gender-based approach to the treatment of survivors of GBV in the Strategy developed by the Ministry of Health. An emphasis has only been made on the material base of psychiatric clinics and hospitals.
There are regulations and conditions for providing social services (listed as legal Acts under which there are measures regarding both social and psychological SGBV victims' needs) mainly run by NGO's.

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1.2.2 SGBV protection and mental health in Germany

In Germany, the Federal Ministry for Health is the leading national authority responsible for mental health issues related to SGBV. Mental Health issues related to SGBV for victims with migrant and refugee backgrounds without legal residence or permit to stay in Germany are under the responsibility of the Federal Ministry for the Interior and is executed on local level via municipal health departments and social services under the custody of the health authorities of the 16 German states. The Federal Ministry for Families is the head authority for administrative and financial support of NGOs working in the field of front-line services for SGBV victims and survivors. The Violence Protection Act came into force in Germany in 2002. Its purpose is to protect a person from all forms of violence in the private and domestic sphere and to safeguard mental health of victims and survivors of SGBV and DV. Other legal systems prosecute such acts of violence only under ordinary criminal law, e.g. as bodily harm or coercion and do not include mental health. What is new about the Protection Against Violence Act is that the person who poses a threat of violence can be expelled from the home by the police, while the victim of domestic violence remains and does not have to seek refuge to protect its mental health. First the Protection Against Violence Act was intended to provide a clear legal basis for protection order issued by the family court in cases of intentional and unlawful injury to the person's body, health, or freedom, including threats of such injury. Protection orders under the Protection Against Violence Act are also possible in cases of certain unreasonable harassment.

The violence protection and support system in Germany is largely organized on a federal level. The different responsibilities of the federal, state and local governments mean that the responsibilities of these actors are often shifted from one level to another. As a result, the protection against violence in Germany is organized very differently from region to region. The states and municipalities draw up plans of action in an uncoordinated manner and with different emphases. In some cases, laws and regulations that affect the issue of violence against women are also the responsibility of the states (e.g. police laws or the education

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system). Even after ratification of the Istanbul Convention, combating and preventing violence and supporting those affected remains dependent on political majorities and the financial resources thus made available in the respective federal states.[6]

There is no uniform legal definition of sexualized violence or sexual harassment in Germany. While the term "sexual harassment" is used in both the General Equal Treatment Act (AGG) and the Criminal Code (StGB), "sexualized violence" is not a formal legal term. (...) In legal discourse, the term sexualized violence is also used to describe violations of the right to sexual self-determination. For example, the German Institute for Human Rights describes sexualized violence as gender-based violence and a human rights violation.[7] Section 177 of the *German Criminal Code* provides that sexual assault and rape are felonies punishable with imprisonment of one year or more. The coercion of the victim by force, by the threat of imminent danger to life or limb, or by exploiting a situation in which the victim is unprotected and at the mercy of the offender is an essential element for criminal liability.
Laws for the protection of mental health care are based on State laws of the 16 federal states in Germany. There are then 16 State laws on “Protection of mental health and access to mental health services”. In addition, it was introduced a multilingual nationwide help telephone “Violence Against Women” offering first-time advice and, if necessary, an introduction into the support system on the spot and access to first-step mental health support for victims and survivors of SGBV.

Policy to care for frontline SGBV workers’ general and mental health in Germany are based on the Country’s protective law for workers and employees in public or private institutions. Most social service providers, public authorities and NGOs provide regular services such as supervision, group briefing on health and mental health, work revision briefings for their

[6] Alternative Report BIK – Association Istanbul Convention
[7] Gesis, Kompetenzzentrum Frauen in Wissenschaft und Forschng, Geschlechtsbezogene und sexualisierte Gewalt in der Wissenschaft.
https://www.gesis.org/cews/themen/geschlechtsbezogene-und-sexualisierte-gewalt/rechtliche-situation-in-deutschland

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employees. In addition, professional associations such as the German Social Workers Association, trade unions and social work advocacy groups offer seminars and sessions for social workers and frontline service providers in general and especially for professionals working in the fields of SGBV and domestic violence to protect their mental health.

1.2.3 SGBV protection and mental health in Greece

The State of Greece follows the women-centred approach to gender-based violence. In Greece, the State is responsible for the provision of mental health services aiming at the prevention, diagnosis, treatment, care and psychosocial rehabilitation and social reintegration of adults, children and adolescents with mental disorders and autistic disorders and learning problems (these includes also workers and survivors).

Greece declared the beginning of *Psychiatric Reform* in 1983, with the Law 1397/83, which indicated the transition from Asylum Psychiatry to Social - Community Psychiatry and Psycho-Social Rehabilitation. The subsequent laws covered institutional gaps existing in Law 1397/83 and today Psychiatric Reform is equivalent to the total of interventions that allow the treatment of mental health issues without preventing the individual from remaining an active citizen. The State is responsible for the provision of mental health services aiming at the prevention, diagnosis, treatment, care and psychosocial rehabilitation and social reintegration of citizens. Law 2716/99 defines the establishment, operation, staffing and funding of the Office and Committee for the Protection of the Rights of Persons with Mental Disorders and the Mental Health Units, public or private, that are to provide mobile health aid.

Despite the existing national legal framework for adults and children SGBV survivors[8], no specific provisions are foreseen regarding refugees' and migrants' mental health. The

[8] Relevant legal framework for children includes the following: a) Law 2101/1992, b) Law 2716/1999, c) Joint Ministerial Decision C3a/C.P..44342/2019 Government Gazette 2289/B/11-6-2019, d) Joint Ministerial Decision A3a/.876/2000-Government Gazette 661/B/23-5-2000

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responsibility for the mental health care of people in transit seems to be entirely on related NGOs.

Frontline workers' mental health support seems to be also neglected as no official policy paper referring to professionals working with SGBV survivors was found during the desk research.

1.2.4 SGBV protection and mental health in Italy

In Italy, following the ratification of the Istanbul Convention, the Parliament approved on the 15 of October 2013, the Law no. 119 "Conversion into Law with amendments of the Law Decree 14 August 2013, n.93. Containing urgent provisions on the safety of survivors aiming at tackling gender-based violence as a subject of civil protection enforcing commissioner of the provinces". Recognizing the magnitude of the phenomenon of violence against women, the Italian Parliament approved a new law aimed at strengthening the judicial response to domestic and gender-based violence and to introduce further provisions for the protection of the victims.

Law n.69 (July 2019) intervenes in the Penal Code, the Procedure Code, the Anti-mafia Code and the penitentiary system. In particular, criminal law introduces four new crimes into the existing code to fully address SGBV in Italian society. However, even if the current Civil and Penal Code and domestic laws for the prevention and response to SGBV are in line with international protection standards and the Istanbul Convention, there is still a lack of adequate implementation of the protection systems and a low level of criminal judgment and persecution for perpetrators and abusers. In addition, there is a lack of dedicated resources to promote the effective implementation of the laws.

Only in the recent years, SGBV against migrant and refugee women have been recognized by domestic law: forced and/or early marriage, female genital mutilation, forms of sex

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harassment, sex trafficking, torture. These forms of violence have been included among the possible crimes within the legislative system.

The Italian Constitution protects the right to mental health in article 32 which is one of the fundamental articles for all population. The Basaglia Law, n.180/1978, led to the closure of mental hospitals and the recognition of human dignity also for those affected by mental illness, who previously were considered as dangerous. Only in recent years, interventions for the care of migrant and refugee women's mental health have been recognized in domestic, not binding, national Guidelines.

National health and safety management standards refer to the European framework agreement on work-related stress prevention and response. The agreement was transported into Italian Law by Legislative Decree 81/2008 which implies voluntary acceptance by the signatories of the responsibility to take measures to implement the standards in the workplace. These measures foresee communication, training and information aimed at preventing, reducing or eliminating work-related stress. The Legislative Decree is monitored by the Department of Medicine in the workplace of the National Institute for preventing Accident at Work (INAIL).

1.2.5 SGBV protection and mental health in Serbia

In the Republic of Serbia domestic violence was first incriminated by national legislation in 2002. National legislation and public policies do not define Gender-Based Violence nor a specific form of violence. The accepted definition in the national context can be found in the Law on Ratification of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence.

According to the First report of the Council of Europe's Expert Body (GREVIO) national minorities, women - migrants and asylum seekers are particularly exposed to Gender-Based Violence in Serbia. Some of the key challenges women in Serbia are facing according to the

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Report are the lack of efforts to prevent sexual violence and forced marriages (especially in-migrant communities). Also, there are deep-rooted gender stereotypes, as well as the lack of services for victims of violence, especially victims of sexual violence.

The National Strategy for the Prevention and Suppression of Violence against Women in the Family and Intimate Partner Relation (2011-2015) was set to determine directions for action to combat violence against women. Since 2015, when this strategy expired, a new one has not been adopted.

The Parliament passed in 2016 the Law on Prevention of Domestic Violence. In the Article 12, it is stated that "State bodies and institutions responsible for the application of this law are obliged to quickly, effectively and in a coordinated manner prevent domestic violence and criminal offences determined by this law and to provide victims protection, legal aid and psychosocial and other support for recovery, empowerment and independence". Then, in terms of providing support to the victim, an individual plan of protection and support is also defined by this law (Article 31).

Serbia has incorporated the provisions on mental health and psycho-social assistance to women victims in its strategic documents that have been developed in the past few years. Such documents are also in line with the Action Plan for Chapter 23 of Serbia's negotiation process with the European Union.

It has also been adopted the Strategy for Prevention and Combating gender-based violence against Women and Domestic Violence for the period 2021-2025. The specific document depicts the factual situation and problems in providing psychosocial support to women victims of violence and preserving their mental health. The Strategy recognizes that psychological support to women victims of SGBV is not at a satisfactory level and it needs improvement.

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Regarding the protection of the mental health of women victims of SGBV, Serbia adopted the Law on Health Protection. Article 11 of the Law states that social groups for whom such healthcare is particularly intended, are victims of domestic violence and victims of trafficking.

As for refugees and migrants in 2019, the Republic of Serbia adopted Standard Operating Procedures for the Prevention and Protection of Refugees and Migrants from gender-based violence. However, this document does not say much about their mental health and the need for psychological support, only that urgent psychological support to victims should be provided without specifying the competent institution.

1.3 Conclusions

Analysing the policy frameworks of the countries involved in the WeToo Project, specific legislations on the issue of gender-based violence is highlighted. All the countries involved recognize somehow the extended and structured phenomenon of domestic violence (with different measures and intensity when referring judicial laws).

The countries that have adopted the Istanbul Convention have an updated and complex legislative system on the subject of preventing and combating gender-based violence, while the government of Bulgaria does not recognize all forms of violence perpetrated based on gender, considering the Convention still as in contrast with the Constitution.

Nevertheless, when coming to the judicial systems there are still few measures that definitively and strictly sanction the crimes committed by men against women because of their gender. For this reason, the EU systems of protection of women victims of violence are handled by police officers and judicial courts involved, and they still remain fragmented. Not all are adequately prepared on SGBV or have adequate resources to respond to the phenomenon with a high risk of re-victimization for the survivors.

There are no ad hoc policies on the issue of the intersectionality of gender-based violence, although in some countries the legislative system is being updated to include multiple

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traumata of violence identified with forms of violence, e.g., against migrant and refugee women (such as forced/early marriage, FGM).

The issue of mental health is regulated in all countries with specific attention to the treatment and care of mental illness. The institutions in charge of the care and support of people who show signs of psychological and psychiatric distress are defined by the national health system. On the other hand, there are few, or in some countries no, references to the system of protection and prevention of stress and mental discomfort both with regard to the workplace and for people (especially women and minors) who suffer from mental issues as consequences of forms of gender-based violence. For this reason, these invisible wounds are treated as contingency and do not find forms of recognition and compensation at the level of the national legal and health system.

2. Demographic and statistical data related to SGBV cases (national and migrant population)

Data on SGBV are fundamental in order to effectively address the phenomenon and understand the impact it has on migrant and local population (especially women and children who are disproportionally affected by SGBV).

Each country has a different time gap between which data were collected, so it was not possible for the research team to create a standardised statistical and demographic overview of all Countries' Partners since all national authorities and/or CSOs have different methodologies and indicators to report and analyse SGBV cases. Therefore, the data collected on the number of SGBV cases only gives a partial picture of the scope of this phenomenon.

When data are absent or not updated at national level, policy frameworks and related social protection programs are less accessible for victims and are not aligned with their needs. Furthermore, less funds are available to support public and private services for the protection

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of survivors' rights. To practice social innovation in programs to prevent and respond to SGBV is important to rely on updated statistics, which deeply describe the phenomenon.

In ***Bulgaria***, ***Serbia*** and ***Italy***, due to the absence of the National states, CSOs are the main entities which took responsibilities of collection of data on SGBV cases (analysing the requests they received from the victims) while National sources are less available or updated. In ***Germany***, instead, the Ministry of Interior is yearly committed in publishing data on SGBV cases. In **Greece**, the General Secretariat for Family Policy and Gender Eqaulity – GSFPGE, published the 1st Annual Report on Violence Against Women[9] providing landmark information on the SGBV cases reported during November 2019 – October 2020.

In some countries, like ***Germany, Greece*** and ***Italy***, it was detected by Statistics Institutions how the emergency period of the Covid Pandemic led to increasing in SGBV cases (especially domestic violence).

As a starting methodological point, official accurate statistics on the number of SGBV cases should be disaggregated by the sex of victims and perpetrators (this was available only for ***Germany***). Furthermore, the relationship between victims and perpetrators should also be recorded for femicide and other GBV cases. This would make it possible to disentangle the number of femicide and GBV victims committed by current and former intimate partners and other family members from all other crimes.

In 2019, WAVE[10] carried out at EU level research on the accessibility of women's protection centres. In this report, data on feminicide are also available for each EU country and sources are mentioned as important references in order to understand the perception at social and Institutional level on the phenomenon.

[9] General Secretariat for Family Policy and Gender Equality (2020). *1st Annual Report on Violence Against Women.* Athens: Ministry of Labour and Social Affair. Retrieved from https://isotita.gr/wp-content/uploads/2021/04/First-Report-on-Violence-Against-Women_GSFPGE.pdf

[10] WAVE, WAVE NETWORK & EUROPEAN INFO CENTRE AGAINST VIOLENCE https://www.wave-network.org/wp-content/uploads/WAVE_CR_200123_web.pdf

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Findings on the situation of femicide in Europe TABLE 17: Reported number of femicide victims in EU Member States in 2018 (WAVE – Women against violence in Europe- Country report 2019: The Situation of Women's Specialist Support Services in Europe)

EU Member States	**Reported number of femicide victims**	**Data collected by the state (official sources) and/or other entities**
Bulgaria	40	No official data on femicide
Greece	6	Estimated number based on media monitoring – No official data on femicide
Germany	147	Data collected by Federal Criminal Police Office. They do not use the term 'femicide'.
Italy	115	Data was collected by the NGO Casa delle donne per non subire violenza di Bologna. Official data on the number of women killed by current or former intimate partners and other family members are also collected by the National Statistical Office.
Serbia	30	No official data on femicide. Women's NGOs collect data on femicide by conducting media monitoring. The femicides recorded only cover women who were killed by current or former intimate partners and other family members. These were killings committed by current or former intimate partners (20) and other family members (10). Number provided is based on media

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		monitoring by a women's NGO.

Few States in EU such as ***Germany*** (not ***Bulgaria, Germany, Greece, Italy*** and ***Serbia***), include the category of 'femicide victims' when collecting data on all homicide victims and also count femicide victims perpetrated outside the family sphere. This is due to a lack of legal recognition of this specific crime, which is linked to social patriarchal norms still active in EU societies.

2.1 Available data on SGBV cases in Bulgaria

Official statistics in Bulgaria do not include data on cases of domestic violence and other forms of violence against women. Thanks to the Report made by the Bulgarian Helsinki Committee "The murders of Women in Bulgaria" it is possible to detect that in the period 2012-2017, district courts handed down at least 102 convictions for the premeditated murder of women by men. The Bulgarian authorities do not gather statistical data about the numbers of femicides in the Country. Such data is gathered only by the media and NGOs.

According to statistic by the Animus Association Foundation for 2020 the beneficiaries of the social/protection programs were as follows:

- "ZONA ZAKRILA" - Sexual violence -30 clients, Domestic violence - 330 clients;
- CRISIS CENTRE FOR SURVIVORS OF VIOLENCE - Domestic violence -27 accommodate clients;
- COMMUNITY SUPPORT CENTRE TO THE SOCIAL SERVICES CENTRE FOR CHILDREN AND FAMILIES - Sexual violence -1 client, Domestic violence - 37 clients;
- NATIONAL HOTLINE FOR SURVIVORS OF VIOLENCE - Sexual violence - 27 calls, Domestic violence -1631 calls.

In total, 58 clients are survivors of sexual violence, and 2025 clients are survivors of domestic violence.

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Bulgarian State Agency for Refugees (SAR) collects monthly statistics on the number of asylum seekers identified as vulnerable. In August 2018, SAR began collecting and reporting separate statistics for victims of psychological, physical and sexual violence (prior to this, victims of different forms of violence were all grouped into one category). Since August 2018, SAR has identified only one asylum seeker as a victim of sexual violence, 10 as victims of physical violence and seven as victims of psychological violence. Considering the higher prevalence of SGBV and other forms of violence in migration and displacement contexts, even though the numbers of asylum seekers in Bulgaria have decreased significantly (see below), the number of victims of sexual, psychological, and physical violence appears very low. This could be due to a lack of awareness on the part of asylum seekers on their rights and how to claim them, the non-recognition of this type of violence as a violation of their rights, fear of the repercussions that reporting could have on their application for international protection, as well as a lack of capacity of first responders to identify victims of violence, including SGBV, and provide adequate response in such cases.

2.2 Available data on SGBV cases in Germany

In 2020 around 82.000, out of 5.3 million crimes recorded in Germany, could be assigned to crimes against sexual self-determination, the so-called sexual offences[11]. Broken down into categories of crime, criminal acts in the category of SGBV in 2020 amounted to 30.567 recorded cases with 8% male victims and 92% female victims. Out of these victims, 54.1% were adults, 15.7% were young adults, 25% were youth (14-18ys) and 5.2% were children[12].

[11] Source: Federal Office for Statistics: https://de.statista.com/themen/800/sexual-und-drogendelikte/ (20.08.2021)

[12] Source: Bundesministerium des Innern, für Bau und Heimat: Polizeiliche Kriminalstatistik 2020 – Ausgewählte Zahlen im Überblick, Berlin 2021 (Federal Ministry for the Interior, Living and Home: Criminal report 2020, selected statistics in an overview), p. 36

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Many cases of SGBV affecting migrant and refugee women remain unreported. The official statistic represents a misleading situation with only 834 migrant SGBV victims out of a total of 57.205 reported cases in 2020[13]. Due to the lack of data on migrant and refugee background of SGBV victims in Germany, an expert group was established by the federal government in 2019. A first statistically and scientifically valid report from this group is expected to be published in 2022[14].

In reference to SGBV and case of child-pornography and forced sex affecting children as victims, there has been a severe increase from 2019 to 2020 which is seen in coincidence with the impact of the Covid-19 pandemic situation on families:

- Distribution of pornographic writings (+54.2 percent, +9,403 cases) of which:
  - Distribution, acquisition, possession and production of pornographic writings for minors (+56.1 percent, +1,116 cases)
  - Distribution, acquisition, possession and production of child pornographic writings (+53.0 percent, +6,499 cases)
- Sexual abuse of children (+6.8 percent, +924 cases)

Data on SGBV cases are yearly updated by National Authorities (Ministerial sources – such as the Federal Ministry of Interior) in Germany. A full aggregated data table of criminal records in the field of SGBV between 01.01.2020 and 31.12.2020 can be found (in German) at the Federal Office for Criminal Investigations (Bundeskriminalamt)[15]. From these data, it is

[13] Bundeskriminalamt: Kriminalität im Kontext von Zuwanderung, Bundeslagebild 2020, Wiesbaden 2021, p. 24.

[14] See: Deutsches Forum Kriminalprävention 2020, in: ter Horst, Hannah Noemi: Der Stand der Umsetzung des Ubereinkommen zur Verhutung und Bekämpfung von Gewalt gegen Frauen und hauslicher Gewalt in Deutschland unter besonderer Berucksichtigung des Themenfelds Femizid, Düsseldorf, 01.07.2020, Master Thesis Universität Düsseldorf, p. 25.

[15] Polizeiliche Kriminalstatistik, Opfer - Tatverdächtigen – Beziehung, V1.0 erstellt am: 21.01.2021 https://www.bka.de/SharedDocs/Downloads/DE/Publikationen/PolizeilicheKriminalstatistik/2020/Bund/Opfer/BU-O-05-T92-O-TV-Bez_xls.xlsx?__blob=publicationFile&v=4 (excel sheet)

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possible to understand the nature of the crimes (sexual, physical, and psychological) and the relation of the victim with the perpetrator (intimate partner violence etc.)

2.3 Available data on SGBV cases in Greece

In Greece, the 1st Annual Report on Violence Against Women published by the General Secretariat for Family Policy and Gender Equality - GSFPGE provides landmark information on the SGBV cases reported during November 2019 - October 2020. The data was derived from the databases of the Counselling Centres, Women Shelters and SOS Support Helpline. During the reported period, 4872 women victims of SGBV and multiple discrimination received support from the Counselling Centres of GSFPGE.

According to the 1st Annual report and the data derived from the SOS 15900 Support Helpline the professionals received 6986 calls, 6042 of which reported incidents of violence and 944 asked for information regarding gender-based violence.

Furthermore, in the above-mentioned report these data were collected: 269 women (69 of them were refugee women) and 270 children (117 of them were refugee children) found shelter in the Women Shelters of the GSFPGE, with the majority (69%) being unemployed and survivors of domestic violence (79%). A smaller percentage were victims of sexual harassment (3%), rape (6%) or trafficking (2%), with women's spouse (53%) or partner (21%) being the most common perpetrator. Regarding their age, 21% of the residents were up to 25 years old, 32% were between 26-35 and 21% were between 36-45 years old. Their educational level varied: 6% were illiterate,19% had completed primary school, 19% lower secondary education, 14% secondary education, 8% post-secondary education, 2% vocational education, 6% university and 1% post-graduate education.

Moreover, regarding the interpretation services provided by the Greek NGO METAdrasi through its cooperation with UNICEF Greece and the Research Centre for Gender Equality (KETHI) between April-October 2020, 71 women received support (75% psychological, 7% referrals to health services, 14% useful information provision, 2% legal information provision)

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via interpretation in French, Farsi, Kurdish, Urdu, Dari, Somali, Tigrinya, Arabic, Amharic, English and Pashto.

Moreover, in the beginning of March 2020, the first restrictive measures against COVID-19 were taken by the Greek State due to the first wave of the pandemic that ended two months later. During that period, the Counselling Centres of GSFPGE, the Women's Shelters and the SOS Helpline noticed a rapid increase in their services, leading to what scientists refer to as "shadow pandemic" growing amidst the COVID-19 crisis.

2.4 Available data on SGBV cases in Italy

The last data analysed from 2004 to 2014 by the National Institute of Statistics reported that: 6 million 788 thousand women have suffered some form of physical or sexual violence in their lifetime. In 2018, more than 29.000 women accessed the services provided by anti-violence centres for GBV survivors.

According to data available about emergency rooms, in the three years 2017-2019, women who had at least one access to the hospitals with indications of a diagnosis of violence were 16,140. In Italy, the most updated data on gender-based violence are collected by the emergency calls to 1522.

This toll number is the national telephone service for reporting cases of violence and asking for help. The analysis of calls from 2020 to 2021, compared with the ones reported in the same period of previous years, can provide useful information on the development of the phenomenon of gender-based violence during lockdown: typologies of requests and users of the service.

The number of valid telephone calls and text messages in the first quarter of 2021 were impressive: 7,974 calls and 4,310 victims registered. This data shows an increase of 38.8% compared to the previous yearwhile the peak occurred during the second quarter of 2020 (12,942 valid calls).Text messages and chats also increased by 11.5%.

Among the reasons for contacting the anti-violence telephone service, there was a sharp increase in calls for 'requests for help from victims of partner's violence'. Compared to the

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same period of the previous year, they increased by 109%, while calls for information on the 1522 number decreased (-37.6%). The number of women who called 1522 for the first time in the first quarter of 2021 was 84.8%. The percentage of victims who directly contacted the hotline was 88.1%. Victims who contacted 1522 reported having experienced more than one type of violence in 62.1% of the cases.

The 1522 service played an important function as a hub connecting different local services and supporting 66.5% of victims, by referring them also to other protection services available in the context (a figure that is decreasing compared to 2020). Among the victims, the 57.1% (equal to 2,462 persons) were sent to an Anti-Violence Centre for specific support.

During the first semester of Covid Pandemic, the demand for help from migrant women had almost disappeared because their capacity to connect with anti-violence centers and to break ties with their communities were very low.. It was also noted that the social distancing imposed in March and April 2020 had a negative impact especially on women in more vulnerable conditions, because they were unable to ask for psychological, practical or economic support to other friends' networks. These include foreign women, of whom all the centres have highlighted the drastic decrease in contacts.

2.5 Available data on SGBV cases in Serbia

According to the official data of the Ministry of Justice, since the change of the Law on Prevention of Domestic Violence (June 1, 2017) until the end of 2020, more than 166,000 cases of violence were considered.

The Republic of Serbia does not have official statistics that segregate victims of gender-based violence by nationality.

In the context of women and girls among refugee and migrant population in Serbia, a relevant source on the prevalence of this phenomenon may be the research published by NGO Atina in 2017, entitled "Violence against women and girls among refugee and migrant population in Serbia", conducted on a sample of 162 women and girls, which shows that 64.8% of the

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respondents experienced physical violence both in the countries of origin, during both the journey and their stay in Serbia, while 24% of them survived sexual violence.

2.6 Conclusions

Criminal justice systems function to deter and punish violence against women only if the cases of SGBV are recorded and investigated in a significant proportion.

Statistics in this area are generally poor, and to the extent that data exist through research, they show that, for sexual violence, rape, femicide and other forms of GBV, such as domestic violence, there is a substantial under-reporting. Among these cases only a very small proportion of the recorded crimes ever go to court, of which, again, only a minority are punished. Most countries have incomplete data and thus cannot properly monitor the justice system responses to the reported cases.

Available data are often not provided by National authorities, while CSOs are the main entities recording and informing on existing SGBV cases mostly relying on number of accesses to their protection services. As seen above, available data are often not disaggregated due to different approaches adopted by the Countries on the collection of data, e.g., relation of the victims with the perpetrators, typology of the crime perpetrated against a woman because of her gender, request for help in hospitals and emergency rooms because of SGBV etc.

3. Existing organisations working with SGBV and mental health: good practices and challenges of the protection system

In this chapter, we will analyse and compare the protection systems adopted for the supervision of front-line workers and the protection services working to support the re-elaboration of traumas and discomfort of SGBV survivors (considering the special needs of migrant and refugee population).

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The issue of mental health is analysed to define the standards implemented by protection services working at the front-line of gender-based violence, considering that the psychological well-being of workers and SGBV survivors should be one of the priorities of all social, legal and health services operating in the field of helping relationships. The analysis shows how systems and measures of protection, prevention and response to distress are not yet organized and defined in all partner countries by service providers (both Institutional and private), despite the evidence that front-line work causes stress and compassion fatigue and how having suffered gender-based violence causes deep psycho-physical wounds in the survivors.

The good practices analysed are linked to organizational standards implemented by specific social services, where resources, experiences and networks among different stakeholders are valued and put in place for the supervision of front-line workers.

3.1 Good practices and challenges of the protection system in Bulgaria

In Bulgaria, NGOs operate, on project basis, community centres for child and family support as well as Centres for children with special needs - offering mental health services only for children under 18 and their parents. There are Day Care centres and General Psychiatric hospitals as part of the National Health System addressing primarily psychiatric conditions. There aren't any national/sub-national services that are dedicated to SGBV victims' mental health supported by the Government. Services for victims are best developed in Bulgaria due to the Child Protection Act. However, the child advocacy centres focused on violence are supported as pilot programs.

Currently, after the introduction of the new Law on Social Services, a National Map of social services is being prepared for approval, which includes both the already existing services as well as those planned, which need to be further created in the coming years.

A few challenges are identified in the protection system of SGBV survivors in Bulgaria. Protection programs developed by projects by CSOs are often left without municipal or state funding and have a limited duration, which obstructs them from being completely developed.

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Most often they end with the completion of the project and many smaller cities and towns in the country are left without any available services for victims of sexual and gender-based violence.

Regarding workers being in the front-line of SGBV cases, there aren't any national/sub-national services that are dedicated to theirmental health supported by the Government. A few NGO's, IOM and UNICEF offer specialized training focused at SGBV including burnout prevention.

In 2020 a new Social Services Act was adopted, which aim to improve the quality of the offered services.. The Act includes an Ordinance for the Quality of the Social Services (including social services offered to victims of violence), which sets a standard for the workload of the workers in the services. The Act provides an opportunity for burnout prevention through regular supervisions, staff meetings and additional training. In addition, the Act will provide a possibility for the creation of missing services for victims of gender-based violence, both sexual and domestic. At this time, crisis centres, some of the centres for consultation and psycho-social support and a map of the services are being worked on. Despite the application of the Act, many services are not yet included in the network that implement it and that can benefit from it because they don't receive governmental financing.

3.2 Good practices and challenges of the protection system in Germany

Most cases of work in the field of SGBV in Germany are handled by services offered by social workers either employed in public service institutions or working for an NGO. In addition, there are psychotherapists, medical professionals, lawyers and other categories of social work and family-outreach service. The bff (Bundesverband der Frauenberatungsstellen und Frauennotrufe in Deutschland)[16] are the head organization of over 200 helplines and front-

[16] Federal Association of Female Helplines and Counseling Centers for Women and Emergency call line for women in Germany.

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line service centers for women in Germany. These centers handle up to 70% of cases of female victims of SGBV in Germany.

According to an estimate by Brot für die Welt, 89% of all social workers and other professionals working with and for victims and perpetrators involved in SGBV, have a fully trained, qualified and state-acknowledged professional background (diploma of social work), including expertise on mental health related issues and needs of victims. The remaining 11% are low-level volunteers who serve as assistants who generally do not have special knowledge or qualification of mental health needs of victims.

Germany has a dense and well-established network of both state and non-governmental institutions dealing with SGBV and mental health. All these institutions have local branches which are interlinked with each other. These local branches collaborate with state institutions such as health services, police, courts, school and educational system, labour unions, municipal administration, immigration offices and law enforcement offices. In 75% of all cases, social services for victims of SGBV in these NGO networks are offered by fully trained professional social workers and individual counsellors and service providers.

Most of the institutions mentioned in the German national report offer services which are dedicated to frontline SGBV workers' mental health. These services include seminars and protective training, phone service and hotlines, group supervision, individual supervision, reflective therapy, systematic analysis and buddy-systems of social workers in frontline positions. Many of these services are offered for free or at minimum costs, or are provided by the employer. As already mentioned, despite a solid system of services dedicated to frontline SGBV workers' mental health in Germany, the use of these services is not satisfactory. Many frontline SGBV workers do not have time, access, to some extent financial resources or time to travel to profit from these offers. Services including multi-day trainings or seminars for SGBV frontline workers often lack participants due to time restrictions, the duty linked to severe and urgent cases and other private obligations of social workers.

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3.3 Good practices and challenges of the protection system in Greece

In Greece, the State is responsible for the provision of mental health services aiming at the prevention, diagnosis, treatment, care, and psychosocial rehabilitation and social reintegration of adults, children and adolescents with mental disorders and autistic disorders and learning problems. Mental health services are structured, organized, developed and operated under the provisions of the law, based on the principles of sectorisation and community psychiatry, the priority of primary care, outpatient care, deinstitutionalization, psychosocial and social rehabilitation, reintegration, continuity of psychiatric care, as well as information and voluntary community assistance in promoting mental health.

Despite the existing national legal framework for adults and children SGBV survivors, no specific provisions are foreseen regarding refugees' and migrants' mental health. The responsibility for the mental health care of people on the move seems to be entirely on related NGOs. In fact, the first time the mental health of frontline workers was set at the forefront of public institutions' concern was during the Covid-19 emergency, but not specifically for SGBV cases. The initiative frontline-covid19.com provides useful information and tools for the best handling of the psycho-social impact of the pandemic on professionals offering crucial services, considering that they are more exposed to SARS-CoV-2 and its consequences. This initiative aims to reach a range of Covid-19 professionals, which may or may not manage SGBV cases, and only during the pandemic.

In the Greek context, there is a range of organisations and services targeted to the best support of SGBV victims, either adults or children, with a special concern of their psychological support. Regarding State's provisions, the work of the General Secretariat for Family Policy and Gender Equality (GSFPGE), with the operation of the 15900 SOS Helpline, the Counselling Centres and Women's Shelters is remarkable. The work of the Research Centre for Gender Equality (KETHI) supporting SGBV survivors through its counselling centres and the research conducted and published, also offers a holistic approach to gender-based violence. In the same context, the National Centre for Social Solidarity (EKKA) provides counselling sessions, psychosocial support, shelter, and mediation with public entities, among other services. Next

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to State's efforts lays a large network of relevant NGOs, which aims to work either supplementary or fill the existing gaps at the national level. Towards this direction, the role of the Centre for Research on Women's Issues "Diotima" and the Greek Delegation of the Doctors of the World is of high importance, providing systemic support to women, from legal and psychosocial support to career counselling.

3.4 Good practices and challenge of the protection system in Italy

The Italian protection system for the protection of mental health and prevention of mental distress at work relies on a method proposed by the National Institute for Insurance against Accidents at Work (INAIL), which consists of four main phases; each one is fundamental to achieve a correct identification and management of the risks:

1. preparatory phase;
2. preliminary assessment phase;
3. in-depth assessment phase;
4. intervention planning phase.

The tool proposed by INAIL, if effectively adopted, presents the opportunity to increase the quality of the workplace and promote the involvement of the workers in the definition of their work-related risks, and therefore uses a participatory method to draw up a risk prevention plan.

Nevertheless, there are no obligations or constraints for the implementation of this system to verify and monitor workers' stress and to prevent it. In addition, the tool is a general framework, and it is not tailored to social services, such as protection centres and CSOs working with people who have suffered SGBV - rather it is aimed at private and productive sectors. Stress is therefore seen as a risk for the overall productivity of workers involved in the private sector.

According to the National Plan of Social Interventions and Services (2021 - 2023) approved by the Ministry of Labour and Social Policy, (psychological) supervision of staff working in the

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field of social protection should be ensured for adequate management of interventions and teamwork. The National plan defines team supervision in the following way:

- Professional supervision is characterized by a process of support for all the aspects of the professional intervention of social workers, educators and psychologists. This work is an accompaniment of a process of revision of the professional action. It is a tool to support and promote difficult case management and team relationships between professionals.
- Supervision must enable and support workers to build effective professional relationships, develop good practice, and exercise both professional judgement and discretion in decision-making.

Unfortunately, these protection measures are not mandatory for protection services and lack of resources on the sector led to a low use of these safety standards for front-line workers.

At the national and sub-national level to prevent and respond to the phenomenon of SGBV an “integrated SGBV network" is present all over the Country. The roles of public and private servicers mention below are not only dedicated to SGBV protection, but all of them are entitled to respond to the phenomenon:

- CAVs (anti-violence Centres)
- CSOs operating on the regional territory – some of them are registered in regional system of voluntary-charity organizations
- Health Service
- Social Services
- Police forces
- Public Prosecutor's Office
- Regional Authorities
- Provinces and Municipalities (including public welfare system)
- Territorial School Offices (to report cases of SGBV identified among students)

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Any entity in the SGBV network has a specific role, according to its area of intervention, in the identification of the survivors and in the referral activities within the territory.

The main professionals of above listed entities are employed within the SGBV network. The front-line workers in the SGBV network are the reference personnel for the identification and care of survivors, referral activities within the territory and monitoring the conditions of the victim.

The Anti-Violence Centre can support women who have suffered serious traumas to access the local mental health district for psychological and/or psychiatric support.

Related to health care and medical reporting, the good practice *Codice Rosa* (Rose Code) deserves to be mentioned: it is a clinical network that defines the access modalities and the social and health programs for the victims who are identified in the Emergency Rooms of the Hospitals. The Codice Rosa intends to protect and support women victims of gender-based violence (program tailored for women) and for victims of violence caused by vulnerability and discrimination (program tailored for victims of hate crimes).

The anti-violence centres can support women who have suffered serious traumas to access the local mental health district for psychological and/or psychiatric support.

It is important to highlight, however, that, the effectiveness of any intervention aimed at supporting victims of gender-based violence is closely related to the capacities of professionals involved to engage a multi-disciplinary network of protection services, whether the intervention takes place in an emergency or when the woman has already escaped the violence and needs to process the trauma.

3.5 Good practices and challenge of the protection system in Serbia

In Serbia, most NGOs are engaged in providing direct support to persons from the refugee and migrant population. In addition to NGOS, a significant part of State institutions has the mandate to provide support and ensure the rights of refugees and migrants, especially victims of gender-based violence.

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The *Standard Operating Procedures of the Republic of Serbia for the prevention and protection of refugees and migrants*, created and published by the UNFPA (United Nations Population Fund) provide for urgent response measures in case of gender-based violence. Anticipated response measures include:

- emergency medical interventions and assistance related to sexual and reproductive health;
- provision of psychological first aid;
- special protection measures.

In addition to the Ministry of Health, psychiatric services are provided by an international organization (IOM - International Organization for Migration) and a local non-governmental organization (IAN - International Aid Network), while the presence of psychologists is provided by local non-governmental organizations (e.g., PIN - Psychosocial Innovation Network, INDIGO, IAN).

In addition to the aforementioned narrowly specialized organizations for providing psychological support to persons among the migrant and refugee population, a significant number of organizations provide psychosocial support, which also includes the provision of psychological first aid. According to the data obtained through this research and the field, victims of gender-based violence among the refugee and migrant population have access to psychological first aid provided mainly by civil society organizations.

Regarding programs directly aimed at preserving the mental health of professionals, at the system level there is a lack of services and programs that would be available in the long run. Most professionals rely on their own resources and team support. Several NGOs have support available in the form of supervision and peer-vision, while for most organizations this type of support is organized on a project basis, with limited duration.

3.6 Conclusions

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Mental health for SGBV survivors according to data reported by Partner organizations is in charge to the mental health systems and to psychological assistance ensured by anti-violence centres and CSOs. Good practices mentioned are related to multi-disciplinary interventions of support where private and public stakeholders cooperate in networks to respond to the special needs of survivors, giving space to their psycho-social needs as well.

Mental health for front-line workers in relation to stress management and prevention to burn out is linked to safety and security standards at work, which are protected by the law in some countries (***Germany*** and ***Italy***), but are not well spread in all countries of intervention.
As stated in the National Report for Germany, the increased demand for psychiatric and psychotherapeutic health care services associated with the epidemiological trend poses major challenges for the health care system and social insurance. Sound scientific knowledge is needed to ensure the effective and future-proof design of the complex health care system. For this reason, mental illnesses are also the subject of many funding priorities at EU level, even if not all countries register the same level of engagement to respond to this issue.

4. Data analysis from the interviews and/or FG to the front-line workers in Partner countries

Each partner country delivered individual qualitative and quantitative FG and/or interviews addressed to professionals and to women victims and survivors of SGBV. The FG and/or interviews will be complete the desk researched already carried out, in order to obtain the needed information for answering the questions of the study.
All partners were supposed to interviewed 20 professionals and 15 (25 for Italy) women. The total number of interviewees was not reached by all partner country especially regarding interviews and FG to women due to difficulties related to the availability and safeness of some women to speak and answer the questions. As for professionals, partner country has done

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their utmost to contact and establish contacts with as many sectors as possible but they have not always received positive responses or even some circles have not even responded.
In this chapter the results of the qualitative research carried out in the five partner countries of the project are analysed with a comparative and transversal approach. The qualitative and quantitative data collected will serve as a basis for developing self-assessment tools for work-related stress on the front line together with industry experts.

4.1 Profile of the participants, their organisations and their work with migrants and local women victims of SGBV

The number of the interviewed frontline professionals working in the SGBV context is 149. It means that 149 interviews have been conducted by the WeToo Consortium in Partner countries on the link between mental health and SGBV. The number of contacted, reached and informed frontline workers about WeToo project through emails, e-meetings, phone calls or texts may increase the data, but we checked and validated only interviews fully conducted and under-coverage of consent.

In specific, Partner organizations interviewed:

- 20 frontline professionals (18 women, 2 men) in ***Greece***
- 35 (30 w, 5 m) in ***Germany***;
- 22 (17 w, 5 m) in ***Bulgaria***;
- 31 (29 w, 2 m) in ***Serbia***;
- 41 (40 w, 1 m) in ***Italy***.

In total, 134 women and 15 men were engaged in responding to the agreed questionnaires (reported in the methodology of the research).

In line with the gender-sensitive indicators listed in the methodology, the gap in the presence of professional care between men and women has been detected. Data show how high the gender gap is in this working area, that it is also in line with the trend on a global level: only

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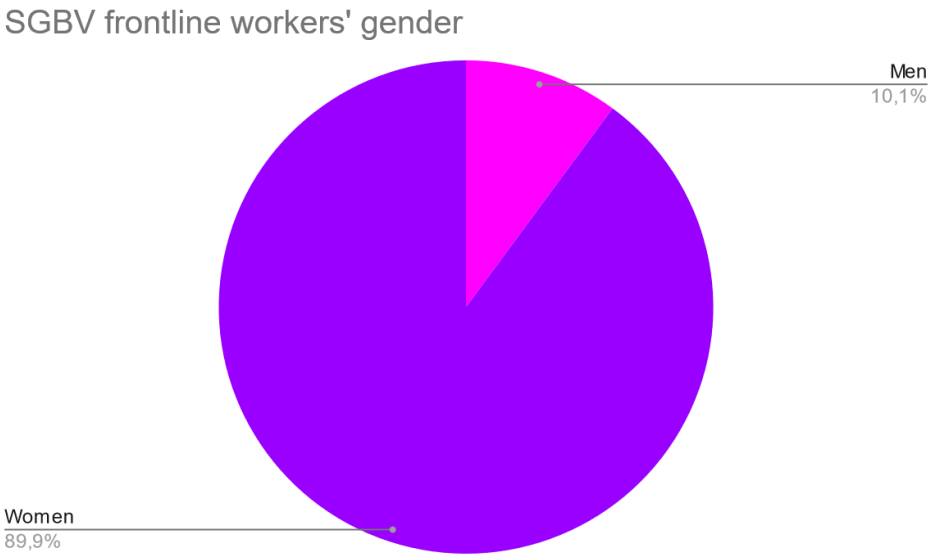
10,1% of the interviewees are of male gender. Due to privacy requests expressed by the interviewees, it has not been possible to detect the difference of role/responsibility in the organizations the professionals work in.



Graph 1: SGBV frontline workers' gender

Most frontline professionals work for local NGOs; public institutions; social services centres; protective or counselling centres.

In ***Serbia***, the highest number of women received assistance and support from NGOs and in that sense, NGOs can be considered the most important resource in protecting women and children's migrants and refugees who survived SGBV. Quite the opposite, in ***Italy*** and ***Greece***, professionals mostly work for services and organisations that are mostly dependent on public funds: Ministry of Interior, Department of equal opportunities, Ministry of Health. While in ***Germany***, public institutions are highly involved in the response to SGBV, while CSOs provide further assistance after the emergency phase.

As shown in Graph 2, the participants covered a range of job titles, including social workers / educators and counselling centres (63 interviewees), psychologists/psychotherapists and

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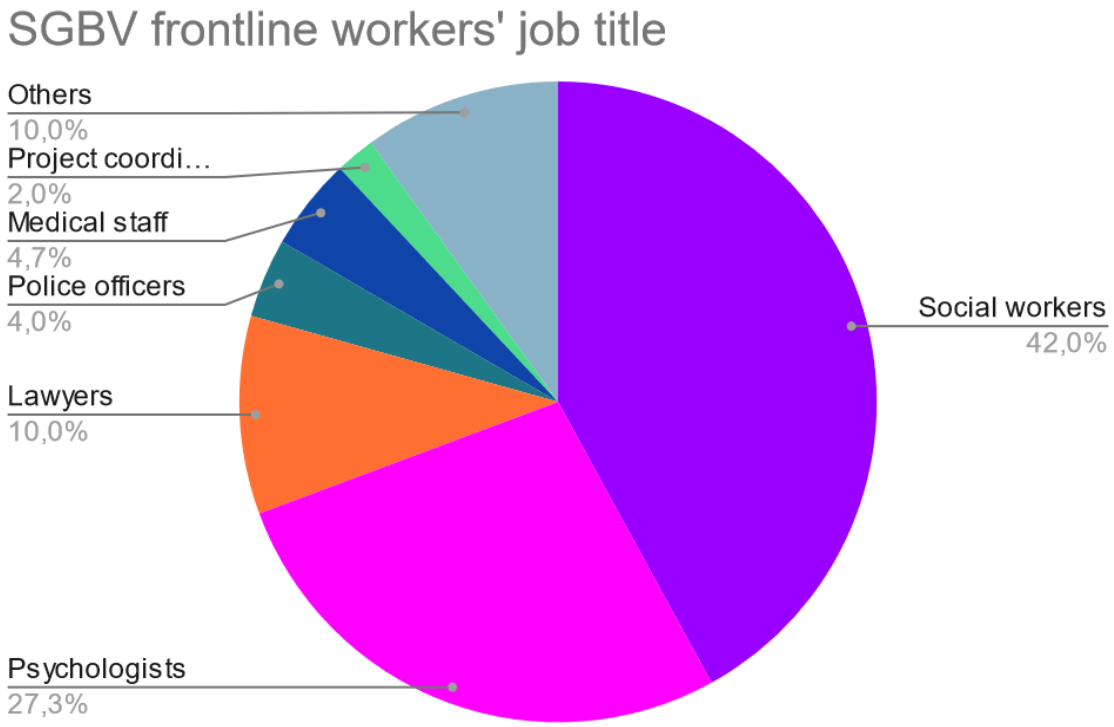
staff of anti-violence and anti-trafficking agencies (41), lawyers (15), police officers (6), medical staff (7), field officer or project coordinators (3), other professions working in reception centres, associations for migrants (15).



Graph 2: SGBV frontline workers' job title

According to the interviewees and to the international bylaws, when it comes to SGBV, it is necessary to establish cooperation in a multidisciplinary team: in Bulgaria in most of the SGBV cases, the specialists work with other professionals such as cultural and linguistic mediators, various medical professionals, state agency experts, representatives of child protection services, embassies, donors and others. In Greece, part of the professionals interviewed specifically work with migrant and refugee women – being specialized to support this target group. In Germany, public and private social services were contacted within the local context; mainly CSOs staff were interested in participating to the analysis. In Italy, both public and private organizations were contacted with half participants working in the public sector and

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other working in anti-violence centres and reception centres. In Serbia, representatives of local NGOs who participated in the research are engaged in the field of human rights protection, protection of women victims of trafficking and gender-based violence, protection of children, provision of legal support and representation, provision of services to migrants and refugees (61.7% of the interviewees). Representatives of the institutions that made up the sample in the research are employed mainly in the field of social protection (29%). The rest work in international organization for migrant and refugee support and protection.

Some of the interviewees in all countries requested to not share their names and organizations when sharing difficulties and challenging at the workplace.

4.2 Needs of migrant and local women and children who suffered from SGBV

Most vulnerable SGBV survivors are the people, especially women and minors, who are more often exposed to SGBV or to the heaviest gender inequality.

According to the interviewees in all the Partners' countries, the following conditions place migrant/refugee women at higher risk of experiencing SGBV. In ***Greece*** and in ***Serbia*** factors of risk for this social group have been accurately listed:

- invisibility to the system of identification of SGBV;
- cultural aspects on the perception of violence - normalization of crimes linked to SGBV;
- lack of knowledge of their legal rights and supporting services;
- financial dependence on the perpetrator or on the community system;
- lack of a supporting social network.

In ***Italy***, the problems faced by refugee women victims of violence are multi-level and multi-disciplinary, so a complex response to their needs is necessary (i.e., to learn Italian, to obtain recognition of refugee status, to find a home and a job, to have proper access to medical care etc.).

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In ***Bulgaria***, even migrants with a legal status don't necessarily have access to services, such as health services or kindergartens for their children, due to experiencing difficulties with administrative tasks, such as being registered at a residential address, which is vital to gaining access to many of those services. There is very little governmental support when it comes to finding a job and to access protection services.

In ***Germany***, interviewees reported that migrant women and girls often are not aware of their rights in Germany, and they suffer from patriarchal structures in their families, while some are afraid of being deported. Often social workers in Germany are not trained to read and understand all the needs that interfere with the recovery from the trauma of the refugee survivor, who remains in a condition of dependency on social and protection services. Building trust with multi-traumatised people requires a long-time process, often public services do not have this time available, and they implement short term or emergency programs. This looks like a common challenge in all partner countries.

In ***Serbia***, undocumented girls who travel alone or with "family" (for girls' protection along with the route or artificial and pretextual bonds which can hide again or advantages for the adults) are recognized as the most vulnerable people within the social group of the refugees.

> *"We realised that girls who are suspected of travelling alone can be seen alone can be seen along the entire route, but that there is a systemic blind spot; we noticed that the strategies used by girls travelling alone are different from those used by boys and that this makes them less visible for service providers unless they identify themselves."* –
> (Representative of an international organization, Serbia)

In ***Bulgaria***, even women from the Roma ethnic minority risk being more vulnerable than the average: e.g., themselves, their Roma community and even national law enforcement tolerate sexual abuse of Roma children. Moreover, girls' early cohabitation with older men rooted in a patriarchal tradition, hides the violation of the Bulgarian legislation and the normalization of a crime.

Other factors identified as those increasing vulnerability and difficulty in overcoming SGBV are related to mental health and disabilities of victims. Moreover, when access to health and

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social services is caused by mental health disorders, SGBV trauma is usually unidentified and underreported. It is possible to note that the coexistence of SGBV with mental disease is a risk factor all over the countries. More than that, when patients with mental distress are also SGBV survivors, they do not interrupt or are less likely to interrupt ongoing SGBV, due to their social isolation and the underestimating trend to recognise SGBV when tied to mental disease. As told by a social worker of the public services in Italy, the seek for help and the interruption of violence can be slower and more difficult:

> "*Once a disabled woman was suffering from SGBV perpetrated by a care assistant, but she didn't report it to the police. She decided to report after suffering for 5 months*." (Social worker, Italy).

4.3 Difficulties faced by front line workers in their work with women who suffered from SGBV (considering also managing stress and burnout)

When public institutions are not involved in combating SGBV as in Serbia and in Bulgaria where CSOs are the ones supporting survivors, there are several consequences as reduced resources of state institutions/reduced public funds, lack of training. Together with all these consequences there other aspect to consider such asshortage of mechanisms to hold them accountable in case of omission, violation of procedures and discrimination of victims, secondary victimization, lack of sensitivity in conduct, long procedures aimed at discouraging a person to persist in them, non-application of legal solutions. In the paragraphs below lay some of the challenges that professionals cited when it comes to systemic support.

In ***Bulgaria***, participants expressed their concern as following: professionals in these areas quickly burn out at work and become discouraged. There is a high turnover rate both in state and in CSOs that provide social services to victims. At the individual level, people try to help each other and sometimes we can see good initiatives and mutual assistance.

Regarding the ***Greek*** system and its procedures, participants stressed the following gaps and its effectiveness in supporting SGBV survivors: short-run programs, lack of common guidelines

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and protocols between services which lead to cooperation problems, lack of training and awareness in SGBV, turnover of staff, and low level of funding.

In Germany the 80% of the respondents mentioned i) the lack of professional mediation to overcome linguistic and cultural barriers, ii) the allocation of insufficient time for services, iii) the low financing of staff positions in local NGOs, and iv) the lack of finances resources to act quickly in cases of emergency as the most challenging difficulties they face A considerable 25% of participants identified the following issues when dealing with survivors in Germany (especially among migrant and refugee population):

- Lack of self-confidence and self-being of migrant victim including misbalance between duties and person skills for individual development;
- Access to male members within some migrant families is difficult to start a change of behaviour (i.e. sensitization activities, social welfare access etc)
- Problems when women are both victims and perpetrators (i.e., in a daughter-mother relationship)
- Working with children affected SGBV is difficult, especially if children must be separated from their (migrant) families. Cases in which these families take legal action to get back the child pose also a challenge.

In ***Italy***, educators reveal to feel helplessness in dealing with SGBV cases because their theoretical tools and their work experience deal just with psychological/educational issues. Therefore, some of them revealed their lack of competences in gender awareness and in identification and care of SGBV cases. Their lack of knowledge is followed by low-quality work performances and while they mentioned experiencing psychosomatic symptoms such as eating disorders ("*I eat anything*"), mouth's sores and skin rashes, strong headaches, shortness of breath ("*My throat was closed, it was a hard story to digest*"). Thefeeling of an overload of the work they undertake was also present in their asnwers.

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In addition, despite the national and international guidelines, still, the SGBV frontline workers deal with non-gender-sensitive workplaces[17] in all Partners' countries (this was reported especially in Italy and Greece): it means that unequal power relations among genders are still ongoing in work environments, and that in the judicial context for example, patriarchal or stereotyped gender convictions still affect all the law procedures, including the language, the type of questions, the judges' attitude and their verdicts.

In ***Greece***, patriarchy and the discrimination women face due to their sex and gender identity were the most widespread argument among participants. In addition, exposure to violence from early childhood (direct and indirect), drug addiction, motherhood, ignorance of the existing supporting services, young age and low self-esteem were identified as some of the characteristics of their beneficiaries. On the educational and financial level, Greek participants expressed that the public nature of their services attracts mostly women from the lowest socio-economic class, as the wealthier women tend to prefer private services.

Frontline workers recognize these physical and psycho-emotional sign and/or somatic symptoms on survivors due to their traumatic experiences of violence (part of these feelings are expressed by front line workers in all Partner countries):

- Low or zero self-esteem, lack of self-confidence and self-being;
- Suicidal thoughts/attempts;
- Body unawareness;
- Mood disorders: depression, bipolar disorders;
- Infections, acute inflammations;
- Fear, panic;
- Insomnia or discontinuous sleep;
- Feelings of isolation;

[17] Over 2016-2018 in Italy Superior School of Judiciary, the most important public authority for training in law, has organized 6 training courses on SGBV. Only 5% of judges has taken part in them. https://www.dire.it/17-07-2021/654793-violenza-domestica-commissione-femminicidio-magistrati-avvocati-e-psicologi-senza-formazione-perizie-ctu-critiche/

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- Exhaustion;
- Anxiety;
- Negligence in physical and space care;
- Post-traumatic stress disorder (PTSD);
- Compromised sense of danger/sense of reality;
- Mistrust, diffidence and disappointment from the system;
- Insecurity towards self and the outside;
- Closure to the outside;
- Loss of memory;
- Omnipotence: “I will save him” (talking about the perpetrator);
- Helplessness;
- Frustration, inadequacy;
- Sense of guilt, shame, self-blame;
- Skills inhibition;
- Compromised parental skills;
- Not recognition of the violence suffered.

In ***Serbia***, participants of the focus group which brought together representatives of psychosocial support providers, cited forced child marriages as a particular risk of discrimination in the future, assuming that due to economic consequences of the Covid-19 pandemic this practice of abusing girls will become even more frequent.

When asked about a self-assessment on SGBV expertise, most Bulgarian, Italian and Serbian participants answered, *“I possess some skills but it’s difficult to manage SGBV situations”*.

Among the skills necessary for work with victims of SGBV, participants listed interpersonal and intercultural skills, teamwork, emotional containment or resilience and continuous work on the improvement of personal strengths and capacities. In Serbia, front-line workers

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specifically dealing with migrant survivors expressed concern about the lack of consideration of the concept of intersectionality in response to the challenges faced by migrant women.

4.4 Training needs and recommendations

Most participants in all Consortium countries expressed that they feel unprepared when they have to handle stress-related behaviours of SGBV survivors. Most of the interviewees expressed the need to receive training on practical and theoretical tools for managing work-related stress.

Over 80% of ***German*** participants express the need for better knowledge for handling trauma related to SGBV; 29% of ***Serbian*** ones never underwent a completed training on mental difficulties experienced by SGBV victims. ***Bulgarian*** participants recommended extending the training courses on SGBV issues to police officers, prosecutors, judges, journalists and all the professionals in public institutions or private sector, who have the legal responsibility in some Countries in combating SGBV, or at least in avoiding perpetuating discriminatory or violent acts in workplaces.

> *"It is not enough just to claim compensation for the physical pain of rape, but to add the mental suffering - suicide attempts for example, whether there is a reflection of the victim's intimate life, etc. This shows the judges that a single act can affect the victim's life for five or more years. It is important for the court to be aware of mental suffering."* (Bulgarian interviewee)

In ***Greece***, regarding their communication with survivors, front-line workers mentioned that they faced challenges deriving from the different cultural backgrounds of their beneficiaries, such as establishing a common terminology on violence, overcoming misperceptions regarding violence (e.g., women are responsible for the violence they experience) and in recognizing the violence women are subject to. Participants detected general incompetence among professionals not only in handling SGBV cases, but also in interdisciplinary cooperation. Regarding their previous training on survivors' mental health, half of the

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participants indicated that they had not received any relevant, despite some of them having received training in gender-based violence and gender equality issues. Out of the participants that had not received any training on SGBV survivors'mental health, two were psychologists and one a social worker.

In ***Italy***, some professionals stated that it is precisely through training that burnout is prevented because it allows them to see their work from an external perspective (as a subject of study and reflection), to take time to increase their professional skills and to compare themselves with other experts in the field in a dialogical way.

Implications of the front-line's work on SGBV survivors' mental health may have a huge impact on their lives. Professionals who are untrained or afflicted with mental distress may more likely work against the SGBV survivors' reinstatement of rights and may cause secondary victimization.

Alongside harmful consequences of physical, psychological, sexual economic violence, sometimes after the primary violence SGBV survivors have to go through the so-called *secondary victimizations*. In these situations, the survivor undergoes violent or discriminatory acts for the second time: in front of untrained courts, with law enforcement that have no gender-sensitive approach and health care personnel not trained for this situation, the media that propose false narratives and the social media through discriminatory context. This highlights the need for an approach to survivors which affords to avoid secondary traumatization.

The following list represents all the frontline workers' expressed training needs:

- specific techniques and steps on how to respond to SGBV survivors' mental health: scientific theories must be combined with case studies, practical experiences for individuals and small groups; role play, survey tools and discussions with experts and peers working in the protection field;

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- appropriate methodologies from a cross-cultural and ethno-psychological perspective;
- intersectional studies on SGBV;
- psychological first aid kit (PFA) modified to SGBV;
- specific techniques and guidance on survivors' empowerment;
- self-care techniques;
- common guidelines for the team of workers with evaluation and self-evaluation modules;
- more networking activities among colleagues and among institutions that can be facilitated during traning/workshop activities;
- Specifics in providing support and assistance of children victims of sexual violence

"The training courses helped me learn the procedure, to recognize the consequences, to feel a little safer in the situation when I work with potential victims. I think it's a base we couldn't do without, but when it comes to taking care of myself, it seems that it all boils down to - burnout is bad, take care of yourself - and that's the end of it." (Representative of an international organization in Serbia)

Front-line workers' mental health was at the heart of the discussion during the focus groups and the relevant questions raised particularly their interests. Interviewees point out that everyone who comes into contact with SGBV survivors must be included in specialized training with specific measures for mental health protection. Regarding their support system, the supervision sessions provided by their organizations and the peer support deriving from co-working stance of solidarity were admired by the vast majority of the participants. A selection of the opportunitied mentioned by the SGBV frontline workers or emerged with the research for the protection of their mental health is following:

- The mental health-centred approach in the workplaces and settings;

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- Upgrading courses and training on SGBV (phenomenon and local procedures of action) held by a multidisciplinary team for better SGBV identification and support; to combat SGBV as a multidimensional issue, e.g. with a cross-cultural approach;
- Supervision policy at the organizational level and provision of periodical professional team supervision
    - assured periodical individual counselling sessions;
- Training on mental health and burn-out prevention for employers, front line workers, managers and coordinators, considering the efficient contribution of mindfulness;
- Integration and cooperation of the protection services of the anti-violence network and to promote connections among members of anti-violence services (*"if the network is fragile, the operator is fragile and the SGBV survivor's care is fragile"* - Social worker in Italy);
- Boundaries between different parts of working and private life;
- Resilience after emergency work;
- No gender stereotypes and prejudices, which affect procedures and everyday work activity;
- Gender-mainstreaming in the access to justice in order to dealing with women's and men's needs in the justice system;
- Holistic or systemic vision of the SGBV survivor and of her/his care;
- Participation of survivors in developing and designing protection and care services;
- Empowerment of survivors and of their capacities to plan the future through psycho-counselling activities in all supporting phases.

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5. Data analysis from the FG/interviews to women survivors of SGBV in Partner countries

5.1 Brief description of the participants

The research team managed to interview 92 SGBV survivors. Although the number of the interviews conducted by WeToo Partners all over Europe is 92, the number of contacted, reached and informed SGBV survivors about WeToo project through emails, e-meetings, phone calls or texts increase the data. However, the Research team checked and validated only interviews fully conducted and under-coverage of consent.

All interviewees are of female gender, with an age over 18 years old. In specific,

- 17 women have been interviewed in ***Greece***
- 5 in ***Germany***;
- 19 in ***Bulgaria***;
- 29 in ***Serbia***;
- 22 in ***Italy***

In total, 92 SGBV female survivors have been interviewed. Around 54% of them are migrant and refugee women. In ***Serbia*** (for the number of 29 interviewees) and ***Greece*** (10), the majority of participants identify themselves as refugees or asylum-seeking migrants.

The absence of male, transgender, transexual and queer interviewees shows a minor connection and a consequent low or zero impact of the anti-violence network on specific social groups, such as LGBTQIA+. The gender gap in health or social services dedicated to the support of not-female SGBV survivors must be underlined and taken into account.

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5.2 Main findings on SGBV protection services accessibility from the point of views of the target group (opportunities, good practices and lack of the system identified)

As acknowledged in desk research, from the interviews it can be noted that the support system for SGBV survivors presents serious challenges in most of the Partners' countries. Interviewees have been asked 1) about their contact to the protection services, 2) their level of satisfaction and participation in the protection service use and 3) their social support in making long-term plans. Partners have collected a set of data that can lead to certain analogies and differences in these three fields from a transnational perspective. After and as a result of this collection of data, analogies and differences of research will be shown in all Partners' countries.

In ***Bulgaria*** the number of the existing accommodation centres for women is insufficient and their provision of care and support is ineffective. There are no services developed for male victims of violence or gender-based violence: e.g., some Bulgarian services would refuse to give help to men because of the existing legal framework, which acknowledges only domestic or sexual abuse and human trafficking and excludes homophobic acts as violent or criminal acts. In general, SGBV survivors wonder for a long time before reaching the services support because of lack of information, distrust in national institutions, lack of communication and cooperation among institutions and services, both State and NGOs. Bulgarian partner also underlines that SGBV survivors end up returning to the services which helped them when the networking among support services is absent or ineffective. In these cases, dependence and over-reliance on social services are developed.

For refugees/asylum seekers – SGBV survivors in ***Greece***, the social services and the educational activities constituted the most-used services in the shelter while the less-used were the psychological and the legal counselling service. It suggests the idea that their mental health was perceived quite as a secondary issue. Three women out of a total of ten refugee

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women faced difficulties in entering the shelters, referring mostly the bureaucratic procedures and the long-time waiting time. Regarding participant local survivors, their experiences were slightly different than those of refugees: they used both social services and psychological support. Nevertheless, the localparticipants in Greece expressed their dissatisfaction with the relationship they had developed with the professionals.

In ***Italy***, refugee women are supported also by the local welfare system, and they encounter social workers. The participant SGBV survivors accessed the legal desk and the reception centre of Oxfam thanks to the Social Welfare System after a period in an emergency shelter (where the local Prefectures accommodated them after reaching the Italian coast through the Mediterranean route). Most of the Italian women interviewed underlined how operators of the anti-violence centre were able to immediately create a warm, open and welcoming atmosphere, devoid of judgments. It emerged the need and the will for a continuous search for individual well-being, personal growth related to increased self-esteem. Women expressed the need to give and receive trust and thus recover their self-esteem to be ready to open themselves in the social and emotional sphere.

In ***Germany***, due to the sensitivity of the topic and despite the many attempts through different channels in the Partner's network, only a low number of women agreed to take part in the interview. These interviews confirm a high level of satisfaction with SGBV protection services. In terms of future planning, over 50% of the interviewees declare *"to receive help from her religious beliefs and that religion gives stability and long-term perspective"*.

In ***Serbia***, respondents stated that the most significant aspect of the support program was safe accommodation, followed as second priority by the provision of psycho-social support, i.e., the feeling of security. Most interviewees saw the need for improvement of the legal support for women (65%) and to improve social inclusion and education. Moreover, respondents stated that regarding their plans for the future, they were most confident in the

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existence and availability of programs of economic empowerment and acquisition of skills. These programs are twofold: in addition to empowerment, they contribute to cultivating mental health.

Conclusions and recommendations

Desk and field research have underlined how wide the phenomenon of SGBV is in European society, with a sharp increase of cases during the Covid Pandemic.

It was outlined how in ***Germany***, ***Italy*** and ***Greece***, good practices and national procedures for mental safety in the workplace are present within social and health services, but all these tools are not binding or mandatory by national and regional laws.

In ***Serbia*** and ***Bulgaria*** there are any policies framework to protect front-line workers from work related stress and burn out. Good practices do exist but are confined within NGOs experiences.

In addition, it has been detected in all Partner countries the insufficient resources and staff dedicated to supervision and protection of the mental health of both front-line workers and survivors. Both (even if in very different ways) are exposed to the stigma of suffering from mental distress.

It was mentioned in many national reports, that victims who suffered from mental disorders are less likely to be believed, to report SGBV and to be taken care for this. However, SGBV can deeply influence and affect the psycho-emotional well-being of a survivor.

Front-line workers are highly exposed to stress and pressure, and public services implement only few mechanisms of burn out prevention, while some CSOs carry out supervision processes which are recommended in order to improve the quality of the teamwork and the protection interventions towards SGBV survivors.

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In ***Serbia*** and in ***Bulgaria***, the political and social context is extremely unsupportive regarding the SGBV issue: legal regulations bylaws do not sufficiently follow the obligations from international conventions and plans outlined in strategic documents. There is no state-run facility in which such support could be maintained. The Republic of Serbia does not provide sustainable psychological support to victims of trafficking. On one hand, the only available and specialized safe accommodation for victims of trafficking in Serbia is the one operated by NGO Atina, which also provides psychological support to victims. On the other hand, professionals who see the need to improve these blind spots in the system face the challenge of lack of funding for women's programs, universalization of programs, lack of service development, and adaptation of programs to the needs of the male majority of migrants. Most professionals who are in daily contact with women victims are in a situation of high workload (mentioned by professionals for both countries Bulgaria and Serbia). They remain in a position of continuous training to recognize cases of SGBV, but in practice, they cannot provide alternative and necessary solutions due to a number of circumstances at the system level. Therefore, professionals seek support, both supervisory and psychotherapeutic, in order to prevent the symptoms of stress they cope with and the helpless position in which they often find themselves.

In ***Greece***, the Covid Pandemic has exacerbated the vulnerability of migrant and refugee population. Survivors of SGBV are more likely to experience other forms of violence and abuse. In addition, protection services (both public and private) have less funds and resources available to face the crisis. Good practices and training were developed and disseminated before the Pandemic. KMOP contributed to several training for professionals on SGBV prevention and response, nevertheless the situation of crisis has increased the need of support for professionals. This can be achieved providing comprehensive training sessions to front-line workers handling SGBV cases that will give them the opportunity to learn more on stress, mental health distress and trauma related to SGBV. Training activities to front line workers should be integrated by awareness campaigns, to sensitize the society as a whole in issues relating to mental health of SGBV survivors and professionals working in this field.

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Concerning the victims and survivors of SGBV, empowerment workshops and psycho-social counselling sessions for the inclusion of women, would help in the recovery from SGBV-related trauma and distress.

In ***Germany***, social workers as SGBV frontline service providers overall are satisfied with the overall system and organization of services. However, complaints focus on time constraints, lack of staff resources, lack of public awareness of SGBV and lack of time and other resources for attending vocational trainings and continuing trainings despite a well described need. Volunteer services still play an important role in Germany in the provision of support for victim and survivors of SGBV. Therefore, training and supervision for volunteers needs to be increased and improved on sensitive aspects such as SGBV prevention and response, creation of relation of trust with survivors taking into account safe and protection standards.

In ***Italy***, it was outlined how good practices and national procedures for safety in the workplace are present within social and health services, but all these tools are not binding or mandatory by national and regional laws. For this reason, few services provide psycho-social support to field workers (this is particularly dramatic for doctors, nurses and police officers working in the emergency phase/first contact – also responding to sexual and physical violence).

Taking into account the results of the research and data comparison, it is concluded that creating better support system when it comes to SGBV survivors would consequently reduce stress among professionals working to recognize SGBV, as there is still a huge gap in available support programs to improve the mental health of professionals, as well as refugees and migrants who suffered from SGBV.

Thanks to data collected, especially those provided by front-line workers, the research team will elaborate two self-assessment tools: one to assess (and self-assess) the mental distress of front-line operators and one to assess the mental distress of SGBV survivors among local and migrant population. The first tool will be elaborated in collaboration with psychologists

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who have experience in supervision, which has been identified as a good practice for organizations operating for the social protection of survivors. ***The (self) assessment tool for the frontline workers*** will take into account the findings of the research as well as the long-term experience of professionals working in the support of front-line workers (supervisors/psychologists). As symptoms and feelings of stress have been detected in all countries and related to organization of the work, pressure of the legislative and bureaucratic system present at local/regional level, level of human and financial resources available in the context, an effective tool should take into account personal, organizational and contextual risks which can affect the wellbeing of front-line workers. Detecting their feelings and make them aware of their level of wellbeing is an important step to empower front-line workers. A further step is the organizational level, management and coordination of services should be engaged in order to promote the tools within their entities and to strength their internal and networking safety measures. The (self) assessment tools for front-line workers must be adapted to each Partner country in order to take into account challenges and opportunities present in the context of the intervention.

The ***assessment tool for SGBV survivors*** will be elaborated in collaboration with psychologists and psychiatrics expert in trauma rehabilitation. Feelings and social inclusion of survivors should be at the centre of any protection intervention. Accessing in a safe, confidential and agreed space the emotions of survivors and monitor their process of recovery and empowerment should guide the composition of the tool. Other tools are already available in anti-violence centres when survivors firstly access the service. WeToo project intend to collect these tools and share good practices to understand survivors' feelings, needs and desires connecting them to the local context with the time requested by them. Training activities on stress management and trauma recovery for the survivors will follow the development of the tools, considering the recommendations and concerns shared by front-line workers in each partner country during the assessment phase.

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