Multi-agency response for reporting of GBV in maternal health services

RESPONSE

WS 1 Report

Situation analysis

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SECTION 1: FRAMEWORK

INTRODUCTION

THE RESPONSE PROJECT

The RESPONSE project provides capacity building in five European countries (Romania, Austria, Germany, Spain, and France) in order to increase, in maternal health settings, the referral rates to specialized services for gender-based violence survivors.

Gender-based violence (GBV) refers to physical, sexual, psychological and economic violence against women and girls and was defined by the United Nations Declaration on the Elimination of Violence against Women as, "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life". GBV is a known risk factor for women's health, which may lead to unintended pregnancies, gynecological problems, induced abortions and sexually transmitted infections, including HIV, miscarriage, stillbirth, pre-term delivery and low birth weight[1].

In the European Union, 70% of women experienced in their lifetime physical and/or sexual violence from their partner[2]. In 2014, 43% women from 28 European Union countries stated that they experienced in their lifetime psychological violence from their partner[3]. In the same year, 23% of non-heterosexual women from the European Union affirmed that they experienced physical and/or sexual violence from their partners compared with 5% heterosexual women. Moreover, 34% of women who suffered of a health problem or disability experienced physical or sexual violence in their lifetime from their partner compared to 19% of women who didn't suffer of any health problem or disability[4].

Taking into account the physical and emotional consequences of GBV and the prevalence and incidence in women, identifying women survivors of GBV and referring them to specialized services is necessary. Health care providers are considered most trustful by women survivors of GBV who intend to disclose the abuse. Moreover, health care providers are likely to be the first professional contact for women who are GBV survivors, even if they do not disclose the violence. Routine perinatal care visits offer a crucial opportunity for identification, safety planning, referral and reporting of GBV in pregnant women who are at high risk during this vulnerable period. However, the majority of obstetrical care providers and midwives lack these skills, resulting in high underreporting and missed opportunities to report to specialized gender violence services as specified in the Istanbul Convention[5].

Healthcare providers can address GBV by identifying the survivors, offering support and referring them to community agencies. Unfortunately, they face personal, interpersonal and organizational barriers in addressing GBV. Personal barriers refer to their attitudes and perceptions regarding gender-based violence, fear of offending the patient or fear of the abuser and lack of confidence and training on screening techniques[6]. Hewins discovered that 55% health practitioners felt uncomfortable and 23% felt afraid talking with patients about abuse. Fifty percent of the professionals didn't believe it was their job to screen for gender-based violence, 9% believed that abuse is rare and some health practitioners blamed the women. The same researcher observed interpersonal barriers are related to language and culture and the perception that patients are difficult to be screened because of psychological effects of abuse and organizational barriers refer to time constraints, lack of resources and

[1] Halpern CT, Spriggs AL, Martin SL, Kupper LL. (2009). "Patterns of Intimate Partner Violence Victimization from Adolescence to Young Adulthood in a Nationally Representative Sample". Journal of Adolescent Health, p. 508-516
[2] WHO. (2013). "GLOBAL AND REGIONAL ESTIMATES of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence"
http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/
[3] European Agency for Fundamental Rights (FRA). (2014). "Violence against Women: An EU-wide survey". Brussels, FRA
[4] European Agency for Fundamental Rights (FRA). (2014). "Violence against Women: An EU-wide survey". Brussels, FRA
[5] Council of Europe, "Convention for the Prevention of Violence Against Women and Domestic Violence", the Istanbul Convention, http://www.coe.int/en/web/istanbul-convention
[6] Hewins, E., DiBella, B. & Mawla, J. (2013). "Domestic Violence and the Role of the Healthcare Provider: The Importance of Teaching Assessment and Intervention Strategies". Robert Wood Johnson University Hospital and the Center on Violence Against Women & Children at the School of Social Work, Rutgers University, New Brunswick, NJ., p. 13-14

support and lack of procedures for screening. Furthermore, 68% of practitioners' lack education and training about identifying, screening and referring patients that face gender-based violence[7].

Screening for GBV is very important as 70-93% of survivors don't know where to ask for help or are unable to seek help[8]. ***RESPONSE aims to address this problem by increasing referral to specialized services for survivors of GBV using a gender and survivor focused approach***. The project is organized in five work streams focusing on performing a situation analysis in each of the 5 partner countries (Romania, Austria, Germany, Spain, and France) (WS1), performing and evaluating capacity building seminars in each partner country (WS2), strengthening multi-sectoral and multi-disciplinary cooperation (WS3), and on developing and implementing an effective communications and dissemination package through collaboration with specialized networks (WS4).

AIMS OF THE REPORT

The report is a deliverable of WS 1 of the RESPONSE project. Work stream 1 aimed to conduct a situation analysis in the five RESPONSE partner countries who implement capacity building activities (Romania, Austria, Germany, Spain, France) in order to identify, for the health care setting enrolled in RESPONSE, the strengths, weaknesses and behavioral levers of:

1. *existing health care infrastructure* related to the reporting of GBV by obstetrical/gynecological professionals, nurses and midwives confronted with survivors coming for routine pre- and perinatal care.
2. *existing social work infrastructure and specialized services at the maternity clinic* related to the provision of support for survivors who are pregnant or in first year after pregnancy
3. *partners* involved regarding identification of GBV within the health setting and reporting to specialized GBV services.

This report responds to objective 1 of the RESPONSE project, namely: *To perform **a situation analysis** in each of the 5 partner countries in order to identify the strengths, weaknesses, behavioral levers of the existing health care infrastructure related to the reporting of GBV by obstetrical care providers, nurses and midwives providing routine pre- and perinatal care.* The report provides partners with knowledge of the strengths, weaknesses, behavioral levers of the five health care settings (clinics), knowledge of existing materials/resources/protocols in place in the five settings and knowledge of the existing national legal frameworks for provision of care in the five countries.

METHODOLOGY

Assessing the current GBV situations in the five partner countries, where capacity building activities are implemented, is a vital step not only for the RESPONSE project but also in designing and updating national policies, strategies and plans addressing GBV. For the RESPONSE project, this situation analysis helps us understand how health care practitioners and health care infrastructure respond to GBV situations in the maternity health care settings from each of the five partner countries. The identified strengths and weaknesses in reporting GBV in each country will inform the development of the capacity building seminars delivered in the maternity health care units enrolled in the project. Besides answering the RESPONSE needs, this situation analysis can help establishing GBV health priorities that can be addressed by practitioners, researchers and policy makers in each partner country.

SITUATION ANALYSIS

Situation analysis is an evaluation of a health situation and it is used for creating policies and strategies. The situation analysis should contain the current and future health issues and their determinants. Therefore, a situation analysis should include the social determinants of health, the needs, the disease burdens and health

[7] Hewins, E., DiBella, B. & Mawla, J. (2013). „Domestic Violence and the Role of the Healthcare Provider: The Importance of Teaching Assessment and Intervention Strategies". Robert Wood Johnson University Hospital and the Center on Violence Against Women & Children at the School of Social Work, Rutgers University, New Brunswick, NJ., p. 14

[8] Hewins, E., DiBella, B. & Mawla, J. (2013). „Domestic Violence and the Role of the Healthcare Provider: The Importance of Teaching Assessment and Intervention Strategies". Robert Wood Johnson University Hospital and the Center on Violence Against Women & Children at the School of Social Work, Rutgers University, New Brunswick, NJ., p. 14

challenges. Moreover, it should address the expectations, the health system performance, the health systems resources such as human, physical, financial and informational and the stakeholder positions.

Taking into account the WHO definition of situation analysis, the project objectives and the previous environmental scan conducted in the IMPLEMENT project which had similar objectives, we decided to include in the situation analysis the following sections:

Infrastructure: we addressed availability in the maternity health care settings from each partner country of (1) A department/staff, budget, policies to address GBV; (2) A mechanism for screening, rapid response, referral and initial counselling for GBV survivors; and (3) Data collection and reporting process of the prevalence and incidence of GBV cases.

Collaboration: we addressed availability of (1) Organizations offering specialized support and support groups for GBV survivors, (2) Networks for GBV prevention practitioners; and (3) Policies for multi-agency *collaboration.*

Capacity: we addressed (1) availability in the maternal health setting of trainings of GBV for health care providers; and (2) availability in the educational curriculum of GBV training for medical and non-medical staff during college years.

MEASUREMENT INSTRUMENT

To collect data for the situation analysis, we used a semi-structured interview guide (Appendix 1). The interview guide was structured in four sections, each section addressing a baseline information about the maternity health care settings enrolled in RESPONSE:

1. Respondents' perception. This section addressed participants' feelings regarding GBV, their experiences with GBV situations, their perception regarding the relevance of GBV at their workplace and their perceived self-efficacy in dealing with GBV cases.
2. Infrastructure and mechanisms in place. This section assessed if the maternity health care setting (a) provided a mechanism for GBV data collection and data reporting, GBV screening for pregnant women, GBV response and referral, and GBV prevention activities; (b) allocated a budget for services addressing GBV survivors; (c) set on their agenda managing GBV as a priority; (4) followed specific GBV legislation and policies.
3. Multi-agency-response. This section addressing the existing cooperation and networks that interview participants are aware of. Questions addressed the existence of networks for GBV prevention practitioners, of organizations delivering GBV specialized support, of support groups for GBV survivors, and of policies for multi-agency management of GBV cases outside the enrolled maternal health care units. Questions also addressed GBV counselling services and projects conducted inside the enrolled maternal health care units
4. Skills. This section addressed the GBV trainings that health care providers (i.e., medical staff, midwifes, nursing staff, social workers) took during their formal education or during their practice at the maternal health care unit enrolled in RESPONSE.

The semi-structured interview guide was translated in the national language of each partner country and interviews were conducted by one of RESPONSE Project staff members in each country.

RESPONDENTS

Maximum variation sampling method[9] was employed to recruit study participants. We used this purposive sampling method[10] as we were interested to 1) select participants with particular experiences regarding GBV and to 2) look at the GBV phenomenon from different angles. By selecting diverse stakeholders from varied contexts

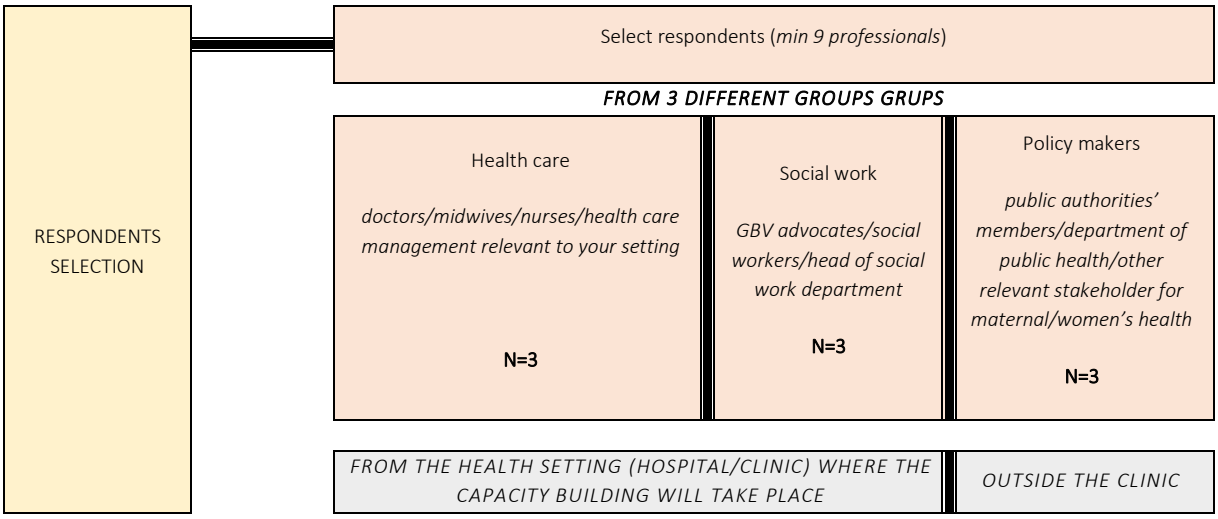
[9] Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4.
[10] Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63-75.

experiencing GBV, we aimed to achieve a greater understanding on the GBV phenomenon in order to inform RESPONSE capacity building seminars and national GBV policy changes.

In terms of eligibility, we targeted health care professionals (doctors/midwives/nurses/health care management), social workers (GBV advocates/social workers/head of social work department) and policy makers (public authorities' members/department of public health). Main criteria in recruitment were working in the enrolled maternity health care setting and having knowledge and/or experience within the GBV field.

To recruit interview participants, a recruitment methodology (Fig. 1) was developed and shared will all partner countries.

Fig 1. Recruitment methodology



All health care professionals were enrolled from the maternity health care setting where the capacity building activities will take place, as this is an inclusion criteria. Within the clinic, each partner had the option to either recruit interview participants for each of the above category or to focus on those professions mainly dealing with GBV at the enrolled maternity clinic. Within the social work group, partner countries could opt in recruiting social workers working within or collaborating with the maternity health care setting, as there are settings where social workers do not actually work only in the maternity health care clinic. With regards to the policy makers' group, partners were advised to enroll participants working with the enrolled maternity health care unit or participants working at the local/regional level and having responsibilities in the GBV field. As social workers and policy makers might have been recruited from outside of the clinical settings, partners were advised to avoid recruiting social workers and policy makers working with the control clinics, as this confounding variable would have affected RESPONSE findings [this doesn't apply for policy makers]. A list of interview participants was established by each partner. Table 1 presents the number of respondents answering the interview.

Table 1. Number of respondents participating in the situation analysis interviews

	Austria	France	Germany	Romania	Spain
Health Professional					
Doctor	2	1	1	2	1
Nurse		1	2		1
Midwife	4	1	1		2
Social worker/GBV advocate		3	2	3*	3
Policy maker	2	3	3	3	3
No. of Respondents	*9*	*9*	*9*	*8*	*10*

**one interview was conducted with the psychologist working at the clinic; but she didn't have any background in GBV therefore her interview was not analysed due to missing information in most section of the interview guide.*

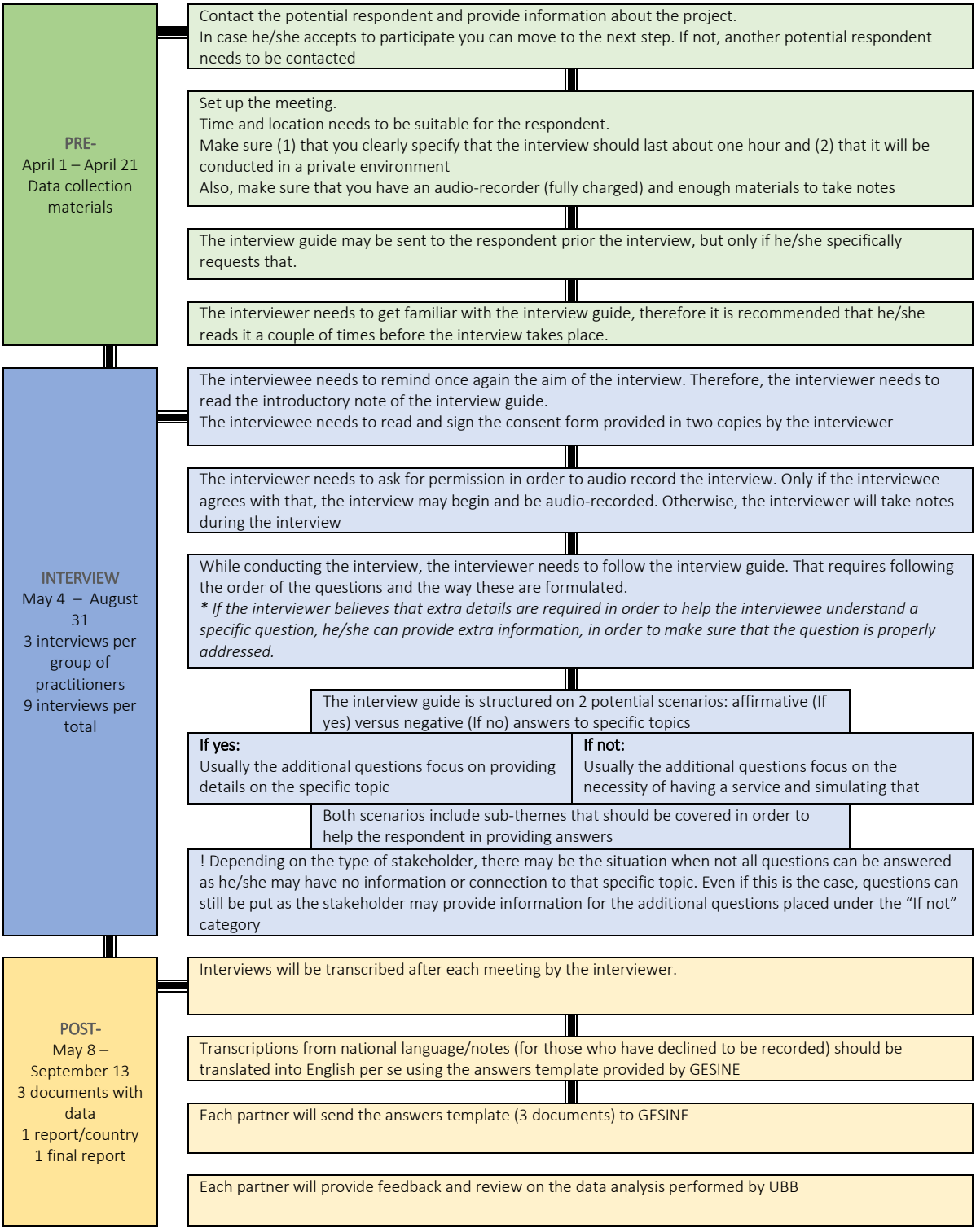
DATA COLLECTION

All partners were trained in applying a unitary methodology for data collection. The coordinating team developed and shared a data collection flowchart (Fig 2) with all partner countries, prior to data collection. Although deadlines were clearly specified in the methodology, they were also flexible, as the coordinating team took into account possible difficulties in recruiting interview participants. Data collection materials were provided on time and the interviews took place as follows: May 4 – June 4 in Austria, between May 16 and June 29 in France, between May 4 and June 14 in Germany, between May 19 and August 31 in Romania and between May 9 and May 22 in Spain. In Romania, interviews were fist conducted between May 19 and May 30. However, due to participants' retreat from the project (one psychologist and one social worker), we conducted interviews with two more social workers. Data analysis started at the beginning of July and partners were sent on July 10 the first draft for review. Partners' reviews were centralized until August 1, and the second report draft was delivered on August 30.

Interviews were conducted in each partner country by one member of the RESPONSE project. Staff members conducting the interviews approached participants using a verbal script (Appendix 2) developed by the coordinating team and translated by each partner country. The verbal script described the project, the interviewer's role in the project and the interviewing process. After delivering the verbal script, if participants decided not continue the interview, the research team contacted the next person from the list of stakeholders until the interviews provided valuable information upon the topic. The responses of the subjects who did not completing the interview were not considered valid. The same procedure was used for participants dropping out the study during the interview, as their answers were excluded from the study.

Participants accepting to answer the interview had to sign an informed consent form (Appendix 2) before starting the interview. The consent form described the interview procedures, the benefits and risks of study participation, participants' rights and data confidentiality and asked for participants' consent to audio-record the interview discussions. Interviews were conducted at participants' workplace or in a location selected by participants. Interviews lasted for approximately one hour and were audio-recorded. Each partner country provided translated interview transcripts in a template required by the coordination team.

Fig2. Data collection methodology



SECTION 2: RESULTS

This section details the situation analysis results for each country. Results are focused on three components, as follows:

Infrastructure	Availability of a department, budget and policies addressing GBV
	Mechanism for screening, rapid response, referral and initial counselling for GBV survivors
	Data collection and reporting process of the prevalence and incidence of GBV cases
Collaboration	Organizations offering specialized support and support groups for GBV survivors
	Networks for GBV prevention practitioners
	Policies for multi-agency collaboration
Capacity	Availability in the maternal health setting of trainings of GBV for health care providers
	Training certificates for medical and non-medical staff

For a country comparison based on situation analysis, please see Table 2.

SITUATION ANALYSIS

AUSTRIA

MATERNAL HEALTH SERVICES IN VIENNA, AUSTRIA

Vienna offers various services for women's health. Health care services for women are integrated in the medical services delivered by the Hospital in Vienna named "Wilhelminenspital", the University in Vienna, and the Department of Gynecology of the General Hospital. With regards to midwifery services Vienna offers the Center for Midwifes in Vienna, Midwife (with long experiences) and Trainer in Education for midwifes „Hauptberuflich Lehrende am Studiengang der FH Wien für Hebammen and the freelance Midwifes - midwifes who are not working in the clinics, but working independent but in cooperation with hospitals and with gynecologists. Vienna also runs a prevention project for early support called "Frühe Hilfen".

METHODOLOGY

Study participants. Four midwifes, two doctors and three policy makers answered the interview questions.

Health Proffesional 1	Midwife	Center for Midwifes in Vienna
Health Proffesional 2	Midwife	Center for Midwifes in Vienna
Health Proffesional 3	Midwife	Independent Midwife but in cooperation with hospitals
Health Proffesional 4	Midwife/Midwife trainer	University in Vienna
Health Proffesional 5	Gynecologist	Hospital in Vienna "Wilhelminenspital"
Health Proffesional 6	Gynecologist	General Hospital in Vienna
Policy Maker 1	Project member	Prevention project for early support called "Frühe Hilfen"
Policy Maker 2	Forensic Doctor	University in Vienna

Data collection. All nine interviews were conducted by Maria Rösslhumer and Natascha Ickert from the Austrian Women's Shelter Network. Interviews took between 45 minutes and 90 minutes. Interviews were conducted by phone, by email and face to face. Interviewers also delivered the transcription for all interviews. Interviews were not audio-recorded. Interview notes were translated into English by a researcher from the colleagues in the AÖF Office. Translations were used to fill in a specific template shared by the coordinating team.

RESULTS

Interview participants from Austria referred to GBV as relevant to address during their work. Respondents dealt with sexual, physical and emotional GBV approximately two to three times per month, one respondent reporting meeting GBV cases once per week. However, as data on GBV is not systematically reported, accurate values for GBV incidence and prevalence are unavailable.

Few of the respondents felt prepared to address GBV in their practice. All three midwifes interviewed do not feel ready to address GBV cases and they report the need for "advanced training, experience in counselling, networks with institutions against violence and women's institutions" (Midwife), "Further trainings, supervision, teamwork, networks with other institutions" (Midwife) and information on „how to recognize signs of abuse ... and how to handle and talk with the women" (Midwife). The midwife who is also a trainer at university considers health practitioners are not prepared to address GBV and to interpret signs of abuse. She considers practitioners need „courage to address the topic and knowledge of how to address it" and that „They are afraid of falsely suspecting violence ...That is why many only intervene when physical traces of violence are visible." The gynecologist feels partially prepared to address GBV due to working with many GBV cases „experience of many cases helped me gain security in dealing with patients affected by violence" but she would need more institutional support to feel comfortable in dealing with GBV cases. Only one gynecologist considers midwifes and the nursing staff to be prepared in addressing GBV as „in the department of gynecology and maternity clinic at the "Allgemeines Krankenhaus Wien" the midwifes and the nursing staff, as well as people working in the management are trained regularly. Every 3 months there are trainings and education regarding violence or similar topics". The same respondent states that „Through the victims' support group and the ongoing trainings, I have the feeling most of the staff members are well prepared and are able to offer adequate help. The victims support group was very helpful, as well as other victims support group (AÖF, Interventionstelle, Women´s Shelter), with the police."

Infrastructure

Availability of a department, budget and policies addressing GBV

One of the enrolled maternity clinic does not have a specific *department* coordinating GBV activities, respondents stating that the clinic is too small for having a GBV focused department. Although they consider an asset having a GBV department, in their perspective, only a larger clinical setting, such as the maternity clinics from Vienna, justifies having a GBV prevention and intervention department. Other departments inside the clinic don't take responsibility for GBV prevention. Respondents from the same clinical setting had different perspectives regarding how the management of the clinic perceived GBV. Some respondents reported addressing GBV as a priority for the unit management while other respondents perceive the management as not interested in the maternity sector. No *budget* was allocated, at the interview time, for GBV prevention and intervention services and GBV addressability was not considered, when assessing the quality management of the health setting. Although the clinic has strict *policies* for case management; but guidelines were not provided in case of violence.

Managing GBV cases varies between clinical settings. One gynecologist from a different clinical setting than the one where the capacity building activities will take place, reported the availability of a "statutory survivors' support group" inside the clinical setting, a very active group in charge with staff trainings and with publishing (i.e., booklets, flyers) information helpful for GBV survivors. This health care settings are equipped with a consultation room allocated only for women survivors of GBV. In this setting, GBV is considered a priority, all departments and all staff being trained on medical examination of GBV and on data collection using the MEDPOL documentation sheet. Besides using MEDPOL and the WHO guidelines for examining GBV cases, this clinical setting owns an online platform – INTRANET – which allows documentation of cases and access to all medical staff.

In terms of legislation for GBV, laws exist but are not enforced. At a national level a "doctor's law exists, which obliges doctors and midwifes to report severe violence (e.g., grievous bodily harm, physical injuries) to the police.

Small injuries (hematoma or swellings) can also be reported, but don't have to. Normally the survivor gets asked and convinced to agree to report to the police. There are survivor protection groups in public hospitals compulsory by law. It proclaims that all public hospitals need to install an interdisciplinary team of doctors, nurses and social workers, who have to care for adults affected by violence adequately and educate the personal. Unfortunately, this law is not transformed into action yet in all states. One policy maker stated that "In Austria health institutions are legally bound to build-up violence protections groups of adult persons affected by domestic violence. It is their task as well to provide guidance of the survivors, early detection of domestic violence and the sensitization of the medical staff for this specific topic."

Mechanism for screening, rapid response, referral and initial counseling for GBV survivors

Pregnant women do receive a detailed anamnesis, when arriving at the care unit. However, addressing GBV during the consultation is conducted for pregnant women only if violence is suspected. An early identification and rapid response mechanism is missing and so is a referral mechanism for GBV. However, as one gynecologist stated "everyone knows where they need to and can send the women: the numbers of women helplines and emergency calls are known, consulting institutions, women shelter, migrant institutions, brochures and leaflets lie out everywhere."

Data collection and reporting process of the prevalence and incidence of GBV cases

Data collection and publishing activities depends on the institution. One maternity clinic does not record GBV data while the other setting collects data and "yearly reports it to the survivor-protection groups of the hospital. Personal data get encrypted with the AKIM system, to which only certain people have access to. The peak times for cases are mostly after holidays or around Christmas.", stated one gynecologist.

In terms of documents/reports at national or European level showing the link between GBV and pregnancy or women's health, one policy maker specified Eltern-Kind-Vorsorge Neu, Krankenanstaltenverbund, Roses Revolution, and the FRA-study.

Collaboration

Organizations offering specialized support and support groups for GBV survivors

When interested in referring patients, health care staff can access Battered women's shelter, Women's Helpline (0800/ 222 555), Interventinsstelle, Police, Network of Organisation "Frühe Hilfen" for prevention of violence in families. However, collaboration is considered "one way" as GBV survivors are transferred from the hospital to a shelter but with no follow-up information. (Midwife)

Networks for GBV prevention practitioners

Network of Organisation "Frühe Hilfen" for prevention of violence in families was reported as a network for GBV prevention practitioners. One gynecologist declared that also an "interdisciplinary working group meets up every 3 months where members of the survivor-protections groups, women-shelters and police take part". Other support services, depending on the gender, age and origin of the person who experienced violence were:

Frauenhelpline gegen Gewalt (women´s helpline against violence): 0800 - 222 555; www.frauenhelpline.at

Opfernotruf (general survivors helpline): 0800 - 112 112; www.opfer-notruf.at

Kindernotruf (children´s helpline): 0800 - 567 567; www.kindernotruf.at

Rat auf Draht: 147; www.rataufdraht.at

Die Möwe: 0800/80 80 88; www.die-moewe.at

Kinder- und Jugendanwaltschaften: www.kija.at

Gewaltschutzzentren/Interventionsstellen: www.gewaltschutzzentrum.at

Pro Senectute - Beratungstelefon bei Gewalt gegen ältere Menschen: 0699/112 000 99

Orient Express: 1/728 97 25, www.orientexpress-wien.com

Männerberatung Wien (Men´s Support Vienna): www.maenner.at/start.asp?ID=13

Capacity

Availability in the maternal health setting of trainings of GBV for health care providers

Most participants stated that medical doctors, nurses and social workers don't receive any GBV education during their academic studies, while midwifes receive training on GBV during preparatory school. Training on GBV for social workers depends on the university, university centers from Vienna being referred as including GBV in their curriculum for social workers (i.e., "Violence in the Family").

Training certificates of medical doctors, nurses, midwifes, social workers

Maternity clinics are delivering GBV trainings and workshops at least once per year, in one maternity clinic trainings for midwifes and nurses being delivered every three months. Moreover, the medical and non-medical staff participated outside their clinical setting in continuing education trainings and workshops on GBV, depending on their personal and professional interest; but there is the availability of such trainings. As workshops, "Gewaltfrei Leben" was mentioned, and as capacity building projects implemented in the clinical setting, the "livingFREE of violence" and "the survivor protection day" were mentioned. One policy maker specified a large list of trainings for medical staff delivered by the „Wiener Interventionsstelle" (*En.,* Domestic Abuse Intervention center in Vienna) and the "Association of the autonomous Austrian women´s shelter (AOF)", trainings focused on domestic violence, evidential documentation and securing the evidences, survivor protection laws and support facilities. Moreover, during 2017, among other trainings for medical staff, the following were delivered: Congress for Patients' Security – design and dialog, Survivors Congress, Donau-Universität Krems, ÖGGM Congress (Österreichische Gesellschaft für Gerichtliche Medizin), Training workshop, Ludwig-Boltzmann-Institut Forensische Radiologie (*En.,* Ludwig-Boltzmann-Institute for Forensic Radiology), (*En.,* Office of the local Government of Vorarlberg) and Ärztekammer Vorarlberg (*En*., Medical Association or Ombudsman for doctors), ÖÄK- diploma training Geriatrie 2017 (*En.,* ÖÄK- Austrian Medical Association - diploma training geriatrics), Seminar 1. Akademie der Ärzte (*En.,* Seminar 1st Academy for Medicals), Workshop injury documentation and Krankenhaus Göttlicher Heiland (*En.,* Hospital named Göttlicher Heiland) and Wiener Interventionsstelle gegen Gewalt in der Familie (*En.,* Domestic Abuse Intervention center in Vienna).

FRANCE

MATERNAL HEALTH SERVICES IN PARIS, FRANCE

In France maternities are classified into 3 levels, as follows:

Level 1 establishments welcome future mothers whose pregnancy and, a priori, the delivery of the child is risk-free.

Level 2 maternity units have a neonatal or neonatal intensive care unit on site or nearby. They can accommodate children whose prematurity is more than 33 weeks, namely they need care but not heavy care, especially on the respiratory level.

Level 3 maternity units have a neonatal resuscitation service and are specialized in the follow-up of pathological pregnancies (hypertension during pregnancy, gestational diabetes) or multiple risks known from the conception to present a risk to the unborn child. Large premature babies (less than 33 weeks old), for example, are born in this type of facility, as doctors have to intervene immediately for reasons of respiratory distress.

METHODOLOGY

Study setting. Seven interviews were conducted at Port-Royal Maternity (the training maternity clinic for RESPONSE), a maternity hospital located in the center of Paris. Port-Royal is a level 3 maternity unit registering 6000 births per year. Women with no other related health issues attend this maternity unit at the beginning of their pregnancy and before giving birth. When not attending Port-Royal, they attend midwives' services. Other two interviews were conducted at the Maternity ward of Saint-Joseph hospital, a level 3 maternity ward - the control maternity clinic for RESPONSE.

Study participants. Health professionals answering the interview questions were three health care providers (one medical doctor, one midwife and one nurse), three social workers (a psychologist, a social worker, a coordinator of the medical-psycho-social staff) and three policy makers (head of the maternity service of Port –Royal, head of the maternity service of Saint Joseph Hospital and the National Coordinator for the Prevention of Violence Against Women).

Health Professional 1	Midwife	Hospital Saint Joseph
Health Professional 2	General practitioner	Port-Royal maternity ward
Health Professional 3	Nurse	Port-Royal maternity ward
Social Worker 1	Coordinator of the medical-psychological-social (MPS) department	Port-Royal maternity ward
Social Worker 2	Social worker	Port-Royal maternity ward
Social Worker 3	Psychologist	Port-Royal maternity ward
Policy Maker 1	Head of the maternity ward	Hospital Saint Joseph
Policy Maker 2	Head of the maternity ward	Port-Royal maternity ward
Policy Maker 3	National coordinator for prevention of violence against women	Ernestine Ronai (MIRPOF)

Data collection. All interviews followed the RESPONSE interview guide allowing health professionals to details their specific professional area and to mention whatever seemed relevant. All interviews were conducted face-to face

by two researchers, members in the RESPONSE project. Interviews lasted between 40 minutes and 75 minutes, depending on participants' schedule. All interview discussions were audio-recorded, besides one during which technical difficulties were met. However, notes were taken during that interview. The eight interviews audio-recorded were transcribed and translated and used to fill in a specific template shared by the coordinating team.

RESULTS

All professionals were keen to answer the interview questions. Since they do not keep statistics on GBV, all figures presented during the interview discussions came from observing how many women they had seen on a yearly basis. We consider the numbers to be low in comparison with numbers we find in the general population in France.

Midwifes, nurses, medical doctors and policy makers answering the interviews considered highly relevant to address GBV in their work. The coordinator of the medical-psychological-social (MPS) department from the Port-Royal maternity ward underlined the need to address GBV in health practitioners' work as "Pregnancy reactivates patterns of previous violence or hidden violence between the couple." Thus, besides the need to "provide assistance, do prevention and protect the mother and the child", as the MPS coordinator stated, respondents addressed GBV due to the health consequences for both the mother and the child.

The number of GBV survivors encountered differed from respondent to respondent. Variation was observed among the cases reported by health care providers from the Port-Royal maternity ward. One midwife mentioned that she encountered GBV survivors approximately 2 to 3 times per month out of the 300 women delivering babies at the maternity ward. The nurse for Port-Royal reported encountering the same number of GBV cases. The MPS coordinator reported working with approximately 3-4 cases of GBV per year, while the social worker from Port-Royal reported working with 30 GBV cases per year. The general practitioner from Port-Royal did not report a specific number of GBV cases. However, this practitioner reported that, from collaborating with the MPS coordinator and the social worker from Port-Royal, he remembers the MPS coordinator meets around 6 cases per year and the social worker around 60 cases per year, out of 5600 births per year. However, as data on GBV is not systematically reported, accurate values for GBV incidence and prevalence are unavailable, and differences in identification might have to do with the different number of patients each staff has, the different training and skills to identify victims or different ways of remembering.

Respondents do not feel prepared to address GBV in their patients, and previous training has never been provided. The nurse reports no training participation while the midwife reports that one of her midwife colleague "is currently doing a university diploma on violence against women at the University of Paris 8 thanks to the training program" they have. Training and dissemination materials (i.e., flyer) on GBV identification and on addressing GBV was reported as necessary to increase GBV skills in health care providers. The Head of the maternity ward from the Hospital Saint Joseph confirms that also in this setting no GBV trainings exists yet, however the respondent details the current planning of a training "We are currently putting in place a training with Ghada Hatem (Women's house). I propose to finance for all those interested this training, which will take place outside of the hospital. Similar with the interviewed health providers, both social workers do not feel prepared to address GBV and state the need for trainings and informative materials.

Infrastructure

Availability of a department, budget and policies addressing GBV

The enrolled maternity health clinic where the capacity building activities will take place does not have a special department addressing GBV. However, the clinic has a medical-psycho-social (MPS) staff comprising doctors, midwives, pediatricians and social workers. All GBV cases, if detected, as referred to the MPS. The MPS coordinator from the Port-Royal maternity ward described the process of addressing GBV cases: "general practitioners identifying a survivor, refers the survivor to me, I call her to tell her that we will do the upmost to help her, I coordinate the social services, psychiatrist, and external organizations … If urgent, we hospitalize her so that she can get some distance from the perpetrator and that she is safe." Besides the MPS staff, the MPS coordinator stated that a group meets once a month to discuss cases. Around 20 people participate at these meetings, and, among them, staff from the maternity clinic, social workers, midwives, personnel from the center for medico-psychological care, and doctors.

The control clinic is missing a special department addressing GBV. However, as the head of the maternity ward at the Saint Joseph Hospital mentioned, the control clinic has "a social service which is not just for the maternity but

in which our patients can go to and we have a team consisting of a psychiatrist and two psychologists, who intervene in the maternity ward and in neonatology who help us with this problematic issue.".

All respondents consider addressing GBV represents a priority for the entire maternity and thus, midwives are taking classes on GBV and evaluate patients using a self-reported questionnaire GEGA (*Eng.,* Group of Studies on Pregnancy and Addictions). Moreover, the MPS coordinator from the Port-Royal maternity ward considered the "management of violence as a quality criteria for the clinical setting". However, the maternity does not have a special budget allocated for GBV prevention and intervention services.

None of the respondents were aware of any existing law regulating the GBV services in maternity health care settings.

Mechanism for screening, rapid response, referral and initial counselling for GBV survivors

The risk of GBV in pregnant women is assessed in the prenatal interview, the self-reported questionnaire GEGA and by "asking the partner, the family and the other children in the family" (Midwife, Saint Joseph Hospital). However, there is no mechanism in place for early identification of GBV. Either the survivors disclose the abuse or practitioners look for specific signs such as: "the person's attitude, small words shared… For example, the partner is always with her …. comes to each visit with her…to the anesthesiologist, to the midwife, social worker, ultrasound….it is a sign of control on behalf of the partner, to control what she can say" (Social worker, Port-Royal Hospital); "patients which are not doing well psychologically, that is noticeable" (Head of the maternity ward, Port-Royal Hospital) "speaks very little" (Nurse, Port-Royal Hospital).

There is no initial counselling for GBV survivors. However, in terms of referral, respondents presented three possibilities that they deliver, based on the case: 1) referring the survivor to the social worker from the maternity clinic; 2) referring the survivor to specialized services outside the clinic; and 3) informing the person about "the option to file charges, the Centre national d'information sur les Droits des Femmes (CNIDF), about shelters".

Data collection and reporting process of the prevalence and incidence of GBV cases

Respondents were not aware of any documented process of GBV prevalence and incidence at their maternity health clinic and of any documents or reports at the national and European level presenting information on GBV and pregnancy/women's health.

Collaboration

Respondents perceived collaboration inside the maternity as appropriate and were satisfied with the MPS staff. However, they were unaware of organizations offering specialized support and support groups for GBV survivors and networks for GBV prevention practitioners.

Capacity

Respondents expressed a lack of trainings of GBV for medical students and for nurses during the college years. The midwife from the Port-Royal Hospital confirmed midwifes had GBV integrated within their curriculum during the college years. Respondents did not express information regarding GBV trainings for social workers or the information presented was not clear.

The intervention clinic does not offer trainings on GBV and respondents were negative regarding GBV trainings outside the clinic took by the medical and non-medical staff. The MPS coordinator from the Port-Royal maternity ward mentioned the "Monday morning staff meetings" where GBV was addressed a couple of times.

GERMANY

MATERNAL HEALTH SERVICES IN ENNEPE-RUHR COUNTY, GERMANY

GESINE is situated in the Ennepe-Ruhr County. Three clinical settings with maternal facilities are located in this county. The first clinic has been a long-term cooperation partner in the GESINE network and has also been cooperating with GESINE in IMPLEMENT. The second clinic had some training in the forensic documentation of GBV, especially in confidential documenting. The third clinic, which, enrolled in the RESPONSE project has a social anthropological approach to women's health and a maternal department with very good reputation and patients' reviews. Among the socio-demographic characteristics of the women accessing the third clinic, are a high educational status, high socio-economic status and age above the average age of pregnant women. Moreover, a low percentage of migrant patients access the services of the third clinical setting.

Support concerning GBV in the county is provided by one women shelter (Frauenhaus) and by women support center (Frauenberatung) having three sites. Both facilities are operated by the association Frauen helfen Frauen (*En.,* Women help Women). GESINE Network is the "health department" of the association and provides networking, training and coaching for various health facilities including clinics.

METHODOLOGY

Study settings. The main clinic enrolled in RESPONSE is Gemeinschaftskrankenhaus Herdecke Clinic in Herdecke, one of nine small to middle cities in the county of Ennepe-Ruhr. The clinic is a well-known as a center of anthroposophic medicine in this region. It´s a middle-sized clinic with 474 beds. The women's health and a maternal department is certified for its "mother & child sensitivity" and attracts especially women patients with high education, high socio-economic status and a strong health consciousness. The clinic has a very low percentage of migrant patients in comparison to the other clinics in the county. The control clinics site is Hagen, a neighbouring middle town not belonging to the county of Ennepe-Ruhr. It´s called Evangelisches Krankenhaus Hagen-Haspe. With 314 beds, altogether it´s quite a bit smaller than the Herdecke-clinic, but the women's health and a maternal department is comparable. It also has a very good reputation, but of cause it´s a more "mainstream" hospital than the Herdecke clinic with its anthroposophic focus as a unique characteristic in this region. Both clinics have women as heads of the department.

Study respondents. Three health professionals, two social workers and three policy makers participated in interviews. Three of the interview participants worked in the medical field: a gynecologist, a coordinator midwife and a pediatric nurse who is also a very experienced midwife, worked in several clinics and now is a freelancer. With regards to social workers, important mentioning is the fact that social workers in German clinics rarely work with patients on issues like GBV. They focus mainly on supporting patients in finding shelters after hospital release when returning home is dangerous. Two of the interview respondents were social workers, one working at the shelter, the other at the women support center. Both have long-term experience in working with pregnant GBV patients and also in cooperating with maternal clinics. Participants answering the interview questions and corresponding to the policy makers category were (1) an equal opportunities officer on county level who is also executive secretary of the regional roundtable on domestic violence, (2) a trainer for midwives on trauma, violence and a political instructor on these issues (working freelance for Medica Mondiale), (3) a leading doctor of a clinic, activating in round table discussions against domestic violence organized by the GESINE network and in several professional associations.

Health Proffesional 1	Midwife – coordinator of the midwifes department	Gemeinschafts-krankenhaus Herdecke clinic
Health Proffesional 2	Gynecologist	Gemeinschafts-krankenhaus Herdecke clinic
Health Proffesional 3	Midwife & Paediatric Nurse	Freelancer in Ennepe-Ruhr-County
Social Worker 1	Social worker	Women support center(Frauenberatung EN) &

		cooperating with the Gemeinschafts-krankenhaus Herdecke clinic
Social Worker 2	Social worker	Women Shelter (Frauenhaus Ennepe-Ruhr-County) cooperating with the Gemeinschafts-krankenhaus Herdecke clinic
Policy Maker 1	Equal opportunities officer at a county level & Executive secretary of the regional roundtable on domestic violence	Ennepe-Ruhr-Kreis County Administration
Policy Maker 2	Trainer for midwives on trauma, violence, coach and political instructor	Medica Mondiale
Policy Maker 3	Leading doctor	Helios clinic Schwelm

Data collection. All interviews followed the RESPONSE interview guide. However, questions were adapted for policy makers. All interviews were conducted by a certified psychologist. Interviews took between 45 minutes and 90 minutes. Six interviews were conducted on-site and two by phone. All face-to-face interviews were audio-recorded and transcribed, except for the phone interviews which were not recorded. However, notes were taken during those interviews. Interviews were transcribed and translated by the psychologist conducting the interviews and used to fill in a specific template shared by the coordinating team.

RESULTS

Respondents consider addressing GBV during pregnancy a priority, as experiencing violence is "more serious during pregnancy because is the time when violence often starts" (Social worker, Women support center). However, respondents reported dealing with GBV cases "quite rare" and were not able to estimate a number of GBV cases. Only one social worker working at a shelter and collaborating with the intervention clinic reported dealing with GBV cases "more than once a week". All respondents, besides one, consider themselves and other health care providers not prepared for addressing GBV in pregnant women due to rare encountering of GBV cases and due to poor trainings, guidelines and information:

> *"No, I think they are not prepared and they even don´t know about the amount of violence their patients experience" (*Equal opportunities officer at a county level & Executive secretary of the regional roundtable on domestic violence)
>
> *„No, midwives are usually not prepared. Some have started to get more prepared, to train, but most still have to learn about violence and trauma and how to deal with it and especially with the fact, that in this context the midwife herself maybe traumatized herself, may remember old violence and will need support – this is even more tabooed." (*Trainer for midwives on trauma, violence, coach and political instructor)
>
> *"No I don´t think staff is prepared to recognize violence and to ask about it. They need to learn how to show that they are ready to talk about violence and they might learn to ask. Because women don´t talk about it usually."* (Social worker, Women support center)
>
> *„No, they are not prepared. Midwives especially are very concerned with the existence (as a profession) and it´s only single midwifes taking the issue on board – and also there happens violence during the process of giving birth. And from my experience doctors are not prepared at all to talk about the issue."* (Social worker, Women's shelter)
>
> *„No, not really – we´d need some tools and ways to identify violence"* (Leading midwife, Gemeinschafts-krankenhaus Herdecke clinic)
>
> *„No, I don´t feel prepared for this – it´s a lack of dealing with it on a daily base, no routine or guidelines" (*Gynecologist, Gemeinschafts-krankenhaus Herdecke clinic)

> *„No, in the clinic, from my experience most are not prepared – it would need some extra training, tools and contacts"(*Midwife & Paediatric Nurse, Freelancer)

> *„I personally yes, because I´ve got some training and experience but most of the staff won´t be adequately prepared"(*Leading doctor, Helios clinic Schwelm)

Infrastructure

Availability of a department, budget and policies addressing GBV

The enrolled maternity clinic does not have a specific department or staff responsible for addressing GBV, although respondents consider it important. All respondents agreed that training on GBV would be necessary for all medical and non-medical staff. However, they underlined the necessity of having in the clinic a person taking the lead on GBV activities conducted in the clinic:

> *"it would really good to have somebody coordinating the issue, may be a nurse because they stay much longer usually",* (Social worker, Women support center)

> *"it would be could to have somebody who is in charge in the team, somebody who knows about contacts and the support system"* (Social worker, Women's shelter)

> *"I think what you need are dedicated person who take the issue on board and always hold it "fresh" – training for everybody is important, but not enough, you need these leads." (*Equal opportunities officer at a county level & Executive secretary of the regional roundtable on domestic violence)

Only one respondent considered GBV a priority for the management of the maternity clinic, "priority in the sense that the issue is taken serious and projects are easily taken on board" (Leading doctor Helios clinic Schwelm), the rest of the respondents agreed that all staff, including the management, take GBV seriously and consider it important, "but still it isn´t a priority". The maternity clinic does not allocate a specific budget for GBV prevention and intervention activities. Respondents consider a budget should be allocated for trainings and materials on GBV but also for paying a person who can take the lead on GBV initiatives in the maternity clinic. At the same time, specific policies for GBV in the maternity clinic don't exist and laws regulating the provision of GBV services by health professionals in Germany are missing.

Mechanism for screening, rapid response, referral and initial counselling for GBV survivors

On-going screening for GBV in pregnant women is not conducted in the maternity clinic. Respondents see GBV screening as a necessity not only for pregnant women but also for all women accessing the clinic's health care services.

The leading nurse of the intervention clinic sees reacting to „red flags"/warning signs instead of screening as a much more realistic approach in their daily routine. This attitude was in line with the RESPONSE approach.

However, respondents are reluctant on how to approach this topic with GBV survivors, as it is a sensitive topic. The maternity clinic does not have a mechanism for early identification and rapid response in case of GBV. The leading nurse from the intervention clinic considers useful to "develop a mechanism, like card/flowchart to look at when necessary". However, they are reluctant about having a mechanism as this process involves a lot of effort, not only for its development but also for implementing such a mechanism. An option preferred by respondents would be to address GBV during the anamnesis. A mechanism for referral in case of GBV is also missing and so are services for initial counselling for GBV patients.

Two respondents referred to the IMPLEMENT project, when talking about a mechanism for early identification and rapid response. From their knowledge, some of their colleagues working at the clinic enrolled in the IMPLEMENT project followed the procedures learned during the IMPLEMENT project. However, the procedure is not applied in a uniform manner by all medical and non-medical staff.

Data collection and reporting process of the prevalence and incidence of GBV cases

Information regarding prevalence and incidence of GBV in the maternity clinic is not systematically collected and, as far as the German partners know, it's not collected at all. In terms of reports/papers on GBV and pregnancy, respondents remember a representative study conducted in Germany in 2004, a pilot study conducted by GESINE, a paper published in "Frauenarzt" and the "Roses Revolution".

Collaboration

Although a written policy for interdisciplinary collaboration concerning GBV is missing, interview respondents report collaborating with other professionals from the women's counseling center, NGOs for GBV, social workers, etc. Although a mechanism for referral is not in place, social workers report being contacted by the clinic to deliver initial counseling or to take the GBV survivor to a shelter. Some respondents were aware of the women shelters and women supporting center but with no specific information about the name and attributes of these organizations.

All respondents acknowledge GESINE a network for GBV prevention practitioners, meaning that GESINE is well disseminated among medical doctors, social workers, midwives and policy makers.

Capacity

Most respondents reported that the medical school does not include GBV in their curriculum, as part of the medical training for future doctors. However, one participant remembered approaching sexual violence, not in a comprehensive manner, but as a topic, during the forensic medicine class. Respondents were not aware if nurses, midwives and social workers have classes on GBV included in their curriculum. However, for midwives, GESINE was acknowledged as providing trainings and one policy maker confirmed teaching a seminar at the midwifery school focusing on GBV.

The maternity clinic was not involved in any GBV projects before. However, respondents recall that another maternal clinic in the county, one which cooperated with GESINE in IMPLEMENT, was involved in projects on men, violence and health. Moreover, the *Women Support Center* delivered trainings in the maternity clinic. Moreover, respondents considered that the medical and non-medical staff of the clinic did not participate in other capacity building initiatives delivered outside the maternity clinic, as it was not sustainable for the staff.

ROMANIA

MATERNAL HEALTH SERVICES, IN CLUJ-NAPOCA, ROMANIA

In Cluj-Napoca, women's health is approached from three perspectives.

- First, women's health is address at a local level through the obstetrics and gynecology clinics and obstetrics and gynecology departments. Cluj-Napoca has two state owned obstetrics and gynecology hospitals - Obstetrics and Gynecology I Clinic and Obstetrics and Gynecology I Clinic „Dominic Stanca" – and three private clinics – Gynia, Novogyn, HIPOCRATE. Women's health is also addressed through departments of obstetrics-gynecology existing in private medical centers such as gynecology departments within the Medstar Medical Center, Regina Maria Private Health Network and Cardiomed Medical Center, Provita Medical Center.
- Second, women's health is address at a local level through family planning services existing in both state-owned hospitals and in private family planning offices.
- Third, an ONG – Cuibul Berzelor (Engl., Storks' Nest) delivers classes for parents – classes focused on the post-partum period, on breastfeeding, on nutrition during childhood, emotional relationship between the mother and the child - and classes focused on family planning.

At a national level, GBV is addressed by the **National Agency for Equal Opportunities between Women and Men (ANES),** a governmental organization subordinated to the Ministry of Labor and Social Justice with responsibilities in implementing measures for preventing and combating domestic violence and GBV and therefore, having the responsibility of developing, implementing and enforcing policies on GBV. At national level the following policies tackle the issue of GBV:

- Law no. 217/2003 on preventing and combating violence within the family
- National Strategy on preventing and combating violence within the family (2013-2017)
- Law no. 30/2016 on the ratification of The Council of Europe Convention on preventing and combating violence against women and domestic violence.

Another major institution with responsibilities in the prevention and control of GBV is the Inter-Ministerial Committee on Preventing and Combating Violence against Women, a committee established in 2016, with no current activities in 2017.

METHODOLOGY

Study settings. The Cluj County Emergency Hospital, a university and level 3 trauma hospital, served as the clinical setting providing the intervention and the control gynecology and obstetrics clinics enrolled in RESPONSE. The hospital has two gynecology and obstetrics clinics as part of their hospital administration: (1) Gynecology and Obstetrics I Clinic serves as the training maternity clinic for RESPONSE and (2) Gynecology and Obstetrics II Clinic serves as the control clinic. Annually, both clinics provide health care services for approximately 6000 women patients. Two interviews were conducted with medical doctors that work at Gynecology and Obstetrics I Clinic in Cluj-Napoca. Interviews with social workers were scheduled at the same Clinic. However, we encountered two limitations in conducting these interviews. First, Gynecology and Obstetrics I Clinic has 1 employed psychologist addressing psychological counseling for all women patients seeking counselling. The psychologist mentioned having no previous training in GBV, no previous recall of being approached by women victims of GBV and being unaware of any capacity to tackle GBV in the health setting she works. Moreover, the psychologist refused to take part in the RESPONSE training, therefore her answers were not considered for the situation analysis. The second encounter limitation referred to the social worker serving the whole hospital, whose main location is at the County's Hospital's Emergency Department. Although he initially accepted to participate in the interview and to serve as a support worker in the RESPONSE Project, the social worker declined both situations.

To compensate for these limitations, we decided to recruit participants outside the clinical setting. Thus, we conducted one interview with a social worker from the Atena-Delphi NGO and two social workers from the Department of Social and Medical Support of Cluj-Napoca Town Hall. The two local policy makers were recruited

from the Police Department and the Public Health Inspectorate from Cluj County, while one national policy maker was recruited from the "Carol Davila" University of Medicine and Pharmacy, Bucharest

Study respondents. Two health professionals, three social workers and three policy makers participated in the interviews. Both health professionals are specialized in obstetrics-gynecology and are currently conducted research activities within the field of obstetrics and gynecology. Both health professionals work at the IMOGEN – Medical Research Institute. However, one health professional has been working as a gynecologist since 2012 and is currently working at the intervention clinic enrolled in RESPONSE, while the other health practitioner has been practicing in the field of obstetrics and gynecology since 2015 and is delivering the obstetrics and gynecology services within one private obstetrics-gynecology clinic – Novogyn - and one private medical center – Napoca Medical Center.

With regards to social workers, one interview was conducted with a support worker who is being trained to be a social worker. She is currently working at the Atena-Delphi NGO who focuses with the support of women survivors of GBV and administers the Women Shelter in Cluj-Napoca. The other two interviews were conducted with two social workers from the Directorate of Social and Medical Assistance, Municipality of Cluj-Napoca. One of the social workers is the head of the Child and Family Protection Service, Directorate of Social and Medical Assistance, Municipality of Cluj-Napoca and the other social worker is the head of the Social Protection Service, Directorate of Social and Medical Assistance, Municipality of Cluj-Napoca.

As stated above, policy makers were recruited outside the clinical context.

Health Professional 1	Obstetrician/gynecologist	IMOGEN - Medical Research Institute
Health Professional 2	Obstetrician/gynecologist	Gynecology and Obstetrics I Clinic
Social Worker 1	Social worker, Coordinator of the Women Shelter	Atena-Delphi NGO, Women Shelter
Social Worker 2	Social worker, Head of the Child and Family Protection Unit	Child and Family Protection Service, Directorate of Social and Medical Assistance, Municipality of Cluj-Napoca
Social Worker 3	Social worker, Head of the Social Protection Unit	Social Protection Service, Directorate of Social and Medical Assistance, Municipality of Cluj-Napoca
Policy Maker 1	Physician and Professor	Department of Public Health and Management, "Carol Davila" University of Medicine and Pharmacy, Bucharest
Policy Maker 2	Counsellor	Cluj County Public Health Authority
Policy Maker 3	Police Commissioner	Cluj County Police Inspectorate

Data collection. All interviews followed the RESPONSE interview guide. However, questions were adapted for policy makers. Six interviews were conducted by a researcher trained in qualitative data analysis and interpretation and two interviews by a psychologist member in RESPONSE, with background in qualitative data collection and analysis. Seven interviews were conducted on-site and one interview was conducted using Skype. All interviews were audio-recorded and transcribed by the two researchers conducting the interviews. Although translations into English were identical with the original transcripts, statements irrelevant to the project context were omitted.

RESULTS

Addressing GBV in pregnant women is seen as a priority by the Romanian heath care providers due to the health risks GBV represents for the women and for their babies. Moreover, it is considered a priority because, as the Obstetrician/Gynecologist from the IMOGEN - Medical Research Institute stated, "we don't have any solutions to offer for women who are GBV survivors". GBV is not only recognized as a risk factor for pregnancies in the research environment, but also meet by gynecologists during their medical consultation, the Obstetrician/Gynecologist from Gynecology and Obstetrics I Clinic stating that "I have women wanting to proceed abortion due to the GBV they experience at home….and I had one pregnant woman for which I could not even deliver a gynecological consultation due to the bruises she presented over her entire body". A policy maker underlines that not the frequency of GBV is relevant in addressing it, but its severity, thus stating that "We shouldn't look at numbers, as each case of GBV should be managed by authorities" (MD, Counselor, Cluj County Public Health Authority). Moreover, as the Police Commissioner from the Cluj County Police Inspectorate stated, "GBV is one type of criminality…and thus police deal not only with its prevention but also with intervention".

With regards to the *prevalence of GBV*, the Obstetrician/Gynecologist from the IMOGEN - Medical Research Institute who also works in private gynecology clinics mentioned that GBV cases in private health care centers are pretty rare. However, during her practice as medical residents, she usually encountered around one case of GBV per month. The gynecologist working in the intervention clinic reported meeting approximately 10 cases in the past five years since working as a gynecologist in the state-owned clinic. The same 10 cases encountered during the last three years were by the social worker from the Child and Family Protection Unit during while the social worker from the Atena-Delphi NGO reported that 10 cases per month reach the NGO.

When asked about the *readiness to address GBV* cases, both gynecologist expressed not being ready to address GBV cases because they don't know how to intervene when recognizing signs of abuse. If they were to improve something, they both reported improving "…first of all, the approach. Maybe I don't know what to do with them in each situation…and second, the referral…knowing where to refer them" (Obstetrician/Gynecologist, Gynecology and Obstetrics I Clinic); "We should know, in the first place, what to do with the patients, where to refer them, who takes the case further on" (Obstetrician/Gynecologist, IMOGEN - Medical Research Institute). Social workers from the NGO and the Child and Family Protection Unit felt prepared in dealing with GBV cases, due to their training. However, they both expressed the need for in depth trainings as "GBV cases differ one from another. In some cases, violence is manifested at an emotional level…while in others at a physical level….and women try to hide signs on abuse" (Social worker, Atena-Delphi NGO). Thus, as the social worker from Atena-Delphi NGO stated, to be able to adapt the approach for each "woman's coping mechanism", more training is needed. All three policy makers consider that medical personnel is not prepared to properly approach the GBV cases, one policy maker stating that "The medical staff has a limited role in this matter. Of course, they are the ones obliged to identify and report any sign of abuse…. but besides the severe cases of GBV, abuse is manifested on a subtler level and it rather manifests at a verbal and psychological level…. a level for which the medical staff is neither prepared to address nor has the obligation to do so" (Medical doctor and Professor, "Carol Davila" University of Medicine and Pharmacy, Bucharest). However, the same policy maker stated that "…the medical staff is the most appropriate one to identify GBV signs…. however, when we identify GBV signs in hospitals is too late." Trainings for health care practitioners "Complex trainings for identifying sings of abuse…visible and psychological or internal, is needed for the medical staff, so they can send exact information for the authorities investigating the source of abuse" (Police Commissioner, Cluj County Police Inspectorate).

Infrastructure

Availability of a department, budget and policies addressing GBV

Both gynecologists affirm that a *specific department* addressing GBV inside the gynecology clinics is missing. However, they both recognize the need of such a department have personnel trained to "deal strictly with this problem…. someone to whom we care refer the cases and who can take these cases and who knows how to address them" (Obstetrician/gynecologist, IMOGEN - Medical Research Institute). Although a specific department does not exist, the gynecologist from the intervention clinic remembers that in 2012, at the gynecology clinic where she was working back then, there was one social worker to whom she referred GBV cases. None of the interviewed social workers know about the existence of a GBV department inside the gynecology clinics, however, they reported being contacted by various physicians regarding GBV. All three policy makers express that none of the gynecology clinics they know have a GBV department. One policy maker expressed the utility of such a

department composed by "a medical doctor and a nurse with proper training but also a psychologist"(MD, Counselor, Cluj County Public Health Authority) while the policy maker form the "Carol Davila" University of Medicine and Pharmacy, Bucharest underlines that "It does not exist and it shouldn't exist in the hospitals. The mission of the hospital is to treat acute health problems. We must not accept to have GBV as an acute problem. Prevention is not made in the hospitals. It is not the mission of the hospital. Prevention should be made in the household, in schools, in the community."

Although departments inside gynecology clinics are missing, social workers notify the presence at a local level of one unit administered by the town hall and one directorate administered by the Cluj County Council. First, the Child and Family Protection Unit, belonging to the Department of Social and Medical Support, Cluj-Napoca Town Hall, deals with GBV cases. Social workers are trained to screen and intervene, but mostly for GBV against children. However, as most of the times "If there is GBV against the child, there is definitely violence against the mother" (Social worker, Child and Family Protection Unit), this unit also manages cases of GBV against women. Second, the General Directorate of Social Assistance and Child Protection (DGASP) has a department addressing domestic violence and serving both children and adults.

The two gynecologists and the three policy makers stated that *GBV is not considered a priority* in the clinical settings. However, all perceive that GBV should become a priority for the gynecological settings, besides the policy maker from "Carol Davila" University of Medicine and Pharmacy, Bucharest who underlined that a priority should be the prevention of GBV, a prevention that should take place in other context, outside the hospital settings and should involve other practitioners that have the appropriate knowledge and skills to prevent GBV. Although this opinion contradicts the RESPONSE approach, it is valuable for our proposed advocacy work as we strongly support involving medical doctors in identification and referral of GBV survivors, not necessarily in GBV prevention. Romania has also ratified the Istanbul Convention who mentioned in Art. 15 the importance of training of health care staff in the identification and referral of GBV. The responsibility of implementing this article should fall under a shared task between the Ministry of Health and Ministry of Labor and Social Justice.

The social worker from Atena-Delphi NGO underlined that she is not aware of this situation and the respondents from the Department of Social and Medical Support focused their answers in the budgeting mechanism that the Cluj-Napoca Town Hall administers in addressing GBV. Cluj-Napoca Town Hall allocated currently allocated a budget for GBV by (1) financing projects addressing GBV, (2) supporting the Child and Family Protection Unit. Inside this unit, coordinators are currently working on developing a counseling and prevention center for victims of domestic violence and a shelter, both budgeted by the Cluj-Napoca Town Hall.

Mechanism for screening, rapid response, referral and initial counseling for GBV survivors

At national level, two ways to get immediate help in case of domestic violence is encouraged: 1) to call the national number for emergency service 112, the call will be directed to the police, and 2) to call a free HELPLINE for victims of domestic violence 24h/24h, 0800.500.333, administered by ANES.

The two interviewed gynecologists mentioned that no procedure for screening GBV in pregnant women exists, no mechanism for early identification and intervention, and no referral mechanism is in place. Pregnant women don't receive on-going screening for GBV. Questions regarding GBV are addressed by the medical doctor only if the woman presents bleeding, pain, risk for premature birth or if the woman presents bruises or signs of physical violence. The interviewed social worker presented the availability of an NGO for GBV that is usually contacted by the medical personnel in case of GBV. However, no procedure for referral is in place. Initial counseling for GBV survivors is missing.

The coordinator of the Child and Family Protection Unit says that the unit has an identification and response mechanism, but a mechanism focused more on preventing GBV. The unit has one psychologist and seven social workers trained to ask the proper questions and to intervene. The respondent described the steps as follows: "After the person is referred to us, we do an initial evaluation at the first contact with the person. At that point, we decide if we can intervene or if we have to refer the person to other authorities. If the abuse is severe, we either refer it to the General Directorate of Social Assistance and Child Protection (DGASP), notify the situation to the Police Department or counsel the women to ask for help. If we decide we can manage the case, because we are talking either about preventing GBV or about signs which we are not sure are signs of abuse, we include the case in a complex evaluation procedure followed by a a service planning process. Afterwards, we deliver the planned services, monitor the case and, in the end, close the case…However, the main services we deliver refer to informing, counseling, mediating, negotiating and offering support in administrative matters".

Data collection and reporting process of the prevalence and incidence of GBV cases

Gynecologists, the social worker from Atena-Delphi NGO and one policy maker from the Cluj County Public Health Authority express the absence from the medical system of data documenting the prevalence and incidence of GBV. The policy maker from the policy department considers highly probable that the medical systems has a GBV data base, at they have one at the Police Department. This information is supported by the policy maker from the "Carol Davila" University of Medicine and Pharmacy, Bucharest who stated that in the medical system „...an injury diagnosis is reported following the International Classification of Diseases – version 10. However, GBV implies much more than physical injuries.", the respondent underlining that GBV is underreported in the medical system. The Family and Child Protection Unit collect their own data regarding GBV for the cases they manage. However, the problem is that „if the person has multiple problems and among them GBV, in the data set we will report the first problem identified". (Social worker, Family and Child Protection Unit).

Collaboration

Both gynecologists were unaware of organizations offering specialized support and support groups for GBV survivors, of networks for GBV prevention practitioners and of policies for multi-agency collaboration. The only department they are reaching in case of GBV is the Police Department. Social workers regarded the General Directorate for Social Assistance and Child Protection (DGASPC) as an institution offering services and shelter for GBV survivors and mentioned Atena Delphi NGO as an active NGO and Artemis as an NGO active a while ago. Both social workers and the policy maker from the Cluj County Public Health Authority and the one from the Police Department mentioned the local interdisciplinary group comprised of lawyers, social workers, psychologists, university professors, NGOs' representatives, police officers, members from the DGASPC that meet on a monthly basis and discuss GBV cases, but no specific information about the work of the group was found. Both policy makers belong to this interdisciplinary group and as a part of these interdisciplinary group activities, cases are discussed and address by the participant members. The policy maker at a national level report that "UNICEF had a project, several years ago, focused on interdisciplinary training.".

Capacity

All respondents expressed a lack of trainings of GBV for medical students, nurses, midwives and for social workers during the college years. One medical doctor and one social worker confirmed that GBV was integrated in the curriculum for social workers during the college years, as topic for discussion but not as independent coursework.

Both gynecologist mentioned they don't remember receiving trainings on GBV or being involved in projects addressing GBV, besides the RESPONSE project. The same situation was reported by the policy maker from the Cluj County Public Health Authority. The social workers from the town hall, on the other hand, report participating in trainings and having colleagues specialized on this matter. However, trainings were not delivered in clinical settings.

SPAIN

MATERNAL HEALTH SERVICES IN MADRID, SPAIN

Maternal care is addressed, in the Community of Madrid, during and after pregnancy and it's carried out on the basis of the public health system structure:

- Public hospitals (specialized care): are used for high-risk pregnancies and puerperia, and during deliveries. Therefore, the majority of women only have contact with the hospital during the actual delivery and, after that, they're referred to the Primary Care clinic.
- Health centers (primary care): "Normal" pregnancies and puerperia—that is, low risk—are dealt with in Primary Care. The midwife is the key figure (during the pregnancy) and the nurse and the pediatrician are the key figures during the puerperium.

GBV in maternal care is addressed in Spain by the Technical Commission of Actions in Health against the GBV. This structure was created in 2005 and promotes the work in prevention and assistance to the GBV. The structure is based on the approach and instruments of public health. The Technical Commission of Actions in Health is embedded in the Department of Health of the Community of Madrid together with Hospitals (Specialized Care), Health Centers (Primary Care), Public Health, the Directorate General of the Coordination of Citizen Services and the Humanization of Medical Attention, SUMMA (Urgent Care Medical Service of Madrid), Mental Health. Moreover, included in the Department of Social Policies and Family of Community of Madrid is the General Directorate of Women.

Besides the Technical Commission of Actions in Health against the GBV, GBV in women is addressed in Madrid in (1) specialized care (public hospitals): one Hospital Commission against Violence in each hospital, and within each Commission a case manager-a social worker, (2) in primary care (health centers): Responsible for GBV in Primary Care (REGBV). REGBV is represented in primary care within the Primary Care Management Team of Community of Madrid (1 REGBV), which is divided into seven Healthcare Assistance Directorates - each assistance directorate owning 1 REGBV. Each Healthcare Assistance Directorate has assigned a certain number of health centers- in each Primary Care Health Center, there should be 1 REGBV, theoretically. Other GBV services should be available in the Municipal Points of GBV of Community of Madrid, depending on GENERAL DIRECTORATE OF WOMEN of Community of Madrid and in the GBV Care Service of the City of Madrid (SAVG 24h), depending on Madrid City Council.

METHODOLOGY

Study settings. Four interviews were conducted at the Hospital Doce de Octubre de Madrid, one interview at the San Andrés Health Center, three interviews at the Madrid Health Service (SERMAS) and one interview at the Orcasitas Health Center and one interview at the San Cristóbal Health Center. Taking into account the structure of maternal health services in Madrid, interview participants were recruited from both Primary Care and Specialized Care. Thus, the specific sanitary geographic area enrolled in RESPONSE includes the Primary Care Health Center and its reference hospital "Hospital Doce de Octubre de Madrid". The Health Center - which includes San Cristóbal Health Center, San Andrés Health Center and Orcasitas Health Center - is affiliated, by geographical area, to Hospital Doce de Octubre, and there's coordination between the Health Center and the Hospital. Patients (pregnant women, in this case) are assisted in both (hospital and health center), depending on their needs during pregnancy and after giving birth.

Study respondents. Four health professionals, three social workers and three policy makers participated in interviews. In primary care, the following professionals participated in interviews: two medical professionals (one midwife and one pediatric nurse), one social worker, and one policy maker from regional level.

In specialized (hospital) care, the following professionals from Hospital Doce de Octubre participated in interviews: one midwife, one obstetrics-gynecology physician, one case manager, one social worker; one policy maker from a

local level – a paediatrician from Hospital Doce de Octubre (halfway between a technical vision and a management vision), and one policy maker at a regional level. Below you can find a distribution of the study participants per institution:

Health Professional 1	Gynecologist
Health Professional 2	Midwife
Health Professional 3	Pediatric nurse
Health Professional 4	Midwife
Social Worker 1	Case manager (Maternity area social worker)
Social Worker 2	Social worker
Social Worker 3	Social worker (manager profile)
Policy Maker 1	Assistant director
Policy Maker 2	Head/Manager
Policy Maker 3	General Director

Data collection. All ten interviews followed the RESPONSE interview guide and were conducted by a research member with expertise in qualitative methodology and with extensive experience in this area. Interviews took between 36 minutes and 80 minutes. All interviews were conducted face-to-face and audio recorded. The interviewer also delivered the transcription for all interviews. After interviews were transcribed and translated into English by a native American from Wesleyan University, Middletown, CT, having a BA diploma in History and Spanish. Translations were used to fill in a specific template shared by the coordinating team.

RESULTS

Gender-based violence in pregnant women is considered a very relevant subject by the interviewed respondents, as "it affects the health of the woman, her children, and anyone she is responsible for, like her parents" (Policy maker, assistant director). Moreover, respondents consider hospitals as "unique places for detecting cases in its early stages, because women regularly go to appointments, gynecological check-ups" (Policy maker, general director). Respondents consider that during pregnancy a GBV survivor is more predisposed to bring the GBV subject, as the woman is "more dedicated to the pregnancy and the situation, and to the defense and protection of the child" (Policy maker, assistant director). However, respondents report the need of a standardize procedure for identifying and addressing GBV cases. Physical, verbal, emotional violence but also the Stockholm syndrome and female genital mutilation were encountered by the interview respondents. However, not all were able to approximate a prevalence of GBV cases in their maternity clinic. The gynecologist from the Hospital stated "I wouldn't dare to estimate how many cases we see", participant's reluctance being caused by the lack of a screening tools and thus the fear of under- or over-estimating the numbers. The midwife from the Health Center reported meeting around five cases per year while the policy maker of SERMAS report 3 cases per week. One of the social workers felt incapable of estimating the numbers of GBV, as "there aren't very many cases that make it to the Social Work Team" (social worker). The same respondent observed that when working in the hospital, few GBV cases were reported while when working "for other external social services resources, or from the 'Municipal Point of Violence', we saw women who were survivors of violence every day there".

The four health practitioners from the maternity clinic felt inadequately prepared to address GBV and suggested the need for trainings and tools to improve their skills in addressing GBV. Health practitioners considered more appropriate to be trained in detecting GBV and referring them to specialized care than being trained in addressing GBV. Thus, a protocol for detecting and referring GBV cases was perceived as necessary in a maternity clinic.

One social worker felt unprepared to address GBV situations while the other social worker felt adequately prepared due to the trainings on GBV and the working experience with GBV cases: "I am specifically trained in GBV, I've been working with female survivors of GBV for more than 15 years. That's why I started working at the Hospital Violence Commission. Because I came from working at the 'Observatory of Violence'…" (social worker).

Infrastructure

Availability of a department, budget and policies addressing GBV

The maternity clinic has a Violence Commission where all hospital departments are represented. This commission meets once a month and is "reviewing all of the protocols surrounding GBV, child abuse, elderly abuse, so that everyone in the hospital deals with the cases in the same manner" (Midwife, Hospital). Although a protocol in managing GBV exists, one respondent, member in the Violence Commission – a midwife from the Hospital, stated the protocol is under revision. Health practitioners respect the existing protocol which focuses first on encouraging the survivor to report the abuse and second on making a decision for the case together with the social worker, the family doctor and other health practitioners working with the GBV survivor. The gynecologist from the Hospital notified that the protocol exists and is helpful for "very obvious cases of physical assault". However, the practitioner was reluctant about the protocol for GBV cases difficult to identify. The clinic also has Social Work Department and social workers are present in the clinic each day during mornings. Health professionals are comfortable in referring GBV survivors to the social workers, as survivors "will probably receive better advice and better support, and better guidance to solve the problem, when it has been recognized as a problem" (Paediatric nurse, Hospital).

Addressing GBV is considered a priority for a policy maker who views it "a priority line within the Primary Care Management and in health centers, insofar as it is considered as a Public Health problem" (Policy maker, assistant director). Moreover, a social worker considers GBV is a priority for the hospital as she has been working for 10 years to address it inside the hospital. However, not all respondents agree that GBV is a priority for the hospital management. They consider GBV "has social importance" (Paediatric nurse, Hospital). However, as no active projects on GBV detection and no raising awareness campaigns exist in the hospital, respondents don't perceive GBV as a priority for the hospital management.

Respondents are not aware of a specific budget allocated for GBV prevention and intervention services inside the hospital. The social worker from the Madrid Health Service reported that "part of the budget is set aside exclusively for training about issues related to violence". The same aspect was reported by one policy maker when referring to GBV in primary care: "We have a budget that is only intended to be used for training, and from this training budget an important part goes to GBV." (Policy maker, assistant director).

With regards to policies concerning GBV part of the quality management, respondents reported there is a Quality Department inside the hospital having the responsibility "to sanction and to spread the word about the protocols for the hospital, produced by the Violence Commission of each hospital" (Social worker, Madrid Health Service). Besides the "doctor's legal obligation to send out the injury report" (Midwife, Health Center), respondents were not aware about any legal framework addressing GBV. However, two social workers and one policy maker were aware of the General Gender Violence Law:

> *"All professionals who see clients are included in the law; we're all obligated to identify [GVB] and report it."* (Case manager)
>
> *"There's a law against violence at the state level. And the 'December 20th 5/2005 law' is the one at the level of the Community of Madrid. The 10th Article refers to the need to train healthcare professionals so that they are more aware of the topic and can detect cases of GBV, all with the objective of minimizing the suffering a woman goes through when something like this happens to her."* (Social worker, Health Center)
>
> *"We have the Law against GBV; the country-wide one and the Community [of Madrid] one. But… it´s not that directed toward health professionals, it goes to an array of people; not specifically to healthcare workers or public health workers." (*Policy maker, Assistant director)

Mechanism for screening, rapid response, referral and initial counseling for GBV survivors

Three out of four health practitioners report not screening for GBV or being aware that other colleagues screen for GBV in pregnant women. However, one midwife from a Health Center reported using a survey at some point during the pregnancy:

> *"Right now, in terms of knowing what we consider to be violence and what we don't consider to be violence, we give the women a small survey, and I'm very content. Because a lot of dialogue is established…We don't do it in the first interview. But we always do it at some point during the pregnancy. And there are times when we also do it during the postpartum period, if someone hasn't done it during the pregnancy, they it out afterwards. At home or…here, with us in front of them. And so after we talk about it. And we talk about what violence really is and isn't. We did this on March 8th, Women's Day, and the truth is that it helps us to destroy myths surrounding violence."*

Social workers are not aware of any screenings addressing GBV in pregnant women and policy makers acknowledge the existence of guidelines in primary care, however, applying them depends on the hospital policies:

> *"The Guidelines for Primary Care Delivery say that yes (all women should be asked). Obviously, we have Guidelines for Action, a comprehensive handbook and a shorter handbook with the protocols… And there is an algorithm of decisions that says that, at the moment that she is asked, if the woman shuts down, at the next visit, you try to continue asking. If the woman recognizes it, you try to identify to what degree, in what type of abuse situation she is in, what consequences this situation could have; identify if it´s a serious situation and , therefore, a security plan must be established for the woman and the people living with her. All of this is established in the Guidelines. The Guidelines are a support tool for professionals. ". (*Policy maker, Assistant director)

Health practitioners were not familiar with any mechanism allowing early identification and rapid response in case of GBV. The Violence Commission member reported the commission is currently working on developing a protocol. Moreover, they were not aware of existing guidelines for referral. However, all four health professionals chose to include in their consultation methods to identify the risk for GBV and contacted social workers when needed. Social workers have a different perspective regarding mechanism for early identification and for referral. They consider guidelines exist, however the limited consultation time does not allow health practitioners to follow the guidelines. Health practitioners first contact *"the social work team. And if social work isn't there, they call the Unit of Family Services (Police) because this is what the flowchart says to do, the intervention procedure. There you can find the reference phone numbers for the SAVG (Assistance Service for Female Survivors of GBV), the violence service, or the specific family unit. That is all in the protocol."* (Social worker, Health Center). Moreover, social workers have specific guidelines, once a GBV survivor is referred to them: *"Everything is organized and explained in the Guidelines. As I said at the beginning, the Case Managers are the people that are in charge of coordination. Once they have assessed the case, and they've decided with the woman the ideal way to move forward- always letting the woman be the one who really decides- the coordination mechanisms have to be put in place. You always have to alert her primary care doctor. Normally this is done through the social worker at the Health Center, but since there isn't a social worker at each Health Center, sometimes you have to try to get in contact directly with her doctor by phone or email.". (*Social worker, Madrid Health Service)

A policy maker, a General Director of the Healthcare Coordination, Madrid Health Department, confirmed "There's a protocol that link us to Social Services, the Police and to psychological support. When GBV is detected, these services are offered. And often, people accept it."

For initial counseling, health professionals reported not having this service, one professional assumed social workers do initial counseling for GBV and one professional reported directing a GBV survivor to special services: "*We told a GBV survivor to call 016 phone number. And this woman called the number. She also had to go to the psychiatrist because she had significant depression as a result of the violence*." (Midwife, Health Center). Social workers agreed that they address initial counseling for GBV survivors *"The initial advice is the responsibility of the Case Manager (a social worker) so yes, this initial advice is provided in every case." (*Social worker, Madrid Health Service)

Data collection and reporting process of the prevalence and incidence of GBV cases

Policy makers confirmed data on GBV is collected. However, the accuracy if these data and its availability are questioned. Usually, GBV information is collected "under the name detection of familial abuse under which is

included GBV, child abuse and abuse of the elderly" and "if the case it's notified, there's the ICPC-2 (International Classification of Primary Care) where the information gets also registered" (Policy maker, assistant director). Social workers are also aware of "a kind of template in the clinical history, detection of gender violence, for all medical professionals" (Social worker, Health Center), a template that they usually use to record GBV cases. Health practitioners are not aware neither of any data collection on GBV in their clinic and nor on reports at national or European level showing the link between GBV and pregnancy or women's health. Policy makers and social workers were also unaware of reports on GBV and pregnancy.

Collaboration

Networks for GBV prevention practitioners

In terms of networks for GBV prevention practitioners, two social workers from a Health Center and the Madrid Health Service reported:

> *Roundtable on Gender and Health* works mainly work on raising awareness, prevention, and everything related to GBV. "Now we also work on the topic of health. It's a community initiative because the health center participates".
>
> *Technical Commission for the Coordination of Health Actions to face GBV* which is a part of the Health Department of Madrid. In this group, responsible professionals of each area of the Health Department that may be directly or indirectly related to the actions against GBV, take part. The General Directorate of Women of the Community of Madrid also takes part of this Commission.

Policies for multi-agency collaboration

Health practitioners were unaware of aware of any policy for interdisciplinary/multi-agency collaboration concerning GBV in the maternity clinic. Social workers and policy makers had the same perspective regarding policies for interdisciplinary approach of GBV. When asked about organizations offering specialized support and support groups for GBV survivors, referred to Clara Campoamor Woman's Center, the Equality Service (from the local government), the Municipal GBV Point – part of part of the Directorate General of the Woman (of Madrid), Social Services as organizations specialized "in everything related to violence. There's a legal counselor and a psychological counselor there." (Social worker, Health Center)

Capacity

Training certificates of medical staff, nurses, midwifes, social workers

All four health practitioners doubt there is a class on GBV for medical students and resident doctors. The rest of the respondents also stated that classes focused on GBV for medical students are not available. However, resident doctors have mandatory classes in Gynecology, Pediatric services and Internal Medicine where GBV is integrated. Moreover, classes on GBV are mandatory for traumatology residents and for emergency first responders. Respondents were not aware if GBV is a part of the curriculum for nurses, midwives and social workers.

Availability in the maternal health setting of trainings of GBV for health care providers

The four health professionals interviewed did not recall any trainings, workshops, and raising awareness activities conducted in their setting. However, they report participating in GBV trainings offered by the Ministry of Health and through the Primary Care. Social workers confirmed participating in GBV trainings inside the clinic

> *"There's a group of people who do training about violence as part of our continued training and they came to explain a bit about the Brief Guide to Violence, and another course about practical cases of GBV."* (Social worker, Health Center)
>
> *"We've done a few things here…they've done activities to raise awareness about women, on the most important days, against GBV and such"* (Social worker, Health Center)

Moreover, social workers recall delivering different trainings and raising awareness activities for medical and non-medical staff of the maternity clinic *"Here, through the social work department in the Maternal-Child Hospital, what we're trying to do is to provide trainings, informative talks every now and then so that medical professionals are more aware of those risk factors, those indicators that can bring them to directly identify a situation of abuse*

*between woman and her current partner." (*Case manager). Social workers also recall a Community of Madrid Technical Commission on Actions Against GBV where "Hospitals, Mental Health Centers, Primary Care Centers, Drug Addictions Centers, Public Health Department, etc. are all represented in the Commission… There are a lot of people in the Commission. SUMMA (Emergency Medical Service of Madrid) is also part of it." (Social worker, Madrid Health Service).

Table2. Situation analysis for the health care services/settings where capacity building activities will be implemented	Austria	France	Germany	Romania	Spain
Health care setting infrastructure					
Health setting has a department/staff that is responsible for the coordination of GBV prevention activities	N	N	N	N	Y
Other departments/health care units, within the hospital, have some responsibility for GBV prevention	N	Y	N	N	Y
GBV was identified as a priority by the management of the health setting	Y	Y	N	N	Y
Health setting has a dedicated budget for services to survivors of GBV	N	N	N	N	N
GBV prevention and addressability is a part of the quality management of the health setting	Y	N	N	N	N
Law for health professionals to provide services for GBV	Y	N	N	Y	Y
Health setting offers screening for GBV in pregnant women	N	Y	N	N	N
Health setting has a mechanism allowing identification and rapid response to GBV	N	N	N	N	Y
Health setting has a mechanism allowing referral of GBV to specialized support agency	Y	N	N	N	Y
Health setting documents the prevalence and incidence of GBV, including socio-economic circumstances	Y	N	N	N	Y
Health setting develops reports that include specific/broader information on GBV patients treated in the health setting	N	N	N	N	Y
Health setting offers initial counseling for GBV survivors	Y	N	N	N	Y
Multi-agency collaboration to address GBV					
Policies for multi-agency collaboration concerning GBV in the maternity clinic		Y	N	N	Y
Additional organizations that the health setting can contact regarding specialized support services to survivors of GBV	Y	N	Y	Y	Y
A network for GBV prevention practitioners exists at a local/regional level	Y	Y	Y	Y	Y
Support group for GBV survivors	Y	N	N	N	N
Capacity					
Medical staff receives training on GBV, or violence prevention and survivor protection during their residency or medical school	N	N	N	N	Y
Midwifes receives training on GBV, or violence prevention and survivor protection during their residency or medical school	Y	Y	N	N	Y
Nursing staff receives training on GBV in particular, or violence prevention and survivor protection during nursing school	N	N	N	N	Y
Social work staff receive training on GBV, or violence prevention and survivor protection, during their social work training	Y	Y	N	N	Y

Health setting have or had in place (*in the last 5 years*) capacity building initiatives for the medical and/or non-medical staff on GBV	N	N	Y	N	Y
Medical/Non-medical staff participated (*in the last 5 years*) in capacity building initiatives on GBV	Y	Y	Y	N	Y
Health setting partner is involved (was partner in the last 5 years) in any other projects on GBV (excluding RESPONSE)	Y	N	Y	N	Y

CONCLUSIONS AND RECOMMENDATIONS

Care for survivors of gender-based violence at maternal health care units

Treatment of care for GBV in maternity units is deficient in all settings enrolled in the RESPONSE project. However, the degree of addressing GBV varies largely between the enrolled settings due to organizational, systemic and legislative protocols existing in each country.

Addressing GBV in the maternity clinic from Austria is impeded by the following barriers: (1) the clinical setting is small and thus, specialized services for GBV don't exist, (2) no available budget for GBV prevention and intervention is allocated, (3) management does not consider GBV a priority, (3) guidelines for addressing GBV don't exist, (4) GBV is not considered when improving the quality of health care, (5) other hospital departments don't address GBV, (6) GBV prevention services are missing and so is an early identification and rapid response mechanism and a referral mechanism for GBV, (7) existing GBV laws are not enforced, (8) addressing GBV during the consultation is conducted for pregnant women only if violence is suspected, and (9) GBV education during college years for medical and non-medical staff is missing..

The maternity clinic in France does not have a special budget allocated for GBV prevention and intervention services. Other barriers in addressing GBV in this maternity unit are the absence of (1) a specialized department for addressing GBV, (2) laws for addressing GBV, (3) counseling services for GBV, (4) early identification and response mechanism, and of (5) trainings during college years for medical and non-medical staff.

Respondents from the maternity unit from Germany stated as barriers in addressing GBV in their unit and in other units from Germany the absence of (1) guidelines for identifying and responding to GBV cases, (2) a referral mechanism for GBV survivors, (3) guidelines for applying GBV existing procedures (from the IMPLEMENT project) in a unitary format, (4) trainings during college years for medical and non-medical staff, and of (5) trainings for medical staff during their clinical practice.

In Romania, barriers in addressing GBV in women in the maternity clinic enrolled and in other units are due to (1) the absence of departments, staff, budget and policies to address GBV in Romanian maternity clinics, (2) the fact that GBV is not considered a priority in the clinical setting, (3) the hospital focusing on treatment not prevention while GBV needs prevention not intervention, (4) the absence of a mechanism for early identification and intervention and for referral. Similar with the other settings, GBV trainings during college years for medical and non-medical staff are missing.

Respondents from Spain focused more on the absence of projects and raising awareness campaigns in the hospital addressing GBV, the low priority granted for GBV and the limited consultation time as barriers in addressing GBV in their maternity unit.

A common barrier identified for all maternity clinics enrolled for providing the capacity building as part of the RESPONSE project is the lack of a specific budget for identification and referral of GBV. Having a specific budget to tackle this issue is a clear indicator of commitment to prevent and combat GBV. Another common barrier is the poor dissemination at an organizational level concerning the available resources, existing tools and mechanisms, existing referral options (where present) and existing laws for addressing GBV. As a consequence, in each maternity clinical setting, contradicting information was present in the interviews, when we analyzed the interviews based on the groups of stakeholders: health care professionals, social workers and support services, policymakers. Therefore, these finding shows the need of increased collaboration and multi-response actions to identify and report GBV.

Facilitators and needs in addressing GBV

Although barriers in addressing GBV are present in each enrolled maternal health services, we were also able to identify common aspects stated by the respondents which would facilitate addressing GBV cases. First, all respondents presented a high interests and willingness to address GBV in their practice and some of them (e.g., mention the country here) took the decision to include in their every-day patient consultation methods to identify

the risk for GBV and contact social workers when needed. Additionally, respondents held a strong belief that most health practitioners, given specific guidelines and resources, would screen and address GBV in their daily practice. Second, respondents considered that GBV cases are more approachable if GBV is seen as a priority for the hospital management. Third, existing NGOs, shelters and other organizations focused on GBV are considered very helpful by all interview respondents, as it facilitates referral and placement of GBV survivors, when the patient is released for the hospital. When present, such is the case of Spain, GBV mandatory classes in Gynecology, Pediatric services, Internal Medicine, for traumatology residents and for emergency first responders where seen as highly relevant in teaching medical staff to identify and report GBV cases.

In terms of needs to improve the addressability of GBV participants expressed:

- ✓ Training, tools and dissemination materials on GBV identification and on addressing GBV to increase GBV skills in health care providers
- ✓ Existing guidelines for identifying and addressing GBV
- ✓ A responsible in each unit for addressing GBV such as a psychologist or a social worker specialized in offering support for GBV survivors
- ✓ Protocols for detecting and referring GBV cases
- ✓ NGOs, shelters and different organizations need to become more visible among health practitioners.
- ✓ Unitary information on GBV screening and intervention for all parties involved in addressing GBV: medical staff, social workers, NGOs representatives, policy makers.

APPENDIX 1. INTERVIEW GUIDE

Introductory note

Hello! My name is [name] and I am a [professional position] within the [organization], [city]. Our institution is involved in the project **Multi-agency response for reporting of GBV in maternal health services (RESPONSE)**, which allows us to thoroughly gather data from Austria, France, Germany, Romania and Spain in order to understand their role regarding GBV and address any potential gaps

As a part of the study, we would like to find out which are your opinions when it comes to your role regarding interacting and providing assistance to survivors of GBV. We use gender-based violence to *refer to a physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Art. 3 a, Council of Europe Convention on preventing and combating violence against women).*

This interview should last about one hour. With your permission, the discussion will be audio recorded, to avoid omitting any information you provide and to perform a correct analysis. Only the research team will have access to the recordings, and you will not be identified by name or any other way, to respect your privacy. Also, we would like you not to share what is discussed during this interview with other persons.

You may choose not to answer the questions you see as being inadequate or to stop the interview at any time. If you have any question with regards to the interview, you may interrupt me anytime to ask for more information.

Before we start the interview, we would like to mention that, within this interview, there are no right or wrong answers. Feel free to express your disagreement with regards to the current situation in [country].

RESPONDENT'S PERCEPTION	
Let's start by talking about your feelings and experiences regarding gender-based violence. Do you think gender-based violence is a relevant issue in your work?	If yes, can you provide more details? If no, can you think of a moment / situation when it may become relevant?
Can you give an estimation how often you see patients experiencing gender based violence?	You may think of number of cases / month or / year Also, how would you describe the majority of them?
Do you feel adequately prepared to deal with the issue/these patients?	If yes, what do you think helped you in order to feel like that? If no, what would you improve and how?

INFRASTRUCTURE AND MECHANISMS IN PLACE	
Is there a department/staff that is responsible for the coordination of gender-based-violence prevention activities?	If yes, can you provide more details? For instance its name and main activities? Regarding the involved Staff: what is her/his educational and professional background? What are the activities that she/he is involved in / responsible for? If no, would one such a unit be useful? How would you envision it? What would be its main responsibilities? What kind of staff should be involved in coordinating it?

Are you aware of other departments/health care units, within the hospital, which have some responsibility for gender-based-violence prevention?	e.g. those with responsibility for data, policy, provision of care or program development related to specific issues of GBV If yes, can you describe their role, their main activities? If no, do you consider that other departments should have any kind of responsibility on this? Please justify your answer.
Is GBV set as a priority by the management of the maternity clinic?	(e.g. is it listed as a priority issues within a document or plan) If yes, can you think of the goals to be reached? Who is in charge of these? If no, would you list it and why? How would you envision it?
Is there a dedicated budget for providing services to survivors of GBV?	If yes, could you provide more details upon: Prevention programs related to GBV; Research related to GBV; Capacity building related to GBV; Interest group to address GBV; Partnership with a network / organization to coordinate GBV activities at health setting/hospital level If no, do you think that would be necessary? And if so, what would be the percentage that you would allocate for this? What would you allocate it for specifically? (for instance: Prevention programs related to GBV; Research related to GBV; Capacity building related to GBV; Interest group to address GBV; Partnership with a network / organization to coordinate GBV activities at health setting/hospital level)
Is a policy concerning GBV part of the quality management of your health setting?	If yes, please provide any details that you are aware of If no, would such a policy be necessary? Why? What should it cover?
Do you have a specific law for health professionals to provide services for GBV?	If yes, do you know any details about it? How have you heard about it? If not how you consider such a law as part of the health care legislation? How would you envision it?
Do pregnant patients get screened for GBV risk?	If yes, can you briefly describe the procedure? Who is in charge of that? If no, would it be necessary? How would you envision it?
Is there a mechanism in place that allows early identification and rapid response to GBV?	If yes, please describe briefly: Who is in charge of identification: Doctors, Midwifes, Nurses? If no, would such mechanism be necessary? And how would you make it functional?
Is there a mechanism of referral to (a) specialized support agency/ies in place?	If yes, is this mechanism/referral system a service offered solely in the maternity care unit or it can be found in other settings? Are there any mechanisms to monitor the efficiency of the referral system?

	What is the statute of the mechanism/referral system you are applying? E.g. regional/national law/recommendation, hospital regulation, etc. In your opinion, can this mechanism be improved and how?
	If no, do you think that would be necessary? How would you envision it?
Is there data documenting the prevalence and incidence of GBV, including socio-economic circumstances available for the health setting?	If yes, please indicate how we may be able to obtain this information, if it is not readily available on the internet. Who is responsible of the data collection? What are the data collection instruments?
	If no. would it be useful to collect this kind of data? Who would be responsible of the data collection? What would be the data collection instruments?
Do you have any documents or reports at national or European level showing the link between GBV and pregnancy or women's health?	If yes, please provide Internet link or send it per email to janz@gesine-intervention.de [replace with each country main contact]
	No

MULTI-AGENCY RESPONSE

Does your health unit/clinic provide an onsite initial counselling for GBV patients?	If yes, is the counselling provided by trained clinical staff or by specialists from a cooperating institution (NGO GBV advocates or others). If no, would it be necessary? Please justify your answer How would you envision it?
Are you aware of any policy for interdisciplinary/multi-agency collaboration concerning GBV in the maternity clinic (doctors, nurses, midwives, social workers plus women shelters/ women support agencies)?	If yes, please describe briefly On a scale from 0 to 10, how efficient is the collaboration?
	If no, would it be necessary? Who should be part of? What would be the specific roles?
Is there an organization that the health setting can contact regarding provision of specialised support services to survivors of GBV? This can be an organization / institute / centre / agency including non-governmental agency that has a specific mandate for GBV or a broader mandate including GBV.	If yes, please provide details Briefly describe the organization's mandate Do you consider it to be useful? Are you satisfied with its involvement? Briefly describe a situation when such an organization should be contacted
	If no, would it be necessary? What would be its responsibility? Briefly describe a situation when such an organization should be contacted
Is there a network for GBV prevention practitioners at local/regional level? (If applicable).	If yes, could you provide more details upon it
	If no, would it be necessary? How would you envision it?

Is there a group or a similar form that you are aware of and which is offering support to GBV survivors?	For e.g. we have the case of Austria were Survivors Protection Groups are required by law in hospitals. Can you think of something similar for your hospital or at local/national level? If yes, do you think it is sustainable? If no, would it be necessary? How would you envision it? How would you make it sustainable?
Is your health setting partner (was partner in the last 5 years) in any other projects on GBV, in particular, and violence prevention and survivor protection, in general?	If yes, please provide the name, health setting coordinator, period of implementation, general scope.

SKILLS

Do any members of the medical staff receive any training on GBV in particular, or violence prevention and survivor protection, in general, during their residency or medical school?	If yes, please briefly describe (include no of hours, year of study, trainer's expertise, topics discussed, etc.) If no, would it be necessary? How would you envision it?
Do midwifes working at the clinic receive any training on GBV in particular, or violence prevention and survivor protection, in general, during their training/studies?	If yes, please briefly describe (include no of hours, year of study, trainer's expertise, topics discussed, etc.). If no, would it be necessary? How would you envision it?
Do any members of the nursing staff receive any training on GBV in particular, or violence prevention and survivor protection, in general, during their nursing school?	If yes, please briefly describe (include no of hours, year of study, trainer's expertise, topics discussed, etc.). If no, would it be necessary? How would you envision it?
Do any member of the social work practitioners staff receive any training on GBV in particular, or violence prevention and survivor protection, in general, during their social work training?	If yes, please briefly describe (include no of hours, year of study, trainer's expertise, topics discussed, etc.). If no, would it be necessary? How would you envision it?
Does your maternity clinic have in place or had in place (in the last 5 years) any capacity building initiatives for the medical and/or non-medical staff on GBV (either specific or general on violence prevention)? For e.g: training programmes, educational courses, seminars, workshops, etc.	If yes, please briefly describe the initiatives, the person responsible for them and mention the period of implementation. Are there ongoing, sustainable measures of capacity building? If no, would it be necessary? How would you envision it?
Did any of the maternity clinics's medical and/or non-medical staff participated to any capacity	If yes, please provide the name, role within the health setting (e.g. medical doctor, nurse, social worker, midwife etc.) and capacity building initiative type.

building initiatives *in the last 5 years*? For example training programmes, educational courses, seminars, workshops, etc.	If no, would it be necessary? How would you envision it?

Is there anything else you want to share with me?

APPENDIX 2. VERBAL SCRIPT AND CONSENT FORM

VERBAL RECRUITMENT FOR THE SITUATION SCAN INTERVIEWS

The subjects are being approached in person by following the same procedure in each health setting in Austria, France, Germany, Romania and Spain. For the conduct of the interview, subjects are recruited from the list of stakeholders already identified as being of interest for the project and capacity building activities. They will be interviewed either in their workplace, in an appropriate environment, or in some other private location established on common ground with the interviewer. The duration of the interview will take approximately 45-60 minutes.

The following verbal recruitment script is recommended to be read to each subject before applying the interview questions:

My name is [name] and I am a [professional position] within the [organization], [city]. We are planning to conduct a research study, which I invite you to take part in, which will allow us to gather data from health professionals in Austria, France, Germany, Romania and Spain in order to learn more about how maternal and women's health professionals address gender-based violence in their health setting with patients. Gender-based violence refers to all kind of violence that is directed against a woman, referred as to a physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Art. 3 a, Council of Europe Convention on preventing and combating violence against women).

The responses you provide will help us to design a training to help health professionals improve how they identify and provide assistance to survivors of gender-based violence.

If you agree to be in this study, I will conduct an interview with you at a time and location of your choice. It should last about one hour. With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide, and will be used for transcription purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable at any time during the interview, I can turn off the recorder at your request. Or if you don't wish to continue, you can stop the interview at any time.
I will take notes during the interview. In order to protect your confidentiality, I will assign you a number so your name will not be on my notes. I will not use your name or other personal identifiers in any presentation or research paper. Identifiable information (e.g. audio recordings, names) will be encrypted if stored electronically and locked if stored in hard copy. Identifiable information will include: job (specialization), position, age, gender. This information will not be collected through the interview, but obtained during the stakeholder analysis (information found on the web). The research team is the only one to have access to the collected data that will be stored to a private environment under close supervision. Interviews will be transcribed immediately after applying the interviews. No other institution or entity shall have access to this information, but only to aggregated reports. All identifiable information encrypted and locked will be destroyed in 5 years after the research is over.
Scenario (1)

If one of the respondents will decide not to take part from the beginning in the interview process, the research team will contact the next person from the list of stakeholders until the numbers of responses will be sufficient enough in order to gather valuable information upon the topic.
Scenario (2)
If one of the respondents will decide to drop out the study during the interview, the research team will contact the next person from the list of stakeholders until the numbers of responses will be sufficient enough in order to gather valuable information upon the topic. The responses of the subjects who are not completing the interview are not considered valid.

CONSENT TO PARTICIPATE IN RESEARCH

[Here complete with your country team members similar with the example below]

Principal investigator: Diana Dulf, PhD, Cluj School of Public Health, College of Political, Administrative and Communication Sciences, Babeș-Bolyai University, Cluj-Napoca, Romania, E-mail: diana.dulf@publichealth.ro

National team members: *Romania* - Cluj School of Public Health, College of Political, Administrative and Communication Sciences, Babeș-Bolyai University, Cluj-Napoca: Mara Timofe, PhD(c) & Elena Bozdog, PhD(c)

Introduction

My name is [name] and I am a [professional position] within the [organization], [city]. We are planning to conduct a research study, which I invite you to take part in, which will allow us to thoroughly gather data from Austria, France, Germany, Romania and Spain in order to understand their role regarding GBV and address any potential gaps.

Procedures

In the current project interviews will be employed in each partner country. The in-depth interviews will be individual. If you agree to be in this study, I will conduct an interview with you at a time and location of your choice. The interview will involve questions about your perceived role regarding GBV. It should last about one hour. With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide, and will be used for transcription purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable at any time during the interview, I can turn off the recorder at your request. Or if you don't wish to continue, you can stop the interview at any time.

Benefits

There are no direct potential benefits to you. However, it is hoped that the information gained from the study will help health professionals increase the knowledge about their role regarding GBV.

Risks/Discomforts

No physical or social risks are associated to you. Moreover, you can require at any time to be excluded from the study if you feel uncomfortable or for any other discomfort.

Breach of confidentiality

As with all research, there is a chance that the confidentiality could be compromised; however, we are taking precautions to minimize this risk.

Confidentiality

A subsequent goal of this research is to use this data for future studies, meaning the researchers will maintain access to identifiers. However, the identifiers will be coded and will continue to be maintained in a secured locked drawer in the team leads office upon the close of this project. The research team is the only one to have access to the collected data that will be stored to a private environment under the close supervision of Diana Dulf. Access to the document linking study codes to identifying information will be restricted to primary investigators from each involved country. The English reports on data collected

from the other partner countries will be sent to the lead investigator who will store them under her close supervision. Interviews will be transcribed immediately after applying the interviews. No other institution or entity shall have access to this information, but only to aggregated reports. Interviews (having the consent of the subject) will be conducted in a private environment within each person's office, having approximately 60 minutes duration each

Compensation You will not be paid for taking part in this study.

Rights. *Participation in research is completely voluntary.* You are free to decline to take part in the project. You can decline to answer any questions and are free to stop taking part in the project at any time. Whether or not you choose to participate in the research and whether or not you choose to answer a question or continue participating in the project, there will be no penalty to you or loss of benefits to which you are otherwise entitled.

Questions

If you have any questions about this research, please feel free to contact me. I can be reached at diana.dulf@publichealth.ro

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CONSENT

You have been given a copy of this consent form to keep.

If you wish to participate in this study, please sign and date below.

_____ _____

Participant's Name *(please print)* Date

_____

Participant's Signature

_____ _____

Person Obtaining Consent Date