IMPLEMENT

HEALTH SYSTEM RESPONSE TO GENDER BASED VIOLENCE

2015

ENVIRONMENTAL SCAN REPORT

Gender-based violence advocacy in health care settings

With financial support from the Rights, Equality and Citizenship Programme of the European Union

IMPLEMENT – SPECIALIZED SUPPORT FOR VICTIMS OF VIOLENCE IN HEALTH CARE SYSTEMS ACROSS EUROPE | JUST/2014/DAP/5361

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SECTION I

Gender Based Violence: Concepts

1. INTRODUCTION

Gender based violence (GBV) is defined as, "violence that is directed against a woman because she is a woman, or that affects women disproportionately[1]" affecting them in all aspects of life, bio-psycho-social. GBV encompasses four specific types, physical, sexual, psychological and economic violence, highlighting the negative effects this type of violence can have in a woman's life. Furthermore, GBV violates a number of women's rights, including the right to life, the right to not be subject to torture or to cruel, inhuman or degrading treatment or punishment, the right to equal protection under the law, the right to equality in the family, or the right to the highest standard attainable of physical and mental health. According to the representative 2014 Fundamental Rights Agency (FRA) study surveying violence against women in all Member States in the European Union (EU), one in three women (33%) within the European Union have experienced physical and/or sexual violence since the age of 15 years, and 8% of women have experienced physical and/or sexual violence in the 12 months prior to the survey interview. This means that approximately 13 million women in the EU have experienced physical violence, and 3.7 million women in the EU have experienced sexual violence within twelve months prior to the survey.

(Although) health care systems in Europe remain a key (they are an) underutilized entry point through which victims of GBV can be identified and supported. Health care professionals are in a position to break the silence and offer critical care to women and children who are victims of violence and suffer its health consequences for many years. They are often the ones who have the most contact with survivors. Yet health professionals often fail to identify patients experiencing abuse, and thus only treat the presenting complaints and miss an opportunity to provide the link to specialised GBV services. Other health professionals do not have the infrastructure or legal support to provide the necessary care. It is critical that health professionals play a key role in ensuring that the health care system responds to GBV and protects women's health and rights, and this can only be done by directly connecting the health care system to the specialized support services. IMPLEMENT, a European Union (EU) co-funded project to establish capacity building in six European countries (Austria, Bulgaria, Germany, France, Italy, and Romania) aims to strengthen the specialised support for victims of gender-based violence in health settings. The project aims to better meet the needs of survivors of GBV by securing a strong connection between the health system and women's specialized services[2].

[1] http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm

[2] Blank & Rösslhumer. 2015. IMPLEMENT – Specialized Support for Victims of Violence in Health Care Systems across Europe, Access here: gbv-implement-health.eu

1.1: BENEFICIARIES

The beneficiaries of the project are patients who seek emergency or obstetric care as victims of GBV, and the health professionals (doctors, nurses, midwives) who provide medical assistance.

1.2: TARGET GROUPS

The project target group included: GBV advocates who provide frontline assistance to victims; obstetric/emergency health professionals within clinical teams who are not equipped to assist victims of GBV with their specialized needs; management and front-line staff; and health sector policy makers, for example ministries, and federal and local level entities responsible for health, who are responsible for allocating the resources and institutional measures for specialised support for victims in the health setting.

1.3: DELIVERY

A train-the-trainer seminar was conducted in Vienna, Austria on 21-22 May 2015 by two specialized trainers from the United Kingdom, who have trained selected health care professionals and violence prevention advocates (one clinical lead and one GBV advocate from each partner country) to then establish capacity building into health facilities in the six partner EU countries.

2. METHODOLOGY

In order to undertake such project an environmental scan is essential. This allows us to thoroughly gather data from each country in order to understand their role regarding GBV and address any potential gaps. In order to accomplish this, certain objectives and methodologies were put in place:

2.1: OBJECTIVES of the environmental scan

The environmental scan and situational analyses was performed in the six partner countries participating in the capacity building in order to:

1) identify the strengths and weaknesses of the existing health care infrastructure related to the provision of care for victims – includes discussion with health care managers/staff in each care setting and integrating existing materials/resources/protocols already in place within the settings;
2) identify clinical champions in each of the health settings;
3) identify existing national legal frameworks with regards to provision of care for victims in the health care setting;
4) Identify contact persons at medical/nursing/midwifery schools to promote a gender-based violence module into the curriculum.

Each partner country was asked to use the Environmental Scan (under the format of a list of questions) and two sets of tables to obtain information from both (1) the health setting/hospital side where the capacity building seminars were planned to be organized and implemented, and (2) the support services side**,** which represented the institution from which, as part of the project, the Gender-based Violence Prevention Advocate (GBV advocate) was selected and/or any other support services that were in place in the region.

This report has three main sections that focus on identifying baseline information about the health care units in which the capacity building seminars will take place (Emergency Departments and obstetric clinics) in the IMPLEMENT partner countries:

- Leadership (key people in the community and in the health care unit; potential partner organization; clinical lead; contact persons to promote gender-based-violence prevention education; potential organizational support),
- Infrastructure in the health care setting – Emergency Department and/or obstetric clinic: existing data collection, reporting and delivery of care mechanisms
- Capacity (existing community services; existing policies and legal framework; existing referral system; gender-based-violence prevention modules in health education).

For each of the indicator, a yes or a no answer was attributed in order to set up baseline information to support the implementation of the capacity building seminars: N (no)/Y (yes).

The Environmental Scan (*list of questions*) was translated and applied in the national language, in each partner country, as an interview or questionnaire, depending on the partner's decision on which methodology would work best in their setting.

The Environmental Scan had at least three respondents per partner country, with the primary respondent being the representative of the partner country's implementation team, with support from the other two respondents: one representative of the health setting and one representative of the support services. More respondents were encouraged in order to obtain information as accurate as possible, but all countries have used the three main respondents as required by the methodology proposed by the lead of the Environmental Scan.

SECTION II

Assessment of Countries –

Focus on one health care setting in each partner country

1. AUSTRIA

INFRASTRUCTURE

Currently there is no regularly produced report to include information on GBV patients treated in the health setting. In addition, there is no data documenting the prevalence and incidence of GBV. But as part of the IMPLEMENT Project, progress has been made in this direction. The clinical lead has implemented a data collection process on GBV and violence against children, using the already existing hospital data surveillance system. The system is accessible to all hospital departments which makes the data collection process on GBV and violence against children accessible to hospital level. As a second step, a referral pathway needs to be put in place at hospital level that will have as steps contacting the women's shelter and the GBV advocate.

CAPACITY

The medical staff and the nursing staff does not receive any type of training on GBV or violence prevention and victim protection during their residency or medical school. But there is a Child Protection Group which works as a task force on child rights and protection issues which have received training between 2009 and 2011, at the Hinterbrühl Therapeutic Center. To date trainings for all staff members at the partner hospital are not available, which is a gap that will be field in by the IMPLEMENT Project.

Social work practitioners are in the same situation like medical or nursing staff – there is no particular training on GBV as part of their work environment. As a conclusion, there are no capacity building initiatives for the medical and/or non-medical staff on GBV, in the health setting, so far the health care setting focusing only on the issues of violence against children.

Since 2011 it became mandatory under "the Austrian Legislation" regarding hospital management to implement a victims' support group. Here is the best practice example of the victims support group, including their role:

In 2011, the Austrian Health Facilities Act established "victim protection groups" in hospitals. The law specifies that separate groups are to be set up for children survivors of violence and adult survivors of domestic violence. Two main purposes of these victim protection groups are early identification of violence and sensitization of health care providers on domestic violence. The groups should be composed of at least two doctors specialized in accident surgery and gynaecology/obstetrics, as well as nurses and health care professionals specialized in psychological and psychotherapeutic care. This law transformed already existing practices into a legal obligation. In the General Hospital of the City of Vienna (AKH), not only was a victim protection group set up in 2011, but rules of procedure were also adopted to further specify the groups' aims and tasks: follow advice to health care professionals in contact with survivors of domestic violence; sensitize health care professionals; develop standardized procedures and guidelines for interventions; organize trainings; and coordinate the different departments and case conferences. Although victim protection groups are widely welcome and successful, there

remain some challenges, for instance: provision of adequate human and financial resources; making trainings on GBV mandatory for all health care professionals; and effective cooperation both internally and with external stakeholders, such as shelters, police, or general practice doctors.

LEADERSHIP

There is not one department but in each hospital has to be a victim protection group –Team based on the Austrian federal law. Since 2011 there is an Austrian federal law to provide victim protection groups in health care systems which translates as 'Federal law for the implementation of victims of gender based violence in public health care systems.'[3] According to this law health care systems need to provide victim protection teams for children and adults. One of the key components is to recognize early domestic violence and suspicion of violence in order to strengthen sensitization of the staff on the issue of domestic violence. Women's groups lobbied for this law based on the success shown by child protection groups that are legally mandated in Austria.

The victim protection teams must have two representatives of medical services who are specialists in trauma surgery as well as gynaecology and obstetrics. In addition, members of the nursing service and the persons responsible for psychological and psychotherapeutic treatment in the hospital must belong to the victim protection groups.

This law has been an important improvement for the support of victim protection in health care systems. It has facilitated linkages between the entire staff, medical as well as nursing, and improved the support of victims of gender-based violence.

With this legal framework for health care systems, Austria follows the Council of Europe Convention on preventing violence against women and domestic violence (Istanbul Convention) that states, according to Article 15[4]:

(1) The contracting parties create and offer on suitable trainings and educational measures for prevention and detection of violence, gender equality, the needs and legal rights of victims and prevention of secondary victimisation. This trainings and educational measures are for the members of occupational groups, who are working with victims or perpetrators all within its scope of acts of violence.

[3] Bundesgesetz über Krankenanstalten und Kuranstalten, BGBI. I Nr.61/2010/ KAKuG 2010
Federal Law for the implementation of victims of gender based violence in public health care systems.
[4] http://www.conventions.coe.int/Treaty/EN/Treaties/Html/210.htm

ENVIRONMENTAL SCAN: AUSTRIA – OVERVIEW TABLES

1.1: INFRASTRUCTURE	AUSTRIA
1.Annual or biannual report that includes specific/broader information on GBV patients treated in the health setting	N
2. Data documenting the prevalence and incidence of GBV, available for the health setting	N
3. Mechanism/referral system in place that allows early identification and rapid response to GBV	N

1.2: CAPACITY	AUSTRIA
1.Medical staff receives training on GBV, or violence prevention and victim protection during their residency or medical school	N
2. Nursing staff receives training on GBV in particular, or violence prevention and victim protection during nursing school	N
3. Social work staff receive training on GBV, or violence prevention and victim protection, during their social work training	N
4.Health setting have or had in place (*in the last 5 years*) capacity building initiatives for the medical and/or non-medical staff on GBV	N
5.Medical and/or non-medical staff participated in capacity building initiatives *in the last 5 years*	N
6. Health care setting has a network for GBV prevention practitioners	Y
7. A network for GBV prevention practitioners exists at a local/regional level	Y
8. Health setting partner is involved (*was partner in the last 5 years*) in any other projects on GBV	N

1.3: LEADERSHIP	AUSTRIA
1.Health setting has a department/staff that is responsible for the coordination of gender-based-violence prevention activities	Y
2. Other departments/health care units, within the hospital, have some responsibility for gender-based-violence prevention	Y
3.GBV was identified as a priority by the management of the health setting	
4. Hospital has a dedicated budget for services to victims of GBV	N
5.Additional organizations that the health setting can contact regarding specialised support services to victims of GBV	-
6.There are other NGOs that have some responsibility for victim protection that the health setting can contact for victim assistance, particular, and violence prevention and victim protection	Y

2. BULGARIA

INFRASTRUCTURE

Currently there is no regularly produced report to include information on GBV patients treated in the health setting. In addition, there is no data documenting the prevalence and incidence of GBV, nor is there a mechanism/referral system in place that allows early identification and sensitive response to GBV. One of the reasons why there is no data documenting the prevalence and incidence of GBV is because these indicators are perfectly new for the Bulgarian system and was not identified so far as part of the health settings reporting system.

But as part of the Bulgarian legislation, there is a provision of a medical certificate which is an obligation for any doctor who faces a complaint from a victim of domestic violence. Art. 4 (3) of the Law on Protection from Domestic Violence, it is stated that upon request of the victim *each medical doctor has to issue a document certifying the damages or traces of violence identified by the medical staff.* But there are issues with the enforcement of such regulations as some doctors refuse to do it based on personal beliefs while no reporting system is in place to document the incidents. At hospital level an issues of privacy and personal data was also brought to surface when implementing these regulations.

CAPACITY

The medical staff and the nursing staff does not receive any type of training on GBV or violence prevention and victim protection during their residency or medical school. However, social work practitioners receive the types of training mentioned above during their social work training.

Because the issues of GBV is not fully recognised in practice and the evidence-informed actions are just present in theory not in practice, there are no capacity building initiatives for the medical and/or non-medical staff on GBV, in the health setting. Finally, there is no network for GBV prevention practitioners in the health setting, nor at the local or regional level.

Progress can be made in the partner health setting. Doctors and other members of the medical community were identified as resources to prevent GBV, and who are willing to be trained and disseminate the gained knowledge. The existing medical universities and other establishments for qualification of medical personnel of different level are a resource for promoting the implementation of GBV curricula as part of the medical and nursing training.
Another identified resource to be explored is through the joint work with the Ministry of Health and NGOs dealing with GBV around the different advisory and consultative bodies we participate jointly in, like the Advisory Committee on Gender Equality at the Council of Ministers.

Increased and special attention should be given to the actions of the representatives of health sector in cases of rape and other forms of sexual violence now that with the Istanbul Convention all forms are explicitly listed as GBV and there will be increased requirements for special mechanisms and protocols to be put in place.

LEADERSHIP

In Bulgaria, the health setting does not have a department or staff responsible for the coordination of gender-based violence prevention activities. GBV has not been identified as a priority by the management of the health setting and the hospital does not have a dedicated budget for providing services to support victims of GBV.

As part of the IMPLEMENT Project a group of NGOs (*there were 10 NGOs identified which are members of the Alliance for Protection against GBV*) that can be contacted for support for victims of violence and survivors were identified. Within IMPLEMENT Project, survivors will receive the referral toward these NGOs. NGOs are considered to be an asset for future developments and support for survivors of violence, and a valuable partner for health practitioners' response to GBV, such practices can be further developed.

ENVIRONMENTAL SCAN: BULGARIA – OVERVIEW TABLES

2.1: INFRASTRUCTURE	BULGARIA
1.Annual or biannual report that includes specific/broader information on GBV patients treated in the health setting	N
2. Data documenting the prevalence and incidence of GBV, available for the health setting	N
3. Mechanism/referral system in place that allows early identification and rapid response to GBV	N

2.2: CAPACITY	BULGARIA
1.Medical staff receives training on GBV, or violence prevention and victim protection during their residency or medical school	N
2. Nursing staff receives training on GBV in particular, or violence prevention and victim protection during nursing school	N
3. Social work staff receive training on GBV, or violence prevention and victim protection, during their social work training	N
4.Health setting have or had in place (*in the last 5 years*) capacity building initiatives for the medical and/or non-medical staff on GBV	N
5. Medical and/or non-medical staff participated in capacity building initiatives *in the last 5 years*	N
6. Health care setting has a network for GBV prevention practitioners	N
7. A network for GBV prevention practitioners exists at a local/regional level	N
8. Health setting partner is involved (*was partner in the last 5 years*) in any other projects on GBV	N

2.3: LEADERSHIP BULGARIA

1.Health setting has a department/staff that is responsible for the coordination of gender-based-violence prevention activities	N
2. Other departments/health care units, within the hospital, have some responsibility for gender-based-violence prevention	
3.GBV been identified as a priority by the management of the health setting	N
4. Hospital has a dedicated budget for services to victims of GBV	N
5.Additional organizations that the health setting can contact regarding specialised support services to victims of GBV	N
6.There are other NGOs that have some responsibility for victim protection that the health setting can contact for victim assistance, particular, and violence prevention and victim protection	Y

3. FRANCE

INFRASTRUCTURE

Respondents stated that A&E social services are responsible for, "prevention, identification and treatment of IPV." In order to do so, yearly data regarding IPV is collected. At the level of emergency departments there is a protocol implemented for medical and paramedical staff on how to deal with victims of domestic violence, and it is available on the emergency departments' website. To this protocol, there is in place a mechanism that links the police departments with the emergency departments, to provide care and assistance to victims: "Federation nationale solidarite femmes" (FNSF).

CAPACITY

In regards to capacity medical students do receive classes on violence against women during medical school. Additionally social workers train physicians and the paramedical staff on GBV issues. Social workers are also given training regarding GBV and continued education is available. Therefore, in this case, the social workers are the main contributors and a liaison for capacity building and leadership.

Moreover, there are three national plans that focused on violence against women prevention: PLAN 1: *Global plan to tackle violence against women (2005-2007)-10 steps towards women's autonomy*; PLAN 2: *Twelve goals to tackle violence against women" –Second global three year plan (2008-2010)*; PLAN 3: *Interministerial plan for tackling violence against women (2011-2013)*. These three plans were and are the policy environment under which, the health setting is implementing any national legal framework for providing victim protection.

LEADERSHIP

The Environmental Scan and Situational Analysis Planning was conducted in the Helios-Clinic in A&E Hospital Cochin, France. In the hospital, social workers seek to improve the "treatment provided to victims of IPV while raising awareness of this topic among the medical and paramedical team." Simultaneously, social services can contact the police department, victim support organizations, "Samu social," youth welfare office, and forensic medical units, which are all services that address GBV. Currently the hospital is working with MIPROF and NGOs that the health setting can contact for victim assistance.

ENVIRONMENTAL SCAN: FRANCE – OVERVIEW TABLES

3.1: INFRASTRUCTURE	FRANCE
1.Annual or biannual report that includes specific/broader information on GBV patients treated in the health setting	Y
2. Data documenting the prevalence and incidence of GBV, available for the health setting	N
3. Mechanism/referral system in place that allows early identification and rapid response to GBV	Y

3.2: CAPACITY	FRANCE
1.Medical staff receives training on GBV, or violence prevention and victim protection during their residency or medical school	Y
2. Nursing staff receives training on GBV in particular, or violence prevention and victim protection during nursing school	N
3. Social work staff receive training on GBV, or violence prevention and victim protection, during their social work training	Y
4.Health setting have or had in place (*in the last 5 years*) capacity building initiatives for the medical and/or non-medical staff on GBV	Y
5. Medical and/or non-medical staff participated in capacity building initiatives *in the last 5 years*	Y
6. Health care setting has a network for GBV prevention practitioners	N
7. A network for GBV prevention practitioners exists at a local/regional level	N
8. Health setting partner is involved (*was partner in the last 5 years*) in any other projects on GBV	N

3.3: LEADERSHIP	FRANCE
1.Health setting has a department/staff that is responsible for the coordination of gender-based-violence prevention activities	Y
2. Other departments/health care units, within the hospital, have some responsibility for gender-based-violence prevention	N
3.GBV been identified as a priority by the management of the health setting	N
4. Hospital has a dedicated budget for services to victims of GBV	N
5.Additional organizations that the health setting can contact regarding specialised support services to victims of GBV	Y
6.There are other NGOs that have some responsibility for victim protection that the health setting can contact for victim assistance, particular, and violence prevention and victim protection	Y

4. ITALY

INFRASTRUCTURE

Respondents stated that, “the ASL AT updates the information about GBV victims treated in the Emergency Department every two months.” ED has a mechanism that allows early identification and rapid response to GBV.

CAPACITY

In regards to capacity medical and nursing students do receive training specific to GBV. In 2011 there was two main capacity building initiatives, “It’s possible to go out from violence” and “The path of the victim of GBV in the ASLAT.” Simultaneously, ASLAT was partners with a project called, “Empowering Women & Providers: Domestic Violence and Mental Health” and in 2011 undertook the project, “The money of solidarity-Women victims of violence, the path within the Hospital Cardinal Massaia.”The network for GBV prevention exists at a specific regional or provincial funding.

LEADERSHIP

The Environmental Scan and Situational Analysis Planning was conducted in the Complex Operative Unit and Emergency Surgery, Asti and Belbo Valley, Italy, which is responsible for the coordination of gender-based-violence prevention activities. The hospital includes, the Emergency Department in the Hospital "Cardinal Massaia" in Asti and the Point of First Aid in the Hospital "Santo Spirito-Valle Belbo" in Nizza Monferrato.
Simultaneously, within the hospital there is a program called, “hidden sleeping bed,” where GBV victims can find immediate help. There also additional organizations that the health setting can contact regarding services for victims of GBV as well as NGOs that have some responsibility for victim protection. These organizations and NGOs are CISA Asti Sud, CO.GE.SA Asti Nord and the Counseling Center. GBV has not been identified as a priority by the management of the health setting and the hospital does not have a dedicated budget for providing services to support victims of GBV, but the head of the health setting fully supports any regional legal framework (Regional Committee Resolution n. 14-12159/2009), which is the policy environment regarding the implementation of any national legal framework for providing victim protection.

ENVIRONMENTAL SCAN: ITALY – OVERVIEW TABLES

3.1: INFRASTRUCTURE	ITALY
1.Annual or biannual report that includes specific/broader information on GBV patients treated in the health setting	Y
2. Data documenting the prevalence and incidence of GBV, available for the health setting	Y
3. Mechanism/referral system in place that allows early identification and rapid response to GBV	Y

4.2: CAPACITY	ITALY
1.Medical staff receives training on GBV, or violence prevention and victim protection during their residency or medical school	N
2. Nursing staff receives training on GBV in particular, or violence prevention and victim protection during nursing school	Y
3. Social work staff receive training on GBV, or violence prevention and victim protection, during their social work training	Y
4.Health setting have or had in place (*in the last 5 years*) capacity building initiatives for the medical and/or non-medical staff on GBV	Y
5.Medical and/or non-medical staff participated in capacity building initiatives *in the last 5 years*	Y
6. Health care setting has a network for GBV prevention practitioners	Y
7. A network for GBV prevention practitioners exists at a local/regional level	Y
8. Health setting partner is involved (*was partner in the last 5 years*) in any other projects on GBV	Y

4.3: LEADERSHIP	ITALY
1. Health setting has a department/staff that is responsible for the coordination of gender-based-violence prevention activities	Y
2. Other departments/health care units, within the hospital, have some responsibility for gender-based-violence prevention	Y
3.GBV been identified as a priority by the management of the health setting	-
4. Hospital has a dedicated budget for services to victims of GBV	N
5.Additional organizations that the health setting can contact regarding specialised support services to victims of GBV	Y
6.There are other NGOs that have some responsibility for victim protection that the health setting can contact for victim assistance, particular, and violence prevention and victim protection	Y

5. GERMANY

INFRASTRUCTURE

Respondents state that there are no reports regarding GBV patients that are regularly produced. There is however some data documenting the prevalence and incidence of GBV in the department of gynecology/obstetrics through a pilot-routine-enquiry in 2014, which is available through GESINE. There is not yet an efficient mechanism/referral system that allows early identification and rapid response to GBV but a start has been made. There is currently no statute of the mechanism/referral system.

CAPACITY

In regards to capacity, the medical staff generally (if trained in Germany) does receive some training on GBV as they receive a "psychosomatic certificate." Similarly, nurses generally also receive some training on GBV as part of their curriculum which is the same for social workers. This specific clinic-department also has in place building initiatives for the medical and/or non-medical staff on GBV through a training provided by GESINE. In this training all doctors and some nurses and a secretary were able to participate. There is no network for GBV prevention practitioners in this health setting. There is a network on the county level, GESINE-Network Health, EN in which Dr. Leven as leading doctor of the department is an active partner for several years. This clinic-department has been involved in other projects regarding GBV, specifically a routine-inquiry-pilot in cooperation with GESINE.

LEADERSHIP

The Environmental Scan and Situational Analysis Planning was conducted in the Helios-Clinic in Schwelm, Germany, more exact in the department of gynecology/obstetrics – Dr. Andreas Leven is leading doctor of the department and IMPLEMENT clinical lead. The clinic does not yet have a department/staff that is responsible for the coordination of gender-based-violence prevention. There are no other departments/ health care units within the hospital that are responsible for GBV. GBV has been identified as a priority by the management of the clinic but currently there are no goals in place. The clinic does not have a dedicated budget for providing services to victim of GBV. The department does have a contact regarding provision of specialized support services to victims of GBV which is the *Women's Support Center EN*. There is also another NGO that addresses GBV which is the Weisser Ring (mainly financial support)

ENVIRONMENTAL SCAN: GERMANY – OVERVIEW TABLES

5.1: INFRASTRUCTURE	GERMANY
1.Annual or biannual report that includes specific/broader information on GBV patients treated in the health setting	N
2. Data documenting the prevalence and incidence of GBV, available for the health setting	Y
3. Mechanism/referral system in place that allows early identification and rapid response to GBV	N

5.2 CAPACITY	GERMANY
1.Medical staff receives training on GBV, or violence prevention and victim protection during their residency or medical school	Y
2. Nursing staff receives training on GBV in particular, or violence prevention and victim protection during nursing school	Y
3. Social work staff receive training on GBV, or violence prevention and victim protection, during their social work training	Y
4.Health setting have or had in place (*in the last 5 years*) capacity building initiatives for the medical and/or non-medical staff on GBV	Y
5.Medical and/or non-medical staff participated in capacity building initiatives *in the last 5 years*	Y
6. Health care setting has a network for GBV prevention practitioners	N
7. A network for GBV prevention practitioners at a local/regional level	Y
8.Health setting partner is involved (*was partner in the last 5 years*) in any other projects on GBV	Y

5.3: LEADERSHIP	GERMANY
1.Health setting has a department/staff that is responsible for the coordination of gender-based-violence prevention activities	N
2. Other departments/health care units, within the hospital, have some responsibility for gender-based-violence prevention	N
3.GBV been identified as a priority by the management of the health setting – but no goals were set yet	Y
4. Hospital has a dedicated budget for services to victims of GBV	N
5.Additional organizations that the health setting can contact regarding specialised support services to victims of GBV	Y
6.There are other NGOs that have some responsibility for victim protection that the health setting can contact for victim assistance, particular, and violence prevention and victim protection	Y

6. ROMANIA

LEADERSHIP

The Environmental Scan and Situational Analysis Planning was conducted in the Emergency Department in Mures County, Romania, which is part of the Mures County Emergency Hospital. Within the hospital there is a Social Service department, which operates at the hospital level, it is responsible for the coordination of gender-based-violence prevention activities. In this department there are seven social work practitioners, which have the responsibility to provide care and assistance to victims of violence. For monitoring gender based violence events they have a social workers' patient chart in which all information relevant to the event are collected. There are also other departments within the hospital which have some responsibility for GBV prevention such as the Mures Public Health Department (DPS Mures) and the Tirgu Mures Forensic Institute. Simultaneously, the emergency unit can contact East European Institute for Reproductive Health (EEIRH) and the Center for Monitoring and Control of Violence regarding provision of specialized services for victims of GBV. There are other NGOs that address GBV such as Save the Children Mures and the Veritas Foundation. Currently GBV has not been identified as a priority however this is a goal to be reached.

INFRASTRUCTURE

In regards to infrastructure respondent's state that reports regarding GBV patients treated in the ED are not regularly produced, however there is partial data that documents the prevalence and incidence of GBV. Due to confidentiality reasons this information cannot be obtained. Information such as prevalence and incidence can be requested by submitting an official request. The health setting has in place the referral system called: Integrated system to monitor and offer referral in domestic violence cases RO: *Sistemul Informational Integrat de Inregistrare si Referire a Cazurilor de Violenta in Familie*. The mechanism/referral system in place and allows early identification and rapid response to GBV. This mechanism/referral system was developed by East European Institute for Reproductive Health (NGO) together with UNFPA and has two referral components. The referral system is guided by the statute of the Emergency Department internal regulation and by an inter-institutional collaboration protocol signed at county level (Mures County, Romania) by a number of stakeholders. The policy environment under regarding the implementation of any national legal framework for providing victim protection is the Law-217/2003 regarding prevention and control of violence and is the one who permitted the development of the referral system.

CAPACITY

Concerning capacity, the medical staff receives no specific training on GBV or violence prevention and victim protection during their residency or medical school. However respondents stated that resident doctors receive 1-2 hours of training from social work practitioners on risk assessment of GBV victims. Nurses also do not receive specific training but there is information regarding, "the psychological factors that might affect the health/condition of the patient" in the nursing curricula. "Social work practitioners have an optional course during their bachelor program on Gender Issues, in which they discuss different topics related to gender issues." The

European Institution for Reproductive Health and Romanian Ministry of Health respectively organized training on GBV prevention which allowed social workers to attend. Currently, the ED does not have any capacity building initiatives for the medical and/or non-medical staff on GBV but respondents stated, "social work practitioners employed by the hospital (n=7) work closely together and act as a network." Although their health setting partner is not involved in any projects on GBV specifically, the ED was involved in two injury prevention projects. Furthermore there is a network for GBV prevention practitioners at a local and county level.

ENVIRONMENTAL SCAN: ROMANIA – OVERVIEW TABLES

6.2: INFRASTRUCTURE	ROMANIA
1.Annual or biannual report that includes specific/broader information on GBV patients treated in the health setting	N
2. Data documenting the prevalence and incidence of GBV, available for the health setting	Y
3. Mechanism/referral system in place that allows early identification and rapid response to GBV	Y

6.3: CAPACITY	ROMANIA
1.Medical staff receives training on GBV, or violence prevention and victim protection during their residency or medical school	Y*
2. Nursing staff receives training on GBV in particular, or violence prevention and victim protection during nursing school	N
3. Social work staff receive training on GBV, or violence prevention and victim protection, during their social work training	Y
4.Health setting have or had in place (*in the last 5 years*) capacity building initiatives for the medical and/or non-medical staff on GBV	N
5.Medical and/or non-medical staff participated in capacity building initiatives *in the last 5 years*	Y
6. Health care setting has a network for GBV prevention practitioners	N
7. A network for GBV prevention practitioners exists at a local/regional level	N
8. Health setting partner is involved (*was partner in the last 5 years*) in any other projects on GBV	N

**they only receive training during residency and this activity is specific to the health setting involved in the Scan, it's not a requirement at national level.*

6.4: LEADERSHIP — ROMANIA

1.Health setting has a department/staff that is responsible for the coordination of gender-based-violence prevention activities	Y
2. Other departments/health care units, within the hospital, have some responsibility for gender-based-violence prevention	Y
3.GBV been identified as a priority by the management of the health setting	Y
4. Hospital has a dedicated budget for services to victims of GBV	N
5.Additional organizations that the health setting can contact regarding specialised support services to victims of GBV	Y
6.There are other NGOs that have some responsibility for victim protection that the health setting can contact for victim assistance, particular, and violence prevention and victim protection	Y

7. References

Convention on the Elimination of All Forms of Discrimination against Women. United Nations Entity for Gender Equality and the Empowerment of Women. (2000-2009). Retrieved from http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm