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CASCADING EFFECTS

Mediating the unutterable sufferance of gender-based violence in migratory flows

Denise Filmer

1 Introduction

Humanitarian organizations have been striving in recent years to raise awareness of sexual and gender-based violence perpetrated in crisis settings (Amnesty International 2015 HRW 2019; IASC 2015; IOM 2018; UNHCR 2016, 2018 to list a few). The latest publication by the International Organisation for Migration (IOM 2018) for instance proposes an *Institutional Framework for Addressing Gender-based Violence in Crises* in response to the 'hidden aspect' of Mediterranean migratory flows (Freedman, 2016). The framework aims to tackle gender-based violence[1] (GBV) on three major fronts: Risk reduction in crisis operations; support for victims through 'survivor[2]-centred multisectoral services'; and by challenging the 'inequitable power dynamics and patriarchal gender norms' that are its 'root cause' (2018, p. 10). Gender-based violence is not isolated geographically and is diffused across the globe; its various forms of abuse violate the basic human rights enshrined in the United Nations Declaration: 'The right to life; the right to security of person; the right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment; the right to equal protection' (ibid., p. 5). Humanitarian crises such as the ongoing migratory flow through and from Africa towards Europe's coastlines cannot but intensify the risk of exposure to Sexual and Gender-Based Violence (SGBV). Women are particularly vulnerable along such journeys that create conditions engendering the use of violence and sexual abuse, such as:

> displacement and family separation of relationships, scarcity of essential resources to care for most basic needs, substance abuse, collapse of community and/or State-led protection systems (such as security and rule of law), disruption of community services, changes in cultural and gender norms

> (including towards increased acceptance of violence), weakened infrastructure, increased militarization, and increased ethnic and racial discrimination.
> *(IOM, 2018, p. 11])*

Subjugated to cruelty and violence during their enforced detention in Libya, those men, women, and children who survive the journey across the Mediterranean will reach Italy's coastline in conditions of physical and psychological distress. There they face multiple language barriers to recount the horrors of their journeys. This chapter reports on interviews held with those involved in the cultural and linguistic mediations that occur upon their arrivals. Adopting ethnographic methods, the small-scale study combines documentary evidence extracted from the websites and publications produced by humanitarian and other NGOs with semi-structured interviews carried out in-situ with operators, medics, and intercultural mediators (see discussion in Section 3). The study investigates procedures involved in the identification of survivors of SGBV on arrival at Sicilian ports and was motivated by the need to ascertain what (and indeed if) provision is made for psychological support. Most crucially, it focuses on the pivotal role of the intercultural mediator in the clinical settings that ensue.

The first part of the contribution provides the essential background information that serves to contextualize the data: The Italian government's current stance on immigration is discussed and its closed-door policy and accord with Libya is outlined. The sections that follow summarize national and international legal frameworks regarding the provision of intercultural mediation for migrants in clinical settings. The second part of the study analyses data collected from the interviews and discusses the issues involved in intercultural mediation for survivors of SGBV. The study begins by defining terms; the delineation of GBV and SGBV in humanitarian discourse in the context of migration.

1.1 The boundaries of GBV and SGBV

According to the UNHCR (2016, p. 4) SGBV is one of the most widespread, yet socially accepted human rights violations. The Inter-Agency Standing Committee (IASC) defines GBV as,

> any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty.
> *(IASC GVB Guidelines, 2015, p. 5).*

Instead, the UNHCR website[3] uses the longer acronym SGVB and specifies that it originates in contexts where an asymmetrical power balance prevails:

> Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services. It inflicts harm on women, girls, men and boys.

Any form of SGBV, physical or not, is viewed as a violation of human rights, denying human dignity and impairing human development (ibid.). Engrained in societal attitudes that tolerate violence in the family, in the community, and by the State, SGBV is not only a risk along the migratory journey but is in fact a reason for displacement; the threat of female genital mutilation or persecution due to sexual orientation can constitute grounds for refugee status. Sexual violence can also be 'a terrible consequence of the breakdown of family and community structures that accompanies displacement' (UNHCR 2016, p. 5). Lastly, SGBV may be perpetrated by the very people who are entrusted with the task of protecting refugees and displaced persons, for example within a reception centre by operators. It is evident from this broad definition of what constitutes an act of SGBV that identifying who qualifies as a 'survivor' is problematic, and even more so considering language barriers. Italy's current policy on linguistic mediation and intercultural communication is strictly linked to the heated debate on migration and needs to be contextualized within the Italian government's recent shift to the right; the ideology and politics of refoulment and closure at national and European level are creating a cascading effect on the humanitarian crisis in the Mediterranean Sea.

2 Migratory flows: An overview of current European/Italian approaches

Since 2011, the ebb and flow of migrant movement from Africa towards Europe has necessarily passed through Libya. For women refugees who want to reach Europe the cost of the passage by sea invariably includes 'survival sex' (UNHCR, 2016a) in the form of prostitution or sexual abuse. In its report entitled *Desperate and Dangerous* (UNSMIL, 2018), The United Nations Support Mission in Libya (UNSMIL) lists a catalogue of violations to human rights perpetrated against migrants held in Libyan detention centres or those at the mercy of human smugglers. The Libyan authorities are accused of refusing to implement the recommendations made in a previous report published by UNSMIL and OHCHR, '*Detained and Dehumanized': Report on Human Rights Abuses Against Migrants in Libya* (UNHCR, 2016b), and denounces the continued use of torture, inhumane living conditions, and sexual violence against not only women and girls but also men and boys.[4] The report begins thus:

> The overwhelming majority of migrant and refugee women and older teenage girls interviewed by UNSMIL in 2017–2018 reported either being raped by smugglers or traffickers in Libya or witnessing others being taken out of

> collective accommodations and returning distraught, physically hurt and/or with torn clothes.
>
> *(UNSMIL, 2018, p. 31)*

While refugees and asylum seekers are being held in Libya, simultaneously, the reception system for migrants[5] in Italy is being systematically dismantled. On the 22 January 2019 one of the largest reception centres in Europe, CARA[6] di Castelnuovo di Porto near Rome was shut down. In one day its 500 guests were evicted. Compared to the deportation of Jews during WWII in the Italian media[7], the subsequent public protest prompted a more cautious approach to expelling the 1,200 migrants who are currently housed in CARA di Mineo in Sicily. The regional authorities have gradually moved groups of approximately 50 migrants from the CARA to smaller centres (CAS[8]) around the island. The current Italian government, with Matteo Salvini as Minister of the Interior, legitimizes the reduction in reception facilities and what is effectively the elimination of an integration policy with the decline in migrant arrivals. From a peak of 181,436 in 2016[9], the total of arrivals in Italy in 2017 fell to 19,369. As can be seen in Tables 4.1 and 4.2, from 2017 to 2018 the arrivals in Europe decreased by 35%. Italy saw the greatest drop with 85% fewer arrivals compared to 2017.

These results were largely due to the Memorandum signed in February 2017 between the former Minister of the Interior, Social Democrat Marco Minniti, and the leader of the UN-recognized government, Fayez al-Serraj introducing closer cooperation between the Libyan and Italian coastguard. The Italian government agreed to provide training for the Libyan coastguards and four patrol vessels to block migrants attempting to cross the Mediterranean. Subsequent agreements with the present Lega-5SM coalition government have further reinforced Libya's operational freedom on stopping the migration flows. Since coming to power in June 2018, Salvini as Minister for the Interior has implemented increasingly aggressive anti-immigration/integration policies: Revoking what were called 'humanitarian

TABLE 4.1 Arrivals by sea and deaths in the Mediterranean 2017

Total arrivals by sea and deaths in the Mediterranean 2017

164,908 total arrivals by sea.
3,113 total dead/missing

COUNTRY	*ARRIVALS*	*DEATHS*
Italy	117,120	2,844
Spain	20,043	208
Greece	27,244	61
Cyprus	501	0
Malta	0	0

Source: IOM. All numbers are minimum estimates. Arrivals based on data from respective governments

TABLE 4.2 Arrivals by sea and deaths in the Mediterranean 2018

Total arrivals by sea and deaths in the Mediterranean 2018		
107,583 total arrivals by sea2,133 total dead/missing		
COUNTRY	*DEATHS*	*ARRIVALS*
Italy	1,285	23,011
Spain	681	52,678
Greece	167	29,782
Cyprus	0	930
Malta	0	1,182

Source: IOM. All numbers are minimum estimates. Arrivals based on data from respective governments

residence permits'; reducing funds to those reception centres (CAS) that continue to exist; refusing to allow humanitarian ships to disembark migrants found at sea[10] at Italian ports, thereby contravening several universal human rights laid down in the UN's declaration (1948). Notwithstanding the international controversy surrounding his immigration policies, Salvini has galvanized popular national consensus because his closed doors strategy is evidently, if superficially, effective. The consequent 'bottle neck' of migrants imprisoned by the Libyan authorities, however, is brutally ignored. The EU, and Italy in primus, disregard the growing number of migrant detainees, despite the crescendo of petitions from every humanitarian organization on the planet.

2.1 Libya and beyond

A recent Human Rights Watch report entitled, *No Escape from Hell: EU Policies Contribute to Abuse of Migrants in Libya* (HRW, 2019) accuses Europe, and Italy specifically, of being responsible for the human tragedy caused by the arbitrary detention of migrants in Libya. HRW (2019, p. 58) claims that the EU is effectively funding the Libyan Coast Guard to facilitate the interception of migrants and asylum seekers at sea. The report denounces the 'inhuman and degrading conditions and the risk of torture, *sexual violence*, extortion, and forced labour' (my emphasis) that are intrinsic to the Libyan detention system. Having endured months or possibly even years of rape, violence, and inhuman living conditions, if the survivor eventually manages to embark one of the unseaworthy vessels to cross the Mediterranean, one of three things could happen:

(1) they do not arrive at all;
(2) a vessel signals its distress as it navigates towards the European coast but, the migrants are 'rescued' by the Libyan Navy, they are returned to whence they escaped;
(3) they manage to arrive at a Sicilian port.

What can the psychological state be of those women and men who have survived so much? In her study of female refugees' experience of SGBV on their journey to Europe, Freedman (2016, p. 19) condemns EU policy that focuses on the repression of trafficking and prevention of illegal migration, rather than the protection of the rights and lives of migrants who are desperate to reach Europe. Furthermore, she (2016, p. 24) argues that the EU's current immigration strategies increase the vulnerability of victims of SGBV. She underlines that the precarious and under-resourced reception services in Europe are 'failing to provide adequate medical or psychological support for the women who have been victims of violence in their countries of origin or their migratory journeys' (ibid.). UNSMIL's report (2018, p. 6) states that the high percentage of the women and older teenage girls who have been 'gang raped by smugglers or traffickers […] are in need of *tailored* medical and psychological support and rehabilitation'. The horrors of Libya, compounded by a perilous journey before and after, urge specialized and appropriate medical and psychological care for those who survive, administered with the support of professional, sensitive, and judicious intercultural mediation.

Europe's inability to deal with irregular immigration, and its disavowal of the situation in Libya triggers a cascading crisis (see Pescaroli and Alexander, 2015) in the increased number of migrants arriving with serious mental disorders and psychological disturbances. The scant provision of psychological support thus becomes a major issue worsened by limited availability of linguistic and cultural support to facilitate medical care (Granero-Molina *et al.*, 2018, 7). Within this hostile landscape, the already precarious provision for intercultural mediation has sensibly worsened. Along with the reduced migratory flow comes the reduction in social, medical and psychological services during disembarkation and subsequently in the SPRAR centres (Servizio centrale del sistema di protezione per richiedenti asilo e rifugiati [Central protection system for asylum seekers and refugees], which are being closed. Detecting and treating victims of SGBV depends greatly on their willingness to come forward, which is discussed in the next section.

2.2 Reporting SGBV in European migration settings

The efforts made by responders and policy makers to heighten operators' awareness to SGBV issues within the context of the European immigration crisis (Frontex, 2019; IOM, 2017; UNHCR, 2016; Amnesty International, 2015) are futile if 'emergency' conditions that rely on ad hoc responses with no forward planning continue to prevail (see Federici, 2016). According to Frontex[11] women accounted for 18% of all illegal border-crossings on entry from third countries in 2018 the vast majority of whom were subject to sexual abuse or violence. For the SGBV survivor, reporting acts of sexual violence to the authorities is arduous and stressful under any circumstances. Feelings of shame, embarrassment or fear of reprisals can discourage the victim. In the case of migrants and refugees, either on arrival at a disembarkation point during the identification process, or later at a reception centre, those difficulties are multiplied (UNHCR, 2016). Not only

must they overcome their own cultural frames that might tacitly acquiesce to some forms of sexual violence, or that conversely might be considered a societal taboo, but, as Freedman (2016, p. 23) points out, 'there are additional barriers such as not knowing the language' that further impede the victim from making a statement.

It is this linguistic and cultural impasse that Translators without Borders (2017, p. 23) note, especially when dealing with migrant women who are in the midst of their journey and wish to continue without further delay: 'Women who have been victims of GBV are reluctant to stop and talk to medical, psychological or legal support services, even where these do exist, for fear that this will delay their journeys'. Scarcity of female interpreters in minority languages such as Bengali or Somali represent a further deterrent resulting in the underreporting of sexual exploitation and abuse (ibid., p. 12). The IOM (2017) has reported an increase in cases of sexual violence perpetrated in Libya against women and minors with a subsequent rise in women arriving in Italy pregnant. These victims are particularly vulnerable[12] and likely to be affected by 'mental illness or serious psychological disorders or highly traumatised' (IOM, 2017). The UNHCR (2016) training pack for operators, medics, and community workers, who encounter SGBV survivors, states that 'Asking a survivor to repeat their story several times to different persons, every time recalling the traumatic experience, can expose them to further psychological and even physical harm. It can also jeopardize their safety if confidentiality is breached'.

The interviews carried out for this study sought to understand how these extremely delicate cases are treated within the current Italian asylum system and what linguistic and cultural mediation facilitates psychological care in these cases. The following section outlines the European and Italian policy on providing language services in clinical settings

2.3 The national, international and European legal frameworks on linguistic diversity in healthcare settings

The current migratory phenomenon, according to Schäffner *et al.* (2013, p. 2) has 'the most far reaching implications for interpreting practice in its entirety'. Within the context of the European Union where both internal mobility and external migratory flows are changing the landscape of language needs, '[f]or persons who lack adequate command of the societal language, whether they are mobile EU citizens, migrants, or asylum seekers, translation and interpreting services play an important role in providing access to public services' (2015, p. 2). Angelelli's recent report (2015) on language provision across the EU in the healthcare sector notes that there is no specific EU legislative framework for the provision of language services, 'which would appear to be at odds with the international frameworks, such as the Universal Declaration of Human Rights, where language is regarded as an absolute right' (2015, p. 24). Conducted on standard cross-border patients from EU member states, her investigation concludes that with

> alarming frequency […] when patients and providers/administrators do not share a language, translation, interpreting and other less formal practices of language support (e.g. intercultural mediation) including language brokering performed by non-professional translators and interpreters are used to enable access to information and services.

There are several aspects that make linguistic mediation in healthcare contexts particularly problematic and make language support of vital importance; Angelelli (2015, p. 4) summarizes them as follows:

(1) uneven levels of health literacy and power differentials among participants: More vulnerable participants in communication (patients) vs. expert participants (healthcare providers);
(2) management of sensitive and confidential information (e.g. patient's medical records, treatment alternatives and their side effects);
(3) decision-making and responsibility on sensitive issues that may impact directly on a patient's health and well-being (e.g. provider requesting and patient giving informed consent to a treatment/procedure).

In patient care for migrant survivors of SGBV, these factors are amplified (see Merlini, 2015; Valero-Garcés, 2015).

The UNHCR's training guidelines, *Sexual and Gender-based violence: Prevention and response* list minimum response services that must be provided in cases where identified survivors of SGBV require psychological support. The list includes accessible services in terms of distance, availability, and affordability, the gender of the staff in relation to the survivor, and significantly *staff who speak the language* (UNHCR, 2016, p. 14). The use of the definite article 'the' implies that the patient will speak only one language, and it is further assumed that 'speaking' 'the' language will suffice in mediating where cultural difference is an equally crucial issue. Instead, as will be discussed in the second part of this study (see Section 3.4), vehicle languages such as English, French, or Standard Arabic are used if the mediator is Italian. So-called 'native speaker' mediators on the other hand might have a minority language but not necessarily the right one – furthermore their knowledge of Italian could be insufficient, as in the case described in section 3.3. In either case, it is extremely unlikely that mediation will take place in the patient's first language.

There is no binding national legislation regarding the provision of language services in Italy; it is the regional governments that set the agenda for what is generally referred to as intercultural mediation (for an overview, see Filmer and Federici, 2018). Angelelli notes the importance of the figure of intercultural mediator specifically to the Italian context:

> This person links the institution with the community and brokers communication between providers, staff, patients and family members. It is essential to note that translation and interpreting are core tasks expected from and

> performed by the intercultural mediator yet there are no regulations or standards in place to require that they demonstrate ability in such competencies.
> *(Angelelli, 2015, p. 59)*

Intercultural mediators have been described as a 'new breed of linguists' (Amato and Garwood, 2011) whose working environment and scope of responsibility are still very much open to discussion (Amato and Garwood, 2011; Katan, 2015; Filmer and Federici, 2018; Spinzi and Rudvin, 2014; Vigo, 2015). In medical settings, Montalt (2019, p. 122) suggests that the interpreter (or mediator/translator) has the agency to choose which stance to adopt within the interpreting triad: 'Translators and interpreters have their own professional and personal ethos. They can position themselves in a range of ethical angles – from mere conduit of medical information to facilitator of comprehension to victim advocate'. While intercultural mediators in Italy are not trained to become 'invisible' interpreters, they are used to operating through interventionalist approaches (Merlini, 2009, p. 78), within the Sicilian context, Taviano (2019) goes further proposing that the intercultural mediator can embrace translation practices and processes that 'seek to create spaces of negotiation and resistance'. Mediation from this perspective is activism, with an agenda to overcome prejudice on either side.

From immediate humanitarian needs, to complex legal issues, the intercultural mediator should be a crucial figure in trying to explain what happens at institutional and legal levels so that the asylum seeker or refugee is clearly informed on what is taking place. This figure should clearly also represent the human face of cross-cultural understanding. In an ideal world, the highly charged multilingual situations that arise from immigration might benefit from a collaborative approach with two mediators with different linguistic and cultural backgrounds: An 'interpreting square' rather than triangle. This might balance out the 'trust' conundrum and alleviate fears of undue advocacy. However, as the political climate in Italy stands, intercultural understanding at any level be it first reception or long-term integration are not on the agenda of the governing powers. Restrictive immigration policies are likely to bring more instability to the 'interpreter's habitus' (Inghilleri, 2005) within the already uncertain and fluid sphere of cultural mediation in Italy.

The following section offers an overview of the methods adopted for data collection, and goes on to discusses some significant issues arising from the interviews on the question of mediating for victims of SGBV.

3 Methods, informants, and the data

Adopting ethnographic methods (Crabtree *et al.*, 2012; Rouncefield and Tolmie, 2016), the small-scale study collected qualitative data which are interpreted within the wider view that single events, (for instance, unplanned mass immigration), can trigger multiple cascading effects. Among these possible repercussions are acts of sexual or gender-based violence (SGBV). In scenarios such as the Mediterranean

migration crisis, the added complexity of linguistic and cultural difference raises issues of planning and preparedness to support gender-based victims of violence in multilingual contexts, and furthermore, the long-term implications for integration. This sample study was devised in order to investigate the level of provision for intercultural mediation (combining both linguistic and cultural needs) in such contexts. It also aimed to find out what difficulties and obstacles need to be overcome so that communication in such circumstances is effective and sensitive to cultural, linguistic, and emotional needs. A natural continuation to previous research carried out in collaboration with University College London (Research approval 6625/001 – see Filmer and Federici, 2018), the current project followed similar procedures and protocols.

Before beginning the interviews, participants were asked to sign a consent form following a clear and simple explanation of the research rationale in both written and spoken form in English or Italian. They were given due time to ask questions if they so wished. Their permission was granted to record the interviews, which were subsequently transcribed and stored. Anonymity of the informants was paramount to ensure the interviews were conducted within the most humane, respectful, and ethical parameters. All potential identifiers (backgrounds, place of work, etc.) have been omitted.[13] What can be identified, however, are the type of organizations involved in providing support and services for migrant victims of SGBV arriving in Sicily.

Table 4.3 lists the categories of participants and their numbers: Two psychologists (one male, one female), one medical doctor, four operators working for co-operatives providing reception services for migrants, two specifically within a protected shelter for women survivors of GBV.

The interviews were carried out in-situ in English or Italian following a semi-structured format. Informants were asked about their working practice in the field; the dynamics of their relationships within the interpreting triad, and the specific difficulties surrounding intercultural mediation during clinical situations, identification, and treatment of migrant victims of SGBV arriving in Sicily in order to respond to the overarching research questions.

3.1 The organizations and the individuals

I contacted four non-profit humanitarian organizations that offer social and healthcare services to SGBV survivors and operate in and around Southeast Sicily. I obtained consent from the manager of each organization to contact their members. I gave them a detailed outline of the aims and objectives of the study and a list of my questions. All four organizations gave consent with the proviso that informants would remain anonymous. Three associations agreed to be mentioned in order to explain the work they do with victims of SGBV: MEDU, LILA, and Fondazione San Giovanni Battista, presented below. The fourth, a social co-operative that works specifically to support immigrant women who are victims of trafficking preferred to remain anonymous.

TABLE 4.3 Overview of informants

Code	*Informants Role*[14]	*Informants' details*
P1	Psychologist 1	Male Italian. Works as part of the socio-medical team for a local religious non-profit organization that manages several CAS and until very recently, SPRAR.
P2	Psychologist 2	Female Italian. Works with a non-profit organization
M1	Medical doctor	Female Italian. Works for non-profit organization
O1	CAS Operator	Female Italian. Trained as an intercultural mediator (ICM) at university. Works as an administrator/ ICM for a co-operative association that runs CAS
O2	CAS Operator	Female. Social worker.
ICM1	intercultural mediator 1	Female. Native speaker of Arabic. Speaks French and very little English.
ICM2	intercultural mediator 2	Female. Native speaker Arabic. Speaks French and English. Holds MA in intercultural mediation and completed regional training course and medical training.
ICM3	Intercultural Mediator 3	Female. Italian. Has a degree in Cultural Mediation. Speaks Arabic and English.
V1	Volunteer 'Servizio Civile'	Female. Has a degree in Intercultural Mediation. Speaks English and Arabic.
O3	Operator in a religious association that runs several shelters and reception centres.	Male. No training or language skills pertinent to the position.

MEDU is a humanitarian healthcare organization that supports migrants who are victims of torture and cruel, inhuman, and degrading treatment. Victims of SGBV fall within this overarching category. The association supplements the inadequate institutional provisions for psychological care by going into reception centres with its team of doctors and mediators. By law, these centres must have a psychologist as part of the full-time staff but as attested by the informants' narratives discussed below, the underfinanced service is erratic, scarce, and cannot possibly cover the demand. A MEDU spokesperson explains that 'with the new 19 euros a day budget that CAS are allotted per guest, psychological health has been reduced to 20 minutes per month per guest.'

LILA's (Italian League against AIDS) project to improve access to sexual and reproductive health services for refugee and asylum seeker victims of SGBV was set up with the support of the UN and the UNHCR. In the course of their work, members of the medical team (through LILA's own mediators) attest that vulnerable female and male victims of SGBV asked for their help.

Fondazione San Giovanni Battista is a religious foundation run by the Catholic Church with the statute of a social cooperative. It is based in the province of Ragusa and manages 12 small CAS of between 16–30 people dotted around the province. It also organizes volunteers and training for the 'civic service', a form of voluntary national service. The association also ran a protected house for migrant victims of gender-based violence but this has recently been closed due to the government cuts in spending on reception facilities.

Before discussing the specific issues related to linguistic and cultural mediation, what needs to be emphasized, as confirmed by all the informants, is the derisory institutional provision for psychological support for migrant victims of SGVB. P1 reiterates the inadequate capacity for CAS structures to deal with increased vulnerable cases who will then have no pathway for social (and linguistic) integration:

> The priority has been given to the CAS. Salvini says first [CAS] reception cannot be denied but as for second reception, the [CARA] centres where integration, learning new skills and, in particular, learning Italian are part of the curricular, as well as psychological and social, support, according to Salvini, Italy needs to cut back on these.

The centres where migrants learn Italian, where they can find the type of psychological and moral support to help them heal and move on, are those under threat of elimination by Salvini's measures. According to P1,

> the figure of the psychologist in the [CAS] is marginal figure because we are given 10 hours maximum a week for each reception centre. In the largest centre where I worked there were 64 beneficiaries[15], and those hours must be divided among them.

The sections that follow deal with the three problem areas indicated by interviewees concerning language and mediation for survivors of SGBV.

3.2 Identifying SGBV Victims/Survivors

The IOM, UNHCR, and the Red Cross have their mediators and medical teams on hand at the disembarkation points. ICM3, who worked during the height of the arrival in 2016 at the Port of Pozzallo during the disembarkation process, which can take days, explains that it is usually the IOM that identifies possible SGBV. 'If they are women or girls from Nigeria, as they disembark, they are automatically taken aside' as assumed victims of SGBV due to their provenance and gender. Identification can occur even earlier, on board the ship while waiting to disembark. But as ICM3 explains,

> it's unlikely that a victim will open up immediately on arrival and say what they might have endured […] all of them arrive in a state of shock, they are

> starving, undernourished, they're carrying terrible burdens, they won't speak on that first day.

Although the humanitarian teams have psychologists and social workers to hand in the landing area, for those that are in the human chain that is formed during the identification process speed is of the essence. At the peak of the migration crisis in 2014–2016, ICM3 saw the moment of assessment as an additional difficulty: 'Unfortunately, there isn't an instruction booklet telling you how to recognize a victim of SGBV'. So numerous were the cases that IOM and UNHCR have since developed training guides on the subject (see section 1) and MEDU organizes training sessions for operators on how to recognize possible symptoms of psychological disturbances.

In fact, according to ICM3, experience plays a significant role in recognising signs of physical abuse,

> you learn to look very closely at people in the eye and you understand from their expression. If you mediate during medical check-ups you learn to distinguish between burns caused by being too close to the engine on board the boat and burns cause by torture in Libya.

ICM3 concludes, there are different types of responses from possible victims of GBV; 'those who don't speak, those who respond, those who lie…there are reception centres specifically for victims of human trafficking'. What is left unsaid here by ICM3 is explicated by O3, who manages such a reception centre. He is more cynical regarding the veracity of the responses given by some arriving migrants: 'The word gets around in these communities. If you give the right answers you get into a nice reception centre', revealing a common prejudice. P1's view is equally doubtful: 'Sometimes I have my doubts that what I am being told is the truth. You can never be certain'. On the contrary, P2 affirmed 'There *have* been times when I doubted whether the patient was telling me the truth, but in cases where the patient claimed s/he had *not* been sexually abused'.

How do we know about victims of GBV or human trafficking? V1 explains that if they are in a CAS it is unlikely that they will have the opportunity to meet a psychologist, or at least, very rarely. While medical assessments by MEDU and LILA are conducted in the large CARAs every week, this does not happen in the CAS. '[I]t is the operators who contact the medical teams if they think that someone needs psychological support. Otherwise the teams do not go there' V1 explains, and there were even disputes over this. V1 continues: 'MEDU are a professional team of psychologists and they cannot reveal what was said to them by the guest during a session, yet the operators of the centres want to know what is going on and this causes conflict. Often MEDU are not called at all to these centres'. This would imply that there are SGBV cases undetected and untreated within the CAS system due to incompetence rather than lack of funds.

The following sections discuss what have emerged from the data as the main difficulties on question of comprehension on linguistic and cultural levels in mediated patient-doctor triad in cases of suspected or ascertained SGBV.

3.3 Obstacles to comprehension – English or Englishes?

Varieties of the English language (Crystal, 2007) are possibly the most common lingua franca for communicating between social actors involved in the Mediterranean migrant crisis. As Antonio Gramsci so accurately wrote,

> Every time that the question of language surfaces, in one way or another, it means that a series of other problems are coming to the fore: The formation and enlargement of the governing class, the need to establish more intimate and secure relationships between the governing groups and the national popular mass, in other words to reorganize the cultural hegemony.
>
> *(1935/1985, pp. 183)*

Unsurprisingly, then Guido (2015, p. 47) warns that 'ELF used in immigration domains typically reflects […] the power/status asymmetries involved in cross-cultural situations of unequal encounters between non-western supplicants (i.e., African immigrants and asylum seekers) and western (Italian) experts in authority'. Understanding African varieties of English is one of the first and most obvious obstacles to communication, even for the cultural mediator. Before conducting over 20 interviews with refugees and migrants for researcher purposes (see Filmer and Federici, 2018; Filmer, forthcoming), I had not anticipated this problem would affect me as an English-native speaker. P1 relates how the Italian Intercultural mediator with whom he regularly worked described the experience:

> In the reception centre for women where I worked 90% were Nigerian. They spoke English but a macaroni English, broken English, as my mediator colleague told me. Initially she found it difficult to understand them. The mediator only knew British English. She asked them to speak a more fluent English and they replied that this was the only English they knew.

Other Italian mediators I interviewed shared the same experiences and issues in understanding Pidgeon, Nigerian, or any other English variety spoken by members of the migrant community. As ICM3 put it: 'I am ashamed to say, one of the main difficulties I had was with English. It wasn't easy to understand them – they spoke English badly, varieties of English that I didn't know'. The linguistic judgment chimes with Guido's observation. Even mediators with a university background in languages and mediation demonstrate a negative evaluation of non-standard English varieties such as Nigerian Pidgin English[16] (see also Iemmolo, 2018). The next section discusses the fundamental aspects of culture, religion and gender in the mediation for SGBV victims.

3.4 Obstacles to communication

The main obstacles to communication are intertwined with religious beliefs, cultural customs, and are gender specific. M1 affirms that the ethnic origin and life experience of the mediator plays a key role in how meaning is negotiated within the interpreter triad. She observes: 'Let's not forget that these mediators, most of them, have a past. Those who have had similar experiences to the patient for whom they are mediating, this can influence their approach'. She describes different approaches:

> They can have an attitude of 'I made it through, I survived' and distance themselves too much from the patient. Another reaction is to discriminate against who is outside their culture: 'You, doctor, how can you suggest these things (abortion, contraception), that are not sustainable for our religion?'

M1 provides the example of a mediated clinical assessment in which she proposed the termination of an unwanted pregnancy to a refugee woman 'not as a solution but as a possible option'. The male, Muslim mediator said that, as a believer, he could not pass on this information to a Muslim woman. Such censorship in mediating the message clearly prevents communication on vital information between patient and medic. For M1, 'Religion can be a great constraint to mediation because it imposes a biased vision […] Mediation should be performed form a position of neutrality, but it is difficult to reach this "0" point'. M1 concludes 'the issue of gender is always at the root. Male mediators are certainly not suitable in these types of clinical situation'.

When asked how he communicated with those whom UNHCR refer to as 'rights holders' and whom P1 refers to as 'beneficiaries' he responds: 'It was very difficult, especially in the first months, we were considered strangers. They didn't open up at all'. ICM2 concurs and specifies that 'it's difficult to approach the Nigerian community. I don't know if they are like that by nature'. Here the implication is that what blocks communication is the culture but P1 then observes: 'The problem was not the language barrier. They, quite rightly, found it difficult to express their suffering in any language'. ICM2 agrees that the biggest obstacle is the silence:

> It's clear that a guest has suffered abuse […] when as soon as you mention Libya, they beg you not to mention that place. They want to cancel it from their lives. A person who has been through the desert, been through the detention centres in Libya, has been through all of this – they don't want to talk.

Yet, all three medics agreed that bringing out the pain into the open by speaking, and therefore by default via mediation, is essential to the healing process. Sometimes forms of non-verbal communication, especially in these circumstances, transcend the spoken word. P1, for example, often overcomes the silence and the language barrier through other means: 'We did drawings. I tried to interpret how and what

they drew, the colours they used, the images they portrayed. In this way I managed to understand them and earn their trust'. M1, on the other hand, works to gain the patients' trust through Neuro-Linguistic Programming (NLP), a set of language and sensory-based interventions and behaviour-modification technique to treat fears, phobias and post-traumatic stress disorder. Achieving this across language and cultural barriers requires, according to M1 exceptionally competent mediation 'I need the help of a woman with a similar background to the patient – but even then, it is not enough to know the language. The fundamental issue of trust-building remains. This is what needs to be overcome'.

Gender is a key factor in the dynamics of communicating SGBV. The scope of this contribution cannot extend to the vastly under-researched and even more problematic issue of SGBV against men and boys in migratory contexts. Here, however, it is worth noting the comment of P2. She is a female psychologist and has treated male patients with a female mediator. She affirms that the most important thing is to be free from prejudice and embarrassment. It is a question of professionalism. On the contrary, when the mediator's own prejudices and beliefs take precedence over their role as neutral mediator the consequences can be extremely negative. She explains:

> Once during an asylum hearing in front of the territorial commission the official mediator sniggered during the asylum speaker's declaration of being persecuted in his homeland because of his sexual orientation. In cases like this we are dealing with the most intimate details of someone's life. We cannot afford to have unprofessional and untrained mediators.

ICM1 is a female mediator has worked with P2 in treating male patients and observes 'A man may have difficulty opening up in front of a woman whereas a male mediator might succeed'. ICM1 assumes here that the mediator leads the interview with the patient rather than the medic. Nevertheless, she provides evidence that trust is more important than gender:

> We had a case just yesterday. The man began the session by stating point blank that in front of two women he would not speak. But after coaxing and by understanding that he was not being judged or derided, he finally opened up.

P1 confirms that sometimes the female patients are unwilling to speak to him about sexual abuse because he is a man. Even more so if the mediator is also male. He describes a case:

> The patient was very embarrassed when she perceived that she was being spoken about by two men – one of whom was myself but the other, the mediator was her co-national – but he was the only person who spoke Tigrinya. This certainly put her in a difficult position.

The choice of mediator, as P2 acquiesces, is only in part dependent on gender. 'In the end the choice comes down to availability on that day and only to some extent the gender'. For the mediators, what are the main difficulties on their task? ICM1 admits:

> I have the most difficulty if the patient's narrative contains episodes of violence, for example physical violence perpetrated by a brother or the father, which reflects my own personal experience. In that moment I see my own past before me once again, a story that repeats itself. In fact, in order to deal with this, I am seriously thinking of undergoing psychotherapy myself in order to confront those demons from my past.

ICM.1 left her home country 13 years ago, therefore a considerable period of time has lapsed since she experienced physical violence by family members. Yet, her past still haunts her in professional settings where she is there to perform a task as neutral facilitator of communication. ICM1's candid admission allows us to confirm what may logically be deduced, and that is, a victim of physical or sexual gender based violence, or a refugee who has travelled for months across the desert, has remained in Libya for months in abysmal living conditions and been physically abused, these people cannot be expected to function as neutral conduits of information of such a highly charged emotional content. By the same token, we cannot expect to send young Italian neo-graduate mediators into situations that can be psychologically distressing without adequate preparation and training.

All three medics spoke of the benefits of collaborating with the same mediator over a period. P1 pointed out that having to change mediator during a course of treatment is also 'destabilizing' for the patient. All three medics were asked if they thought they would work better without a mediator. That if, despite the cultural and linguistic gaps, patient care would be more successful in such emotionally charged situations as discussing a case of sexual abuse if it were dyadic rather than triadic. All three agreed that provided that the intercultural mediator was 'professional' then their assistance was invaluable. P1 responded that he had no choice but to work with a mediator as he does not speak any other languages apart from Italian but added that it was not just a question of language; a professional mediator was essential to providing cultural information that would help to understand patient behaviour. P2 also believes that the mediator facilitates understanding when culture comes into play. On the other hand, if she does not feel that the mediator is professional enough, she prefers to do without language support if she is able to do so.

The refrain is too often thus: Too many so-called intercultural mediators lack the necessary training and skills where extremely delicate mental health issues are at stake. P2 explains:

> What is needed is mental elasticity – a university course is essential – vocational training courses are not enough. Knowing the culture thoroughly and

> knowing the basics of psychology is a great advantage. Psychology helps because it gives insight into how to approach the patient during a session. In the end what makes a good mediator in these circumstances is the approach they have with the patient.

4 Concluding remarks

With the current anti-immigration climate, further cuts to services for migrants are on the political horizon and the already precarious figure of the professional intercultural mediator seems destined to disappear at a crucial moment in Italy's history when integration and comprehension are so desperately needed. Investigating the practices of linguistic and cultural mediation in clinical settings related to SGBV on migrants, this chapter reported predominantly on the situation in Italy, where the role of the intercultural mediator is still ill defined. The answers to the question on how linguistic and cultural differences are bridged when dealing with clinical settings and the highly sensitive question of SGBV can be summarized. The first point concerns the lack of medical and psychological care for the arriving migrants who have been subjected to sexual abuse or violence in their own country, along the migratory route or even within the reception system. From a purely pragmatic viewpoint, not treating these people will lead to a cascading crisis whereby no longer housed within the SPRAR system, an increasing number of migrant women and men who need psychological care will end up on the street. In this context, a professional intercultural mediator can have a crucial role, yet in Italy there is still scant education and training for those who profess to be such. According to Giussy *et al.*'s 'Sexual violence and unwanted pregnancies in migrant women' published in *The Lancet* (2017),

> It is the responsibility of humanitarian non-governmental organizations and of the accepting countries to provide safe abortions to women who become pregnant as a result of rape and adequate ethnopsychiatric care for post-traumatic stress disorder. This care will improve women's health and human rights and save lives.

The current political regime in Italy seems ill-equipped and unwilling to achieve this. Equally, how should such sensitive issues be linguistically but more importantly culturally mediated? One thing is clear: Without the necessary skills and knowledge, the intercultural mediator becomes more of a hindrance than a help. While it would be true to say that progress has been made with raising awareness of the issues surrounding SGBV in migrant contexts, the question of linguistic and cultural support for all three participants of the interpreting triad in such contexts still needs to be addressed.

Notes

1 In line with terminology adopted by the Inter-Agency Standing Committee (IASC), the International Organization for Migration (IOM) adopts the term 'gender-based

violence' (GBV) and recognizes that sexual violence is one type of GBV. Other organizations, as we will see, prefer the term 'sexual and gender-based violence'.

2 IOM uses the term 'survivor', while in other contexts such as legal or medical, 'victim' is more common. According to IOM, '"survivor" is preferred in the psychological and social support sectors because it implies resilience' (2018, p. 6). The question of terminology will be discussed further in Section 2.

3 See www.unhcr.org/sexual-and-gender-based-violence.html (accessed 20 March 2019).

4 Crimes of SGBV are systematically under-reported, especially if the victim is male (UNHCR, 2016, p 36).

5 No term surrounding migration is ever neutral; some terms have very specific legal meanings (e.g. refugees, asylum seekers, permanent residents, etc). For expediency, I use the term 'migrant' to cover all categories of people landing on the coasts and at the ports of Italy having moved from their place of origin, and 'immigration' for legally specific policies dealing with people movement in the Italian juridical system.

6 CARA is an acronym for Centro Accoglienza Richiedenti d'Asilo [welcome centre/reception centre for asylum seekers]. At the moment the 'welcome' seems tragically ironic as migrants are being 'invited to leave' to take up residence on the street.

7 See www.stranieriinitalia.it/attualita/attualita/attualita-sp-754/bonafede-non-accetto-che-si-parli-di-deportazioni-dei-migranti-come-per-gli-ebrei.html (accessed 20 March 2019).

8 Centri di Accoglienza Straordinario [emergency/extraordinary reception centre]. For a more in-depth discussion see Filmer and Federici (2018, pp. 231–234).

9 Cf. www.iom.int/news/mediterranean-migrant-arrivals-top-363348-2016-deaths-sea-5079 (accessed 20 March 2019).

10 At the time of writing the key members of the Italian government, Salvini, De Maio and Prime Minister Conti were awaiting the outcome of a Senate vote as to whether or not they will go on trial for abuse of power, illegal arrest and aggravated abduction of the 177 migrants on board the costal ship Diciotti in August 2018. The government refused to let them disembark on Italian soil and they remained on the ship for several days in unhygienic and cramped conditions.

11 See https://frontex.europa.eu/media-centre/news-release/number-of-irregular-crossings-at-europe-s-borders-at-lowest-level-in-5-years-ZfkoRu (accessed 1 April 2019).

12 The humanitarian discourse regarding SGBV and the adoption of keywords such as 'survivor' rather than 'victim', 'resilience', and 'vulnerability' is a timely discussion but beyond the scope of this contribution. Butler et al's volume, *Vulnerability in Resistance* (2016) offers some insightful contributions to the debate, in particular, Bracke's 'Bouncing Back, Vulnerability and Resistance in times of Resilience' (2016, pp. 52–75).

13 The data collection started within a research collaboration and followed the ethics processes approved by the ethics committee of University College London (UCL Research Approval no 6625/001). The data collection continued beyond the collaboration with UCL and respected rules and regulations of the University of Catania, whilst retaining the exact, same, stringent data collection methods approved by UCL's ethics committee.

14 All interviews with informants were conducted in Italian. All translations into English are mine.

15 This term refers to migrants living in Italian reception centres run by religious associations.

16 Nigerian Pidgin NigP 'is a medium of communication for African peoples who have no first language in common […] its vocabulary is predominantly English based, but these lexical forms have changed their meaning to fit into the value system and world view of the African people' (Schneider, 1966).

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