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

RESPONSE

WS 3 Report

System analysis on the decision making cycle for GBV related policies regarding the provision of support for GBV victims in health care settings

Co-funded by the Rights, Equality & Citizenship Programme of the European Union

This report has been produced with the financial support of the Rights, Equality and Citizenship (REC) Programme (2014-2020) of the European Union under grant agreement no JUST/2015/RDAP/AG/MULT/9746. The contents of this report are the sole responsibility of RESPONSE project team and can in no way be taken to reflect the views of the European Commission.

TABLE OF CONTENTS

Table of Contents ***1***

general Framework ***1***

PART 1. Interview analysis ***3***

Methodology **3**

Results **7**

Part 2. Content analysis of GBV legal frameworks existing at a national and European level ***13***

EUROPEAN UNION LEGISLATION 13
UN REGULATIONS 14
EUROPEAN COUNCIL REGULATIONS - ISTANBUL CONVENTION 19
Conclusions 19
Analysis 21
QUESTIONS: 22
Results 23

Conclusions **30**

GENERAL FRAMEWORK

The RESPONSE project provides capacity building activities 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. The project is organized in five work streams and focuses 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 developing and implementing an effective communication and dissemination package through collaboration with specialized networks (WS4).

Aims of the report

The current report is an output of WS3 and describes the decision-making cycle for GBV related national and EU policies with regards to the provision of support to victims of gender-based violence (GBV) in health care settings.

Assessing the decision making cycle of current national and EU GBV policies is important not only for the RESPONSE project but also for the improvement of national and EU policies, strategies and plans addressing GBV. For the RESPONSE project, this system analysis helps us understand what policies exist in each of the five partner countries with regards to the provision of support to victims of gender-based violence (GBV) in health care settings. Moreover, this system analysis helps us understand how policies addressing the GBV victims' protection are developed and adopted in each of the five partner countries.

The objective of WS3 is to strengthen multi-sectoral and multi-disciplinary cooperation (obstetrics/gynecology doctors, midwives, social workers, women's shelters, and police) in each partner

country in order to increase reporting to specialized services of GBV victims, in maternal health settings during routine pregnancy care. WS3 has five main activities and three outputs, the current report addressing the first activity (conducting a system analysis in the five RESPONSE partner countries) and the first output (Systems analysis report on decision-making cycle) of this work stream. To describe the decision-making cycle on GBV related policies, starting from a specific clinical setting, we have used data from interviews conducted with health practitioners and policy makers from five maternity units (one maternity unit from each partner country). In Part II, discussions with project partners and content analysis of legal frameworks that currently exists at national level and in the EU with regards to provision support to victims of gender-based violence in the health care setting was performed. Taking into account the two step process employed in the current system analysis, this report has two parts presenting the methodology and the result for each step:

Part I – describes the information regarding GBV related policies, information obtained through interviews with health practitioners and policy makers enrolled in each partner country.
Part II – describes the information regarding GBV related policies, information obtained through a content analysis of legal frameworks existing at a national and European level.

PART 1. INTERVIEW ANALYSIS

METHODOLOGY

Measurement instrument. To collect data for the current system analysis, we used a semi-structured interview guide. The interview guide was structured in four sections, each section addressing a baseline information about the maternity health care settings enrolled in RESPONSE. These interview guide helped us collect both data reported in the Situation Analysis Report (WS1) but also data comprised in the current System analysis report (WS3). The interview guide and detailed information regarding the methodology employed in developing the interview guide is available in the RESPONSE Situation Analysis Report (https://www.dropbox.com/s/43fxccv89x1hg0k/19-10-17_RESPONSE_Situation%20analysis_vf.pdf?dl=0).

Participants. Maximum variation sampling method[1] was employed to recruit study participants. We used this purposive sampling method[2] 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 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 (see the RESPONSE Situation Analysis Report) was developed and shared will all partner countries. Within the clinics, 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 profile of respondents answering the interview.

Data collection. All partners were trained in applying a unitary methodology for data collection (see the RESPONSE Situation Analysis Report) developed and shared by the coordinating team with all partner countries.

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

[1] 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.
[2] Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63-75.

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.

Data analysis. To inform the decision making cycle of GBV related policies aiming to support victims of violence we analyzed data in two steps. First, we analyze the three main questions related to policies and laws (Table 1). Consequently, Step 1 in data analysis for this report mainly focused on the answers provided by interview respondents to these three questions.

Table 1. Questions addressing GBV policies in health care settings

Main question	*Additional questions*
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?
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?

Table 1. RESPONSE interview respondents per participant country

Austria			
Health Professional 1	HP1	Midwife	Center for Midwifes in Vienna
Health Professional 2	HP2	Midwife	Center for Midwifes in Vienna
Health Professional 3	HP3	Midwife	Independent Midwife but in cooperation with hospitals
Health Professional 4	HP4	Midwife/Midwife trainer	University in Vienna
Health Professional 5	HP5	Gynecologist	Hospital in Vienna "Wilhelminenspital"
Health Professional 6	HP6	Gynecologist	General Hospital in Vienna
Policy Maker 1	PM1	Project member	Prevention project for early support called "Frühe Hilfen"
Policy Maker 2	PM2	Forensic Doctor	University in Vienna
France			
Health Professional 1	HP1	Midwife	Hospital Saint Joseph
Health Professional 2	HP2	General practitioner	Port-Royal maternity ward
Health Professional 3	HP3	Nurse	Port-Royal maternity ward
Social Worker 1	SW1	Coordinator of the medical-psychological-social (MPS) department	Port-Royal maternity ward
Social Worker 2	SW2	Social worker	Port-Royal maternity ward
Social Worker 3	SW3	Psychologist	Port-Royal maternity ward
Policy Maker 1	PM1	Head of the maternity ward	Hospital Saint Joseph
Policy Maker 2	PM2	Head of the maternity ward	Port-Royal maternity ward
Policy Maker 3	PM3	National coordinator for prevention of violence against women	Ernestine Ronai (MIRPOF)
Germany			
Health Professional 1	HP1	Midwife – coordinator of the midwifes department	Gemeinschafts-krankenhaus Herdecke clinic
Health Professional 2	HP1	Gynecologist	Gemeinschafts-krankenhaus Herdecke clinic
Health Professional 3	HP1	Midwife & Paediatric Nurse	Freelancer in Ennepe-Ruhr-County
Social Worker 1	SW1	Social worker	Women support center(Frauenberatung EN) & cooperating with the Gemeinschafts-krankenhaus Herdecke clinic
Social Worker 2	SW2	Social worker	Women Shelter (Frauenhaus Ennepe-Ruhr-County) cooperating with the Gemeinschafts-krankenhaus Herdecke clinic
Policy Maker 1	PM1	Equal opportunities officer at a county level & Executive secretary of the regional roundtable on domestic violence	Ennepe-Ruhr-Kreis County Administration

Policy Maker 2	PM2	Trainer for midwives on trauma, violence, coach and political instructor	Medica Mondiale
Policy Maker 3	PM3	Leading doctor	Helios clinic Schwelm
Romania			
Health Professional 1	HP1	Obstetrician/gynecologist	IMOGEN - Medical Research Institute
Health Professional 2	HP1	Obstetrician/gynecologist	Gynecology and Obstetrics I Clinic
Social Worker 1	SW1	Social worker, Coordinator of the Women Shelter	Atena-Delphi NGO, Women Shelter
Social Worker 2	SW2	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	SW3	Social worker, Head of the Social Protection Unit	Social Protection Service, Directorate of Social and Medical Assistance, Municipality of Cluj-Napoca
Policy Maker 1	PM1	Physician and Professor	Department of Public Health and Management, “Carol Davila” University of Medicine and Pharmacy, Bucharest
Policy Maker 2	PM2	Counselor	Cluj County Public Health Authority
Policy Maker 3	PM3	Police Commissioner	Cluj County Police Inspectorate
Spain			
Health Professional 1	HP1	Gynecologist	
Health Professional 2	HP1	Midwife	
Health Professional 3	HP1	Pediatric nurse	
Health Professional 4	HP1	Midwife	
Social Worker 1	SW1	Case manager (Maternity area social worker)	
Social Worker 2	SW2	Social worker	
Social Worker 3	SW3	Social worker (manager profile)	
Policy Maker 1	PM1	Assistant director	
Policy Maker 2	PM2	Head/Manager Neonatal care manager	
Policy Maker 3	PM3	Healthcare Coordinator Officer of Madrid	

RESULTS

Availability and characteristics of GBV related policies regarding the provision of support for GBV victims in health care settings

This section details the results on the decision-making cycle for GBV related policies regarding the provision of support for GBV victims in health care settings. Results are focused on the availability and characteristics of (1) GBV policies as part of the quality management of the health setting, (2) health professional laws to provide services for GBV victims and of (3) policies concerning multi-agency collaboration to address GBV in the maternity clinic.

GBV POLICIES AS PART OF THE QUALITY MANAGEMENT OF THE HEALTH SETTING

Austria. Out of the eight respondents interviewed, six were not aware of any GBV related policies that health care staff should follow to support a GBV victim. However, these six participants considered a priority to have GBV related policies and considered they should refer to victims' admission, care, transfer and support, staff trainings and surveys. The two respondents discussing the availability of policies addressing GBV victims' support referred to policies developed through national projects and respecting WHO requirements. One policy maker, a forensic doctor from the University in Vienna discussed about existing **policies developed through the projects „gewaltFREI LEBEN" and „Durch mein Krankenhaus",** policies addressing the management department of health institutions. Based on PM3's description, these policies should support implementation of quality standards in hospitals regarding the support of GBV victims. The content of this guideline are orientated on the requirements and recommendations of the WHO and cover the following areas:

- Victim orientated medical care;
- Primary care of victims of violence and the transmission to support facilities;
- Protection and help for victims in the health institution and afterwards;
- Correct treatment of potential offenders; Injuries and complaints;
- Development of police reports;
- Cooperation with victim support groups, police, Children´s and women´s facilities and forensic medicine.

A health care practitioner, a gynecologist from the General Hospital in Vienna presented the **guidelines developed through WHO** and the examination guidelines developed by MEDPOL, guidelines available for and used by doctors via INTRANET. These guidelines referred to:

- Documenting victims of knockout drops
- Handling the victim
- Taking urine samples for GBV victims arriving at the emergency department to identify cases of knockout drops

France. The seven respondents answering the interview questions did not specify any existing GBV policy being implemented in their health care setting. However, all respondents see the existence of a GBV policy as highly important for their health care setting. The two health care practitioners interviewed, a midwife from the Hospital Saint Joseph and a general practitioner from the Port-Royal maternity ward, stated that "addressing GBV is a part of the global patient care", although they did not mention any policy guiding the support of GBV victims.

Germany. All eight respondents answering the interview questions underlined the absence of a policy guiding health professionals in addressing GBV victims. Besides one policy maker, a trainer for midwives on trauma, violence, coach and political instructor from the Medica Mondiale, who sees a GBV policy as a matter of financial quality management and a way to disseminate the hospital services, all interview respondents perceive a GBV policy as an important part in the quality management of the health setting. The gynecologist from the Gemeinschafts-krankenhaus Herdecke clinic considers a written policy as useful for unexperienced staff, the midwife working as a freelancer in Ennepe-Ruhr-County sees such a policy useful after training health professionals in addressing GBV and the social worker working at the Women Shelter (Frauenhaus Ennepe-Ruhr-

County) cooperating with the Gemeinschafts-krankenhaus Herdecke clinic sees as a useful of a GBV policy an assessment component addressing GBV in all patients accessing the hospital services.

Romania. A policy for addressing GBV is missing, in the view of the eight interviewed respondents, the gynecologist from the IMOGEN - Medical Research Institute considering the low frequency of GBV cases as a reason for missing GBV policies inside the hospital. All respondent consider such a policy useful. In their perspective, a policy should guide the medical support of the victim, counseling, support and referral of the victim and also the case report development. Respondents were, however, reluctant regarding implementing a policy. Even if a policy would exist, implementing it would depend upon "the number of personnel available in addressing GBV, GBV trainings and available time allocated to support GBV victims" (HP3).

Spain. All interview respondents confirmed the absence of a GBV policy in their health setting and considered that a GBV policy is not a matter of the quality management of their health setting. One policy maker, an assistant director), sees GBV policy as a matter of primary care and a midwife working in a Health Center sees it as a matter of sensitivity and not as a quality matter.

> "All the work associated with detection of GBV at the health center is understood to be voluntary, unless it's the obligation to send out the injury report. It's a question of sensitivity and conscience, not an issue identified as quality." (Midwife, Health Center)

The Healthcare Coordinator Officer of Madrid and a social work coordinator mentioned, however, the existence of a Violence Commission inside the hospital, a commission dependent directly on the hospital's Quality Department:

> "The Quality Department of the hospitals is not directly involved with the GBV actions. Indirectly, it does have a responsibility: to sanction and to spread the word about the protocols for the hospital, produced by the Violence Commission of each hospital." (Social work coordinator).

Regarding the usefulness of a policy of this type, the interviewees expressed their point of view:

> "It seems to me that all these commissions and all these things don't help at all. We're not going to be able to do anything until the law is changed. And until the woman that is at-risk is automatically protected. Because the rest are commissions and all you are doing is wasting words and resources and time. There's nothing worse than seeing the situation and not being able to help." (Responsible for neonatal care service)

> "More cases should be detected, because they must exist. But I don't know how you could do this. It's complicated, this is a complicated issue." (Midwife at the Hospital)

HEALTH PROFESSIONAL LAWS TO PROVIDE SERVICES FOR GBV VICTIMS

Austria. Out of the eight respondents interviewed, six were not aware of a specific law for health professionals regarding the provision of GBV services. The two respondents discussing the availability of a specific law for health professionals referred to the Istanbul Convention and the "general doctors' law". The forensic doctor from the University in Vienna detailed the Istanbul Convention as a convention of the Council of Europe established in August 2014. The responded stated that this convention is the first legally binding European convention containing measures for violence prevention and that Austria is obliged to implement its regulations. The forensic doctor from the University in Vienna described that actions specified in the Istanbul Convention apply to victims of violence on women and domestic violence and described three rights stated in this convention:

> "The human right to a life without violence. Violence against women and children and domestic violence is a violation of human rights. International UN conventions for children´s rights or the Istanbul Convention have the goal to make a live without violence possible for women and children. The human rights include as well a good health system, which meets the needs and eights of victims of violence.
>
> Right to self-determination. Women who are affected by violence have the right to be protected against violence and have the right to determine their live on their own. This includes the right to decide to

> separate from the violent partner or not. It includes as well the right to agree or disagree on medical treatment.
>
> Protection of children and juveniles. According to the UN convention on children´s rights and the Istanbul Convention children have the right to live a life without violence and access possibilities to support facilities, if they experience violence or are witnesses of violence. This right is mainly realized through reporting obligation and obligation to notify." (Forensic doctor, University in Vienna)

In terms of and existing GBV law for health practitioners, one health care practitioner, a gynecologist from the General Hospital in Vienna, named the **"doctor's law"** and described this law as "obliging doctors and midwifes to report severe violence (physical injuries) to the police". When describing this law, the respondent stated that it includes the not mandatory reporting of small injuries (hematoma or swellings) and reporting to the police only after the victim is asked and convinced to agree to report to the police. The gynecologist from the General Hospital in Vienna also referred to **a compulsory law stating the obligation of public hospitals to have victim protection groups**:

> "The law 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." (Gynecologist, General Hospital in Vienna)

France. None of the seven respondents were aware of a law specifying the provision of support for GBV victims by health care professionals. Moreover, they were not convinced about the necessity of such a law not only because addressing violence is one's health professional duty but also because they see health professionals' trainings and raising awareness campaigns as more efficient than a law:

> "I do not know if there is a law and I do not think it is necessary. It is important to provide a good training to the health professionals. A law does not solve everything." (Policy maker, Port-Royal maternity ward)
>
> "A law, I do not know. It should be part of the role of a health professional as it is in any case a duty. If there is maltreatment, if there is violence, it is part of our role to treat it." (Nurse, Port-Royal maternity ward)
>
> "For me this law is a universal law applicable for everyone. It is «assist a person in danger." (Social worker, Port-Royal maternity ward)

Germany. All eight respondents underlined the absence of a law specifying the provision of support for GBV victims by health care professionals. At the same time, all respondents agreed on the usefulness of such a law:

> "No we don´t have a law yet, but it would be a good idea. To make clear, who is in charge of the issue, what has to be done – it would be very helpful." (Social worker, Women support center, Gemeinschafts-krankenhaus Herdecke clinic)

However, one gynecologist from the Gemeinschafts-krankenhaus Herdecke clinic and a social worker from the Women support center and the Gemeinschafts-krankenhaus Herdecke clinic, manifested concerns about the real impact of such a law on health care practitioners' daily work. Moreover, the midwife working as a freelancer in Ennepe-Ruhr-County considered training and attitude as more important that a law:

> "It could be helpful first to make people think and talk about the issue. But you have to be carefully, not to evoke more resistance against the issue by strict regulations that just get fulfilled more mechanically without guaranteeing a high quality, sensitive approach." (Midwife, Ennepe-Ruhr-County)

Romania. Interview respondents were aware of the existence of the **Law no. 217** on preventing and combating violence within the family. Besides Law no. 217, Romania also has the **National Strategy on preventing and combating violence within the family (2013-2017)** and **Law no. 30/2016** on the ratification of The Council of Europe Convention on preventing and combating violence against women and domestic violence. 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. 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.

Spain. Respondents had different views on the existence of a GBV law for health practitioners. The four health practitioners were not aware of any law for providing GBV services, besides the doctor's obligation to send an injury report.

> "Apart from the doctor's legal obligation to send out the injury report, I'm not familiar with any law that links healthcare professionals to any type of concrete action, whether that be preventative or palliative." (Midwife in a Health Center)

One policy maker from the Neonatal Care Department (a Healthcare Coordination of Madrid) and a social worker from the Madrid Health Service (SERMAS) were not aware of any existing law. However, an assistant Director, a social worker in a Hospital and the other from central services stated the existence of a **General Gender Violence Law** existing at a state level and at the level of the Community of Madrid. The law addresses all professionals and obliges them to identify and report GBV cases. Moreover, the law specifies the need of training health care professionals in detecting GBV cases:

> "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." (Assistant Director)

> "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 work coordinator in Madrid)

POLICIES CONCERNING MULTI-AGENCY COLLABORATION TO ADDRESS GBV IN THE MATERNITY CLINIC

Austria. Out of the eight respondents interviewed, seven stated the absence of a policy guiding the collaboration on GBV between different agencies. These respondents see this policy as a useful one and as parties participating in the collaboration they mentioned gynecologists/doctors, nurses, midwifes, social workers, women shelter and women consulting as well as translators. They see doctors, nurses and midwifes responsible for the first contact with the victim and for establishing the diagnosis and social workers for further care. One health practitioner, a gynecologist from the General Hospital in Vienna, mentioned the existence of a multi-agency collaboration in addressing GBV through the **INTRANET**, a platform where the respondent observed "good and ongoing notes and comment about this". Moreover, the respondent stated the presence of a very good collaboration with victim-protection-institutions and with the police and the process of collaboration is though through workshops.

France. Besides one social worker from the Port-Royal maternity ward, all six respondents confirmed the existence of a policy for multi-agency collaboration in addressing GBV. Four respondents mentioned the **medical-psycho-social (MPS) staff** where they refer all cases of GBV, they rated the collaboration with the MPS staff as good and directed the interviewer to the MPS staff for further details on multi-agency collaboration. More information on collaboration was obtained from a midwife working in the Hospital Saint Joseph and a policy maker working in the Hospital Saint Joseph. The midwife working in the Hospital Saint Joseph was the reference person for cases of domestic violence, GBV cases being referred to this respondent. In his view, collaboration in managing GBV cases was considered satisfactory as, information on the GBV cases he receives is missing and once women leave the ward, he has to "fish for information" for a case follow-up. The policy maker working in the Hospital Saint Joseph detailed that the MPS staff focuses their work on addressing GBV cases by bringing to the discussion table multiple actors from the hospital and outside the hospital environment.

Germany. All eight respondents, although appreciating the idea of collaboration with agencies outside the hospital, confirmed the absence of a written policy addressing multi-agency collaboration in supporting GBV victims. The policy maker working within the Ennepe-Ruhr-Kreis County Administration mention the cooperation

of the hospital with the women's counseling center and the midwife trainer from the Medica Mondiale expressed to have been working with other specialists and SW2 mentioned the possibility of such a policy existing inside a clinic partnering with **GESINE**. Respondents were however reluctant regarding the sustainability of a multi-agency collaboration, stating barriers such as lack of time for this extra-work, staff changing often, the rare GBV cases needing an interdisciplinary approach.

Romania. Respondents were not aware of any written policies for multi-agency collaboration. However, they were aware of ongoing interdisciplinary collaborations in the form of working groups functioning each time a special situation occurs and practitioners don't know how to approach it. This **local interdisciplinary group** comprised lawyers, social workers, psychologists, university professors, NGOs' representatives, police officers, members from the General Directorate for Social Assistance and Child Protection that meet on a monthly basis and discuss GBV cases. Besides the interdisciplinary group, the **Police Department, the General Directorate for Social Assistance and Child Protection and the Atena Delphi NGO** were referred to, in terms of collaboration.

Spain. Respondents did not mention a written policy concerning multi-agency collaboration to address GBV in the maternity clinic. However, they described different departments and roles for interdisciplinary collaboration in supporting GBV victims. One policy maker, an Assistant director presented information regarding the **Technical Commission on Violence** and the **General Directorate for Women:**

> "Within the Technical Commission on Violence is also represented the General Directorate for Women (DGM), which is the body of the Community of Madrid on which depends the public offering of public services for protection and assistance to women victims of violence. The Department of Health of the Community of Madrid is coordinated with the DGM through this Technical Commission." (Policy maker, Assistant director)

Besides the Technical Commission on Violence and the General Directorate for Women, the Assistant director and the policy maker from the Healthcare Coordination Office of Madrid described the **Health Centers** and the **Social Service Centers** existing in metropolitan and non-metropolitan areas. Health Centers collaborate with Social Services and NGOs to support GBV victims. Collaboration is efficient in small towns, due to direct communication between their representatives whereas in metropolitan areas, communication between these agencies is perceived as difficult.

> "Each health center is coordinated (through the social worker) with both Social Services and NGOs, thus managing the resources for GBV victims, based on available supply in the geographical area." (Assistant director)

> "A Health Center in a small town works a lot with the social workers from the local government's Social Services Center. It's a more direct and personal relationship. The problem comes in big metropolitan areas, because the relationship between professionals is more impersonal. The government social worker in a big city doesn't have the same relationship with the Health Center social workers. Whereas, in small towns, the two government social workers know the eight doctors and the ten nurses from the Health Center personally and they can easily coordinate their actions, in areas with a bigger population, the relationship between those services is more distant and less coordinated. It's difficult to coordinate because we're talking about very powerful organizations, and that, by their very nature, are endogamous. When organizations are so endogamous, there is an inertia that makes the protocols always to look inward. Haven't you thought about the fact that there's intelligent life outside of your hospital?" (Healthcare Coordinator Officer of Madrid)

None of the four interviewed health care professionals was aware of a policy concerning multi-agency collaboration to address GBV in the maternity clinic. However, social workers informed interviewers about the existence of a **Roundtable on Gender** that meets once a month and about collaborating with the **Justice Department**. Although collaboration with the psychosocial teams existing in the Justice Department is essential, the social worker from the Hospital expressed difficulties in collaborating with them:

> "The Justice Department is a complex administration when it comes to communication. And with minors, the same. Often, if the case is in court, they don't give us information that we should have for a

professional practice. The information they have at their disposal is essential to our assessments. Whether to take a protective measure in the case of minors, or a foster home, or an emergency accommodation for a woman if she is in a high risk situation. There (at the Justice Department), there are also teams, psychosocial teams. But you always talk to the court clerk or with the judge who happens to pick up at that time. It's difficult to communicate when so many different calls are made—in some cases the information isn't very clear." (Social worker, Hospital)

PART 2. CONTENT ANALYSIS OF GBV LEGAL FRAMEWORKS EXISTING AT A NATIONAL AND EUROPEAN LEVEL

International legislative framework common to the countries participating in the RESPONSE Project to provide support to victims of gender-based violence in the health-care setting

The international legislative framework common to the States that are part of the RESPONSE project about the supportive provision on the medical care of victims of gender-based violence during pregnancy is insufficient. However, there are a series of general provisions about the attention to victims of gender-based violence in the health sector that are specified in various International Agreements ratified by the EU, General Recommendations, Lines and Principles of action of various organisms, etc. In order to analyze the common legislation, we will review the regulations issued in four blocks: EU regulations, UN regulations and Council of Europe regulations (with special mention of the Istanbul Convention).

EUROPEAN UNION LEGISLATION

As for the European Parliament's activity on this issue, we find the following Resolutions:

1. The European Parliament Resolution of 25 February 2014 with recommendations to the Commission on combating Violence Against Women establishes that the Member States should develop a series of prevent and combating.

> *"Recommendation 2: On prevention and combat measures Member States should develop a series of measures in order to prevent and combat gender-based violence against women and girls. They should namely:*
> *- organise training for officials and professionals likely to come into contact with cases of gender-based violence – including law enforcement, social welfare, child welfare (for victims of or witnesses to violence), healthcare and emergency centre staff – in order to detect, identify and properly deal with such cases, with a special focus on the needs and rights of victims".* [3]

2. The European Parliament Resolution of 5 April 2011 on priorities and outline of a new EU policy framework to fight violence against women, proposes a new comprehensive policy approach against gender-based violence including:

> *"- demands on Member States to ensure training for officials likely to come into contact with cases of violence against women – including law enforcement, social welfare, child welfare, healthcare and emergency centre staff – in order to detect, identify and properly deal with such cases, with a special focus on the needs and rights of victims, (…)*
>
> *- the creation of partnerships with higher education institutions with a view to providing training courses on gender-based violence for professionals in the relevant fields, especially judges, criminal police officials, health and education professionals and victim support staff,(…)*

- the integration of specific identification and diagnosis mechanisms within hospital emergency services and the primary care network, with a view to consolidating a more efficient access and monitoring system for the victims concerned".[4]

---

[3] European Parliament Resolution of 25 February 2014 with recommendations to the Commission on combating Violence Against Women [Available in: http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P7-TA-2014-0126+0+DOC+PDF+V0//EN]

[4] European Parliament Resolution of 5 April 2011 on priorities and outline of a new EU policy framework to fight violence against women [Available in: http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P7-TA-2011-0127+0+DOC+PDF+V0//EN]

3. **The European Parliament Resolution of 26 November 2009 on the elimination of violence against women** stresses the importance of proper training for health professionals on gender-based violence in section 19:

> *"Stresses the importance of proper training for those working with female victims of male violence, including representatives of the justice system and law enforcement, with particular reference to the police, the courts, social, medical and legal services, labour market agencies, employers and trade unions".*[5]

4. **The European Parliament Resolution of 6 October 1997 on the need to establish a European Union wide campaign for zero tolerance of violence against women** also refers to the training of health care professionals in similar terms:

> *"Stresses the importance of training for all those working with women victims of violence including the police, legal services, health care, housing and social services; takes the view that such training should be compulsory for judges presiding over cases of gender-based violence".*[6]

Finally, reference should be made to **Decision No. 7/14 of 5 December 2014, to prevent and combat violence against women from the Ministerial Council of the Organization for Security and Cooperation in Europe** (OSCE), which establishes two recommendations addressed to participating States regarding the protection of victims of gender-based violence and mutual collaboration in the approval of measures on the issue:

"C) Protection

> *5. Encourages the participating States to:*
> *– Ensure that victims of all forms of violence against women receive timely and adequate information on available legal measures and support services, such as sexual violence crisis centres, shelters or other relevant structures, as well as healthcare, and to ensure that they are easily accessible;*
>
> *E) Partnership*
>
> *8. Encourages the participating States to:*
> *– Develop comprehensive and co-ordinated national policies aimed at combating all forms of violence against women, encompassing all relevant actors, such as law enforcement and the justice sector, parliaments, national human rights institutions, healthcare and social services as well as civil society organizations."*[7]

UN REGULATIONS

The **Convention on the Elimination of all Forms of Discrimination Against Women** (CEDAW) is the independent UN body responsible for monitoring the implementation of the Convention on the

[5] European Parliament Resolution of 26 November 2009 on the elimination of violence against women [Available in: http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P7-TA-2009-0098+0+DOC+PDF+V0//EN]

[6] European Parliament Resolution of 6 October 1997 on the need to establish a European Union wide campaign for zero tolerance of violence against women [AVAILABLE IN: http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:51997IP0250&from=EN]

[7] Ministerial Council Decision No. 7/14 on Preventing and Combating Violence Against Women (OSCE, 2014) [Available in: http://www.osce.org/cio/130721?download=true]

Elimination of All Forms of Discrimination against Women. One of CEDAW's functions is to formulate recommendations and suggestions that are forwarded to the member countries. The **General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19** (2017) please the States parties to provide recurrent and effective capacity-building, education and training for health-care professionals, including in the area of sexual and reproductive health (section.30.e).

"B. Prevention

30. The Committee recommends that States parties implement the following preventive measures:

> *(…) e) Provide mandatory, recurrent and effective capacity-building, education and training for members of the judiciary, lawyers and law enforcement officers, including forensic medical personnel, legislators and health-care professionals, including in the area of sexual and reproductive health, in particular sexually transmitted infections and HIV prevention and treatment services, and all education, social and welfare personnel, including those working with women in institutions, such as residential care homes, asylum centres and prisons, to equip them to adequately prevent and address gender-based violence against women. Such education and training should promote understanding of the following:*
>
> *(i) How gender stereotypes and bias lead to gender-based violence against women and inadequate responses to it;*
> *(ii)Trauma and its effects, the power dynamics that characterize intimate partner violence and the varying situations of women experiencing diverse forms of gender-based violence, which should include the intersecting forms of discrimination affecting specific groups of women and adequate ways of interacting with women in the context of their work and eliminating factors that lead to their revictimization and weaken their confidence in State institutions and agents;*
>
> *(iii)National legal provisions and national institutions on gender-based violence against women, the legal rights of victims/survivors, international standards and associated mechanisms and their responsibilities in that context, which should include due coordination and referrals among diverse bodies and the adequate documentation of such violence, giving due respect for women's privacy and right to confidentiality and with the free and informed consent of the victims/survivors".* [8]

The Fourth Conference on Women held in 1995 in Beijing and organized by UN Women, brought together more than 189 governments producing The Beijing Declaration and Platform for Action, serving as a precedent and being the most advanced and progressive text that promotes and defends women's rights. In relation to the legislation that links the RESPONSE and the participating countries, includes, within its Strategic Objective C.1 aimed at increasing women's access to adequate, affordable and quality health care, which governments adopt measures, in collaboration with non-governmental organizations, employers 'and workers' organizations and the support of international institutions to train primary health care workers who can recognize and treat girls and women of all ages who have been victims of violence (section 106.q).

[8] General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19 (CEDAW, 2017) [Available in: http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsldCrOlUTvLRFDjh6%2fx1pWAeqJn4T68N1uqnZjLbtFua2OBKh3UEqlB%2fCyQIg86A6bUD6S2nt0Ii%2bndbh67tt1%2bO99yEEGWYpmnzM8vDxmwt]

"Strategic objective C.1.

> *106. By Governments, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions: (…) q) Integrate mental health services into primary health-care systems or other appropriate levels, develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence especially domestic violence, sexual abuse or other abuse resulting from armed and non-armed conflict".* [9]

Given the close relationship of the subject matter with the RESPONSE Project in health and gender-based violence, it is important to note The World Health Organization. The **World Health Organization** has approved a series of **WHO clinical and policy guidelines** (2013) that look to introduce policies in health services and programs directed towards bettering the health sector's response to violence against women. This document highlights Recommendation No. 8, which makes specific reference to **pregnant women that disclose intimate partner violence**, inciting health personnel to offer guidance on empowerment, support, and security:

"Recommendation 8. Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries is uncertain.

> *Remarks*
> *a) Information about exposure to violence should be recorded unless the woman declines, and this should always be conducted in a discreet manner (i.e. not with labels or noticeable markings that can be stigmatizing for women, especially when health-care professionals label them as "battered"). Women may not wish to have information recorded in their clinical history files, in the fear that their partner may find out. This concern will need to be balanced against the need to ensure adequate forensic evidence in circumstances where women decide to pursue a legal case.*
> *b) A woman should be helped to develop a plan to improve her safety and that of her children, where relevant.*
> *c) Attention should be paid to self-care for providers, including the potential for vicarious trauma."*[10]

Along with the former, it is worth mentioning another series of recommendations on the identification and care of survivors of intimate partner violence, as well as on the training of health service providers and other political decisions on health matters, which are briefly quoted:

"Recommendation 3. Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence (see Box 1, Examples of clinical conditions associated with intimate partner violence), in order to improve diagnosis/identification and subsequent care (see recommendation 30).

[9] Beijing Declaration and Platform for Action (ONU, 1995) [Available in: http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf]

[10] Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines (WHO, 2013) [Available in: http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf?ua=1]

Remarks

a) A minimum condition for health-care providers to ask women about violence is that it is safe to do so (i.e. the partner is not present); they must be trained on the correct way to ask and on how to respond to women who disclose violence (see Minimum requirements). This should at least include first-line support for intimate partner violence (see recommendation 1).

b) Providers need to be aware and knowledgeable about resources available to refer women to when asking about intimate partner violence.

Recommendation 30. Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault (see recommendation 1) should be provided to health-care providers (in particular doctors, nurses and midwives).

Remarks

(a) The health-care provider may have experience of gender-based violence, as either a victim or a perpetrator. This needs to be addressed in their training.

Recommendation 31. Health-care providers offering care to women should receive in-service training on violence against women, ensuring it:

- enables them to provide first-line support (see recommendations 1 and 10);
- teaches them appropriate skills, including: when and how to enquire about violence, the best way to respond to women (refer to sections 2 and 3), and how to conduct forensic evidence collection where appropriate (7-9);
- addresses basic knowledge about violence, including laws that are relevant to victims of intimate partner violence and sexual violence and knowledge of existing services that might offer support to survivors of intimate partner violence and sexual violence (this could be in the form of a directory of community services) as well as inappropriate attitudes among healthcare providers (e.g., blaming women for the violence, expecting them to leave immediately, etc.), as well as their own experiences of partner and sexual violence.

Remarks

a) Training should be intensive and content appropriate to the context and setting.

b) Attention should be paid to self-care for providers, including the potential for vicarious trauma.

Recommendation 32. Training for health-care providers on intimate partner violence and sexual assault should include different aspects of the response to intimate partner violence and sexual assault (e.g. identification, safety assessment and planning, communication and clinical skills, documentation and provision of referral pathways).

Remarks

a) Intensive multidisciplinary training (e.g. involving different kinds of health-care providers and/or police and advocates) delivered by domestic violence advocates or support workers should be offered to health-care professionals where referrals to specialist domestic violence services are possible.

b) Using interactive techniques may be helpful.

c) Training should go beyond the providers and include system-level strategies (e.g. patient flows, reception area, incentives and support mechanisms) to enhance the quality of care and sustainability.

Recommendation 33. Training for both intimate partner violence and sexual assault should be integrated in the same programme, given the overlap between the two issues and the limited resources available for training health-care providers on these issues

General remarks

a) Priority for training should be given to those most likely to come into contact with women survivors of intimate partner violence and/or sexual assault, for example health-care providers in antenatal care, family planning or gynaecologic services, and post-abortion care, mental health and HIV, as well as primary care providers and those in emergency services.

b) Training should include clinical examination and care for intimate partner violence and sexual assault, as well as attention to cultural competency, gender equality and human rights considerations.

c) Training should take place within the healthcare setting, to promote attendance.

d) There should be reinforcement of initial training and the provision of continual support. Regular follow up and quality supervision are extremely important.

e) A clear care pathway of management and referral, a designated and accessible (domestic) violence against women worker, and regular reminders (e.g. computer prompts) were shown in one study to be helpful in sustaining the benefit of training.

Recommendation 34. Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.

Remarks

a) A multicomponent programme including training of health-care providers to make them aware of factors that would raise clinical suspicion and of how to provide first-line support is preferable. A clear referral pathway may also increase effectiveness. This training needs to be repeated regularly, in order to sustain the benefit (see section 2).

b) Offering vertical stand-alone services may be difficult to sustain and have potential harmful effects. For instance, there might be a risk that a currently under-staffed mental health service would be further weakened if it had to provide services specifically for victims of violence, rather than ensuring that all clients (including survivors of violence) get the best possible care.

c) Providing support to the carers and the possibilities of debriefing should also be part of the health-systems response, although this requires additional human resources. It is also important for the health services to meet regularly with other agencies such as police or social workers, to ensure that there is coordination and coherence across services and that referrals are working effectively

Recommendation 35. A country needs multiple models of care for survivors of intimate partner violence and sexual assault, for different levels of the health system. However, priority should be given to providing training and service delivery at the primary level of care.

Recommendation 36. A health-care provider (nurse, doctor or equivalent) who is trained in gender-sensitive sexual assault care and examination should be available at all times of the day or night (on location or on-call) at a district/area level.

General remark

a) Until there is further evidence, countries need to have multiple models to provide care, but evaluation should be promoted to identify what works best and is most cost effective in different settings.

b) One-stop centres, where appropriate, are best located within health services, where the priority for provision of services is women's health rather than being based on legal outcomes. They appear to be best suited for areas with high population density, whereas integrated services within or across health facilities may be more cost effective in rural areas.

c) Whatever model is used, it should aim to reduce the number of services and providers that a woman has to contact (and tell her story to), and facilitate access to services she may need, in a manner that respects her dignity and confidentiality and prioritizes her safety.

d) Violence against women is also a violation of a woman's human rights. Policies and laws need to be revised to ensure they do not discriminate against women and that they adequately penalize acts of violence, including those that take place within the home."[11]

In addition, WHO has approved a **Global Plan of Action** to strengthen the role of the health system within a national multisectoral response **to address interpersonal violence, in particular against women and girl**s, and against children (2016)[12], promoted by **the Resolution of the 67th World Health Assembly** on strengthening the role of health systems in the fight against violence, in particular against women and girls and against children (2014).[13]

EUROPEAN COUNCIL REGULATIONS - ISTANBUL CONVENTION

The **Convention on preventing and combating violence against women and domestic violence by the Council of Europe** (Istanbul 2011), is the first binding regulation, and therefore the most important within our international legislative framework, aimed at combating gender-based violence. The Convention exhorts the Parties to provide or strengthen the appropriate training of professionals that treat victims of gender-based violence, above all in terms of prevention and detection of said violence (article 15.1), as well as to take the necessary legislative or other measures to ensure that victims have access to health care and social services and that these services are adequately resourced and professionals are trained to assist victims and refer them towards the appropriate resources (article 20.2).

"Article 15. Training of professionals

1. Parties shall provide or strengthen appropriate training for the relevant professionals dealing with victims or perpetrators of all acts of violence covered by the scope of this Convention, on the prevention and detection of such violence, equality between women and men, the needs and rights of victims, as well as on how to prevent secondary victimisation.

Article 20. General support services

(…) 2. Parties shall take the necessary legislative or other measures to ensure that victims have access to health care and social services and that services are adequately resourced and professionals are trained to assist victims and refer them to the appropriate services."[14]

CONCLUSIONS

Through this document, a compilation of the most relevant international regulations has been made regarding the provision of support in the health field to victims of gender violence especially that aimed at women who are pregnant and suffer violence. All the regulations that have been presented affect the collaborating countries of the RESPONSE project.

---

[11] Ibid

[12] Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children (WHO, 2016) [Available in: http://apps.who.int/iris/bitstream/10665/252276/1/9789241511537-eng.pdf?ua=1]

[13] 67th WHA resolution on addressing violence (2014) [Available in: http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_ACONF1Rev1-en.pdf?ua=1]

[14] Convention on preventing and combating violence against women and domestic violence (Council of Europe, 2011) [Available in: https://rm.coe.int/168008482e]

This normative framework consists of:

UE:

- From the **European Parliament,** the following Resolutions:

  - The **European Parliament Resolution of 25 February 2014 with recommendations to the Commission on combating Violence Against Women.**

  - The **European Parliament Resolution of 5 April 2011 on priorities and outline of a new EU policy framework to fight violence against women.**

  - The **European Parliament Resolution of 26 November 2009 on the elimination of violence against women.** The European Parliament Resolution of 6 October 1997 on the need to establish a European Union wide campaign for zero tolerance of violence against women.

- The Ministerial Council of the Organization for Security and Cooperation in Europe's Decision No. 7/14 of 5 December 2014 on Preventing **and Combating Violence Against Women** (OSCE).

UN:

- The **General Recommendation No. 35 of the Convention on the Elimination of All Forms of Discrimination against Women** (2017)

- The **Beijing Declaration and Platform for Action in the framework of the Fourth World Conference on Women** (1995)

- The **World Health Organization** has approved a series of **Guidelines for clinical practice and policies** (2013)

  - The **Global Plan of Action** promoted by the **Resolution of the 67th World Health Assembly.**

EUROPEAN COUNCIL

- The **Council of Europe Convention on the Prevention and Fight against Violence against Women and Domestic Violence** (2011)

With the exception of the Istanbul Convention, which is directly and bindingly applied in the countries that have ratified it, the rest of the regulations and resolutions are basically recommendations that need a subsequent regulatory development and therefore do not directly link the States, when configured as mere guidelines for action.

Of these recommendations, the following stand out:

- <u>Training</u>: the main conclusion drawn is the importance of the training of health professionals who come into contact with potential victims and risk groups, in order to favor early detection. The training must be intensive, permanent and mandatory, taking into account social differences, human rights and taking a gender perspective. The training will help professionals in the sector offer effective information to the victim when requesting assistance and social resources, as well as legal support and resources.

- Coordination: It is emphasized that coordination between all professionals and institutions will be essential to favor the judicial process and avoid double victimization.
  Governments are therefore urged to increase the number of existing social means and benefits in order to eradicate gender violence.

- Pregnancy and GBV: There are hardly any specific references to gender-based violence against pregnant women, but the importance of providing more services and training to groups of health workers who are in contact with people who are more vulnerable, such as pregnant women, is stressed.

- Although great progress has been made in recent years, especially with the ratification of the Istanbul Convention, it is clear that legislation in this area is insufficient and unspecific.

Legal framework at national level to provide support to victims of gender-based violence in the health-care setting

ANALYSIS

Through this report, two differentiated and interconnected parts are presented about the legislation on gender-based violence and hospital action, at the international and national levels of the countries participating in the project: Austria, Germany, France, Spain, and Romania.

The first part was carried out researching/conducting document analysis on international and European legislation on the topic of gender-based violence and hospital action, both that with direct application such as the Istanbul Convention, as well as the whole set of recommendations, observations and decisions of international organizations, aimed at governments for its inclusion in the domestic legislation of their countries.

The second part consists of an analysis of the legislations of each setting and country in which the project is being implemented, conducted by each project partner. To do this, twelve questions have been answered by the project partners in order to obtain the information explained below:

- What legislation does the country have regarding gender-based violence and its relationship with the health sector? Given this project is aimed at the detection of GBV during pregnancy, it is important to see if the vulnerability of this group is considered in the legislation, not necessarily with the creation of specific laws aimed at the protection of GBV victims during pregnancy, but with a space within the legislation or health Center protocols given the special characteristics of pregnant victims.

- The decision making process is also important when creating both laws and protocols aimed at the prevention and detection of GBV in the health sector. The aim is to find out which public institutions are involved and whether NGOs or women's organizations can participate either directly in the working groups or indirectly as advisers.

- There is a great deal of debate about the extent to which health personnel can detect a case of gender-based violence and refer it to the relevant police or judicial authorities. It is a question of recognizing which legal asset is more important in each country, whether it is the duty of health professionals to report any cases of gender-based violence, or respect for the professional secrecy and privacy of the patient when she does not wish to initiate the reporting procedure.

In countries such as Spain and Romania, although the duty to report prevails, the debate continues. The health action protocol of the Community of Madrid explains this dichotomy: *"One of the most difficult and conflict-ridden situations faced by health professionals is the collision of legal obligations and ethical principles governing the actions of health workers. This is especially the case when women express a desire not to report, thus leaving health professionals to face the dilemma of fulfilling their duty that the law obliges them to do and respecting women's autonomy and decisions, as well as their right to confidentiality. Issuing a report of injuries without the woman's consent places the professionals in an ethical conflict, as they consider that they are violating professional secrecy and face the possible loss of the patient's trust. The law establishes and specifies the cases in which the safeguarding of confidentiality is not an absolute obligation and medical secrecy must be revealed, such as in the case of suspicion of a crime and in the case of being called to testify in a judicial process."*

- To know what the health Center process is when detecting a case of gender violence. To whom victims are reported, what kind of resources and support are provided, whether this is a standardized protocol and whether there are victim protection groups in health Centers.

- One of the most important points to detect the existence of gender-based violence is the trust and privacy that exists between the patient and the professional. Therefore, one of the objectives is to know what each country's policy is at the time of entering the consultation, if they are private or if patients can always enter accompanied. A debate is opening up around the importance of the patient going to the consultation alone. On the one hand, in maternity it is advocated that she be accompanied as a sign of the father's greater involvement in the gestation of the baby and in the mother's health, however, there is a risk. In some cases the victim is accompanied by her aggressor and if he is present during the consultation, it will be much more difficult for the patient to recognize to the medical professional that she is suffering from GBV for fear of reprisals.

- Finally, the aim is to provide a brief overview of the health coverage provided to undocumented immigrants or refugees, pregnant women and/or victims of ill treatment.

QUESTIONS:

1. Does GBV legislation include explicit references to pregnant victims in the health field?

2. Does your country have specific health care/detection protocols for GBV?

3. If so: do these protocols have specific measures for pregnant women victims of GBV?

4. What institutions/shelters do the health professionals refer the women to once a case of gender-based violence has been detected?

5. Do the national laws or protocols on gender-based violence (with or without regards to pregnancy) include the health professional's duty to report the detected cases of gender-based violence?

6. If a case of gender-based violence is detected, are there any laws regulating a preference order between doctor-patient confidentiality and the duty to report a crime you are aware of?

7. Which types of gender-based violence are considered in the laws and/or health protocols of your country? (e.g.: physical / psychological / sexual /environmental violence)

8. In the case that a woman is accompanied by her alleged abuser, are there any laws or protocols that would prevent the alleged abuser from being present during her medical consultation (including in an emergency room)?

9. Does your country's healthcare system give coverage to pregnant immigrants who are victims of gender-based violence if they are undocumented?

10. And for the refugees?

11. Which agencies or institutions participate in the process of developing legal regulations (Laws, protocols, etc.) on support in the healthcare sector for victims of gender-based violence?

12. What role do NGOs / women's organizations play in the decision-making cycle?

RESULTS

AUSTRIA

1.1 Legislation

Austrian legislation is designed to provide greater protection against domestic violence. The Federal Law on Protection against Violence was put into effect on 1 May 1997. The legislation has been amended and improved several times (2000, 2004, 2006, 2009 and 2013). This legislation includes some of the forms of gender-based violence recognized in the Istanbul Convention, such as physical, sexual and psychological violence. Legislation in GBV includes all victims of violence, but pregnant women are included but not explicitly mentioned.

In the case of Austria, in principle, doctors and other health professionals are subject to confidentiality. The duty of confidentiality may be breached as long as the patient frees the doctor from confidentiality and as the Austrian law (§ 54 para. 2 no. 3 and 4 Doctors G) says, ''the revelation of the mystery by type and content to protect higher quality Public health or justice interests is essential''. The doctor should therefore refer the complaint to the authorities whenever the victim is a minor and whenever there is serious bodily injury.

The Ministry of Health and/or the Ministry of Justice and/or the Ministry of Science, the Universities of Medicine, and the health care education institutes are responsible for the decision-making process in the creation of protocols in the health system are related to victims of gender-based violence. Regional hospital institutes and experts such as forensic doctors also participate in the development of health protocols.

To address the issue of gender-based violence, women's NGOs are invited to work with ministry officials through the creation of interdisciplinary and inter-ministerial working groups with key stakeholders.

1.2 Healthcare and Hospital Action

Austria has 30 shelters specifically for women with 766 places for them and their children. Health professionals can refer victims to them 24/7. Austria also has a 24-hour, anonymous, toll-free, national helpline for women.

In addition, Austria has another model of inter-agency cooperation in the health care sector, called interdisciplinary victim protection groups. A federal legal order has been in place since early 2011 to provide victim protection units in health care systems. According to the law, health care systems must provide a victim protection unit for children and adults. One of the key components is to recognize early domestic violence and suspicions of violence in order to strengthen staff awareness of the issue of

domestic violence. Victim protection groups have two representatives from medical services, who must be specialists in trauma surgery as well as gynaecology and obstetrics. In addition, members of the nursing service and persons responsible for psychological and psychotherapeutic treatment in the hospital must belong to these groups. The members of victim protection groups receive training in gender-based violence. A part of this training focuses on victims in a high risk situation, where pregnant women are included.

Summing up, the medical institutions are obliged to establish victim protection groups for persons affected by domestic violence. However, despite their relevance, they are not available in all public hospitals in Austria.

In case of a high-risk situation, MARAC has also been implemented in Austria/Vienna.

MARAC is a multi-agency risk assessment group that meets regularly at the local level to discuss how high-risk victims can be helped if they are at risk of serious injury or death. Violence experts, police, youth welfare, health, and other relevant institutions debate about the situation of the victim, family, and abuser, and exchange information. The meetings are confidential. Together they create an action plan for each victim. Collaboration is most effective when everyone does their part and when the strategy is clear.

In December 2010, the Vienna Intervention Center began interviewing police and other institutions to help them work together in a multi-agency partnership to prevent violence against women and domestic violence. After a trial phase, the continuation of the project was decided and the MARAC Alliance became a permanent institution for the prevention of violence against women and domestic violence, with a focus on the prevention of severe violence.

When it comes to consultation care, Austria does not have clear legislation on the possibility of the doctor preventing the companion from entering with the patient. However, in obvious cases of violence, aggression or danger, the doctor may call the police or the internal security of the hospital.

1.3 Vulnerable Sectors: Undocumented immigrants and refugees

The Istanbul Convention specifies in its article 4 that no woman can be excluded from health services, including undocumented immigrants and refugees. However, from Austria they specify that in practice, there are only a small number of hospitals that care for undocumented pregnant immigrants who are victims of gender-based violence.

2. FRANCE

2.1 Legislation

In France, the Law against Gender and Domestic Violence dates from 9 July 2010 and includes the different types of violence covered by the Istanbul Convention: psychological violence (including abuse and harassment), sexual violence and physical violence.

Legislation in GBV does not make explicit references to pregnant women victims; however, a pregnant woman can be considered "vulnerable", which could mean that health professionals file a complaint on their behalf, or that they call or the security services or the police, even if she does not want it. There is a law for people who are in a vulnerable situation due to their condition (age, physical or mental health), in which pregnant women are reflected.

The French Penal Code stresses that health personnel are not bound by professional secrecy when reporting a case of gender-based violence, provided that they consider that the woman is in imminent danger. Similarly, health personnel who make a complaint are protected by extinguishing any civil or criminal liability of those who have reported one of these cases, as long as they do not do so in bad faith.

The Ministry of Health and the Junior Ministry for Women's Rights draft such laws. NGOs / women's organizations play an important role of political pressure in the decision-making process. In this way, they influence those responsible for formulating policies and most of them take their experience and analysis very much into account. However, this type of organization faces major problem: the precariousness of resources because financing is not always assured.

2.2 Healthcare and Hospital Action

Once a case of violence is detected in a health, the victim will first be advised to contact the social workers at the center. The social worker will provide the women with several contact numbers of local women's groups (NGOs) affiliated with the Fédération Nationale Solidarité Femmes (www.solidaritéfemmes.org), or contact the victim helpline at 3919.

If the woman is in immediate danger, the health professional has a legal obligation to report the case to the police even if the woman does not want to. The French Penal Code itself exempts health personnel from their duty of secrecy in such cases because of the importance of women's safety. In addition, health personnel may decide to admit the victim to the hospital overnight in order to protect her and facilitate her referral to a shelter, thereby directly arranging for the victim to be transferred from the hospital to the shelter. Health professionals who know that a pregnant woman is a victim of violence are no longer bound by professional secrecy. Female sexual mutilation and rape are among the cases where reporting is always mandatory.

At A&E all patients are seen on their own while anybody who accompanied them must remain in the waiting room. It is NOT the case in the maternity clinics and hospitals. If they so wish, partners/husbands can be there during the entire medical consultation, i.e. the woman is never alone with the health professional.

2.3 Vulnerable Sectors: Undocumented immigrants and refugees

Illegal immigrants, as well as refugees, will have access to medical care regardless of their statutes while they are in French territory.

3. GERMANY

3.1 Legislation

In Germany, there are three major laws on gender-based violence:

1. Act on Protection against Violence (Gewaltschutzgesetz – GewSchG) of 11 December 2001. (Article 1) of the Act to Improve Civil Law Protection against Violent Acts and Stalking as well as to Facilitate Relinquishment of the Marital Home in the Event of Separation.
2. *"Polizeigesetz des Landes Nordrhein-Westfalen (PolG-NRW) § 34a Wohnungsverweisung und Rückkehrverbot zum Schutz vor häuslicher Gewalt of 25 July 2003":* This is a state law (NRW) concerning the police and how they deal in cases of domestic violence.
3. On sexual violence: New Law governing sexual offenses- neues Sexualstrafrecht (since 2016).

Psychological violence is not mentioned in any of the previous laws, however, since 1 February 2018, when the Istanbul Convention entered into force as a valid law in Germany, psychological violence is, thus, being covered by this Convention.

In addition, since 2015 the National Association of Physicians aims to implement the WHO Clinical and Policy Guidelines (Responding to intimate partner violence and sexual violence against women- 2013).

The German Penal Code, in its article Rechtfertigender Notstand -§ 34 StGB (State of necessity) provides certain exceptions to the duty of confidentiality to which health personnel are bound. First, in cases

where it is a serious offence, the doctor may decide to breach his or her professional secrecy. Secondly, if it is a minor who is at risk, the doctor is obliged to notify child protection.

Parliament and ministries are responsible for making decisions on these matters, but a wide range of national NGOs in the sector cooperate to ensure that the Istanbul Convention is implemented and monitored. National associations of physicians will also be stakeholders in the process.

3.2 Healthcare and Hospital Action

There are no specific protocols regarding the protection of victims of gender-based violence during pregnancy. However, Germany has a highly developed victim support infrastructure, with shelters and counseling centers. Similarly, a 24/7 hotline is available to victims every day of the year, where women can be helped in 15 languages other than German.

In addition, the GESINE NGO works with a specific mean of communication named "fax-proactive" between health professionals, specialized victim care services and the victim herself, who gives her express consent for the transmission of information and follow-up of her case.

With regard to consultations, there is no law or protocol that prevents the victim from entering accompanied. However, although with difficulties, the health staff can take advantage of their right in the clinic to decide who enters and who does not.

3.3 Vulnerable Sectors: Undocumented immigrants and refugees

In Germany, all immigrants who have legal residence in the country are entitled to receive regular medical assistance. Undocumented immigrants do not receive medical assistance officially, however, there are associations, doctors and organizations that provide medical care, but as it does not depend on the public sector, it is a very limited service.

Refugees registered during their asylum procedure obtain basic health care through one of these two systems: a "medical treatment certificate", paid by the municipalities or by means of a regular health treatment card, but with fewer benefits compared to the rest of citizens. Medical care in the context of pregnancy and childbirth is covered. An issue causing a lot of problems in communication and care is the common lack of adequate translation services.

4. ROMANIA

4.1 Legislation

Currently in Romania, there are two relevant laws referring to the protection of victims both modified on February 8, 2018 by the ratification of the Istanbul Convention.

Law 217/2003 – regarding the prevention and control of domestic violence and abuse.

> It includes a temporary protection order (OPP) that can be released immediately by the police officer and has a duration of 5 days. The aim of this temporary order it to protect the victim until a permanent protection order (OP) is given by a Judicial Court.
> This law does not specifically mention pregnant women, but according to it, any victim of domestic violence has the right to receive free medical care (art 6.d).

Moreover, the law 217/2003, all shelters should have a collaboration protocol with a hospital or hospital department (art. 17.6) and to offer medical care and assistance to victims that seek help at the shelter (art. 17.2). Also, penalties apply if the victim, who is in pain as a consequence of violence, does not receive immediate medical care. The social worker is the one who requests medical care for the victim (art.40, 1.a).

Law 202/2002 – regarding gender equality and equal treatment for men and women.

It introduces the terminology of gender-based violence respecting the requirements of the Ratified Istanbul Convention.

It also includes training of experts and technicians on gender equality who will be employed in local and central public authorities. This will be a new occupation, targeted at the need to integrate the gender dimension in national policies on education, workforce, social inclusion, social protection, health, and participatory decision-making processes.

Additionally, **Law 95/2006** protects all pregnant women, regardless of whether they are victims of violence; offering a series of free medical services, regardless of whether they are insured or not.

Currently, the Law includes the following types of violence: physical violence, psychological violence and economic violence.

The Romanian Penal Code includes sanctions aimed at the protection of the fetus during pregnancy and childbirth, but does not specifically address gender-based violence or the protection of mother victims. Likewise, health centers and hospitals do not have any kind of protocol or guidelines for the protection of pregnant women who are victims of gender-based violence.

The public institutions responsible for promoting, drafting and intervening in this type of legislation are the Ministry of Health, the National Institute of Public Health, and the National Agency for Equal Opportunities for Women and Men and the Ministry of Labour, Family and Social Protection.

The role that NGOs/women's organizations in the decision-making cycle. Law 52/2003 on the transparency of the decision-making process in public administration refers to the fact that NGOs can request public hearings to debate laws and government decisions; as well as public agencies of public administration that can also request these public hearings, including proposals to modify or supplement laws and government decisions of interested parties (including NGOs).

In addition, there is an inter-ministers committee (CONES – National Committee on the Equality between Women and Men), which includes representatives of NGOs as members along with public bodies representatives. This Committee has responsibilities in the field on gender equality. The NGOs which are part of this committee are: Partner Center for Equality, Association of Women and Families from Rural Areas, Romanian Women Association – they serve a term of 4 years.

The General Authority for Social Assistance and Child Protection has the obligation to organize and provide continuing education for its workers.

The continuous education and training topics are decided by the heads of the institution but employees, during their annual evaluation can express their needs for specific training. In fact, based on the annual employees' evaluations, a *Yearly Plan for Continuous Education and Training* is developed.

4.2 Healthcare and Hospital Action

OUG 18/2017 with regard to medical care for European citizens persons belonging to the European Union mentions the identification and medical supervision of pregnant women at risk of social exclusion and risk of domestic violence; as some of the activities carried out by the community health care (Article 6 H.P).

In turn, Law 217/2003 mentions the fact that victims of domestic violence have the right to receive free medical care and that emergency centres and support centres for victims of domestic violence must have protocols of collaboration with medical services and care units. It does not make specific reference to women victims who are pregnant.

Moreover, there are no specific protocols or guidelines for health care personnel to identify cases of gender-based violence, although there is a standardized plan of action. Women victims of gender-based violence are referred to specialized services, like NGOs or shelters. As an example, locally, there is Athens-Delphi that provides services as counselling, support and that also runs a shelter for victims. One of the workers of this organization has been trained under the RESPONSE project.

Another option for the referral of victims are the two following public institutions that are responsible for providing specialized support to victims of violence: The Medical and Social Welfare Authority (organized at regional/local/municipal level) and the General Authority for Social Welfare and Child Protection (organized at county level).

If there is a need for emergency medical attention, this is offered without any discrimination with respect to citizenship (Law 95/2007, Art. 98, a7).

Regarding the preference order between doctor-patient confidentiality and the duty to report, two perspectives were identified:

From the Criminal Law/Code in Romanian perspective, medical doctors are considered public servants, and all public servants have the duty to report any violence/suspicion of violence toward both adults and children.

There is priority in doctor-patient confidentiality unless the doctor considers that the life of the women or the fetus is in danger, then, in this case, the doctor has to report the case.

From an everyday practice perspective, doctors tend to respect the patient-doctor confidentiality and they do not report/refer without having the patient consent. If the patient is a minor (under 18) they do report/refer the violence.

One of the great advantages of the Romanian model is that medical consultations are generally private. Without the consent of both the patient and the physician, the patient cannot be accompanied during consultations. In the case of emergency visits, the accompanying person is allowed to wait in the rooms set up for this purpose.

Only minors are accompanied by their parents or legal guardians during medical consultations.

The reason why the consultations are private is connected with a logistics issue since hospitals are usually quite crowded which hinders the proper functioning of the hospital organization, and especially, affects the speed of the consultations. Although privacy with health personnel does not address the reason to protecting the privacy of the patient, this measure can be used to improve communication with the patient and favour the early detection of GBV.

4.3 Vulnerable Sectors: Undocumented immigrants and refugees

Although, GBV is present, there are no clear guidelines or specific training for workers in direct connection with immigrants and refugees. However, pregnant women benefit from free medical services and this measure applies as well for female pregnant refugees, since they have the same rights as Romanian or European citizens.

5. SPAIN

5.1 Legislation

Spain currently has Law 1/2004 on Comprehensive Protection Measures against Gender-based Violence and, at the level of the Community of Madrid, Law 5/2005 on Comprehensive Protection Measures against Gender-based Violence, which is not specific legislation for pregnant women, but which does, however, take into account the vulnerability and special characteristics of this group.

Also worth mentioning at the state level is Organic Law 3/2007, of 22 March, for the effective equality of women and men, which establishes in article 27 the integration of equality policy in the health system.

In hospitals and in the health Centers, a series of protocols and guidelines have been developed in which pregnant women are considered group at risk because of their especial vulnerability.

The laws on gender-based violence do not cover all types of violence included in the Istanbul Convention. National law includes physical and psychological violence, but does not recognize sexual and economic violence as GBV. One of the measures to be implemented with the recent State Pact against GBV is the recognition of sexual and economic violence as a form of GBV. National law does recognize children of abused women as victims.

The Law of 2004 includes the creation of a Technical Commission whose task is detailed in articles 15 and 16. This Commission, at state level, together with the Ministry of Health, is responsible for: promoting and encouraging actions by health professionals for the early detection of gender-based violence, as well as proposing the measures they deem necessary; developing awareness programmes and continuous training for health personnel in order to improve and promote the early diagnosis, assistance and rehabilitation of women in situations of gender-based violence; ensuring that the specialisation programmes of the social and health professions include content aimed at training for the prevention, early detection, intervention and support of victims of this form of violence. The Commission will issue an annual report that will be sent to the State Observatory on Violence against Women and to the Plenary of the Interterritorial Council.

Following the provisions of Articles 10 and 21 of Law 5/2005, in 2005, in the Community of Madrid, the Health Department, created the Technical Commission for Health Actions against Gender-based Violence to articulate and coordinate the management of GBV in the health system.

Within each hospital, since 2006, the Violence Commissions have been created to develop the protocols on Gender-based Violence, to ensure their compliance, to monitor cases and to provide training in this area to health professionals, among others.

In the Primary Health Care and Mental Health Centres there is a person responsible for gender-based violence whose functions include promoting actions against gender-based violence in the Health Centre and the community, promoting training and research, directing health care to cases, and coordination with external resources, etc.

5.2 Healthcare and Hospital Action

In Spain, at the state level, there is a common protocol for health action against Gender Violence. In the Community of Madrid, where the study was conducted, both primary health care centers and hospitals have specific support guides for the prevention, detection and care of women who suffer partner or ex-partner violence. The Hospital Care Guide has contents common to all hospital services and also specific to emergency services, outpatient consultations and hospitalization (both guides are available in an extensive and brief format, the latter facilitates the accessibility of professionals to the fundamental contents of health care).

Both Guides include information on the impact of violence on pregnancy, and includes specific questions for screening, as well as signs and symptoms of suspicion although; there is no specific protocol for pregnant women. It is also explained that the continuity in care during pregnancy both in health centers and in the hospital is an opportunity for health personnel to create a bond of trust, detect and monitor violence with women.

The case can be detected by any professional who attends the woman and depending on the psychosocial problem that this presents; it is derived to other services, including social work in the health and / or extra health field. (Comprehensive care networks for attention to GBV, NGOs, etc.)

Regarding the dichotomy between the doctor-patient confidentiality and the duty to report a crime, health personnel have the legal obligation to report. In practice, however, if women do not wish to report it, the health personnel may have an ethical conflict between the duty to report it and respect for women's autonomy and their right to confidentiality.

One of the biggest problems that health workers have when talking to victims is that they are often accompanied to consultations and, unless expressly forbidden by the woman, the doctor cannot prevent the companion from coming into the consultation, so it will be much more difficult for the woman to recognize that she is suffering a situation of gender-based violence in front of her aggressor. Even so, most protocols suggest that the woman be cared for without a companion.

5.3 Vulnerable Sectors: Undocumented immigrants and refugees

This sector is widely protected in Spain. Immigrant women victim of gender-based violence are guaranteed health care. Women in an irregular situation, regardless of whether they are pregnant or not, may obtain a temporary residence and work permit that will become permanent if a judge decrees that they have been victims of gender-based violence.

CONCLUSIONS

Regarding the international legislative framework, it is important to highlight that all countries have ratified the Istanbul Convention, which is, at the international level, the main normative reference in the field of gender violence. In addition to the Istanbul Convention, there is another set of standards that, without being directly applicable, being mere recommendations, also affect the participating countries. The most relevant are:

- General Recommendation No. 35 on the Convention on the Elimination of All Forms of Discrimination against Women (UN 2017)
- Beijing Declaration and Platform for Action (Fourth World Conference on Women, UN, 1995)
- Responding to Intimate Partner Violence and Sexual Violence against Women. WHO Clinical and Policy Guidelines. (2013)

France, Austria, Germany, Romania and Spain have a law in their internal legislation specifically aimed at combating gender violence. In the Spanish law in turn, specific mentions are made to the high risk and the special vulnerability of pregnant women victims.

The forms of gender-based violence recognized in the Istanbul Convention are: physical, psychological, economic and sexual violence. France, Romania and Germany recognize these same types of violence, while in Spain, national legislation does not expressly mention economic violence; and Austrian legislation only mentions physical, sexual and psychological violence.

For the creation of this type of laws on gender violence as well as those sanitary norms or protocols related to it, it is important to analyze who are the agents (governmental and administrative organisms, associations of health personnel, NGOs, etc.) that participate in the decision-making cycle in each country:

- France: the Ministry of Health and the Ministry of Women's Rights participate. NGOs participate actively in decision-making, influencing the formulation of policies since most politicians tend to take their opinion into account.
- Germany: the members of the government and the parliament are responsible for the formulation of laws. In the case of the Istanbul Convention, women's associations and NGOs guarantee their implementation.
- Romania: in addition to the different ministries, NGOs and associations play an important role in decision-making, being able to request a public hearing to debate laws and government decisions. There is also an interministerial committee with representatives of NGOs to guarantee gender equality.

- Spain: the laws are approved in Parliament but, as in other countries, the opinion of associations and NGOs can be important, having a strong political influence and a high capacity for citizen mobilization.
- Austria: they have a system similar to Romanian with the existence of inter-ministerial and interdisciplinary groups together with NGOs for the elaboration of laws in certain matters, including gender violence.

Another major focus of this study was to analyze and compare the hospital protocol in the detection, referral and follow-up of victims of gender violence in the health sector, in addition to knowing which staff is involved in it (doctors, nurses, midwives, social workers):

- France: when a case is detected, the victim is recommended, in the first place, to speak with the social workers of the health center. They refer the victim to associations affiliated to the *Fédération Nationale Solidarité Femmes*, or use the help line 3919.
- Germany: has a good network of social resources and shelters, as well as a telephone helpline for victims in up to 15 different languages. Some associations collaborate with health centers to do the follow up of victims.
- Romania: women victims detected are referred to specialized social services such as NGOs or public institutions. The two main public institutions are The Authority for Medical and Social Assistance at the local / regional level and The General Authority for Social Assistance and Child Protection at the state level.
- Spain: once a case is detected, the victims are referred to the social workers of the center who in turn refer the woman to one of the specialized services such as the Women's Municipal Point, ONGs or directly to the police or to the court.
- Austria: in some public hospitals, a group of professionals in gender violence has been created, MARAC. They meet regularly to track victims and make decisions based on the risk to which they are exposed. They are made up of different professionals, medical nurses and midwives, gynaecologists and obstetricians.

Much emphasis has also been placed on the ethical, moral and legal duality between professional secrecy and the duty to denounce, and these have been the conclusions of each participant's model:

- France: there is no obligation to report as professional confidentiality takes precedence; however, in cases of rape or female sexual mutilation there is the duty to report.
- Germany: the duty to report takes precedence if there has been a serious offense and there is always the duty to report if the victim is a minor.
- Spain and Romania: from a legal point of view, as health professionals are considered public officials, they have the duty to report. In practice, if the victim does not want to report the incident the health professionals tend to respect the victim's personal decision. In the case that the victim is a minor, the duty to report always prevails.
- Austria: professional confidentiality can be broken if the victim is a minor or if a bodily injury is serious. There is no specific protocol mentioning the alleged abuser, the information mentioned above refers to any case of patients being accompanied to the medical consult.

At the time of entering the consultation, we find that in most of the countries analysed, the victim will be accompanied, except for the particularity of the case of Romania:

- Germany, Austria, and Spain: allow accompaniment during visits if the patient and doctor agree. When we have a case of gender-based violence, if the victim is with her aggressor it will be difficult to prevent him from accompanying her to the consultation if the victim doesn't

verbalize it. In Romania medical appointments are considered private, but it is common to allow accompaniment during visits if both doctors and patient agree.

- France: the patients cannot enter accompanied in A&E, but they can in maternity appointments.

Finally, if we analyse the health coverage that is offered to undocumented immigrants or refugees who are pregnant, we see that although international legislation favours equal access to all health resources, each country has its peculiarities:

- France and Spain: has comprehensive protection for immigrations since they all have the right to health care and those that demonstrate that they are victims of gender-based violence can acquire a residence permit and a work permit.
- Germany: protection varies from one state to the other.
- Romania: have free health protection for immigrants but no specific information related to pregnancy was found.
- Austria: only a small number of hospitals offer assistance to pregnant immigrant women.