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

RESPONSE

WS 4 WORKING PAPER

Mapping national and local actors in addressing gender-based violence: a multi-agency approach

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INTRODUCTION

Gender-based violence is widely recognized as a problem that hurts women globally, regardless of ethnicity, socio-economic status or religion. According to World Health Organization estimates (WHO, 2014), around 35% of women worldwide have experienced partner violence or non-partner sexual abuse, with some regional variation. Gender-based violence is a violation of human rights, damaging individuals and families with severe social and economic consequences, requiring a society-wide response. It also damages health, posing a challenge to public health policy and clinical services. Thus, as part of a multi-sectoral response, health care services and public health programmes need to be engaged with adaptation to national and local contexts.

This working paper is part of the RESPONSE Project: *Multi-agency response for reporting of GBV in maternal health services*, a two-year project which received funding from the Rights, Equality and Citizenship (REC) Programme (2014-2020) of the European Union under grant agreement no JUST/2015/RDAP/AG/MULT/9746, that aims to increase maternal health care response to gender-based violence (GBV). Capacity building activities were implemented in partner countries to support disclosure of abuse, referral to specialised services and safety planning for women accessing maternal health services. The activities took place in five EU countries: Austria, Germany, France, Romania (project coordinator) and Spain; with the support of GBV researchers and policy experts at the University of Bristol, UK, for the project evaluation.

This working paper is part of workstream 3 activities of the project, **aiming to identify the main actors (stakeholders and agencies) addressing gender-based violence at different levels in five countries**, exploring their relations and analysing how policy decisions are formulated and implemented or not. A mapping tool was used to visualize information pathways and further development of measures and policies between stakeholders and agencies involved in GBV prevention. A public policy analysis framework was used - **Actor and Interaction Mapping** (Fisher, et al, 2000) -, which articulates stakeholder interactions and dynamics and the emergence of policy decisions from those interactions. The decision-making cycle was identified, and main actors mapped in each country. The focus was on the main actors involved in the process of identification and referral of victims of GBV, starting from a specific setting (maternal health clinics) and mapping a multi-sectorial pathway to respond to the problem of gender-based violence in these settings, from different perspectives and levels.

BACKGROUND AND AIMS

There are a range of analytic methods within public policy research (education, health, administration, security) for understanding cycles of policy decision-making (Divjak and Begicevic Redep, 2015; Gorgulho et al, 2015). Approaches such as multi-criteria decision-making methods, including Analytic Hierarchy Process (AHP) and Analytic Network Process (ANP) are frequently used, based on cost-benefit analyses and aiming to characterise hierarchical power relationships between stakeholders (Saaty, 1994; Liberatore and Nydick, 2008). This methodology was not suited for our analysis for three main reasons.

First, the aim of our analysis was not restricted to identifying, mapping and understanding actors within hierarchical structures. We wanted to better understand how they interact, what was the nature of their interaction and how this interaction could inform better implementation of policies addressing gender-based violence. Second, in this paper we targeted to provide a visual instrument that explains decision-making cycles and could be applied ad a guiding tool by stakeholders and policy makers outside the RESPONSE project, as a sustainable component to guide future analysis of stakeholders' involvement and decision-making. Third, this instrument should be adaptable for different settings, which represents a key feature of Actor and Interaction Mapping. Moreover, while this instrument does highlight power structures, it also reveals interactions between actors that, at a first glance, might seem marginal.

Therefore, Actor and Interaction Mapping (Fisher, et al, 2000) offered a more holistic approach to characterising stakeholder relationships than other methods, consistent with the multi-agency approach of the RESPONSE Project Framework. Originally developed for conflict analysis, this method is based on identifying all actors and contributors to policy decision-making processes, assessing their roles in the process and characterising the range of relationships (Fisher et al, 2000). This has allowed us to map the multi-sectorial response to gender-based violence in each country, highlighting the different layers of interaction and identifying the key actors in the national and local context.

METHODS AND DATA COLLECTION

For the development of the mapping, we used a range of data sources. A general overview of stakeholders in each country was specified in the situational analysis conducted as part of work stream 1 (Situation Analysis Report, 2017) and in the RESPONSE Manual, as part of WS2 (Johnson et al, 2017). Combining the results of situational analysis (work stream 1), training evaluation and follow-up meetings (work stream 2) and document analysis (work stream 3) additional actors and different types of relationships were identified amongst actors which have a role in the pathway of identification and referral of victims of gender-based violence. These roles had served as the basis for multi-agency cooperation and guidance for the mapping process. This *working paper* is reporting designing the analysis for each setting in which the RESPONSE training and capacity building was implemented: Paris Port-Royal Maternity Clinic (FR); Gemeinschaftskrankenhaus Herdecke (GKH) Maternity Clinic from Ennepe-Ruhr-county (GER); Gynaecology and Neonatology Clinic I, Cluj County Emergency Hospital, Cluj-Napoca (RO); Hospital 12 de Octubre, Madrid (ES) and the Maternity Clinic from the General Hospital from Vienna (AT).

The process of data collection started in the first part of the project (work steam 1), when the situation analysis was conducted. A semi-structured interview guide was developed, and it included sections addressing questions about multi-agency responses and infrastructure and mechanisms in place, among others. Respondents were chosen by maximum variation sampling in order to gather information from people with experience and different roles in the field of GBV, focusing on the health care perspective, including the following categories: health care professionals and social workers (working in/with the clinical setting) and policy makers (outside the clinic). These interviews were recorded, transcribed and analysed thematically. A second data set was generated during training evaluation and follow-up meetings (work stream 2) using interviews and focus groups as methods of data collection. The scope of the meetings were the obstacles health care professionals encountered in trying to implement the training in terms of identification of GBV patients and referral. Additionally, information from communications and documents analysed in work stream 3, as part of identifying the national GBV legal frameworks in partner countries, was used.

As an output of work stream 2, The RESPONSE Project Framework (Johnson et al, 2017), identified four main stakeholders:

1. Public Authorities
2. Women's Health Services
3. Women's Support Services
4. Lead Organization

These stakeholders have a role in the pathway of identification and referral of victims of gender-based violence, thus representing the foundation of the mapping process. In addition, for identifying all the other stakeholders and the types of relations they have, the questions below further guided the mapping and characterising the multi-agency response to gender-based violence in each setting:

1. Who are the stakeholders involved?
2. How do they interact?
3. What kind of relationships do they have?

4. Are there any stakeholders that could be considered to be or able to become the lead organization?
5. Are there any external stakeholders relevant to the response to GBV but not directly involved in the decision-making process?

We have used boxes to indicate stakeholders and arrows to characterise type of interaction.

Figure 1. Symbols used for mapping multi-sectorial interaction

Lines among actors indicate different types of relationships, such as:

Straight Line – represents a strong connection among actors, a form of interaction and partnership

Dotted line – represents a form of interaction or communication that is not very strong, is informal and is not enforced by an agreement or a cultivated relationship.

Arrow – Predominant direction of influence or activity

This method allows the visualisation and understanding of all actors involved, how they interact and what type of relationship (if any) they develop among each other.

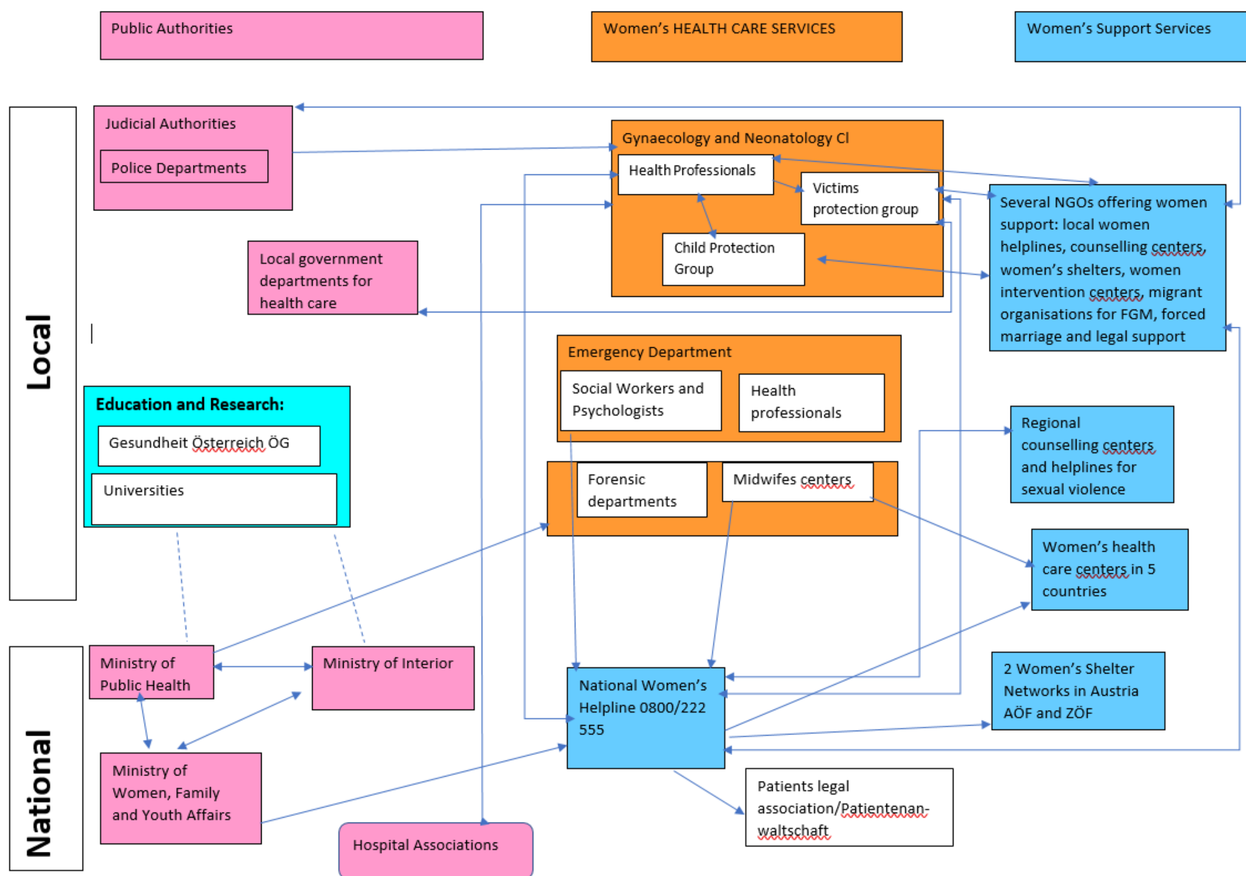
RESULTS

MAPPING OF STAKEHOLDERS' INTERACTIONS CONSTITUTING THE MULTI-AGENCY RESPONSE TO GENDER-BASED VIOLENCE

AUSTRIA

Below is the specific analysis in Austria, together with the different stakeholders in table format. The analysis shows which stakeholders were identified in the specific case of one maternity clinic (women's health services clinic), the relations between stakeholders and an overview of their interactions, articulating the multi-agency response to gender-based violence, including the role of health services.

Figure 2.



Descriptions of Stakeholders' Interactions

We allocated a distinct colour to each main category of stakeholder identified in the RESPONSE framework. The level of action categorisation was based on the reach of the identified institutions, differentiating between local and federal (national) level.

Austria is a federal country, being formed of 9 states. The federal government can pass federal laws, which are mandatory for all states, such as the *Medical Act* including reporting obligations or the *Law for the Implementation of Child and Victim Protection Groups.* Each state can regulate its own laws for the health care system. Each state

has so-called "hospital associations," which can determine human and financial resources, working hours and assess other human resources needs.

Austria has 270 hospitals, but not all of them have obstetrics and gynaecology departments. Not every hospital has a forensic department, but every state has forensic departments where documentation of injuries and violence can take place.

In Austria, medical, nursing and midwifery schools are responsible for the training of health care professionals. At federal level, there are several universities, but each state has nursing and midwifery schools. While medical universities are supervised and financed by the federal Ministry of Science, Research and Economy, they have autonomy in curriculum design and decision-making process.

Medical University have autonomy, they belong to the Ministry of Science. For the other schools (for nurses and midwives) or other professional trainings, activity is coordinated by the Ministry of Social Affairs and the Ministry of Health. The Ministry of Health is responsible for federal legal regulations in the health care system and also for the funding of measures and projects in the sector.

Austria has legally introduced the victim protection groups (officially called Interdisciplinary Victim Protection Units) through a 2011 federal law. This means that all hospitals are obliged to implement the law and organize Victims Protection Groups. State governments are responsible for financing the groups. However, not all hospitals have these groups established and functional. In comparison to this situation, child protection groups have been established in hospitals for more than 15 years.

The main role of victim protection groups from hospitals is to recognize early domestic violence and suspicion on violence in order to strengthen sensitization of the staff for this issue. Moreover, Victim Protection Groups offer trainings on gender-based violence to health care professionals and offer support to the professionals that deal with victims of GBV. The federal state has introduced a standardized documentation sheet for documenting injuries and victim protection groups inside hospitals collaborate with health care professionals in order to have this standardized documentation used correctly in all cases of GBV.

For these professional trainings, the victim protection groups collaborate with experts from the Women NGOs sector, especially with women protection institutions, and offer training together. The transfer to victim protection facilities takes place directly through the victim protection groups or directly through the health workers.

In five states there are also women's health care centres, that are committed to promoting and supporting a healthy lifestyle. As a focal point, the centres offer support and advice on a variety of topics that address physical and mental health, and also counselling for female genital mutilation victims.

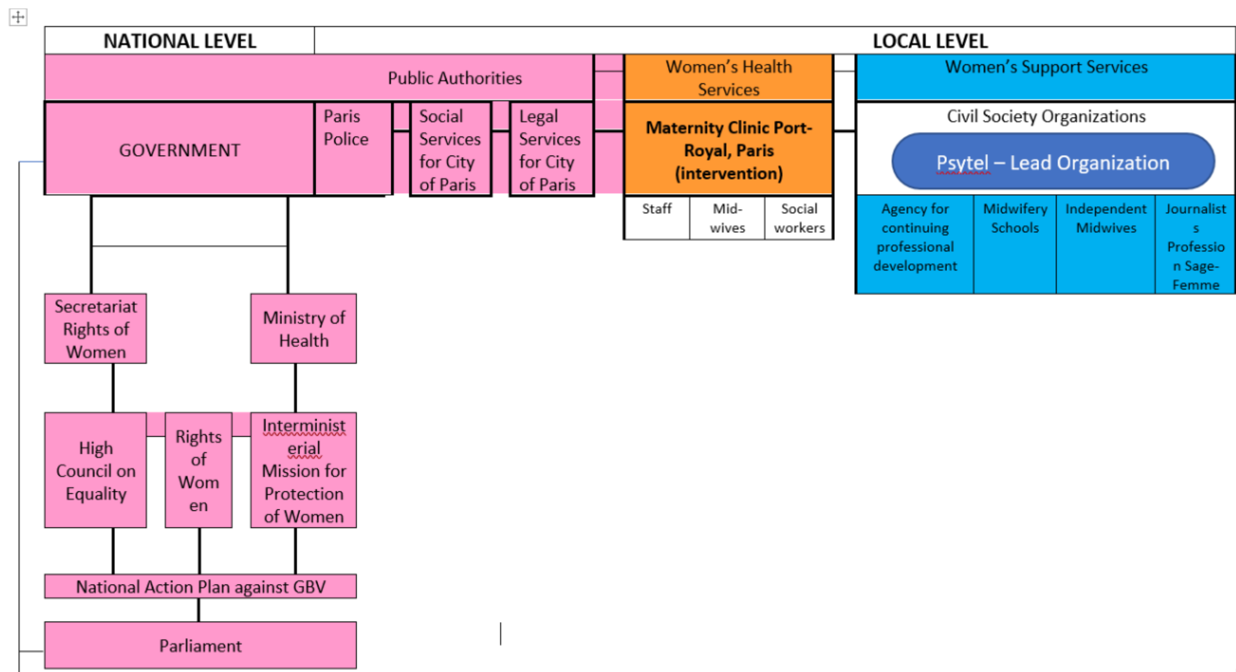
Austria has a national women helpline against violence (24/7) and 30 women shelters. The shelters and support services are organized in the following manner: one shelter for women and girls affected by forced marriage, one emergency shelter for trafficked women, intervention centres for domestic violence with the pro-active approach in all nine federal states, six counselling centres against sexual violence against women and numerous women counselling centres and migrant counselling centres and legal support organizations.

In addition, according to the state legislation, Austrian police officers are obliged to expel perpetrators from the home for 14 days. Usually, in these situations, the intervention centres get the information from the police for each complaint and the staff of the intervention centres contact the victim and offer them specific support (psychological support and legal assistance).

FRANCE

Below is the specific analysis in France, together with the different stakeholders in table format. The analysis shows which stakeholders were identified in the specific case of one maternity clinic (women's health services clinic), the relations between stakeholders and an overview of their interactions, articulating the multi-agency response to gender-based violence, including the role of health services.

Figure 3.



Descriptions of Stakeholders' Interactions

We allocated a distinct colour to each main category of stakeholder identified in the RESPONSE framework. The level of action categorisation was based on the reach of the identified institutions, differentiating between local, and national level.

Psytel is the Paris based NGO that act as a lead in the Paris context of identifying and referring gender-based violence victims. As a lead, Psytel has interactions with all actors from local level, and in addition, being part of civil society organization, it impacts national policies and actors in the field of gender-based violence through advocacy projects.

At the national level, Psytel collaborates closely with the Inter-Ministerial Mission for Protection of Women who leads the coordination of the National Action Plan again GBV for all of France, in collaboration with the Secretariat for Rights of the Women, Rights of Women Service, Ministry of Health and the High Council. The plan has to be ratified by the French Parliament and serves as a legal document to ensure that budget and services are allocated at national level for prevention of GBV. The public authorities work with women's health services, women's support services and with the various government bodies.

At the local level Psytel chose the intervention maternity clinic Port-Royal to perform trainings on-site for medical staff, midwives and social workers at the clinic who all come into contact with women's support services and women's health services. Nevertheless, as the map indicates, at local level, actors that belong to all three main

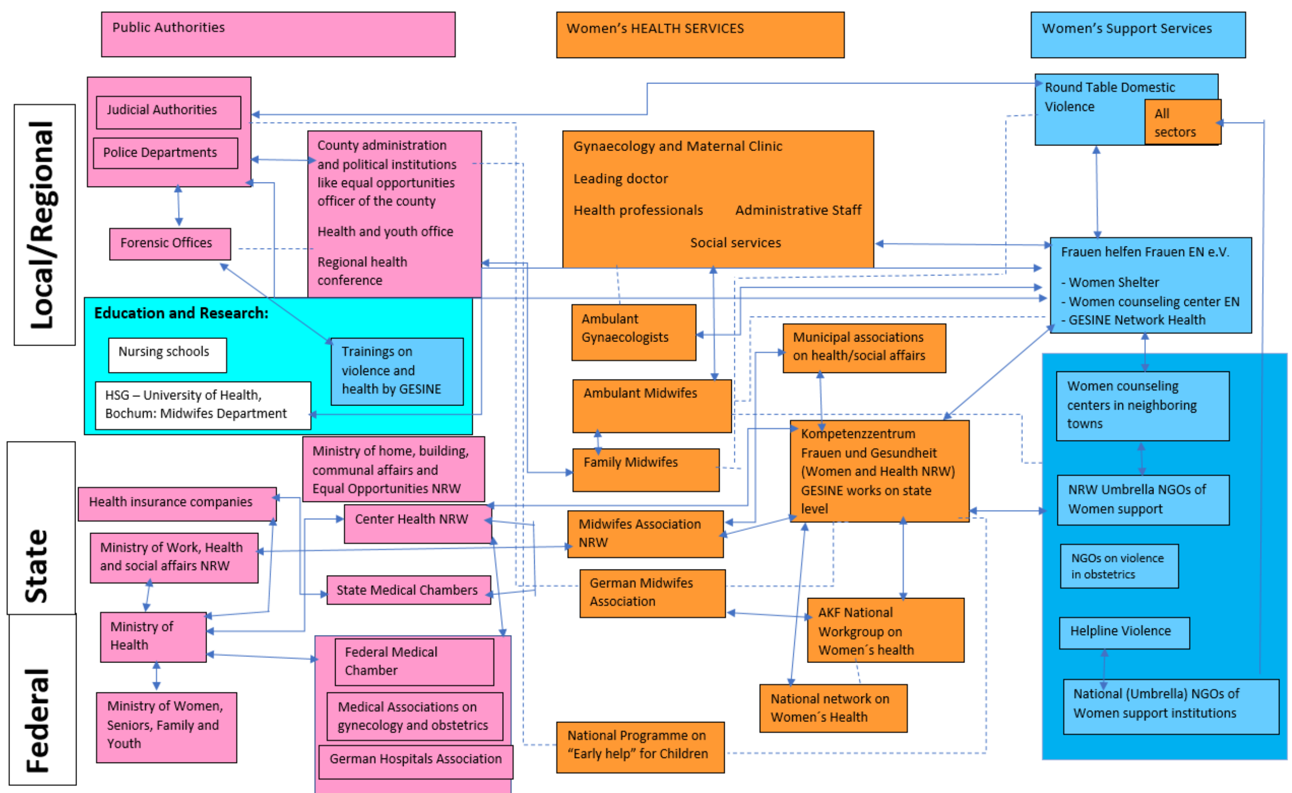
stakeholders (Public Authorities, Women's Health Services and Women Support Services) have interactions among each other and collaborate in the process of identification and referral.

In this project Psytel also contacted the Baudelocque Midwifery School as well as the agency for continuing professional development for developing a teaching module.

GERMANY

Below is the specific analysis in Germany, together with the different stakeholders in table format. The analysis shows which stakeholders were identified in the specific case of one maternity clinic (women's health services clinic), the relations between stakeholders and an overview of their interactions, articulating the multi-agency response to gender-based violence, including the role of health services.

Figure 4.



Descriptions of Stakeholders' Interactions

We allocated a distinct colour to each main category of stakeholder identified in the RESPONSE framework. The level of action categorisation was based on the reach of the identified institutions, differentiating between local, state level and federal (national) level.

1. Federal Level

Germany is a federal republic, that encompasses 16 states. Germany already has a second federal Action Plan on Gender-based Violence, which will be revised in 2019. Also, many states have their own Action Plans on gender-based violence; for example, in North-Rhine-Westfalia (NW), the plan was adopted in 2016. In this sense, some

measures and policies are decided and implemented on federal level, others on state level, depending on the laws and regulations.

The Ministry of Health and the Ministry of Women, Seniors, Family and Youth are the federal actors that decide policies in terms of gender-based violence.

GESINE, which is a local NGO, is active in projects on federal and state level, being the lead organization. GESINE has connections with both the ministries mentioned above first, by being part of the federal working group (Federal Bond-states-Workgroup – FBSW) on domestic violence for many years (representing the NW state association of women shelters) and second, by being a member of AKF – a national (feminist) association on women´s health, whose members are mainly female health workers. The specialized AKF working group focuses on women survivors of gender-based violence – and their children - and currently formulates recommendations for stakeholders on federal and state level. As part of the group, there are two federal NGOs with mandate in the field of obstetrics/maternal violence. The stakeholders with whom both GESINE and AKF interact are: the Medical Associations on Gynecology and Obstetrics, Medical Chambers, German Hospitals Association, Health insurance companies and the Ministries mentioned above. Also, the national programme on "Early Help" for children (financed by federal and state ministries) will be included in the AKF-workgroup priorities.

The federal umbrella organizations of women support services (shelters, counseling, rape/sexual violence centers) and the German Violence against Women support HELPLINE are cooperating with AKF or with the National Network on Women's Health (NNWH), and most of them participate in the FBSW. GESINE/KFG is in contact with all the organizations and groups mentioned above.

2. State Level

For this map, we chose to illustrate the example of Northrine Westfalia (NW), a German state in the "far west" of Germany that has the largest population of the 16 German states (17.91 Mill.). NW is also the home state of GESINE. The Ministry of Work, Health and Social Affairs NW and the Ministry of Home, Building, Communal Affairs and Equal Opportunities NW are the political stakeholders in the field of gender-based violence. Also important are the two Medical Chambers NW (the professional bodies of medical doctors in NW) and the Health Center NW, mandated by the Ministry of Health NW.

Kompetenzzentrum Frauen und Gesundheit NRW (Competence Center for Women and Health NW, KFG) is a state financed programme run by GESINE (and a health department of the University of Bielefeld, NW). KFG is also a member of the National Network on Women´s Health (NNWH), a network of organizations mainly working on federal, sometimes state level on women´s health, for example, the German Association of Midwifes. The Midwifes Association NW is a stakeholder that collaborates with both health care professionals and women support services organizations.

The Municipal associations on health/social affairs are important players in many health fields and GESINE cooperates with them on the topic of disabled women/girls and violence, and young people (girls and boys) and violence - gender-based violence survivors in the maternal context need to be addressed newly.

Shelters and women counseling centers in the regions (as rape crisis lines/centers) have all got umbrella organizations on state level. These are partners in the statewide network Women´s health & violence, founded and organized by KFG/GESINE.

3. Local/Regional Level

GESINE and RESPONSE Project Clinic Gemeinschaftskrankenhaus Herdecke are both situated in the small-town/rural county Ennepe-Ruhr-county (about 325 000 inhabitants, 9 cities). Gemeinschaftskrankenhaus Herdecke (GKH) is the hospital were the project was piloted. The process of implementing the trainings and the victim protection group went relatively smoothly, medical professional being interested in the trainings and the topic. The referral procedure was more challenging; only women who experienced acute physical violence were referred to specialized counseling. The social workers/social service in this hospital (as in most German hospitals) have very distinct tasks; dealing with patients experiencing violence was not included in these tasks, therefore

they weren´t able to participate in the RESPONSE training. One leading nurse participated in the RESPONSE training, but the nursing staff was reluctant to invest more ("too much work to do").

The maternal clinic of GKH cooperates with the county's women shelters (NGO Frauen helfen Frauen – women help women - EN. E.V) and the relationship is a dual one. This fact is caused by the high number of pregnant women from the shelters. GKHs partnership with the county's women counseling centers (three sites in different cities) existed before RESPONSE, but wasn´t well known in the clinic. Quite rarely a counselor drives to GKH for on site or at-the-bed counseling. Female patients in GKH also need contact/addresses from shelters or women counseling centers in the neighboring towns, because many don't live in EN-County. All the shelters (mostly feminist NGOs and counseling centers) in the region cooperate among each other.

GESINE (as the "health unit" of NGO Frauen helfen Frauen EN e.V.) had no strong ties with the maternal clinic of GKH before RESPONSE, but the situation changed within the project. In addition, GESINE has enabled forensic documentation training. In this sense, the clinic became a safe site for confidential forensic documentation and care in cases of sexual violence/rape. The maternal clinic is now a regular partner in the GESINE Network Health. Moreover, GESINE is a member of the Roundtable on Domestic and Sexual Violence, together with healthcare professionals, women support institutions, the public/political sector, police. RT is organized and led by the equal opportunities officer of the county, who has a strong networking position.

Midwifes are trained either in Wuppertal (neighboring city) or for some years now academically in Bochum (another neighboring city) at HSG – University of Health. GESINE provides trainings regularly as part of "Violence and Health" project in different nursing schools and at HSG Bochum for midwives.

Ambulant midwifes in Germany very often work part time in clinics and they provide medical care through home visits to pregnant women. Same for "Family midwives", employed by the (some) city councils and in charge of young families in difficult or precarious situations (not very often the case in GKH maternal clinic).

Usually, women coming to a maternal clinic in Germany have access to services offered by an ambulant gynecologist (and an ambulant midwife, too, in case of clinics like GKH) who is the medical caregiver for the pregnancy period and shortly after the child was born. Health care professionals are willing to implement RESPONSE protocols, but there are confidentiality and privacy limitations in some cases.

In Germany there are maternal clinics that already have protocols in place for identifying and referring women. However, maternal clinics still have room for improvement and implementation of RESPONSE protocols.

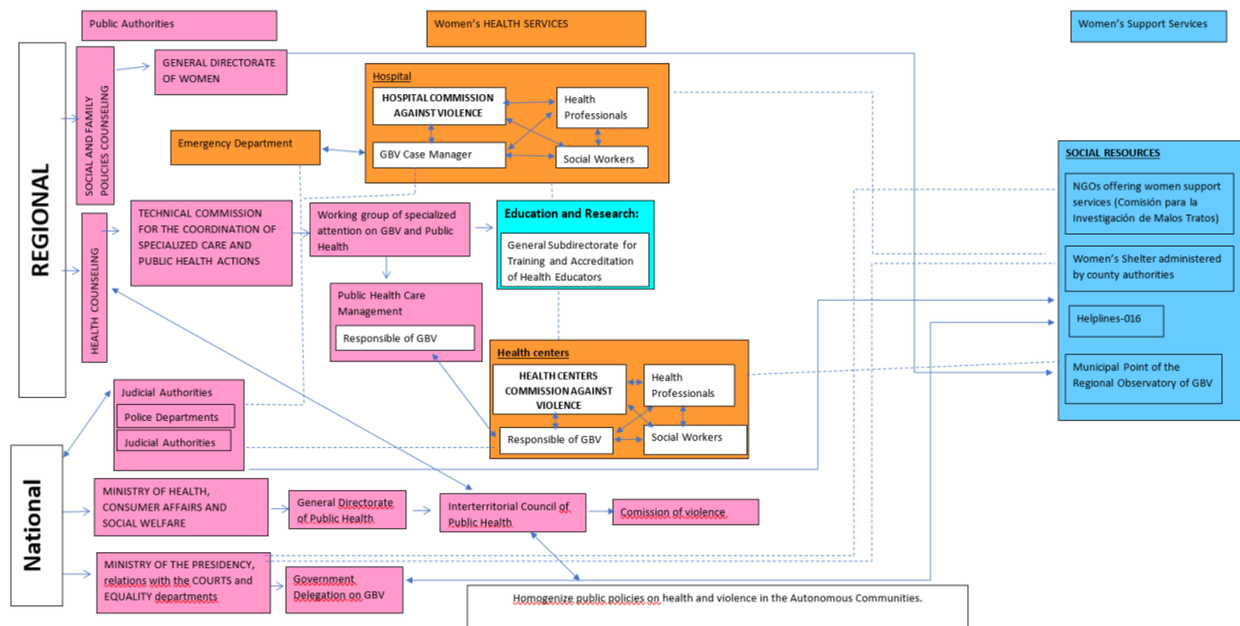
Germany has (at least) two networks for and by women/girls with disabilities and chronical illnesses – one on state (NW) level, one on federal level (= Weibernetz e.V.). Violence represents a problem for both these categories of women, and women's sexuality and reproductive rights are not protected enough through clear measures. GESINE/KFG cooperates with these networks, but the emphasis is not on maternal health yet. In addition, there are other categories of women (lesbians, migrants, refugees) that might be victims of gender-based violence and their interests are not well represented by NGOs or state institutions.

- ✓ In addition, similar to GESINE's mandate, Signal intervention e.V. Berlin works in both national and international projects, addressing state level challenges in terms of health and violence. Signal intervention e.V. Berlin is connected to clinics and healthcare professionals and it will implement a protocol of victim's support groups inside Berlin clinics.

SPAIN

Below is the specific analysis in Spain, together with the different stakeholders in table format. The analysis shows which stakeholders were identified in the specific case of one maternity clinic (women's health services clinic) from Madrid, the relations between stakeholders and an overview of their interactions, articulating the multi-agency response to gender-based violence, including the role of health services.

Figure 5.



Descriptions of Stakeholders' Interactions

We allocated a distinct colour to each main category of stakeholders identified in the RESPONSE Framework. The level of action categorisation was based on the reach of the identified institutions, differentiating between two levels: national level and autonomous community level (regional level).

1. National level.

At the national level, the actors that have been identified are or depend directly on different ministries and their work is directly linked to the institutions of the Autonomous Communities, as well as to the agencies or organizations that provide aid services to women, such as NGOs, helpline, women's attention points, etc. The main actors identified at the national level are: the Ministry of Health, the Consumer Affairs and Social Welfare, the Ministry of the Presidency, collaborating with the Courts and Equality, the General Directorate of Public Health, the National Interterritorial Council of Public Health, the Delegation of the Government in GBV, the helpline016, and different NGOs that act independently at the national level.

The General Directorate of Public Health is the actor responsible for developing and implementing all the policies related to health promotion and disease prevention (epidemiological information, health promotion and prevention of diseases, occupational and environmental health, and sanitary-hygienic requirements of the products for the use of human consumption). It collaborates directly with the Ministry of Health, the Consumer Affairs and Social Welfare and manages the National Interterritorial Council of Public Health, which is the coordinating body designed primarily to ensure equity in health care for all citizens from different Autonomous Communities. The National Interterritorial Council of Public Health is responsible for homogenising policies between the different Autonomous Communities and therefore has a direct relationship with the Department of

Health of the Community of Madrid, although they are independent bodies. It also manages the commission of violence.

The Delegation of the Government in gender-based violence is responsible for implementing and promoting the Government's policies against different forms of gender-based violence. It reports to and collaborates directly with the Ministry of Equality. It is responsible for managing the Helplines 016. It has an indirect relationship with NGOs and women's shelters and women associations.

There are several organizations and institutions of women working to combat gender- based violence and promote effective equality between men and women. The mandates of women's organisations are very diverse and include psychological, legal and social support and advice to victims, as well as advocacy programmes for the promotion of legislative changes, trainings and social awareness campaigns. They represent one of the main social resources for women within the victim support structure. Many of them depend on national public subsidies, although they have private management. They are perceived as a service to the public, so they collaborate with all the institutions as a social resource for women. They form a network with the rest of social resources, as well as with the police and judicial departments.

2. Regional level (Community of Madrid)

The administration of the Community of Madrid is organized in Departments, and the most relevant in Madrid area are: the Department of Social and Family Policies of the Community of Madrid and the Department of Health of the Community of Madrid. The Department of Social and Family Policies of the Community of Madrid is responsible for the development of policies of equality between men and women and gender-based violence. It coordinates the General Directorate of Women which is responsible for implementing policies that promote equality between men and women and the fight against gender violence and manages the Municipal Point of the Regional Observatory of GBV.

The Health Department of Community of Madrid is responsible for the proposal, development, coordination and control of the execution of the policies of the Government in the Community of Madrid. Gender-based violence in the health system is coordinated in the Community of Madrid by the Technical Commission of Actions in Health against the gender-based violence. This structure was created in 2005 and promotes the activities of prevention and reporting of gender-based violence. The work and activities developed by this Commission have a public health approach. The Technical Commission of Actions in Health is made up of health professionals who represent different units from the Ministry of Health, so they create various networks of professionals from the health field, but at meetings the General Directorate of Women participates, without voting rights. This commission coordinates the activities of the Hospital Commissions against Violence and the Responsible for GBV from the Health Centres. It organises training courses that are managed by each network and approved by the Sub-directorate General for Training and Accreditation of Health Educators.

In the public hospitals of the Community of Madrid there are, since 2006, the Hospital Commissions against Violence, advisory bodies of the Technical Assistance Board and of the Medical Management (Assistance Management of the Centre). The Hospital Commission against Violence is responsible for establishing a standardised and integrated guideline for action in the field of violence (general understanding of the concept of violence, not only gender-based violence). The Hospital Commission against violence is the key element for the identification and care of victims of gender violence. They develop teaching activities both in their own center and for the centralized training courses. They carry out actions in the field of referral in terms of collaborating with companies and promoting corporate social responsibility activities. They have promoted task force units with other social assistance actors, State Security Forces and community resources in their area of reference. They develop research projects and elaborate specific protocols. They are in each hospital of the Community of Madrid and collaborate directly with all the health professionals from the hospital. Indirectly, they have relations with the police, judicial resources and social resources. The commission against violence of the Hospital 12 de Octubre meets once a month, although due to increased daily activities, sometimes the meetings are held every two months.

The social worker is the referral figure in the hospital for gender-based violence cases. The Hospital 12 de Octubre is one of the largest in Spain with a large number of social workers, however, they do not work full time so there are times when health professionals cannot contact the social workers because there is no one working or because they have a large amount of work.

Since 2013, in each Health Center there is an officer responsible for gender-based violence. Within the Primary Care Management Team there are seven individuals responsible for GBV, one for each Healthcare Center. The person responsible for gender-based violence is expected to offer support and motivate health staff in order to promote the implementation of gender-based violence tools, to disseminate clinical practice guidelines, action protocols, etc. In addition, the responsible officer is meant to be involved in activities that promote the prevention of gender-based violence within all programmes, especially those of health education that take place in the center.

Likewise, they are the professional responsible for channelling uncertainties about responding to GBV and offer suggestions for the rest of the health center team. The responsible officer for GBV collaborates with the Technical Commission on health actions against GBV and the Department of Health. Indirectly, the responsible collaborates with the police, judicial resources and social resources.

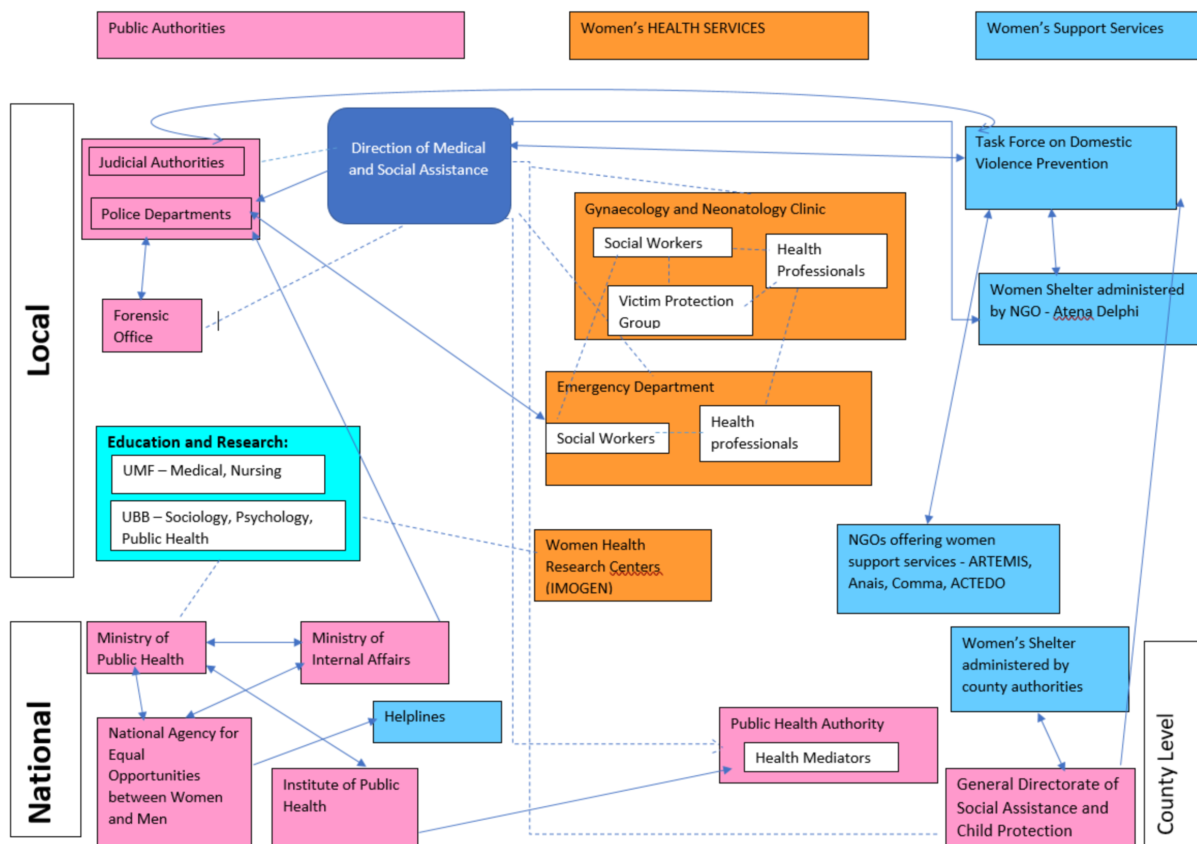
Judicial Authorities and Police Departments are indirectly related to all the professionals who report a case of GBV and with the social workers.

It is important to highlight that this is not an official organizational chart, but a representation of decision-making processes in in the health field regarding gender-based violence, emerging from the interviews in WS1.

ROMANIA

Below is the specific analysis in Romania, together with the different stakeholders in table format. The analysis shows which stakeholders were identified in the specific case of one gynaecology and neonatology Clinic (women's health services clinic), the relations between stakeholders and an overview of their interactions, articulating the multi-agency response to gender-based violence, including the role of health services.

Figure 6.



Descriptions of stakeholders' interactions

We allocated a distinct colour to each main category of stakeholder identified in the RESPONSE Framework. The level of action categorisation was based on the reach of the identified institutions, differentiating between local, county level (regional level) and national level.

Romania has actors that interact on three main levels, which correspond with the national administrative system: national level, county level and local level.

1. National Level

At national level, the identified actors are mainly governmental bodies, ministries and agencies, and they have interactions with both institutions from the same category, but also with institutions and stakeholders from the local and county level. The main stakeholders identified are: The Ministry of Public Health, the Ministry of Internal Affairs, the Institute of Public Health, the National Agency for Equal Opportunities between Women and Men and

National Helpline. Except the Helpline which was identified as a direct women's support services, all the stakeholders mentioned above are public authorities.

The Ministry of Public Health coordinates all the policies in the health sector, including clinical services, and collaborates directly with the Ministry of Internal Affairs and the National Institute of Public Health. It has a weaker relationship with *Education and Research* category, more specifically with Medical and Nursing Schools, as there is a weak influence of the Ministry over medical schools decision-making process (in Romania, universities have autonomy in curriculum design and decision-making process).

A top down relationship has the Ministry of Internal Affairs with the County Police Inspectorates, but this type of relationship is similar to all governmental institutions that have local branches. Consistent with that relationship, the National Institute of Public Health coordinates the policies of local and county level public health authorities.

The National Agency for Equal Opportunities between Men and Women is responsible for coordinating all policies in the field of gender-based violence and is the national institution that provides direction and brings together all national stakeholders that work in the field, such as: the Ministry of Public Health, the Ministry of Internal Affairs, The Ministry of Justice, The Ministry of External Affairs and Ministry of Education and Research, having a collaborative relation with all of them. In addition, it funds the national Helpline, service that offers 24-hour support for the victims.

While at national level, The National Agency for Equal Opportunities between Man and Women has signed various protocols with several national ministries, not all of them are represented in the chart. While we acknowledge the relevance of each actor, clear steps in the field of gender-based violence prevention were taken mainly by the Ministry of Interior and Ministry of National Health. However, the Ministry of Justice has taken ownership in developing a National Register of Protection Order, but the evolution of this project is still uncertain. In addition, at Governmental level, there is an inter-ministerial commission that has a mandate in coordinating activities in the field of prevention and combating gender-based violence. Though, all these initiatives are beneficial, The National Agency for Equal Opportunities between Man and Women is the institution that has an active role in consulting other organizations, initiating policies and coordinating activities.

2. County Level

At county level there are two categories of stakeholders: the General Directorate of Social Assistance and Child Protection and the Public Health Authority as public authorities and Women's Support Services. Although shelters are funded by public authorities (the General Directorate of Social Assistance and Child Protection), some of them are administered by NGOs, therefore, shelters were included in the women's support services category.

3. Local Level

At local level there is dynamic interaction between stakeholders that belong to all main categories mentioned above: public authorities, women's health services, women's support services and education and research.

From the Public Authority category, these are the main stakeholders identified: Judicial Authorities, Police Departments, the Forensic Office and the Direction of Medical and Social Assistance.

Both Judicial authorities and police departments collaborate directly with the Task Force Units on Domestic Violence Prevention. In addition, Police departments have strong relationships with both the Direction of Medical and Social Assistance and Emergency Department. In this sense, Police departments contact the social services for referring the victims to the institutions in charge of social rehabilitation. Emergency departments also work closely with police departments in order to both help the victim, but also to establish the legal circumstances of the crime. The Medical Forensic Department only has a weak collaboration with the Direction of Medical and Social Assistance.

As the map shows, the Direction of Medical and Social Assistance is the institution that has the highest number of connections with actors from various categories, being the formal leader in the field of GBV. In addition, the Direction of Medical and Social Assistance is in charge of coordinating the Task Force Unit on Domestic Violence Prevention meetings and for negotiating the local agenda in term of policies. In terms of relationships developed,

the Direction of Medical and Social Assistance has direct connections with Police Departments, Task Force Unit on Domestic Violence Prevention and Women shelter administered by the NGO, Atena-Delphi. As an interrupted relationship, with potential to become stronger and transform into collaborations, the Direction of Medical and Social Assistance interacts with judicial authorities and the medical forensic department. From the county level category, the direction interacts with the Public Health Authority and with the General Directorate of Social Assistance and Child Protection. Moreover, the Direction of Medical and Social Assistance has interrupted relations with both the Gynaecology and Neonatology Clinic and the Emergency Department. The relation is interrupted because the direction, while involved in the process of referral, interacts with these actors only by request and not as part of a specific protocol.

From the women's health services category, the main actors identified are: the Gynaecology and Neonatology Clinics, the Emergency Department and Women's health research center (in our case, IMOGEN).

The clinical staff from the Gynaecology and Neonatology Clinic I interact with each other, but their relations are fragile. Health professional are not familiar yet with referral procedures and are not clear about the role of social workers in relation to GBV. In addition, social workers from the Gynaecology and Neonatology Clinic collaborate informally with their peers from the Emergency department in order to exchange information or just provide feedback about disclosed cases of sexual abuse. There is a similar pattern with the health professionals that work in the clinic and in the Emergency department. They collaborate on cases of sexual abuse, particularly when they do not know exactly how to approach the victims and ask for advice for referral.

The women health research center (IMOGEN) plays a marginal role in the process of identifying and referring victims, and they marginally collaborate with the University of Medicine.

From the women's support services, the main identified actors are: Task Force on Domestic Violence Prevention, women shelter under the administration of the NGO-Atena Delphi, NGO's offering women support services: counselling, legal and medical care.

The task force unit on domestic violence prevention brings together professionals from various fields and institutions that have experience or, by the nature of their profession, interact with victims of gender-based violence. This working group encompasses stakeholders from all the main categories: public authorities, women's health services and women's support services. In terms of NGOs, at local level, there are NGOs that administer shelters (Atena Delphi) or NGOs that offer specialized services for women (ARTEMIS, Anais, Comma, ACTEDO, etc). They are part of the Task Force Unit on Domestic Violence Prevention and might collaborate with the Direction of Medical and Social Assistance.

The Education and Research Stakeholder has more of a marginal role in the area of policy making and in the process of victim referral. As part of this stakeholder, at local level there were two main education institutions: University of Medicine and Pharmacy and Babes-Bolyai University through its faculties of Sociology, Psychology and Public Health. While all these faculties take initiatives in the field of violence prevention, improving the mechanism of referral systems or developing better ways to address the victims, the projects only have a local impact, but with some transferability potential.

DISCUSSIONS

This mapping exercise revealed the main actors involved in the process of identifying and referring victims, it showed their interactions and collaboration and can represent a starting point for exchange of good practice among countries. As a first observation, all RESPONSE partner countries have a different institutional architecture and variation in relationships between actors. In this respect, one general conclusion cannot encompass all countries and the situations highlighted in the mapping process. Consequently, all the recommendations should be tailored in accordance to national and local characteristics, thus the examples provided for each RESPONSE setting above might be different for other settings.

However, there are some common patterns and actors that appear in each mapping process, like the representation of all main stakeholders and their involvement in gender-based violence identification and referral: public authorities, women's health services and women support services. In this sense, social services, police departments, judicial institutions, all play a significant role in the process of identification and referral of victims. Moreover, to some extent they collaborate with maternity clinics or hospitals for various cases of abuse. It does not mean that the collaboration is robust or systematic, since one of the key feedbacks received from medical professionals was the need of strong partnerships between state authorities and clinics and protocols for the referring system. Work Stream 2 of the RESPONSE project, which consisted in developing the capacity building programmes and the delivery of trainings for health care professionals, brought out how actors from various fields interact or need to establish clear protocols of communication for better collaboration. In addition, civil society organizations that offer integrated services for victims interact with both public authorities and with women health services.

In terms of specific characteristics, we could observe the different political systems and institutional arrangements that might impact the organization of GBV identification and referral pathways. While Romania, Spain and France have centralized systems with a more top-down approach, but with a clear local dynamic and various institutions that address gender-based violence, Germany and Austria are partly devolved federal nations. This means that the national (federal) authorities set only the general policy, but each state is responsible for its procedures and institutions. However, in this particular context, the mapping process indicated that both local and national NGOs are active and collaborate with both clinics and local/national governments in addressing and tackling gender-based violence. Equally important was the fact that NGOs and social workers were identified as having the highest number of interactions with all the other stakeholders, in all five settings were the mapping process was conducted. Therefore, exchange of good practices, implementation of new protocols and capacity building in clinics comes mainly from these stakeholders, which are the lead or have the potential to become the lead in the field of gender-based violence identification and referral.

Using the mapping process, we were able to identify and reflect on the different ways in which actors from various settings interact and have the potential to produce positive outcomes in the process of identifying and referral of GBV. In terms of women health services, the mapping process illustrated similar patterns for all the partner countries, but there are some specific processes that represent examples of good practices. First, all the maternity clinics where RESPONSE project was implemented have a form of collaboration with social services, NGOs and task force units active in the field of offering support to gender-based violence survivors. Second, there are countries (Spain, Austria) that have clear protocols in place and hospital-based commissions that offer support for victims and as well for medical professionals. In addition, these groups collaborate with state authorities and other NGOs in the process of identifying and referral. In other countries (Germany, France) there are NGOs and state social workers that work closely with health care professionals. In Romania, there are social workers as part of the health care units, but rarely they can offer services 24 h/day. In addition, victim protection groups are recently created and not present in all health care units. Therefore, health care professionals still need support and guidance, such as: training, dedicated working groups, leaflets or summary cards for clinicians and registers in order to understand better how to tackle the issue and how to register and refer the victims. In addition, there is a potential of exchange of good practices between countries. For example, Austria has good protocols implemented in hospitals and clinics and gender-based violence working groups encompass both health care professionals and social workers (including NGO representatives). These could be salient for other countries. In

Romania, recent legislative changes have the potential to ease the process of collaboration among actors in clinics and thus working groups can be implemented in different local settings. Equally important is the fact that NGOs, while very active in some countries (Germany, Spain, Austria) could increase their capacity and encouraged to be lead agencies in identification and referral pathways for GBV; a potential solution being the promotion and funding of public-private partnerships.

RECOMMENDATIONS

1. As a general recommendation, all countries where the mapping exercise was conducted should strengthen the collaboration between public authorities (police departments, social workers, judicial authorities), NGOs active in the field of gender-based violence and women health services (especially maternity clinics, but not only).
2. For the countries where the protocols from the health care units are not specific, there is a need for clear guidelines and specific information about the referral process.
3. Following the Austrian or Spanish example, victim protection groups from heath care units should be created and active in all the clinics. Health care professionals should be part of these working groups, aside with social workers specialized in dealing with gender-based violence victims.
4. Health care professionals should have access to more trainings and materials that enable their activities in identifying and referring gender-based violence victims.
5. Legislations for both centralized and federal states should stipulate for the creation of victim protection groups in each health care unit, in accordance to Austrian or Spanish model. In addition, these measures should be accompanied with budgets.
6. Medical Universities and midwifery and nursing schools should include in their curricula courses on gender-based violence. In this manner, the universities could increase their collaboration with health care units, social workers and NGOs in offering interdisciplinary courses for future health care professionals.

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