



Building Relationships through Innovative Development of Gender-Based Violence Awareness in Europe - BRIDGE Project

Care Professionals Survey – 2nd Data Collection – Survey Analysis Report

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This data collection took place within the framework of the regional project [“Building Relationships through Innovative Development of Gender-Based Violence Awareness in Europe - BRIDGE”](#) with the purpose of gathering information on the level of awareness among children and youth on the move on gender-based violence. Data was gathered through a questionnaire encoded in a mobile data collection tool that was used during face to face meetings.

The BRIDGE project is **supported by the European Union’s Rights, Equality and Citizenship Programme (2014-2020)** and is implemented under the lead of Terre des hommes Regional Office for Europe in Hungary, in partnership with Defence for Children International Belgium (DCI Belgium) and FEDASIL (Belgium), Association for the Social Support of Youth – ARSIS (Greece), Kopin (Malta) and Terre des hommes Romania. The aim of the project is to strengthen the response to gender-based violence (GBV) affecting children and youth on the move in European Union countries as well as to empower children and youth on the move to better protect themselves.

1. General

Nine female respondents filled in the care professionals’ survey during the months of February through to August 2020¹. All of them work at the Agency for the Welfare of Asylum Seekers (AWAS)², whether at an open (accommodation) centre or otherwise. The respondents, some of whom work with the agency’s Therapeutic Unit and within the care team, comprise a mix of regular professional staff and other types of workers. Among the respondents, there are unit leaders, coordinators, members of the core team and social workers. Their levels of education range from a high school degree / equivalent (1 respondent) to Master’s degree (3 respondents).

¹ The data collection started in February, and was then suspended due to COVID-19. The survey was reopened in May 2020.

² <https://homeaffairs.gov.mt/en/MHAS-Departments/awas/Pages/AWAS.aspx>

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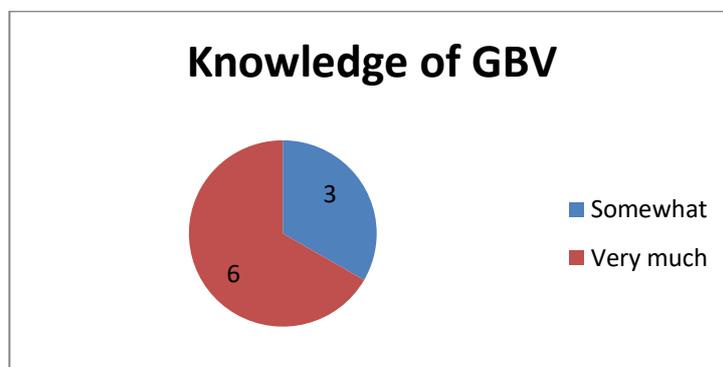




Training received. The large majority of the respondents (8) have received training on gender-based violence (GBV)³ and on migration (7 respondents). Meanwhile, just under half (4 respondents) indicate that they received training on child protection.

The **majority** (six) respondents – **all of whom have received GBV training** – indicate that they **have enough ('very much') knowledge of GBV for their position**. Meanwhile, the other three respondents feel their knowledge is only somewhat enough (see Figure 1). These findings **stand out in comparison to those emerging from the first data collection**⁴ - which took place prior to the GBV training delivered as part of the BRIDGE project – where almost all respondents felt their GBV knowledge was only 'somewhat' enough for their position.⁵

Figure 1 – Perception of whether knowledge of GBV is enough for position held



2. Perceptions of GBV

This section looks at the care professionals' perceptions of GBV, through their responses to the various questions on forms of GBV.

The **majority** of the respondents (7) **consider an act of physical violence against a child that is not sexual in nature as GBV** (with 6 indicating that this is 'definitely' a form of GBV and one replying 'probably'). All of these respondents received training on GBV. However, two respondents who also received GBV training do not consider this act as GBV.

Child marriage is considered as a form of GBV by all respondents, with eight indicating 'definitely', and one replying 'probably'. **All respondents also consider bullying as a form of GBV**, with five indicating that it 'definitely' is GBV.

³ Only one of the respondents did not participate in the Bridge GBV training.

⁴ Kopin. 2019 (October). *Building Relationships through Innovative Development of Gender-Based Violence Awareness in Europe (Bridge Project). Care Professionals Survey – 1st Data Collection – Key Findings. Malta*. Available: <https://childhub.org/en/child-protection-online-library/data-collection-analysis-malta-bridge-project>

⁵ Respondents for the first data collection are not the same ones as those participating in the second data collection.





The **majority** (7) of respondents **consider denial of access to education as a form of GBV** (with 6 replying 'definitely' and 1 'probably'); while two respondents replied 'probably not' and 'definitely not'.

3. Information about the Organisation

Types of support for GBV survivors. Only one respondent (coordinator) replied to this part of the survey. The respondent indicates that their agency – which works with migrant children and young people – provides psychosocial support, health care, legal assistance, child protection program, translation services, as well as other services (where cases are referred to other entities and NGOs as required) to GBV survivors.

When asked whether they consider the services provided to children/young people survivors of GBV are sufficient, two respondents reply that the psychosocial support is 'probably' and 'definitely' sufficient; health care and legal assistance services are 'probably' sufficient, while the other respondent indicates that she does not know; the child protection program is 'probably not' sufficient, while the other respondent does not know; and the translation service is 'probably not' sufficient.

GBV Survivor Identification Procedures. While **three respondents are not aware of whether their agency has formal or informal procedures for identifying GBV survivors, four respondents** (including the two social workers and two respondents from the therapeutic unit) **indicate that they follow informal mechanisms, while two indicate that they follow written protocols** (see Figure 2). Interestingly, the latter two comprise the coordinator and someone from the centre team, indicating that while core / coordinating professionals have knowledge of written protocols regarding disclosure procedures, others (such as those working in therapy and social work) might not.

The same professionals (the worker from centre team and the coordinator) as well as a social worker (**three** in total), **indicate that their agency has specific procedures to identify children survivors of GBV.** However, **three other respondents indicate that their agency does not have such procedures; while three reply that they do not know.**

The procedures indicated comprise:

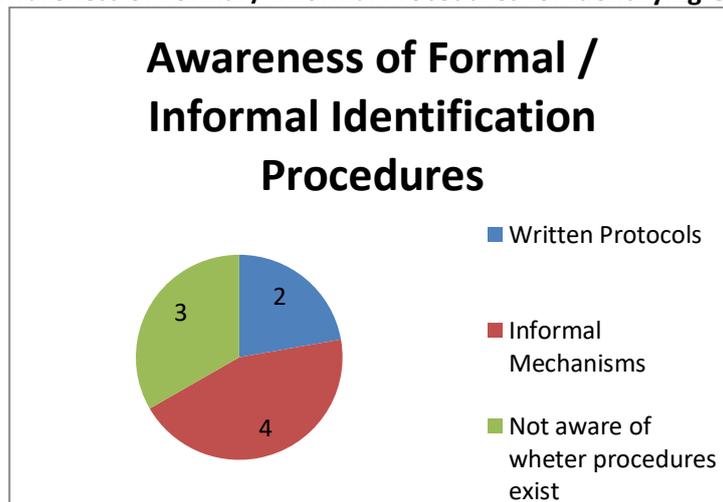
- Psychological and age assessments;
- Identifying the behaviour of the child; interviewing the child; looking at the family unit; and separating child from abuser;
- Care unit and therapeutic unit following up cases of GBV;
- Reporting / referring case to social worker, child protection, *Agenzija Appogg*⁶ (the public national agency for children, families and the community), or police if needed.

⁶ <https://fsws.gov.mt/en/appogg>



It is interesting to note that some of the answers indicated here comprise referral procedures rather than identification ones, possibly demonstrating the lack of (knowledge of) identification procedures among Agency staff.

Figure 2 – Awareness of Formal / Informal Procedures for Identifying GBV Survivors



The **majority of respondents (7) indicate that GBV is identified by the therapeutic unit**; while 3 respondents⁷ mention the care team or care workers, social workers and support workers. Two respondents also mention coordinators while another indicates that everyone who has contact with clients identifies GBV.

The **most common type of GBV identified is physical abuse (8 respondents), followed by emotional and sexual abuse (7 and 6 respondents respectively). Gender-based discrimination is also indicated by six respondents**; while denial of resources is indicated by 5. One respondent also indicates abuse in the workplace as another type of GBV identified.

As seen in Figure 3, **five respondents feel ‘very’ comfortable dealing with a child disclosure**, while two feel only ‘somewhat’ comfortable. One respondent does not really feel comfortable, while one does not know. These findings mark an increase – from the first data collection – in the percentage of respondents feeling comfortable with a child disclosure. While in the first data collection only around one third of the respondents indicated that they were ‘very’ comfortable with such disclosures, in this round of data collection, more than half of the respondents answer in this way. Furthermore, in the first round, almost half of the respondents indicated they were ‘somewhat’ comfortable, while this

⁷ Most of the respondents gave multiple answers.

time round, less than one fourth do so. Finally, while in the first round one respondent indicated that they were not at all comfortable, this time round no one indicates this.

Figure 3 – Comfortableness in dealing with child disclosure

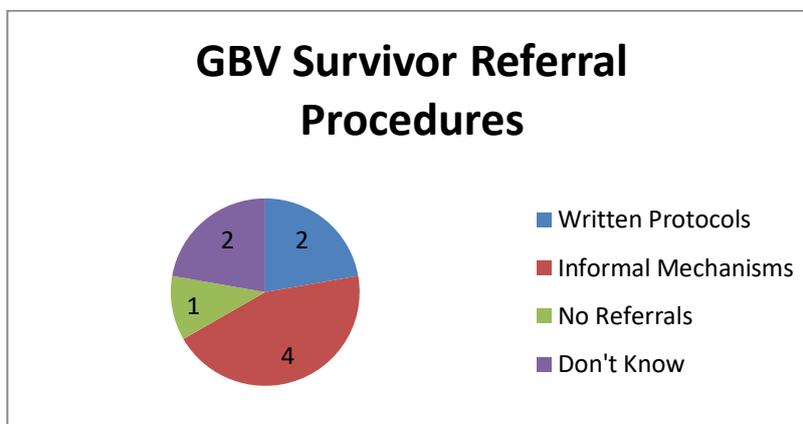


When a GBV case is identified among children or youth, the first step, according to the majority (6 respondents), is liaising with / reporting or referring them to their leader, the therapeutic unit, social worker or other professionals who are able to deal with GBV. One of these respondents indicates she would first provide a safe space; while other respondents mention that they would explain issues of confidentially, conduct an interview, listen carefully, and support the client during disclosure.

Finally, two respondents add that it is very challenging to identify survivors; and that procedures for such identification are not exact, with one respondent indicating that it would be beneficial to have clear procedures where it concerns children / youth and GBV.

GBV Survivor Referral Procedures. As seen in Figure 4, **only two respondents** (the coordinator and the professional from the centre team) indicate that they **follow written protocols when referring a child / young person identified as a GBV survivor**. Meanwhile, almost half (**4**) of the respondents indicate that their agency follows informal mechanisms; while **two respondents indicate that they do not know** whether their agency has either formal or informal procedures for such referrals. One respondent specifies that they do not refer GBV survivors. These findings are similar to those reported on the care professionals' awareness of GBV survivor identification procedures (see Figure 2), where the same two respondents demonstrate knowledge of formal procedures while almost half mention informal ones and two to three respondents do not know.

Figure 4 – GBV Survivor Referral Procedures



Four respondents then delineate the procedures used in referring GBV survivors among children and youth, which comprise reporting or referring the case to a doctor, social worker, legal guardian, psychological team, other professionals and / or *Aġenzija Appoġġ*. (In previous questions, one respondent indicates that sometimes coordinators and/or support workers would notice certain behaviours among clients and refer the client to professionals working within AWAS, including social workers, counsellors, assistant psychology officers, psychologists, and / or nurses).

Two respondents add that the referral process takes too long and people tend to give up; and that it is important to assess the actual situation of the person and to know their family history.

Areas of Need of GBV Survivors. The large majority of respondents (8) indicate that the main areas of need (in relation to GBV) delineated in the questionnaire are needed by children and youth, that is: psychosocial support, health care, legal assistance and translation service; while seven of the same respondents indicate that the child protection program is also a main area of need.

When asked **when a case of GBV should be reported to the police**, the seven respondents who answer indicate the following situations:

- Always.
- When there is a suspicion that a GBV case has occurred.
- Immediately for survivors under 18 years of age; when client gives permission if they are over 18 years of age.
- When the survivor gets physically hurt, is in danger, is being threatened, and / or is in contact with the perpetrator.
- Directly after a referral to Mater Dei Hospital (the national public hospital)⁸ or Genitourinary (GU) Clinic⁹ has been made.

⁸ <https://deputyprimeminister.gov.mt/en/MDH/Pages/Home.aspx>

⁹ <https://deputyprimeminister.gov.mt/en/MDH/Pages/MDH-Genitourinary-Clinic.aspx>

GBV survivor Follow-up. Almost half of the respondents (4) indicate that they do not know if the agency they work with has practices of following-up referred GBV cases (case management); while one respondent indicates that there are no such practices. Once again, the (only) **two respondents indicating that they have written protocols** for this are the one from the centre team and the coordinator; while **three respondents** (including one who replies that she does not know) **indicate they have informal mechanisms.**

Similarly, when asked if their agency has **specific procedures to follow up** children and youth survivors of GBV, the **same two respondents answer in the positive, while three answer that no such procedures exist, and another three indicate that they do not know.**

However, when asked to elaborate, the two respondents who indicate that there are follow-up procedures, detail identification and referral procedures, rather than follow-up ones, including:

- Interviewing, assessing, accompanying and providing psychological support for the survivor;
- Communicating and liaising with the professionals involved in the case.
- Referring to AWAS social workers, psycho-social support workers and therapeutic unit, or to other entities / NGOs if necessary (including *Aġenzija Appoġġ*, Jesuit Refugee Service (JRS)¹⁰, Migrant Women Association Malta (MWAM)¹¹, Caritas Malta¹² and Rainbow Support Service¹³).

Once again, the **same two respondents indicate that their agency has specific tools for GBV case management** (while **four indicate that they do not know, and two respondents indicate that they do not have such tools**). However, the two positive replies demonstrate a conflation of case management tools employed by the Agency and other procedures / by other entities: when asked to specify which tools are used, the replies comprise assessment / referrals / support as well as information sessions held by NGOs in AWAS reception facilities, and online support.

With regard to **collaborating with other services to follow-up on the referred GBV cases during the preceding 12 months**, the frequency with which such collaborations have occurred are detailed below (the brackets detailing the number of respondents):

- Psychosocial support: (almost) always (2); frequently (3); do not know (2).
- Health care: (almost) always (1); frequently (3); never (1); do not know (2).
- Legal assistance: (almost) always (1); frequently (3); never (1); do not know (2).
- Child protection program: frequently (2); rarely (1); do not know (3).
- Translation service: (almost) always (3); frequently (2); do not know (3).

¹⁰ <http://www.jrsmalta.org>

¹¹ <https://migrantwomenmalta.org>

¹² <https://www.caritasmalta.org>

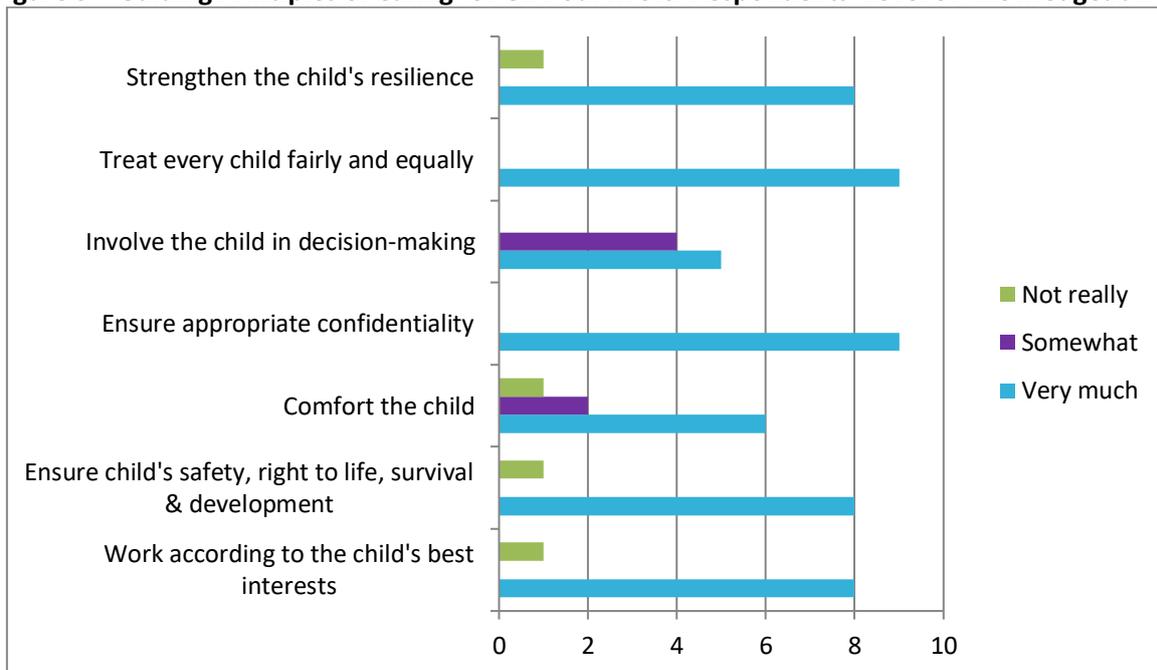
¹³ <http://maltagayrights.org/the-rainbow-support-service>

- Other types of services: do not know (3).

Guiding Principles of Caring for Child GBV Survivors. As can be seen in Figure 5:

- All respondents indicate that they are 'very' knowledgeable regarding the principles of ensuring the appropriate confidentiality and treating every child fairly and equally.
- All respondents indicate that they are 'very' (5) to 'somewhat' (4) knowledgeable in involving the child in decision-making.
- The large majority (8) feel that they are 'very' knowledgeable regarding the principles of: working according to the best interest of the child; ensuring the safety of the child, and their right to life, survival and development; and of strengthening the child's resilience, with only one respondent indicating 'not really'.
- The large majority (8) feel that they are 'very' (6) to 'somewhat' (2) knowledgeable with regard to comforting the child, with only one respondent replying 'not really'.

Figure 5 – Guiding Principles of Caring for GBV Survivors: Respondents' Level of Knowledgeability



These results also demonstrate an overall improvement in the knowledge of care professionals with regard to the principles of caring for child GBV survivors. In this data collection round, for example – unlike in the first one – *all* respondents indicate they are very knowledgeable on two of the principles; while the majority of respondents feel very knowledgeable on all of the other principles.



4. Conclusions and Recommendations

The findings of this second round of data collection demonstrate an improvement in some areas related to GBV case management, including care professionals' knowledge of GBV as well as their feelings of comfort with a child disclosure.

Meanwhile, the findings show that the majority of care professionals responding to this survey are still unaware of the existence of (formal) procedures, protocols and tools regarding identification, referral and follow-up of GBV cases of children and youth. If these procedures exist – as testified by respondents from the core team – the results indicate that there needs to be greater awareness of such processes, especially among the more 'peripheral' workers who work directly with survivors, including care professionals from the therapeutic unit and social workers. Findings also show that identification, referral and follow-up procedures are sometimes conflated, indicating the need for such procedures to be made clearer (as one respondent herself mentions), possibly through training sessions and / or online information.

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