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

RESPONSE

WS 2 Evaluation Report

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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, gynaecological problems, induced abortions and sexually transmitted infections, including HIV, miscarriage, stillbirth, pre-term delivery and low birth weight[1].

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[2].

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[3].

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[4]. RESPONSE addresses 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).

[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] 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
[3] 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
[4] 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

AIM OF THE REPORT

The report is a deliverable of WS 2 of the RESPONSE project to apply a mixed-methods approach to use qualitative and quantitative indicators and comparison to matched clinic. It also included general findings of the follow-up meetings held in the partner countries.

METHODOLOGY

Our evaluation of RESPONSE consisted of a process evaluation (what we did and how), and an outcome evaluation (what difference did the project make). We asked partners to gather indicators for both process (capacity building and training activity) and outcome (recording of disclosures or suspicion of GBV, risk assessment and referrals).

Process indicators for capacity building seminars and training included:

- Health Professional Readiness Questionnaire completed before and after the training; minimum 1 training of 4 hours with minimum 30 health professionals and follow-up contact (minimum 3 hours);

- Number of stakeholder meetings: minimum 4 in total included:

a) dissemination of RESPONSE training manual, project results (1-2 meetings);

b) establishing a Victim Protection Group in a women's health clinic (1-2 meetings);

c) establishing a training module for students of medicine/midwifery/nursing (1-2 meetings).

Process indicators for Maternity-based Victim Protection Group included:

Semi-structured qualitative interviews with the members of the multi-sectoral, multi-disciplinary Maternity-based Victim Protection Group in each country monitoring action towards sustainability of the group and extension to other health settings (interview guide page 9).

Process indicators for Educational Module included:

Health Student Readiness Questionnaire (see pages 7-8) completed before and after each lecture/module to 60 medical school students.

Outcome indicators for capacity building seminars and training in each country for 3 data collection periods included:

At training clinic: baseline 0 (4 weeks before the training), 4 weeks after training, 6 months after training

a) Number of patient contacts total in the clinic in the past 4 weeks;
b) Number of patients the health professional discussed gender-based violence in past 4 weeks;
c) Number of patients identified as being victims of gender-based violence in past 4 weeks;
d) Risk assessment completed for patients in past 4 weeks;
e) Number of patients referred to support services in past 4 weeks.

At control clinic: baseline 0, 4 weeks after training done at other health setting, 6 months after training

a) Number of patient contacts total in the clinic in the past 4 weeks;
b) Number of patients identified as being victims of gender-based violence in past 4 weeks;
c) Number of patients referred to support services in past 4 weeks.

SECTION 2: RESULTS PRE- AND POST- READINESS QUESTIONNAIRE

This section details the evaluation results for the pre- and post-readiness questionnaires for health professionals and students. The data were pooled across the partner countries as per country the sample size was limited.

Table 2 presents the analysis of the questionnaires. The number of responses to the pre (n=134) and post (n=126) training was sufficient to be able to make conclusions about the effectiveness of the RESPONSE trainings implemented. There was significant overall improvement after training compared to before the training for participants on all items questioned. The number of new cases identified changes on average from 0,86 to 1,41 thus an increase of 64% of cases identified. Referrals did not increase over time. One reason could be that the trained participants felt more skilled at dealing with the problem of GBV themselves and therefore did not need to refer or point to the difficulty in referring patients to social worker or specialised services. After the training the actions (question 6) were lower than prior to the training. This may be because the staff felt referrals are only needed in case of acute, mostly physical violence, which is rarely seen in the maternal setting context.

In summary, the data show that the RESPONSE training was effective in improving the clinicians' perceptions of their skills, without any change in their behaviour with regards to their patients experiencing GBV.

Table 1. Results of the Health Professional Pre- and Post- Readiness Questionnaire

ALL PARTNERS	PRE-TRAINING	POST-TRAINING
Total number of responses:	**134**	**126**
	Fairly well+Well prepared combined %	Fairly well+Well prepared combined %
Q4. Please indicate how prepared you feel to perform the following tasks (tick the case which best describes how prepared you feel):		
Ask questions to promote disclosure of GBV with patients	17.1 %	*65.9 %*
Appropriately respond to disclosure about GBV with patients	18.7 %	*63.5 %*
Identify signs and symptoms associated with GBV based on patient history and physical examination	23.1 %	*56.4 %*
Perform a risk assessment on a patient	11.9 %	*35.7 %*
Document violence history and physical examination findings in patient's record	23.1 %	*49.2 %*
Make appropriate referral for a patient	20.9 %	*58.7 %*
	AVERAGE	AVERAGE
Q5. How many new diagnoses (picked up an acute case, uncovered ongoing abuse, or had a female patient disclose a past history) of GBV would estimate you have made in the last 6 months?	0,86	1,41
	%	%
Q6. Which of the following actions have you taken when you identified GBV in a patient in the last 6 months? (Tick all that apply)		
Referral to a social worker and among participants	17.2 %	*19.1 %*
Referral to violence prevention services	19.4 %	*18.3 %*
Referral to a shelter	10.5 %	*5.6 %*
Referral to the police	17.9 %	*15.9 %*
Notification/referral to the court	*5.2 %*	*5.6 %*

Note: Question 4 possible responses were not prepared/slightly/ moderately/fairly well/well prepared and the responses fairly well & well prepared were combined in this analysis. Question 6 possible responses were always/mostly/sometimes/almost never/never and responses always & mostly were combined in this analysis.

SECTION 3: RESULTS OF THE TRAININGS

The training in each country setting was generally positively evaluated based on the training evaluation forms consisting of 14 questions completed by the participants of each training session, including an open-ended question on what could be improved. These were pooled together to provide an overall assessment of the trainings across all country partners. Regarding the overarching question # 1 "how do you evaluate the training overall" the average response was 7.67 on a scale of 1 to 10 (10 very satisfied). The majority reported the training was very well structured (question #2), but only 33% of the participants stated that there was appropriate time allocated to each module (question #3). One reason for this is that the participants would have appreciated more time for each module as the issue of GBV is complex and requires time to discuss. This is also reflected in question #4, that 50% of participants on average stated that there was only "somewhat time for discussion", signaling the need for a longer duration of training, as was reported in the follow-up meetings. The majority found the hand-outs and materials useful (question #5) and 67% of participants found the training relevant for their work (question #6) and 67% of participants found the training would benefit their work (question #7). A total of 82% of participants stated they would recommend the training to others. Across all settings the majority found the trainers to be knowledgeable (question #8) and that the trainers ensured good interaction and exchange among participants (83%, question #9) and had good presentation skills (82%, question #10). Thus, the trainers were recommended for other trainings as well (question #11). Only 50% or participants reported the training facilities were good and 33% excellent (question #12), the breaks 50% excellent (question #13) and the location excellent (50%, question #14). The training facilities responses were influenced by the fact that the trainings were done on-site and thus the room location was limited to be near the clinics.

In summary, the training was found to be of high quality and only the location was suboptimal, but it was important to maximize participation that the training was done on-site. For the open-ended question at the end 'Any comments or suggestions for improving the training' a number of participants stated they would like the clinic to maintain an ongoing training plan, to provide more trainings and to have more case studies. Another suggestion was to make the theoretical part shorter to allow for more role playing.

SECTION 4: RESULTS OF THE FOLLOW UP MEETINGS (OUTPUT 6)

Each country performed follow up meetings in order to address any obstacles or barriers faced by the training participants in implementation of the RESPONSE model. The meetings were performed with training participants and with the data collection representatives (may also have be a participant).

In Germany, one evaluation session (29.06.2018) was a focus group lasting 40 minutes with the participants from the training, namely midwives and doctors in the RESPONSE project in the hospital. The participants stated that there was more awareness of GBV detection and referral since the training and staff felt they were better able to 'look behind the symptoms'. Other participants stated that they felt more competent to bring up the subject of GBV with patients due to the training. The topic of getting the male partner to leave the room came up and the participants shared how they dealt with this issue. The participants wished for a longer training, one complete day and information on referrals for patients who were victims of GBV growing up. Another evaluation session was done with the professionals doing data collection and here the recommendation was to integrate information on GBV into the medical record, so that the data are collected immediately. A third evaluation session was done to ask the trainers how the training went and what could be improved. The trainers' feedback stated the training workshops were a type of training and coaching combined. The trainers also said that the RESPONSE manual was too complex for a 4-hour training workshop, with too much material to process. The trainers asked for the manual to include digital safety and cyberbullying related to sending of pictures via cell phones, tablets, etc.

In France, the evaluation session was done face to face with the participants of the training. The participants commented on the improvement in their knowledge and skills with regards to GBV in their female patients and asked for assistance with one major challenge, the omnipresence of the partner. Together the group brainstormed the following solutions:

- Go to the waiting room, tell the partner: "I will first see your wife alone, and I'll come back to get you." You can then ask the patient open questions: "Is there anything you want to talk to me about, now that we are alone? How are things at home? etc."
- Or have him leave for the clinical examination, after he has listened to the heartbeat of the baby (which can be done when the woman is still dressed). One can talk with the woman after the exam, as he has returned to the waiting room.

The participants felt these solutions should be included in the RESPONSE Manual.

In Austria the evaluation session was also completed face to face but the majority of the participants from the training were not able to be present due to sickness, day off or work shift being too stressful to attend. For the few participants who came, they stated the main challenge was lack of time with the patients to properly ask about GBV, due to the stress of accomplishing the medical tasks. The trainer provided short techniques to ask straightforward but sensitive questions.

In Spain, two focus group evaluation sessions were held during the month of March. The first meeting took place on 2nd March 2018, at the Health Care Directorate "Centro" with primary care professionals who had received training in the health centres (nursing, medicine, midwives and social work). Only 13 professionals out of the 17 who had received the training attended, due to difficulties of being released from their work responsibilities. The second focus group evaluation meeting was held on 7th March 2018, in the Maternal and Child Health section of the Hospital "12 de Octubre" with professionals who had received training at the Hospital (gynaecologists, social workers and midwives). Nine of the 14 professionals who had received the training attended the focus group evaluation meeting. An overview of the framework of the focus group evaluation meeting was provide and the objectives to be achieved. For both sessions a script of open-ended questions was created. The sessions were divided into three sections: the first section was devoted to the perception that professionals had of the changes in their health interventions after the training received; the second section was related to the results of the completed surveys and their interpretation; and the third section was aimed at identifying proposals for improvement. Five health centre professionals had conducted training sessions (after receiving the Response training) for their teammates, and others are planning to do so. The health centre professionals were interested in receiving feedback on whether this session had been effective. Some of the sessions had focused on psychological violence because it is argued that abusive behaviours are more invisible and more naturalized among professionals. Specific training sessions have also been held with gynaecology residents, but not with midwifery residents, although they had received the training included in their academic curriculum.

In Romania, the participants had the following suggestions for improving the health care response to GBV:

- Increase the number of training sessions replicating the information received during the RESPONSE training.
- It was proposed to use the survey to obtain feedback from colleagues and to learn about the effectiveness of the training sessions mentioned above.
- Inclusion of contents related to this problem in maternal education, preparation for childbirth and postpartum self-care groups.
- Incorporate gender-based violence into parenting groups, although there is not much dynamism in these groups at the moment.
- More emphasis on role play games as more aware of the signs of GBV, but staff did not feel comfortable enough to ask more questions and/or to refer victims.
- Shorter theoretical training content.

The following suggestions were made for improvements on-site at the hospital:

- Establish coordination between the different hospital units where care is provided for pregnant women: expectant parents/ delivery room, pathological or high-risk pregnancies and newborns.
- Include information about the GBV risk in the clinical history, taking into account that different computer applications are used in hospitalization and emergencies.
- Promote the RESPONSE training sessions as continuous training to increase attendance

- Promote teamwork and improve communication between professionals.
- Promote and highlight the work and training of midwives in detection of GBV
- Involve the on-site nurses in the next training or follow-up actions.
- Increase the presence of posters and pamphlets in the hospital to make the problem visible, as this would help to raise awareness among the population and the health community.
- Need for coordination between the hospital and community structures for gender equality was also discussed.
- More information about the referral system for patients to victim support services.
- Place posters with contact information in women bathrooms so victims have the chance to visualise the persons/shelters they can contact.
- Provide postal „cards" for medical doctors that include key contact information about social workers/shelter
- Medical doctors suggested that a change in the educational system is needed as well (all levels of education) + courses in the social science faculties and in the Faculty of Medicine to integrate the training for all doctors.

Here is a sample of testimonials that are from the follow-up sessions with participants of the trainings, trainers and data providers for the evaluation to demonstrate feedback on the RESPONSE project across all country partners.

1 – Participant: Midwife (Spain)

"The truth is that I value my experience as very positive in relation to this training received in the framework of this project. Although we are faced with a problem of enormous dimensions that does not have a simple or quick solution, I do believe that it has served me on the one hand to continue gaining awareness in this problem and the ability to contribute my small grain of sand in terms of detection, referral and transmission of this sensitivity to patients, family members and even people around me. The fact of knowing the early signs of detection, alarm, etc., elaborating a safety plan, different support resources and having the availability of the social worker of my health centre, has allowed me to approach the subject more easily, and that it ceased to be an aspect that I did not know how to address. I am encouraged to continue working on this to see that in some people of the Primary Care Team (although few) and in some patients, the transmission of the training received during the training sessions has caught on ".

2 – Trainer: Gynaecologist (France)

"In the professional environment: ESSENTIAL: The training of all personnel in contact with pregnant women should be mandatory. It is essential for the detection and therefore prevention of this problem, so prevalent in our society."

3 – Data Provider: Sanitary Information Systems Technician (Spain)

"From the professional point of view related to obtaining data on Gender-based Violence, in Information Systems, the project favours the analysis and filtering of data that has not been evaluated before, which makes it possible to provide information more and more reliable that will add value to the study ".

In addition, a session was done with the professionals doing data collection and with the trainers. Suggestions for improving the data collection by allowing documentation in the medical record was discussed and trainers identified the difficulty in that participants attended the course with great interest, but with little time to integrate new knowledge and few resources to put this knowledge and improvements into practice. They stated they needed more time to relay the information and simplifying the program, with more emphasis on basic concepts. Regarding the referral pathway, the trainer suggested that the most effective would be that each person in charge of GBV in the centres should draw up a personalized "referral map" on what to do when faced with a case of GBV in their team, according to the situation of vital risk on each day/hour that the situation may arise.

SECTION 5: RESULTS OF THE EDUCATION MODULE DELIVERY

Three out of five partner countries have implemented the educational module for medical students: Spain, Germany and Romania. The Spanish partners provided the educational module to 90 participants (62 nursing students and 28 medical students) on April 11, 2018. This formative session was offered to students of 1st cycle of the Medical degree (1st, 2nd and 3rd courses) and to the 1st and 2nd courses of Nursing. This training module was the result of stakeholder meeting held on 1 March 2018 with the professor responsible for the subject of Health and Gender as well as with the director of the School of Nursing of the Community of Madrid (Autónoma University of Madrid). It was decided to provide training to medical and nursing students jointly with the aim of sharing the points of view of both groups, one of which (nursing students), have within their compulsory training curriculum, gender-based violence. In the case of medical students, they receive training in gender-based violence as part of an optional course on Gender and Health offered at the University for the first cycle of the medical degree and as a freely configurable subject for other degree studies. What RESPONSE brings new to their already existing curricula, is that GBV during pregnancy will be included as topic in the Health and Gender course that it is already offered to medical students.

In Germany two student trainings were implemented. A total of 27 medical students and 20 nursing school students have attended the educational module. one where the medical students completed 27 pre and 23 post Readiness Questionnaires, and the second session for students in the nursing and midwife schools who completed 20 pre- and 17 post-Readiness Questionnaires, for a total of 47 pre- and 40 post- Readiness Questionnaires. These responses were added to the total sample of responses in order to have a large enough sample size. Students stated they welcomed the training and felt comfortable asking about GBV in the interactive exercises but were not sure if they would be able to implement the skills in the health setting without having the approval of the supervisor, regarding routine questioning versus specific questioning.

In Romania, the educational module was delivered in three different sessions to a sample of 22 students, between October 31 and November 26. The event was opened mainly to medical and nursing school students but students from public health, psychology and law attended the sessions. The educational module was shared using Facebook events in partnership with the Cluj Medical Students Organization, 292 people showing interest on the topic. A total of 22 students from medicine, pharmacy, nursing and public health have registered for the module and 15

students with other background have registered, as well. Out of these 22 have participated to the sessions and 16 post-evaluations were completed. Additional to questions from the Readiness-Questionnaire, knowledge testing questions were added to test the learnings of the participants after the training was provided. Overall impression of the module was evaluated between 7 and 10. The knowledge questions were correctly answered by all participants, and as feedback it was recommended to allocate more time to activities and explain the concepts more interactively. Participants appreciated the exercises provided and the discussion part at each of the sessions. In terms of sustainability, the two partners from Romania (Babes-Bolyai University, Department of Public Health and Cluj Country Emergency Hospital, IMOGEN Research Center) have included in the curricula of the Iuliu Hatieganu Medicine and Pharmacy University (one of the main medical schools in Romania) an optional course on Gender Based Violence Identification and Prevention, addressed to 6th year medical students. This is the first initiative to increase the knowledge and skills of medical students in the identification and prevention of GBV.

SECTION 6: RESULTS OF THE OUTCOME DATA OF THE CAPACITY BUILDING

The RESPONSE evaluation data are based on relatively small sample sizes as the partners collected cross-sectional data at a certain point in time and the number of potential patients as victims of GBV is variable and erratic. Therefore, depending on the country, the sizes vary from very small in Germany and France to larger numbers at a large hospital in Spain. The indicators were the same for the intervention and control setting, except for the fact that we did not ask about risk assessments in the control setting. This is because it is not recommended practice to do risk assessments without having the expertise to properly do so; asking this at the control clinic may make the staff aware of the need for risk assessment training and then it would alter the results when comparing the intervention clinic to the control clinic.

Intervention variability. The intervention methodology was the same between the partners, but there were variations in the implementation of the intervention in the different country settings. The RESPONSE model included training health professionals along with social workers within their clinic setting, to identify potential victims of GBV and to refer. Within the health setting, if there existed social workers or a social work department and otherwise together with external resource of specialized services: which was either social workers or other specialized services working in accredited NGOs.

In all countries, the experts that performed the training intervention had substantial experience in the training of professionals in a health care response to gender-based violence, previously trained as trained-the-trainers in the IMPLEMENT Project or other initiatives. The teams in the women's health or maternity settings who participated in the trainings were multidisciplinary, composed mostly of health system personnel: family medicine, gynaecology, midwives and social workers. Each partner chose the setting for the training. The setting for intervention was chosen on the likelihood that it could be implemented in the clinic setting and on sociodemographic criteria (population with a significant number of deliveries and different socioeconomic levels). For example, in Spain, Austria and France large hospitals were chosen with a high number of patients. In Romania and Germany smaller hospitals were targeted but these settings had worked with the partners before successfully.

A strength of the evaluation process was the comparison with control clinics that were in general comparable to the intervention clinics for all partners; in Spain the control clinic was bigger and in Germany smaller.

The average duration of the training was 4 hours across all country partners as it was difficult for medical staff to participate in longer sessions due to workload. For a number of settings, the training room was an issue as there was not enough space or poor air ventilation.

During the training, case studies were used to facilitate knowledge exchange. Case studies used included those in the RESPONSE Manual, as well as real clinical cases from professional practice. Some cases involved the staff witnessing IPV, while others involved late disclosure from the patient (i.e. after the birth). In Austria, it was important for participants to have the legal procedures shown in a case study, regarding whether doctors have to be witnesses in a trial, and type of documentation required in cases of sexual violence. The overwhelming majority of the participants across all settings had no previous GBV training.

The process data collection was a challenge for all settings, particularly Austria, primarily due to the complexity of health systems operations in the partner countries. In the intervention group, participation by medical staff varied, due to being overworked and understaffed. Staff felt they valued the training but did not have time remaining to fill out evaluation questionnaires. The fact that there may be more referrals than cases of gender-based violence detected, for the example in Spain, could be explained by the fact that a woman can be referred to three different support services depending on the woman's needs.

Finally, given that there is no record-keeping of GBV cases in the majority of the settings, the data reported are estimates. In addition, there was some confusion for the staff that did not correctly interpret the evaluation questionnaires (e.g. data collection referred to the previous year and not to the 4 weeks prior to the training). Finally, another important aspect that helps explain the small number of cases reported is that in general there is under-registration of cases of gender-based violence, as the law require reporting to the police.

Table 2 (see below) provides a visual overview of the outcome data, at baseline prior to the training intervention and 6 months afterward. In Germany the training staff went from discussing violence with 0 patients to 75 patients after the training, indicating the staff were more skilled at approaching the topic with patients, but there was minimal change in referrals.

In Romania, where the topic of speaking with women and referral to victim services is relatively new, there was an increase in identification and referral of patients, even though small, and such an increase was not present in the control clinic, mainly because this is a new practice in OBGYN Clinics in Romania, therefore, data on GBV identification and referral is not usually collected.

In France there was a four-fold increase in identification and referral of patients as victims of GBV, which remained unchanged in the control clinic. However, the absolute number of identifications and referrals over 6 months was very small.

In Spain, the intervention group consisted of only two medical professionals due to the pressure of assistance and care and the remaining were social work professionals, who are less likely to detect cases because they see fewer pregnant women. On the other hand, gynaecologists and midwives were the main professionals in the control clinic throughout the entire process, which explains the higher number of pregnant women in consultation. The fact that there are many more referrals than cases of gender-based violence detected is explained by the fact that each woman can be referred to three different support services depending on the woman's needs.

In Austria, there was a three-fold increase in the number of patients identified as victims of GBV and three-fold increase in referrals to support services; this did not take place in the control clinic. However, the absolute number of identifications and referrals over 6 months was very small.

Table 2. Outcome Data of the capacity building interventions

	Germany		Romania		France		Spain		Austria	
	Intervention	Control	Intervention	Control	Intervention	Control	Intervention	Control	Intervention	Control
Baseline data prior to training (capacity building seminars):										
# patient contacts total in clinic past 4 weeks	331	178	1197	903	458	302	1130	3330	1200	800
# of patients health professional discussed violence with	0	0	0	0	50	0	51	0	2	0
# patients identified as victims of gender-based violence	0	1	0	0	0	2	51	33	2	0
# of risk assessments completed	0	Not asked	0	Not asked	0	Not asked	35	Not asked	0	Not asked
# of referrals made to support services	0	1	0	0	0	2	50	74	2	0
Post training data at 6 months:										
# patient contacts total in clinic past 6 months	292	180	1216	1062	438	302	706	2231	1150	890
# of patients health professional discussed violence with	75	0	3	0	83	0	250	0	1	0

# patients identified as victims of gender-based violence	3	2	6	0	4	3	15	26	6	0
# of risk assessments completed	2	Not asked	Not asked by healthcare	Not asked by healthcare	4	Not asked	6	Not asked	1	Not asked
# of referrals made to support services	1	1	3	0	4	2	13	34	6	0

SECTION 7: CONCLUSIONS

Through participation in the RESPONSE project the project partners were able to show improvement in perceived GBV knowledge and skills with regards to the identification and referral of female victims of GBV in maternal and women health settings. Obstacles in the evaluation process included the difficulty of obtaining data from control settings and the challenges of obtaining evaluation data after the training, as participants changed jobs or were not available or did not have the time to complete questionnaires. Providing the evaluation questionnaires online with a link for participants to download at any time assisted in improving the response rates in some but not all partner countries.

In terms of project impact the project partners stated the following:

- Increased awareness-building by health managers in the importance of appropriate care and referral for (potential) victims of GBV and responsibility of health staff to identify and refer to specialist services
- Improved incorporation of the topic of violence as routine practice by doctors and residents of the hospitals during pregnancy visits
- Improved identification of the critical points of the care pathway for pregnant women and the need to publish and distribute to medical staff posters with the steps to follow if a case is detected
- Increased awareness of the need for coordination between the different disciplines involved in the care of pregnant women
- Increased awareness of the need to strengthen the continuity of care between primary care services and hospital care
- Increased opportunities to present the project to stakeholders, all socio-health professionals in the area of influence of the hospital
- Enabled expanding the training on gender violence and pregnancy to a greater number of professionals in maternal and child health hospital services and in primary care in their area of influence

APPENDICES

APPENDIX 1. EVALUATION PROTOCOL

We believe it is important to evaluate the impact of the project to show if it has made a difference and this evaluation is a major deliverable for the European Commission.

For questions please contact Mathilde Sengoelge: mathilde.sengoelge@moresafety.org

The evaluation has two parts, the first is the process evaluation (what we did and how) and the second is the outcome evaluation (what difference did the project make). We ask you to gather indicators for each part. 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).

The key to this evaluation is for health professionals to record disclosures or suspicion of GBV in the patient record, as well as record risk assessments performed and referrals given.

Process indicators for capacity building seminars and training

Health Professional Readiness Questionnaire (see pages 5-6) completed before and after the training; minimum 1 training of 4 hours with minimum 30 health professionals and follow-up contact (minimum 3 hours)

Number of stakeholder meetings: minimum 4 in total for

a) dissemination of RESPONSE training manual, project results (1-2 meetings)

b) establishing a Victim Protection Group in a women's health clinic (1-2 meetings)

c) establishing a training module for students of medicine/midwifery/nursing (1-2 meetings)

Process indicators for Maternity-based Victim Protection Group:

Semi-structured qualitative interviews with the members of the multi-sectoral, multi-disciplinary Maternity-based Victim Protection Group in each country towards sustainability of the group and extension to other health settings (interview guide page 9)

Process indicators for Educational Module

Health Student Readiness Questionnaire (see pages 7-8) completed before and after each lecture/module to 60 students

Outcome indicators for capacity building seminars and training: 3 data collection periods

At training clinic: baseline 0 (4 weeks before the training), 4 weeks after training, 6 months after training

- Number of patient contacts total in the clinic in the past 4 weeks
- Number of patients the health professional discussed gender-based violence with in past 4 weeks
- Number of patients identified as being victims of gender-based violence in past 4 weeks
- Risk assessment completed for patients in past 4 weeks
- Number of patients referred to support services in past 4 weeks

At control clinic: baseline 0, 1 month after training done at other health setting, 6 months

- Number of patient contacts total in the clinic in the past 4 weeks
- Number of patients identified as being victims of gender-based violence in past 4 weeks
- Number of patients referred to support services in past 4 weeks

Timeline:

Spring 2017:

- Identify the training maternity/prenatal or women's health clinic and control clinic (similar in number of patients/clients and economic status of clients seen per month, similar in number of health professionals working in the clinic), preferably in obstetrics/gynecological/prenatal health or women's health setting
- Collect baseline data, indicators, from training clinic and control clinic
- Complete the situational analysis (workstream 1); form to complete will be sent to you
- Set a date for the training of health professionals in training clinic in autumn 2017
- Provide feedback on RESPONSE training manual
- Perform 1-2 stakeholder meetings for establishing a Victim Protection Group (1 trained doctor, 1 trained nurse, 1 trained social worker available for patients who are victims of gender-based violence) in the training clinic and to try to establish a training module for students of medicine/midwifery/nursing (training module will be provided)

The RESPONSE EVALUATION Checklist is to assist you in completing the evaluation.

APPENDIX 2. EVALUATION CHECKLIST

Evaluation activity	✓ = completed
1. Training clinic identified in obstetrics/gynecological/prenatal health or women's health setting Average number of patient contacts per month in training health setting: Number of health professionals working in training health setting (full-time and part-time, all fields):	
2. Control clinic identified, similar in # of clients seen per day, # of health professionals Average number of patient contacts per month in control health setting: Number of health professionals working in control health setting (full-time and part-time, all fields):	

3. Baseline data prior to training collected from both clinics Training clinic: past 4 weeks: # patient contacts total in clinic past 4 weeks # of patients health professional discussed violence with ___ # patients identified as victims of gender-based violence _____ # of risk assessments completed_____ # of referrals made to support services _____ Control clinic: past 4 weeks # patient contacts in clinic in past 4 weeks # patients identified as victims of gender-based violence _____ # of referrals made to support services _____	
4. Training completed: minimum 1 training, 4 hours with minimum 30 health professionals Date of training(s): _____ Duration of training: _____ (hours) # participants: _____ (30 minimum) # of pre-training questionnaires completed: _____ # of post-training questionnaires completed: _____ (see page 4-6 for the questionnaire) Number of hours of follow-up meetings done: _____ (minimum 3 hours)	
5. 1 month after training indicators collected from both health settings Maternity/prenatal/women's health training setting: past 4 weeks # patient contacts in clinic past 4 weeks _____ # of patients health professional discussed violence with ___ # patients identified as victims of violence _____ # of risk assessments completed _____	

# of referrals made _____ Control setting: past 4 weeks # patient contacts in clinic past 6 months_____ # patients identified as victims of violence _____ # of referrals made _____	
6. Six months after training indicators collected from both clinics Training setting: past 4 weeks # patient contacts in clinic past 6 months _____ # of patients' health professional discussed violence with ___ # patients identified as victims of gender-based violence _____ # of risk assessments completed _____ # of referrals made_____ Control setting: past 4 weeks # patient contacts in clinic past 6 months _____ # patients identified as victims of gender-based violence _____ # of referrals made_____	
7. Number of stakeholder meetings (minimum 4 in total): ____ Date of meetings and # persons present: _____ Outcome of meetings: _____ yes/no/maybe for Victim Protection Group _____ yes/no/maybe for training module in school Other:_____	

APPENDIX 3. HEALTH PROFESSIONAL AND STUDENT READINESS QUESTIONNAIRE

Health Professional Readiness Questionnaire

We believe that it is important to collect feedback and comments from participants of this training. By telling us what you think, we can make sure that the training we offer is suited to your needs and requirements. The information you give is confidential and you do not have to put your name on the form.

1. What is your job title? Please circle

❒1 Doctor

❒2 Nurse

❒3 Midwife

❒4 Social worker

❒5 Other, please specify _____

2. How much previous training have you had about gender-based violence (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)?

Estimated total number of hours _____

3a. Is there a protocol for dealing with disclosures of gender-based violence by patients in your health setting? (Tick one)

No / Don't Know / Yes

3b. If yes, is it consistently applied? Yes/ No/ Don't know

4. Please indicate how prepared you feel to perform the following tasks:

(Tick the number which best describes how prepared you feel, 1 = Not prepared; 2 = Slightly; 3 = Moderately; 4 = Fairly well; 5 = Well prepared)

4.1 Ask questions to promote disclosure of gender-based violence with your patients

❒1 ❒2 ❒3 ❒4 ❒5

4.2 Appropriately respond to disclosures about gender-based violence in your patients

❒1 ❒2 ❒3 ❒4 ❒5

4.3 Identify signs and symptoms associated with gender-based violence based on patient history and physical examination

❒1 ❒2 ❒3 ❒4 ❒5

4.4 Carry out a risk assessment and safety planning with a patient

❒1 ❒2 ❒3 ❒4 ❒5

4.5 Document gender-based violence history and physical examination findings in patient's record

❒1 ❒2 ❒3 ❒4 ❒5

4.6 Make appropriate referral for a patient to support services

❒1 ❒2 ❒3 ❒4 ❒5

5. How many new diagnoses (picked up an acute case, uncovered ongoing abuse, or had a female patient disclose a past history) of gender-based violence would you estimate you have made in the last 6 months?

_____

6. In the past 6 months, which of the following actions have you taken when you identified gender-based violence in a patient? (Tick all that apply)

6.1 Referral to gender-based violence prevention services

❒1 always ❒2 mostly ❒3 sometimes ❒4 almost never ❒5 never

6.2 Referral to a shelter

❒1 always ❒2 mostly ❒3 sometimes ❒4 almost never ❒5 never

6.3 Referral to the police

❒1 always ❒2 mostly ❒3 sometimes ❒4 almost never ❒5 never

6.4 Notification/referral to the court

❒1 always ❒2 mostly ❒3 sometimes ❒4 almost never ❒5 never

Any comments to share:

Thank you for completing this form!

APPENDIX 4. INTERVIEW GUIDES

INTERVIEW GUIDE FOR ESTABLISHING VICTIM PROTECTION GROUP

Introduction and informed consent:

Thank you for your willingness to speak with me today. May I please record our conversation so that I can make sure I capture all the information you share with me, in addition to my written notes? If no, end of interview. If yes: Thank you (video or audio recording turned on).

The information you share with me will remain anonymous and will not be traced back to you personally. May I proceed?

We will talk about your experience in trying to establish a Victim-Protection Group in your clinic. A victim protection group is a multi-professional group trained in the identification, risk assessment and referral of victims of gender-based violence. 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). Typically, such a Group has a doctor, nurse and social worker who work together to coordinate specialised assistance to victims.

Intro Questions: Can you tell me about your experience with trying to establish a Victim Protection Group in your clinic? When did you start? What has worked and not worked out?

Probe: Has management (your supervisor, head of the clinic) been in support of creating such a group?

Probe: Do your colleagues think there is value in creating such a group?

If Group established:

1. How does the group function? Probe: internal referral to the Group or mentoring of colleagues or both?

2. What have been the benefits of having the Group?

If Group not established:

3. What have been the main barriers to establishing the Group in your clinic?

For both:

4. What are the next steps regarding this Victim Protection Group?

5. Is there anything else you would like to share with me about your experiences with establishing a Victim Protection Group? Probe: what ‚lessons learned' advice would you give a health professional that wants to try to establish such a Group?

INTERVIEW GUIDE FOR ESTABLISHING TRAINING MODULE ON GBV FOR STUDENTS

Introduction and informed consent:

Thank you for your willingness to speak with me today. May I please record our conversation so that I can make sure I capture all the information you share with me, in addition to my written notes? If no, end of interview. If yes: Thank you (video or audio recording turned on).

The information you share with me will remain anonymous and will not be traced back to you personally. May I proceed?

We will talk about your experience in trying to establish a training module on GBV for medicine/nursing/midwifery school. The aim is to ensure that future health care providers have the knowledge and skills to assists victims of gender-based violence. 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).

Intro Questions: Can you tell me about your experience with trying to establish a training module in a school? When did you start? What has worked and not worked out?

Probe: Has management at the school been in support of having such a module?

If module established:

1. How did you feel the students reacted to the module?
2. Will the module be provided each year from now on?

If module not established:

3. What have been the main barriers to establishing the module in a school?

For both:

4. What are the next steps regarding this training module?

5. Is there anything else you would like to share with me about your experiences with establishing a training module for students? Probe: what ‚lessons learned' advice would you give a health professional that wants to try to establish such a training module.

APPENDIX 5. TRAINING EVALUATION FORM

1. How do you evaluate the training overall, on a scale of 1 to 10?

1-very satisfied 10-not at all satisfied

2. Please assess the following aspects of the training

	Yes, very much	Somewhat yes	No, rather not	Not at all
The training was well structured.	❑	❑	❑	❑
There was appropriate time allocated to each module.	❑	❑	❑	❑
Time for discussion was sufficient.	❑	❑	❑	❑
The handouts and materials were useful.	❑	❑	❑	❑
The training was relevant.	❑	❑	❑	❑
The training will benefit my work.	❑	❑	❑	❑
I would recommend the training to others.	❑	❑	❑	❑

3. How do you assess the performance of the trainers?

	Yes, very much	Somewhat yes	No, rather not	Not at all
I found the trainers to be knowledgeable.	❑	❑	❑	❑
I found the trainers ensured good interaction and exchange with and among participants.	❑	❑	❑	❑
I found the trainers had good presentation skills.	❑	❑	❑	❑
I would recommend the trainers for similar trainings.	❑	❑	❑	❑

4. How do you assess the overall organization/logistics of the training?

	Excellent	Good	Not so good	Poor
Training facilities	❑	❑	❑	❑
Coffee breaks, lunches	❑	❑	❑	❑
Location of the venue	❑	❑	❑	❑
Any comments or suggestions for improving the training?				
Thank you very much for supporting our evaluation!				

APPENDIX 6. FOLLOW UP TOPIC GUIDE

Session #1 (40 min to 1 ½ hours), moderated by a member of the partner in this project or a student/ professional will experience in qualitative research/focus groups; additional one staff member will take notes and mark important quotes.

Participants: health professionals/support staff who were trained, possibly in the form of a focus group (with recording and analysis of content-ask permission first to record!). The trainers can be present as observers only.

Scope of the meeting: to document what obstacles they (health professionals) in trying to implement the training in terms of identification of GBV patients and referral.

Number of participants: 8-10 participants/focus group; if more health professionals would like to participate it is best to organize more sessions with 8-10 participants.

- What challenges have you encountered in identifying your patients experiencing gender-based violence in your daily work?
- Who are you referring GBV patients to?
- What challenges have you encountered in referring these patients to the referral point/team in your hospital?
- If you have made a referral, have you had feedback on the outcome?
- What improvements can we make in the training to make it more effective?
- What improvements can we make in the referral pathway to make it more effective?
- What further support do you need to identify, support and refer your patients experiencing GBV?

Session #2 (20 min. to 1.5 hours) is needed to obtain information about the data collection process on number of patients identified and number of patients referred. The session should be moderated by trainers and health professionals are invited to attend.

Participants: clinic managers/clinical leads/data providers.

Scope: data collection process with persons who provided baseline and 6-month post data. Potential questions:

- What challenges have you encountered in obtaining estimates of the number of victims identified and the number of victims referred?
- What solutions did you identify to help to get this data to be reliable or valid?
- What suggestions do you have regarding how other clinics could get this data?

Session 3 (20 min to 1 hour) to understand how well the trainings went and what changes or improvements could be made.

Participants: trainer(s).

Scope: we need information (qualitative data) from the trainers (those who delivered the RESPONSE training intervention). This is separate from the follow up meeting.

- What were the main challenges for you in delivering the training?
- What modifications do you feel are needed in the RESPONSE training to make it more effective?
- What modifications are needed in the RESPONSE referral pathway?

Document for each meeting:

- Date of follow-up(s): _____ Duration in hours: _____ (in total of 3 hours minimum)
- Number of participants _____ Permission to record received: _____
- Type of participant: trainers ____ training participants _____ manager/data provider ____

Send this with the responses in 1 word or excel document to Mathilde in native language as complete version and a shorter version, translated into English with main content and 3 quotes as testimonials.