COALIȚIA PENTRU EGALITATE DE GEN

Asociația Moașelor Independente

The Response of Health Systems to Gender-Based Violence

LEGISLATION
INSTITUTIONAL LANDSCAPES
SERVICE PROVISION
CAPACITY BUILDING NEEDS

Association of Independent Midwives
Author: Irina Ilisei, PhD
Editor: Carmen Radu
Project Coordinator: Irina Mateescu

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Abbreviations

AMI Association of Independent Midwives
CEDAW The Convention on the Elimination of All Forms of Discrimination Against Women
CMR-IPV Clinical Management of Rape and Intimate Partner Violence
CoE The Council of Europe
DGASPC General Direction of Social Assistance and Protection of Children
EU European Union
FGD Focus Group Discussions
GBV Gender-Based Violence
GREVIO Group of Experts on Violence Against Women and Domestic Violence
INM National Institute of Magistrates
IPV Intimate Partner Violence
LGBTIQ+ Lesbian, Gay, Bisexual, Transgender, Intersex And Queer
MHPSS Mental Health And Psychosocial Support
ANES National Agency for Equal Opportunities between Women and Men
NGO Non-Governmental Organization
PSEA Protection from Sexual Exploitation and Abuse
UN United Nations
WHO World Health Organization
VIF Network The Network to Prevent and Combat Violence against Women

Terminological considerations

- **Victim vs. survivor**

  While in the feminist discourse in Romania, there is a gradual shift from <<victim>> to <<survivor>> terminology, the Romanian legislation refers to people who experience gender-based violence/sexual/domestic violence only as *victims*. The legislation shapes the language that is also used by the staff working in public institutions, including health care professionals. For these reasons we opted for the use of the term victim.

- **Domestic violence vs. gender-based violence**

  Legislation in Romania has been recognizing *domestic violence* and *violence against women* for a long time. The term *gender-based violence* was introduced only after the Istanbul Convention ratification and implementation and is not yet well integrated neither in the legislation nor in the institutional discourse. For these reasons, when analyzing the legislation and institutional framework we preferred using the same terminology that is used by institutions and the legislation and to bridge it to the concept of gender-based violence. Also, in designing the questionnaire, we used both terms simultaneously *victim of domestic violence/ gender-based violence (physical and/ or sexual)* for making sure that the questions were well understood by the respondents.

Executive Summary

This report provides an overview on the response of healthcare systems to address GBV for identifying gaps and proposing recommendations. The research was conducted between July and September 2023 by the Association of Independent Midwives with the aim of mapping relevant policy framework and stakeholders, reviewing protocols and procedures on CMR-IPV provision in primary, secondary, and tertiary healthcare response to GBV. The research is based on a combination of research approaches: (1) analysis of legislation, strategies, and existing frameworks (2) mapping of stakeholders (3) survey data collection with 334 healthcare professionals as respondents, and (4) in-depth focus group interviews with 16 professionals working directly on the topic of gender-based violence.

Romania registers one of the lowest scores in the European Union in what concerns gender equality, with a high prevalence of the gender-based violence phenomenon due to cultural norms but also due to setbacks in the implementation of existent legislation.

Legislation & strategies

In 2016, Romania ratified **the Istanbul Convention** which is a legally binding treaty to combat violence against women in Europe and beyond. The convention signing parties are obliged to take necessary legislative measures to exercise due diligence to prevent and protect survivors, including access to health care. The existing legislation, although not yet fully updated to the provisions Istanbul Convention, together with the national strategies provides a favorable framework for addressing gender-based violence, including in the healthcare system. We note the following:

- National Strategy on Equality between Men and Women & Domestic Violence 2022-2027
- National Strategy for prevention and combating sexual violence
- Law 217/ 2003 on prevention and fight against domestic violence
- Law 202/ 2002 for Equality of Chances between Men and Women

In regard to legislation, there are still some limitations and aspects that need to be addressed such as the use of the concept of *domestic violence* and *family violenc*e, and not *gender-based violence* or *violence towards women*. Also, Law 202/ 2002 on domestic violence was not updated according to the Istanbul Convention. In consequence, not all forms of gender-based violence are covered by the existing legislation which affects not only data collection and getting a clear picture of the phenomenon, but also may also leave out cases where the victim was not living with the aggressor. The report identified a gap between legislation and practice due to a lack of methodologies, working plans and funding. Implementation of existing legislation requires special attention and effort.

Recommendations:

- Update Law 202/2002 in order to include all aspects related to gender-based violence and not only domestic violence.

- Implement existent strategies and legislation, develop a concrete working plan and reporting system for the implementation of the strategies on gender equality.
- Develop a monitoring system for the implementation of the existing legislation and strategies.
- Every public institution with responsibilities to address GBV/ domestic violence should elaborate regular reports on activities concerning prevention and response.
- Ensure financing at local and national levels, and monitor adequate funding.
- Every institution with more than 50 employees should hire/ nominate a person with the responsibility of equality of chances - to create plans and procedures for gender violence prevention, response (including initial internal case management if the case and/ or referral to other institutions), and monitoring.

Stakeholders

The report highlights that the National Agency for Equality of Chances (ANES) has the main responsibility of coordinating the efforts of central and local institutions in tackling GBV. The Ministry of Health, together with National Professional Medical Colleges and other healthcare institutions at the national level have the capacity to validate and implement protocols and procedures for CMR-IPV service provision in primary, secondary, and tertiary healthcare in Romania. The Ministry of Health, together with National Professional Medical Colleges and the National Authority for Quality Management in Healthcare (ANMCS) have the capacity to provide healthcare professionals with training on this matter, as well as to allocate the necessary funding together with Local Authorities for supporting these measures. There is a need for stronger cooperation between the institutions with responsibilities for equality of chances and institutions with responsibilities in healthcare.

Gaps in the health system response are the lack of clinical protocols for healthcare professionals validated at the national level for addressing gender-based violence, a methodology for the functioning of the centers for victims of sexual violence is not yet made official, the standards for the accreditation of healthcare facilities do not mention any responsibility of healthcare institutions to address gender-based violence. Furthermore, the curricula of the diploma studies for healthcare professionals does not include modules on addressing gender-based violence in healthcare. while the very few opportunities for continuous training covering this subject are rather at the initiative of ANES, international organizations, and non-governmental organizations. All these indicate that gender-based violence has not yet become a priority on the agenda of the institutions working in healthcare.

<u>Recommendations:</u>

- The Ministry of Health, in collaboration with other stakeholders and including GBV experts, should elaborate and validate a guideline at the national level for addressing GBV in the healthcare system in primary, secondary, and tertiary healthcare.
- The Specialized Commissions under the Ministry of Health, together with Specialized Medical

Societies and GBV experts, should elaborate and validate clinical guidelines and protocols at the national level, for addressing GBV in different healthcare specialties - with a focus on the specialties that have a greater role to identify and assist the victims: family medicine, emergency, pediatrics, forensic medicine, gynecology, and obstetrics - for all healthcare professionals: doctors, midwives, nurses, and community nurses.

- Ensure the dissemination, training, and implementation of guidelines and protocols for addressing GBV in the healthcare system.
- Allocate funding and ensure the sustainability of the Centers of intervention for victims of sexual violence.
- Standards for Quality Management in Healthcare should mention that every healthcare facility should have available a methodology/protocol/SOP for addressing cases of gender-based violence, which should be updated regularly.
- Raise the level of expertise on gender equality and on gender-based violence among public institutions at national and local levels in order to facilitate the cooperation between ANES and healthcare institutions at national level.

The research results revealed **several issues that prevent victims from receiving the necessary services:**

- GBV is often normalized, minimized, and not identified as abuse;
- low level of awareness among healthcare institutions, decision-makers and professionals concerning their responsibility in addressing GBV;
- healthcare professionals and decision-makers have a low level of expertise in addressing GBV;
- lack of referral pathways and low level of cooperation between healthcare facilities and other local institutions with responsibilities in healthcare;
- inadequate allocation of resources both in terms of human resources and financial.

Recommendations:

- Sensibilization and training of decision-makers and management in healthcare institutions at the national level, professional medical colleges, hospital managers, and heads of hospital departments;
- Include training on healthcare response to GBV during university studies for doctors, nurses, and midwives;
- Advanced training in residency programs and in continuous medical education for professionals in family medicine, emergency, midwives, pediatrics, school doctors and nurses, forensic medicine, obstetrics and gynecology;
- Include training on addressing GBV in the mandatory continuous training of healthcare professionals i.e., every 3 years.
- The training programs for healthcare professionals should be created as a cooperation between institutions with responsibilities in healthcare at national level and GBV experts;
- Create training programs for community nurses, Roma healthcare mediators, school doctors, and other healthcare professionals working with large communities;

- Provide community nurses, Roma healthcare mediators, and family medicine in rural and underprivileged areas with a professional advice support system for addressing GBV
- Include responsibilities for addressing gender-based violence in the job descriptions of healthcare professionals as well in the job descriptions of other professionals working in the healthcare system that have responsibilities in GBV: i.e., social assistant, psychologist;
- Create effective mechanisms to increase human resource capacity. i.e., every emergency hospital should have a 24/7 responsible person that can (1) ensure mandatory reporting of abuse towards minor victims and (2) provide first-line support to the victims, including helping the victims to access information about resources and ensuring internal and external referral pathways to required services such as legal and social assistance, forensic examination, prophylactic treatment against HIV and sexual transmitted infections, emergency contraception, psychological support.

Introduction

The present report outlines the main legislation, policies, and key stakeholders regarding the healthcare sector's response to gender-based violence in Romania. The main aims of the research were:

- mapping of training institutions, protocols, and procedures for service provision in addressing physical and sexual gender-based violence in primary, secondary, and tertiary health care in Romania;
- analysis of the policy framework of GBV in Romania with a focus on the healthcare sector;
- identifying the main capacity building and training needs for institutions and professionals working at the intersection between gender-based violence and healthcare.

The research was conducted between the 15th of July 2023 and the 22nd of September 2023 and is based on a combination of desk review, and qualitative and quantitative analysis. For the quantitative approach, we used as a research instrument an online questionnaire (334 respondents, mostly healthcare professionals). The qualitative methodology was based on 2 focus groups and 2 in-depth interviews with GBV and healthcare professionals, as well as the notes from 14 training sessions on GBV and PSEA with over 200 healthcare professionals.

Socio-cultural environment

Romania registers one of the **lowest scores in the European Union with 53.7 points** out of a maximum of 100 in the Gender Equality Index[1] compared to 68.6 points which is the EU average. Since 2010, Romania registered modest progress in closing the gender gaps with only 2.9 index points while most of the EU Member States registered more rapid improvements. What is most concerning is that Romania registered a negative tendency in the matter of gender equality in the last year, dropping 0.8 points since the previous year – the highest setback among all EU countries.

Healthcare is one of the domains measured in the Gender Equality Index. Based on data from 2020, it captures the initial effects of the pandemic. Romania scored 70.4 points for healthcare, the absolute lowest score in the EU (being followed by Bulgaria with 78 points). Romania also registered a setback here, dropping 0.9 points compared to the previous year.

Attitudes towards Gender Equality and Gender-Based Violence

The Barometer on Gender-Based Violence[2] shows that a high percentage of the Romanian population tends to share patriarchal values: i.e., 62% of respondents the survey done made in 2022 consider men to be the leader of the family and 42% consider that a woman should listen (follow) what a man says.

[1] EIGE *Gender Equality Index 2022*

[2] Centrul Filia. (2022). Barometrul Violenta de Gen. Romania 2022. https://centrulfilia.ro/new/wp-content/uploads/2022/12/Barometrul-Violenta-de-Gen.-Romania-2022.pdf

However, Romania registers a raise in awareness on gender-based violence, especially in what concerns physical and sexual violence: **in 2022 79% of the population considers unacceptable if a woman is slapped by her partner,** while in 2003, only 36% of the population would have considered this situation as unacceptable. The attitudes tend to be more patriarchal if respondents are from a rural area or have a lower educational level.

Regarding social violence and economic violence, there is a slight regression: 26% of the population considers it acceptable for men to not allow their female partner to decide how to spend her own money that she earned and considers it acceptable for a woman not to go out without her partner or to be forbidden to have a group of friends of her own. **25% consider it acceptable if a woman is not allowed to use contraceptive means**. This shows a high prevalence of patriarchal values and a social context in which women experience a notable absence of autonomy.

Although rape is perceived as unacceptable by most of the population, **there is a low level of awareness of what consent means**. The lack of sexual education in the Romanian educational system is seen in analyzing situations when consent was violated, i.e., only 62% of the population consider that it is a very severe situation if a woman is raped after going to a man's home and only 69% perceive as aggravating if a woman was raped because she was dressed in a provocative manner. Furthermore, sexual relations between an adult man and a girl under 15 years old are perceived by 19% of the population as not severe at all, or just a little severe. This leads to victim blaming and normalization of abuse.

Prevalence of Gender-based Violence

Between 87% and 96% of Romanian people perceive that verbal violence, psychological violence, and moderate physical violence are widespread. A lower percentage of the population, between 72% and 81%, perceive physical violence, rape, and sexual relations without consent in a couple as widespread[3].

According to a survey made by the European Union Agency for Fundamental Rights (FRA)[4], 30% of Romanian women have experienced physical and/or sexual violence at least once since the age of 15. Most of gender-based violence happens in the private space: 24% of Romanian women experienced physical and/or sexual violence from a partner. Data shows[5] **concerning numbers of sexual abuses with minor victims**, with an average of 14 new cases every day in Romania. **Romania has one of the highest rates of teen pregnancies and early marriages.[6]**

[3]Centrul Filia. (2022). Barometrul Violenta de Gen. Romania 2022. https://centrulfilia.ro/new/wp-content/uploads/2022/12/Barometrul-Violenta-de-Gen.-Romania-2022.pdf

[4] FRA 2014

[5] VIF Network open letter https://violentaimpotrivafemeilor.ro/camera-deputatilor-amana-sa- voteze-proiectul-de-lege-pentru-protectia-minorelor-si-minorilor-in-fata-agresorilor-sexuali/

[6] https://www.unicef.org/romania/documents/policy-framework-prevent-teenage-pregnancy-and-its-consequences-1

The Police registered a slight increase of domestic violence cases, but the number of registered cases is much underreported.[7]

GBV and trust in institutions

The FRA Report[8] shows that in Romania, only 15% of victims of physical violence and 22% of sexual violence from a partner contact a doctor or a health center. If the perpetrator is a non-partner, the rate of addressing institutions is considerably lower. Also, it should be noted that doctors/ healthcare units and hospitals are the most addressed institutions, even more than the police or other organizations and services. **Women are most likely to contact healthcare services (hospitals, doctors or other healthcare providers)**.

According to the same survey, 23% of Romanian women say that they inform the police on the most serious incidents of violence. This shows an important gap compared to the number of cases registered by the police. Furthermore, **74% of Romanian women do not know any institutions and organizations that are providing services to victims of gender-based violence.** This data reflects a high need for information on the matter.

In 2022 the Romanian Police registered 34.368 cases of hitting and other forms of violence, 1.189 cases of sexual aggression and 275 cases of rape. The number of cases registered by the Police is still much lower than what the anonymous surveys on GBV show. This may be due to a combination of factors such as (1) victims fearing for their lives, (2) victims not trusting the authorities and (3) victims not having a place where to live[9]. Moreover, the number of cases registered by the Police grows each year, it does not necessarily indicate that the phenomenon of gender-based violence is growing but that society has more trust in the police to address the authorities and submit a complaint[10].

International Framework and Legislation

At the international level, Romania has several obligations to address gender-based violence. The most relevant international bodies, laws, and recommendations for preventing and combating violence against women in Romania are:

The United Nations

- Convention on the Elimination of All Forms of Discrimination against Women

[7] Mihaela Săsărman, Mihaela Mangu, Mihai Popescu, Carmen Nemeș. 2023. Raport de monitorizare a serviciilor existente pentru victimele violenței domestice și agresori https://violentaimpotrivafemeilor.ro/wp-content/uploads/2023/07/RAPORT-SERVICII-VIF-2023.pdf

[8] FRA 2014

[9] Centrul Filia. Raport de monitorizare privind violența de gen 2023 https://centrulfilia.ro/new/wp-content/uploads/2023/12/Raport-monitorizare-VIF_2023_Centrul-FILIA.pdf

[10] https://politiaromana.ro/ro/stiri/violenta-domestica-in-atentia-politistilor1684567077

(CEDAW)

- General recommendation No. 19 on Violence against Women
- Beijing Declaration and Platform for Action
- Vienna Declaration and Programme for Action
- Agenda 2030 for Sustainable Development

Romania has signed and ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).

The Council of Europe

- Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention, 2011)
- Convention on Action against Trafficking in Human Beings, 2005
- Recommendation on the protection of violence against women, 2002

Romania signed the Council of Europe's Convention on preventing and combating violence against women and domestic violence. The Convention was ratified in Romania in May 2016 through the Law 30/2016. **The Istanbul Convention** is a legally binding set of comprehensive standards for preventing and combating violence against women in Europe and beyond.

The Convention has a monitoring mechanism that consists of two pillars: the Group of Experts on Action against Violence against Women and Domestic Violence (**GREVIO**), and the Committee of the Parties, a political body composed of official representatives of the parties to the convention.

The European Union

As a member of the European Union since 2007, Romania has to follow the EU legislation and principles for equality between men and women.

- The Gender Equality Strategy 2020-2025
- Directive 2012/29/EU[11] (the Victims' Rights Directive) establishes minimum standards on the rights, support, and protection of victims of crime and ensures that persons who have fallen victim to crime are recognized and treated with respect.

National Strategies and Legislation

At the national level, there are a series of strategies covering the topics of gender equality and addressing gender-based violence.

National Strategy on Equality between Men and Women & Domestic Violence 2022-2027 includes directions of strategic actions such as monitoring, evaluation, reporting, and prevention of sexual violence, training of professionals in all fields and representatives of public institutions

[11] https://eur-lex.europa.eu/TodayOJ/

at the central and local level but also capacity building at institutional level, creating partnerships and gender mainstreaming promoting in all local strategies.

While the section on healthcare does not address GBV, the strategy has a specific chapter on domestic violence and violence against women that includes measures for the healthcare system:

- ➔ to create a compendium that describes the intervention procedures in a unitary manner and to apply methodologies in the field of preventing and combating domestic violence and violence against women, from the perspective of multiple vulnerabilities and discriminations approach, focusing on the activity of several categories of professionals including professionals in the field of health and child protection.
- ➔ to create a unitary system of services for the efficient protection of the victims of domestic violence – interconnection between institutions, including between healthcare institutions and others.

National Strategy for prevention and combating sexual violence "SINERGIE" 2021-2030 was approved through Decision 592/2021. It defines sexual violence as "any sexual act or pursuit an attempted sexual act, unwanted sexual comments or advances, or acts of sexual exploitation, using coercion, threats of harm, or physical force, by any person, regardless of relationship to the victim, in any setting, including but not limited to home and work". The strategy includes several references on how the healthcare system shall support the survivors, namely:

- Victims of sexual violence require comprehensive, gender-sensitive health services to deal with the physical and psychological consequences of their experience and to facilitate and assist their recovery from a traumatic event;
- The types of services that are needed include pregnancy testing, pregnancy prevention, abortion services, STI testing and/ or prophylaxis, injury treatment, and psychosocial counseling. In addition to providing immediate medical care, the health sector can act as an important referral point for other services that the victim may need, for example, social assistance and legal assistance;
- It provides a comprehensive description of short- and long-term consequences of sexual violence that include psychological consequences, unwanted pregnancies and unsafe abortions, sexual transmitted infections;
- The response to sexual violence should include developing a system of services to meet the medical/health needs of victims/survivors; development of a service system that meets the psychosocial needs of victims/survivors; development of a service system that meets the safety/security needs of victims/survivors.

Bellow a selection of the objectives and measures proposed by the Strategy that refers to healthcare:

OS II. Secondary prevention - measures aimed at diminishing the negative evolution/increase in cases of sexual violence and preventing recurrence. Secondary prevention aims at early identification of risk factors for sexual violence, generally counseling actions of children,

girls/women, and aggressors, and preventing the further development of situations of this kind.

3. Continuous professional training of specialists working in healthcare units and in forensic medicine services

OS III. Tertiary prevention/Measures to combat sexual violence - measures aimed at combating sexual violence and limiting the phenomenon. Tertiary prevention aims to reduce the possibility of repeating the situation of sexual violence and its consequences, which are usually long-term. The programs consist of effective medical and rehabilitation treatment, with the aim of reducing the effects of violence, as well as estimating the degree of risk or safety to confirm the security conditions in which the child lives. Preventing revictimization through the action of professionals involved in solving the case is another tertiary prevention activity.

1. The establishment of a national system for monitoring all forms of sexual violence.

6. Information, guidance, and support for victims of sexual violence, including victims of human trafficking, through the free national telephone line, with a single number 0800-500-333, with a non-stop program and the identification of new opportunities regarding the establishment of a national telephone line, free, aimed at the problem of sexual violence

Some other measures proposed under this strategy that refer to healthcare institutions in addressing sexual violence are:

- The creation of crisis centers/integrated services for support of victims of sexual violence (adult and minors), including the support and finance of NGOs at the local level to create such centers. Responsible institutions: ANES, Ministry of Health, Local Public Authorities, County Councils, emergency hospitals at county levels, services of forensic medicine, and NGOs.
- The elaboration of a common Ministry Order - between the Ministry of Health, the Prosecutors' office attached to the High Court of Cassation and Justice, Ministry of Labor and Social Protection, and the Romanian Police - for assistance in case of sexual aggressions.

National Roma Integration Strategy 2012-2020 contains some measures and policies for Roma women and their exposure to violence. The chapter on health covers, the implementation of information campaigns among Roma women concerning the risks associated with early marriage, preventing and combating domestic violence and human trafficking. **The health mediators** in the Roma communities - approx. 500, mostly women– can play a key role in raising awareness and sharing information.

The National Plan of Redressing and Resilience 2021-2024 (PNRR)

The EU's Recovery and Resilience Facility is transposed into the National Plan of Redressing and Resilience 2021-2024 (PNRR), and it includes some measures on gender equality and equality of

chances such as:

- Workshops with professionals involved in the prevention of domestic violence and violence against women;
- Training of all the professionals involved in the prevention and combating domestic violence;
- Elaborate a guide for universities to introduce information on domestic violence and violence against women in their curricula.

The chapter on health has an objective to invest in pre-hospital medical care, such as community centers that serve various groups of disadvantaged populations, including families that are exposed to domestic violence.

The funding lines planned to be developed through PNRR with funding from the European Commission have the potential to contribute to the capacity building of healthcare institutions for addressing GBV.

Law 217/ 2003 on prevention and fight against domestic violence

At the national level, the Law 217/ 2003 (revised and republished) is the main law overseeing gender-based violence in Romania. The law defines domestic violence as any action or inaction that is produced in the family or in a domestic environment between spouses or former spouses independently if the aggressor lives or no longer lives with the victim. One main limitation of this law stems in the concepts on which it operates: domestic violence and family violence, and not gender-based violence or violence towards women. Another critical aspect concerning this law is the fact that it was not updated according to the Istanbul Convention. The Istanbul Convention was integrated into Romanian legislation into law 202/ 2002 on equality between men and women which will be discussed below. This leaves place for interpretation and possible exclusion of victims from services and support if the violence happens between people who do not live/ lived together: i.e., teenage relations, sexual violence from an extended family member, etc. This has negative implications for data collection since the Police collect data based on this law.

According to 217/2003 Law, **domestic violence is a matter of public health**. Local public authorities are responsible for including family violence in their local, county and regional strategies and programs of development. Furthermore, local authorities have a large spectrum of responsibilities such as:

- to establish, directly or in partnership, units to prevent and combat family violence and support their operation. The units can be (a) centers to receive emergencies, (b) recovery centers for the victims, (c) centers of assistance for the aggressors, (d) centers to prevent and combat the family violence (e) centers for information and raising awareness for the population; the units would provide social services free of charge for the victims of family violence;
- to develop programs to prevent and combat family violence;

- to support the access of family aggressors to psychological counseling, psychotherapy, psychiatric treatments, rehab, and alcohol detoxification;
- to develop and implement projects in the field of preventing and combating family violence;
- to include in their annual budgets funding for supporting social services and other social assistance measures to prevent and combat family violence;
- to bear, from the local budget, in serious social cases, the expenses for drawing up legal documents, as well as for obtaining forensic certificates for victims of domestic violence.

The Domestic Violence Law explicitly provides cooperation between public authorities and NGOs working in the field. For example, Article 8, paragraph 2, foresees the signing of cooperation partnerships between public authorities at the local and national level and NGOs in the areas of information, prevention and intervention. Article 13, paragraph 4, of the same law provides for intersectoral working groups in county districts composed of representatives from relevant services (police, health, child protection, etc.) as well as NGOs. Such partnerships may allow for the provision of funding from local budgets.

At county level and sectors of the municipality of Bucharest, the intersectoral team in the field of preventing and combating violence in the family is established, with a consultative role – as part of the General Directorates of Social Assistance and Child Protection (**DGASP**C). The intersectoral team should have in its component one representative of the police, the gendarmerie, the public health department, the family violence department within the general department of social assistance and child protection (from units for preventing and combating family violence), as well as non-governmental organizations assets in the field. Also, a representative of the forensic medicine units could be part of the intersectoral team.

Victims of domestic violence have the right:

- to have their personality, dignity, and private life respected;
- to information regarding the exercise of their rights;
- to special protection, appropriate to their situation and needs;
- to counseling, rehabilitation, social reintegration services, as well as to free medical assistance, under the conditions of this law;
- to free legal advice and assistance, under the law.

Shelters have to provide medical assistance and care, food, accommodation, psychological and legal counseling. **All the shelters have to have a partnership collaboration with a hospital or with another healthcare facility that shall provide medical and psychiatric care,** this is also condition for the shelters to receive authorization for functioning. The convention of collaboration has to be signed between local councils/ councils at county level (that are in charge of the shelters) or the governing bodies of accredited private social service providers. According to the same law, the emergency centers for victims of sexual violence have to provide medical care and forensic

examination, post-traumatic assistance, and counseling for victims of sexual violence. A report conducted in 2020[12] shows that medical assistance is offered in the shelters of 31 counties out of 48, in 1 county the shelter facilitates the access to medical services, in 2 counties the shelters have externalized the service of medical assistance and in 11 counties the shelters do not offer these service, in the rest of the counties the did not provide information. Furthermore, according to the same report only in four counties there are hired doctors for the centers.

As per art. 27, the Ministry of Labor and Social Protection in collaboration with the Ministry of Health and the **Romanian College of Psychologists**, in consultation with the **Ministry of Justice**, elaborates the methodology for participation in special psychological counseling programs organized by public or private specialist services.

The programs of national interests that address GBV, including training for professionals, and support of the victims through health recovery programs should be financed at national level through the National Agency for Equality of Chances Between Men and Women (ANES).

According to an update of the same law - made through the law 174/ 2018 art. 9 – the family doctors and the medical specialists who work in both the public and private sector are obliged to make notes in the **patient dossier** - *fișa pacientului* – on any suspicion that they may have of the patient being a victim of domestic violence. This information can be used to confirm the status of being a victim of domestic violence and to benefit from the available services for victims of domestic violence. One aspect that needs to be clarified is how to ensure confidentiality.

Methodology for Multidisciplinary Teams

H. G. no. 49/2011 for the approval of the Framework Methodology regarding the prevention and intervention in multidisciplinary teams in situations of violence against children and family violence – regulates the responsibilities of institutions in different sectors, including healthcare, in what concerns addressing family violence and violence against children. According to the methodologies, institutions at the local level in various sectors should close protocols of collaboration.

The main aspects referring to the healthcare system are:

- **Directions of Public Health (DSP) -** public institutions at the county level under the supervision of the Ministry of Health - should be part of multidisciplinary teams, organize meetings with the staff for informing on the implementation of multidisciplinary teams, organize meetings with hospital managers.
- A multidisciplinary team should include a medical doctor (usually one working for DGASPC), and, depending on the case, medical doctors of other specialties should be consulted i.e., obstetrics and gynecology or psychiatry.
- **The centers for victims** should have a protocol of collaboration with a hospital.

[12] Mihaela Săsărman, Mihaela Mangu, Mihai Popescu, Carmen Nemeș. 2023. Raport de monitorizare a serviciilor existente pentru victimele violenței domestice și agresori https://violentaimpotrivafemeilor.ro/wp-content/uploads/2023/07/RAPORT-SERVICII-VIF-2023.pdf

Some other stakeholders that are recommended to be part of multidisciplinary teams are representatives of the local administration, labor unions, church, units of forensic medicine, and regional centers of the Internal Administration and Affairs – National Agency Against Traffic.

Regulation on reporting and confidentiality – adult and minor victims

According to Law 46/2003, art 22, healthcare professionals are required to uphold the confidentiality of their adult patients and cannot disclose any incidents of violence to law enforcement or other institutions unless the victim's life or health is in immediate danger or there is a public health concern. For professionals working with minors, including healthcare workers, any suspicions of abuse (physical, psychological, or sexual) or neglect toward a person under 18 years old must be reported to social services, as mandated by Law 272/2004 Art. 96.

Law 202/ 2002 for Equality of Chances between Men and Women[13]

was revised several times and it also includes the provisions of the Istanbul Conventions on gender-based violence. According to Article 17, the Ministry of Health, as well as other healthcare institutions, are responsible for ensuring equal access of men and women to medical services.

According to Law 202/ 2002 Art 2 Alin. 4), institutions that have more than 50 employees nominate an employee to take the responsibilities of equality of chances; the responsibilities of the expert include the elaboration of policies at the institutional level that promote equality of chances, respect of confidentiality, protection against discrimination, preventing and managing the cases gender-based violence – healthcare units, especially hospitals may also benefit of this regulation and hire/ delegate responsibilities to a person with the role of **expert on equality of chances**.

Methodology for preventing domestic violence (OMFTES/OMAI nr. 20266/50/2023)

Refers to prevention methods and activities under the responsibility of local authorities, DGASPCs, Police, and other stakeholders. There is no mention of how healthcare institutions and professionals can contribute to preventing gender-based violence.

[13] https://www.cncd.ro/wp-content/uploads/2021/02/Legea-202_2002_actual.pdf

Recommendations:

- Update Law 202/2002 in order to include all aspects related to gender-based violence and not only domestic violence.
- Implementation of existent strategies and legislation, develop a concrete working plan and reporting system for the implementation of the strategies on gender equality.
- Develop a monitoring system for the implementation of the existing legislation and strategies.
- Every public institution with responsibilities in GBV/domestic violence should elaborate trimestral/yearly reports on activities implemented concerning prevention and case management.
- Ensure financing at local and national level, monitor adequate funding;
- Every institution with more than 50 employees must hire/nominate a person with responsibilities in equality of chances - to create plans and procedures for gender violence prevention, case management, and monitoring.

Mapping Stakeholders in policy-making & protocols, service provision and training for addressing GBV in the healthcare system

International organizations

Romanian governments have made international commitments to advance gender equality. **UN organizations, the Council of Europe** and **EU institutions** advocate by monitoring, providing recommendation based on international standards, provide relevant tools and capacity strengthening to the government[14]

GREVIO (Group of Experts on Action against Violence against Women and Domestic Violence) is the independent expert body responsible for monitoring the implementation of the Council of Europe's Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention). In 2022 they published a baseline evaluation Report on Romania. GREVIO's findings are based on the information obtained during the various steps of the first (baseline) evaluation procedure set out in Article 68 of the convention. These include written reports - a report submitted by the Romanian authorities and additional information submitted by NGOs forming the Coalition for Gender Equality and the Network for Preventing and Combating Violence Against Women (VIF Network). GREVIOs recommendations[15] are focused on the following issues: (1) training of healthcare professionals, especially in regard to recognizing GBV, medical response and referrals, (2) development of protocols and guidelines (3) provision of free of charge documentation of forensic evidence.

Summary of GREVIO Observations and Recommendations around Romanian legislation and service provision policies in regard to addressing GBV in healthcare sector:

GREVIO strongly encourages Romanian authorities to ensure women victims of violence (as covered by the Istanbul Convention) access adequate health services provided by professionals trained to assist victims, in particular by:

- being mindful of the forms of violence against women covered by the Istanbul Convention, responding to the medical needs of victims in a sensitive manner and ensuring referrals to relevant and preferably specialist support services;
- providing free-of-charge documentation of forensic evidence adequate for use by the criminal justice sector.

[14] https://www.ohchr.org/en/press-releases/2020/03/romania-government-must-take-further-measures-ensure-equality-women-and
[15] Grevio's Report, 2022, paragraph 135

Although the law requires all county authorities to provide social assistance to victims of domestic violence, public shelters are still lacking in some counties, due to the insufficient funding allocation. Moreover, research recently conducted by a civil society association in one of the 42 counties about the budget allocation of the mayor's office across all the cities and villages for providing social services for violence against women revealed that the majority (90%) do not finance any social, health or protection services for victims of domestic violence.

Concerns were expressed about the scarcity of the financial resources allocated from the local budgets for victim support services, often on the wrong assumption that these are not needed, or given the low level of reporting to the police.

While the topic of gender-based violence falls under the responsibility of institutions in charge of equality between men and women, policies for addressing GBV can be formulated only in cooperation with different sectors such as healthcare, education, security, etc.

Romanian Parliament

The Parliament is the main body responsible for the legislation process in Romania. There are **two commissions on health** in the Romanian Parliament, one in the Senate (13 members from the following parties: PSD 5 PNL 4 USR 2 AUR 1 UDMR 1) and one in the Deputy Chamber, the Health and Family Commission (27 members: 7 PNL, 10 PSD, 6 USR, 2 AUR, 1 UDMR, 1 Minorities). In the Deputy Chamber, there is also a Commission on Equality of Chances between Men and Women.

People's Advocate institution – The office of the Ombudsman has the role of analyzing relevant legislative aspects, and national and international trends drawing conclusions from statistics and information gathered from national authorities with competencies in combating violence and hate speech.

Romanian Government

The Government is in charge of implementing legislation and developing methodologies for the implementation process but can also adopt legislative acts such as decisions and ordinances (ordinances are simple or emergency ones). Decisions are issued to organize the law enforcement. Ordinances are issued under a special enabling law, within the limits and conditions specified therein.

The decision-making circuit of drafting public policy documents and legislative acts is structured in two phases:

a) preparatory meeting of the Government which ensures the coordination of the process of elaboration, consultation, and approval for public policy documents and legislative acts at the inter-ministerial level;
b) government meetings marking the end of decision-making process through the adoption/approval or rejection of such draft laws.
The following public authorities have the right to initiate public policy documents and legislative acts for adoption/approval by the Government, according to their tasks and activity field:

- Ministries and other specialized bodies of central public administration, subordinated to the Government and autonomous administrative authorities;
- Specialized bodies of central public administration subordinated or coordinated by Ministries, by the Ministries under whose subordination or coordination they are;
- Prefects, county councils, the General Council of Bucharest, according to the law, through the Ministry of Interior and Administrative Reform.

Ministry of Health

While the National Agency for Equality of Chances (ANES) has the main responsibilities in coordinating the efforts of central and local institutions in tackling GBV, the Ministry of Health and specific healthcare institutions have the highest capacity to validate and implement protocols and procedures for CMR-IPV service provision in primary, secondary and tertiary health care in Romania, as well as to provide training of healthcare professionals on this matter.

The Ministry of Health in Romania plays a significant role in developing and approving **clinical guidelines**. It often provides **clinical guidelines** through specialized medical committees and oversight to ensure that protocols are in line with national healthcare policies and standards. Clinical guidelines in Romania are developed by specialized medical committees or expert groups based on national and international guidelines, scientific evidence, and consultations with experts, healthcare professionals and patients. The Ministry of Health can issue Ministry Orders for clinical guidelines that are active at the national level. The goal is to develop guidelines that instruct healthcare practitioners in delivering safe, effective, standardized patient care.

Protocols and procedures in addressing GBV in Healthcare

The other main stakeholders involved in creating clinical protocols in Romania:

- **National Health Insurance House** (*Casa Națională de Asigurări de Sănătate, CNAS*): CNAS is responsible for the management and reimbursement of healthcare services in Romania. They may participate in developing and approving clinical protocols, especially those related to insurance and reimbursement coverage.
- **National Institute of Public Health** (*Institutul Național de Sănătate Publică, INSP*): INSP is active in research, training, public health initiatives, and the development of guidelines and protocols, including clinical protocols, to improve public health in Romania.

- **National Professional Medical Colleges** (*Colegiile Medicale Profesionale Naționale*): These organizations, which oversee medical practice and education, may also be involved in developing and updating clinical protocols to ensure adherence to professional standards - **College of Physicians** (*Colegiul Medicilor*) and the **Order of General Medical Assistants, Midwives and Medical Assistants** (OAMGMAMR).
- **Specialized Medical Societies** (*Societățile Medicale Specializate*): Various medical societies, representing different medical specialties often contribute to the elaboration and revision of clinical protocols within their respective fields.
- **Healthcare Professionals and Practitioners**: Physicians, nurses, pharmacists, and other healthcare professionals actively participate in the development of clinical protocols by providing insights and expertise from their clinical experience.
- **Medical facilities** can develop their own protocols and/or they can take over existing international/national guidelines and validate them at the internal level; after this validation, the protocols become mandatory. The medical facilities are responsible for providing information and training for their professionals to ensure that the protocols are followed.

In the desk research, which included analysis of the webpages of several societies of healthcare professionals including the Society of Obstetrics and Gynecology in Romania[16] and also the webpages of several hospitals for emergencies, **we could not identify any existent clinical guidelines or protocols for healthcare professionals** at national level or validated by a healthcare facility that would cover the assistance of the victims of GBV, addressing GBV in the healthcare system or CMR-IPV service provision. The lack of guidelines validated through a Ministerial Order or protocols and methodologies validated through an official decision at hospital level was confirmed by the participants in the focus groups and to the training sessions.

The **need of protocols and guidelines is also pointed out by the GREVIO report** which strongly encourages the Romanian authorities to ensure women victims of violence (as covered by the Istanbul Convention) access adequate health services by "developing and effectively implementing protocols and guidelines which ensure that all healthcare professionals adequately respond to women victims of all forms of violence, including by acknowledging that women exposed to intersectional discrimination, in particular women with disabilities, migrant women and Roma women, may face significant barriers to help-seeking"[17].

[16] https://sogr.ro/ghiduri-clinice/
[17] Grevio's Report, 2022 paragraph 135

Recommendations:

- The Ministry of Health in collaboration with other stakeholders and including GBV experts should elaborate and validate a guideline at the national level for addressing GBV in the healthcare system in primary, secondary and tertiary healthcare.
- The specialized commissions under the Ministry of Health, together with Specialized Medical Societies and GBV experts, should elaborate and validate clinical guidelines and protocols at the national level for addressing GBV in different healthcare specialties
  - with a focus on the specialties that have a greater role to identify and assist the victims: family medicine, emergency, pediatrics, forensic medicine, gynecology, and obstetrics
  - for all healthcare professionals: doctors, midwives, nurses and community nurses.
- Ensure the dissemination, training, and implementation of guidelines and protocols for addressing GBV in the healthcare system.
- Allocate funding for measures, ensure the financial the sustainability of the Centers of intervention for victims of sexual violence

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Beyond healthcare professionals, **social assistants** (in tertiary healthcare) and **psychologists** (in secondary and tertiary healthcare) may provide support for victims of gender-based violence. Every emergency hospital at county level (with some exceptions) usually has a social assistant.

Existing Procedure of intervention for social workers from emergency units for victims of sexual abuse. It was elaborated by the Ministry of Internal Affairs, the Association of Social Assistants in Romania and the center of training in Social Assistance. According to the procedure, the victims of sexual abuse can receive - free of charge - the following services within the emergency departments of hospitals: testing, treatment, prophylaxis and screening for sexually transmitted diseases. Case management for sexual abuse is done by the doctor who is responsible for the case and by the social assistant.

Some **critical aspects concerning the content of the procedure for social workers that may be improved:**

- The definition of gender violence is limited only to situations when the person was constrained, not when it happened without consent;
- There is no procedure in regard to victims under 18 years old;
- The procedure refers to only a few services that are available for the survivors;
- According to the procedure, the social assistant should contact authorities (Police, Crime Investigation office) and doctors from Forensic Medicine Institutes even when the life of the

victim is not in danger, without the consent of the victim if they perceive a risk. The victim needs to sign a declaration that she does not want the police to be contacted;

- The procedure does not cover key aspects, such as referral to social services, shelters, counseling, emergency contraception, and other aspects that are part of the WHO guidelines;[15]
- The Ministry of Health or any other healthcare institution are not yet involved in the elaboration of these procedures although the procedure has elements concerning healthcare professionals – the lack of consultation of healthcare institutions may affect the implementation of the procedure.

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Forensic evidence collection

plays a key element in the healthcare response to gender-based violence. In Romania, there are **6 National Institutes of Forensic Medicine**: INML Mina Minovici Bucureşti, Institutul de Medicină Legală (IML) Craiova, IML Iaşi, IML Timişoara, IML Târgu Mureş, IML Cluj-Napoca and **forensic medicine services in every county** as well as legal medicine offices. From an administrative point of view, the activity of the National Institutes of Forensic Medicine is coordinated by the Ministry of Health. From a methodological and scientific point of view, it is coordinated by the Ministry of Health and by the Superior Council of Forensic Medicine.

In practice, only few victims access this service. In 2022, there were reimbursed the costs for the forensic certificate -*certificat medico legal*- in only 109 cases from 10 counties, most of cases also from the same counties where there are also active NGOs working on GBV. Some of the existent barriers are that women need to travel long distances to reach a healthcare unit that provides this service, need to have available the money for the transportation first for the examination and later to travel again for the issuing of the certificate[18].

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Education and training in addressing GBV within the healthcare sector

Through the desk research we could not identify any **University of Medicine** that covers in the curricula of the diploma studies aspects related to addressing gender-based violence in healthcare. For example, the University of Medicine has a course on legal aspects in the first year and a course on ethical aspects in the third year. **Gender-based violence, sexual violence, or any other aspect related to these issues are not covered by the existent courses**. Only some Universities, for some specializations, may provide some training on this matter, i.e. The University of Medicine in Timișoara during the residency program on obstetrics and gynecology.

In order to keep their right to medical practice, healthcare professionals (doctors, medical assistants, and midwives) need to accumulate a number of credit points yearly, by participating in continuous training. The organizations that manage and regulate these credit points are: the **College of Physicians (*Colegiul Medicilor*)[19]** and the **Order of General Medical Assistants,**

[18] Mihaela Săsărman, Mihaela Mangu, Mihai Popescu, Carmen Nemeș. 2023. Raport de monitorizare a serviciilor existente pentru victimele violenței domestice și agresori https://violentaimpotrivafemeilor.ro/wp-content/uploads/2023/07/RAPORT-SERVICII-VIF-2023.pdf

[19] College of Physicians Decision 1 18.01/2013

Midwives and Medical Assistants (*OAMGMAMR*)[20].

The results of the desk research indicate some training for healthcare professionals is provided, initiated by International Organizations, NGOs, or of National Agency for Equality of Chances – in partnership or with the support of the Ministry of Health, or professional associations healthcare, DSP, DGASPC or hospitals. However, there is no systematic training of healthcare professionals on GBV, neither in the initial professional training nor in the continuous training.

GREVIO Recommendations in regard to the GBV training of healthcare professionals

GREVIO[21] points out the urgent need to include training – both in the tertiary education but also in the continuous training for healthcare professionals - , especially in regard to screening, identification of GBV cases and professionals' interaction with the survivors.

GREVIO urges Romanian authorities to ensure systematic and mandatory initial and in-service training on the prevention and detection of all forms of violence against women covered by the Istanbul Convention, on equality between women and men, on the needs and rights of victims and on the prevention of secondary victimization for all professional groups, in particular law enforcement, the healthcare sector and the judiciary. All training must be supported and reinforced by clear protocols and guidelines that set the required standards and by appropriate and sustainable funding for the training sessions.

National Authority for Quality Management in Healthcare (ANMCS)

It is a public body at the national level, under the coordination of the Prime Minister. The institution's main responsibilities are: (1) to evaluate the quality of healthcare units in Romania, (2) to create a reporting system, (3) to inform the healthcare staff to improve the quality of healthcare and to ensure patient safety, (4) to train the staff responsible of quality management[22].

ANMCS is currently running the evaluation process for the second accreditation cycle for hospitals in Romania and the first accreditation cycle for ambulatory care, as well as elaborating the standards for the next cycle of evaluation. **The standards for the second accreditation cycle for hospitals, as well as its related criteria and requirements do not mention any aspects directly related to the clinical management of rape or the healthcare response to GBV[23]**. However, some standards could be relevant:

- Standard 02.02 The initial assessment aims to identify the patient's needs in the context of knowledge of exposure to risk factors (environmental, social, economic, behavioral and
- Standard 03.01 The hospital promotes respect for the autonomy of the patient.
- Standard 03.02 The hospital respects the principles of fairness, social justice, and patient

[20] https://www.oamr.ro/programul-national-de-emc/
[21] Grevio's Report, 2022 paragraph 135
[22] https://anmcs.gov.ro/
[23] https://anmcs.gov.ro/web/wp-content/uploads/2022/01/Manualul-standardelor-de-acreditare-2020-1.pdf

rights.

- Criteria 03.02.01 The hospital has policies to prevent discrimination in providing medical services.
- Criteria 03.02.04 The hospital is concerned with the protection of patients in relation to
- the external environment.

Other criteria that are included in the standards that are worth mentioning:

- 03.03.01 The hospital imposes the limitation of practice to the sphere of competence held within the specialty.

In light of this standard, one risk is that healthcare staff is not well informed and trained on their responsibility in providing services to the victims of GBV the above-mentioned criteria could be interpreted as an argument to not provide the required support.

Recommendation:

- Standards for Quality Management in Healthcare should mention that every healthcare facility should have available a methodology/protocol/SOP for addressing cases of gender-based violence, which should be updated regularly.

The National Agency for Equality of Chances between Men and Women
operates under the Ministry of Family, Youth and Equality of Chances and has the responsibility to elaborate, coordinate and apply strategies and policies of the Government in the field of equality of chances between men and women and counteracting domestic violence. The institution was founded on the basis of Law 202/2002 while the Governmental Decision HG 177/ 2016 defines the main role of the institution. ANES is the responsible institution for coordinating the implementation of CEDAW Convention and Istanbul Convention.

ANES is in charge of ensuring the helpline services that provide free counseling to the victims and connect the victims with the local authorities.

ANES initiated and implemented several projects on GBV with the support of EU, Norwegian funding and UN institutions and other sources of external financial support. The main areas of these projects focus on creating awareness campaigns, providing services to the victims (with a focus on social assistance) and training of professionals responsible for addressing GBV.

One of the most important projects of ANES at the intersection between GBV and healthcare, is *Support for the implementation of the Istanbul Convention in Romania*, a project funded through Norwegian Grants.

Through this project, 10 Centers of intervention for victims of sexual violence have been created. Their concept is to provide integrated support and to be a one-stop place for victim needs, namely: medical examination, post-traumatic assistance, orientation and counseling. The centers are accessed through the Emergency Department of the Hospitals and would involve an interdisciplinary team consisting of doctor/medical assistant, forensic doctor, psychologist, social assistant, and police representative. The centers are distributed across Romania, functioning in emergency county-level hospitals in Bucharest, Bacău, Brăila, Craiova, Constanța, Piatra Neamț, Satu Mare, Slobozia, Sibiu and Timișoara and are funded and maintained in partnership with local authorities. In the centers, the victim can receive free medical services and counseling. Also, biological sampling can be done using specific kits that are approved by the Superior Council of Forensic Medicine in Romania. The project included training of healthcare professionals and other professionals that may provide support to the victim[24].

A media article - published in April 2023 by Diana Meseșan, a journalist with experience in covering GBV reports that after 1.5 years after their opening, 15 people received services from 10 centers. However, ANES reports that 22 people have accessed the centers. The main barriers of victims receiving services in these centers, as highlighted in the article are:
(1) the medical emergency personnel in the hospital does not inform the victim of the existence of the center – the victim is referred only to the police; the police take the victim to the police station without providing counseling at the center and the victim does not file a police complaint and does not get forensic examination;
(2) the center works without dedicated personnel and funding; it is supported by the personnel from other institutions (e.g., Hospitals, DGASPC, Forensic Institute) – they may not be available all the time;
(3) due to lack of personnel, the door of centers can be locked when the victim comes;
(4) lack of public awareness campaigns on the existence of these centers and the services they provide.

Moreover, there is not yet any official methodology approved for the functioning of these centers as there are pending discussions between ANES and the Ministry of Health on this matter.

CONES

National Commission for Equality of Chances is an inter-ministry body, with representatives of different ministries, public administration, labor unions, and representatives of non-governmental organizations. It is coordinated by the Ministry of Family, Youth, and Equality of Chances. CONES has the responsibility to identify the best solutions for developing and implementing ANES public policies and to include and promote equality of chances between men and women in the sectoral policies – such as addressing GBV in the healthcare sector.

[24] https://anes.gov.ro/justice/obiectiv-5/

A comprehensive recent analysis[25] of Romanian policies regarding gender mainstreaming and gender budgeting shows that there is a low political support, a lack of financing and a low degree of implementation of the existing legislation. In addition, the analysis shows a lack of technical capacity/ knowledge as well as a low number of personnel. Furthermore, the analysis points out that the ministries do not collaborate among each other and ANES is the only institution responsible for these policies, while other ministries do not take an active role in gender equality policymaking and implementation. Also, according to the same analysis, state institutions lack basic know-how and information concerning equality of chances and gender mainstreaming. This situation unfolds also in the capacity of institutions to address gender-based violence in the healthcare sector.

Recommendations:

- Raise the level of expertise on gender equality and on gender-based violence among the public institutions at national and local level in order to facilitate the cooperation between ANES and health care institutions at national level.
- Increase and foster close cooperation between ANES and institutions with responsibilities in addressing gender-based violence.
- Increase the capacity of ANES for monitoring the activity of Ministries concerning the implementation of legislation and strategies and adequate funding.

Non-Governmental Organizations

Gender-based violence was a focal theme for Romanian organizations engaged in women's rights: running advocacy activities for supporting legislation and implementation, facilitation and participation to working groups with other stakeholders, providing services to vulnerable women, training professionals in various sectors on addressing GBV and organizing online and offline awareness campaigns and protests.

The Network to Prevent and Combat Violence against Women (VIF)[26] is an informal network of non-governmental organizations that actively promote women's rights and fight against gender-based discrimination. Some of the network's organizations such as ANAIS, Sensiblu, Pas Alternativ, Casa Ioana have their work focused in providing services – legal, psychological, and social services, shelters - for survivors of gender-based violence. Other NGOs work on broader

[25] Băluță. 2023. Analiza privind politicile egalității de gen în România
[26] https://violentaimpotrivafemeilor.ro/

topics regarding women's rights and the fight against gender-based violence through advocacy eg: Centrul Filia and Front Association.

The Coalition for Gender Equality[27] is another important network of organizations engaged in women's rights with a focus on education for gender equality (including against GBV). Some of the organizations are part of both the Coalition and VIF.

Moreover, it has to be mentioned the contributions of other organizations which do not necessarily work directly on the topic of gender-based violence. Still, they positively impact these matters, i.e., organizations working on sexual education or patient, children, and refugees' rights.

The non-governmental organizations are participating in working groups both with central institutions, including the Ministry of Health and with local administration and institutions (i.e. DGASPCs and hospitals). One example of NGOs' advocacy success covering the intersection between gender and healthcare is the legislation change that bans on-demand virginity tests (these can now be done only at the request of a courthouse).

NGO sector has made an important contribution to improving the healthcare's system response to gender base-violence. Some examples of such initiatives (non-exhaustive list):

- The local network of professionals working on gender-based violence in Brașov initiated and facilitated by Pas Alternativ Organization;
- Numerous trainings for professionals working on gender-based violence (that included healthcare professional) organized by Sensiblue, Centrul Filia, E-Romnja, ALEG, ANAIS, Pas Alternativ and other organizations with expertise on the subject matter;
- Protocols for addressing GBV for forensic medicine and emergency medicine in tertiary care elaborated by the Institute of Reproductive Rights, used informally at local level in Romania and officially in other countries in the region;
- Training for forensic doctors on sexual violence against children (with credit points), organized by VIS Association with the support of UNICEF;
- Training program for healthcare professionals in the network Care for Mothers that included sessions on GBV and PSEA - implemented by AMI with the support of UNICEF.

The results of the NGOs work show that there is a high need for continuation of these initiatives. However, due to limited capacity and resources, the efforts of the civil society cannot replace the work of public institutions and only serve as good practice models worthy to be scaled at national level.

[27] https://ongen.ro/

From policies to practice: access, service provision, and capacity building needs. Results Overview on Empirical Research

Research Methodology

In order to find out the level of implementation of the existing legislation, strategies, and measures, the research includes an empirical component based on a combination of qualitative and quantitative methods.

The qualitative approach consists of two semi-structured focus groups and two in-depth interviews with representatives of the National Agency for Equality of Chances, non-governmental organizations, and healthcare professionals working on gender-based violence from all main regions of Romania. There were 16 respondents, GBV experts and trainers, social workers, healthcare professionals, and project coordinators from 9 non-governmental organizations and institutions active in the area (see Annex 1). The interview guideline for the focus groups is available in Annex 2.

The quantitative methodological approach was based on an online questionnaire (Annex 3) that was shared among healthcare professionals and healthcare institutions. The questionnaire was answered by 334 respondents: 40.7% nurses (a significant part of them working in obstetrics and gynecology), 40.4 community nurses, 5.1% Midwives. The rest of the respondents work at the intersection between GBV and healthcare. 91,3% of the respondents are females. The questionnaire was sent to healthcare facilities and healthcare professionals across Romania, over half of the respondents were from rural areas, 22,2% from small urban areas (towns with less than 30000 inhabitants) and the rest from larger municipalities in urban area. To ensure the respondents that their answer is confidential the questionnaire did not ask information on the county of the respondents, however, the questionnaire included a non-mandatory question with the name of the institution that they for - over a half of the respondents shared the name of the institutions that they work for and these are located in over 10 different counties in Romania from all three historical regions of Romania. 90.4 of the respondents work in the public sector.

While the sample is not necessarily representative at a national level, it provides relevant insight into the current practices and protocols as well as on capacity building and training needs concerning the healthcare response to gender-based violence. The over-representation of women to the survey matches the actual overrepresentation of women working in the healthcare system as nurses and midwives in Romania. One main limitation of the survey stems from the data collection: due to limited resources the invitation to answer the questionnaire was send by the Association of Independent Midwives (AMI) via email to healthcare units and healthcare professionals across Romania, it can be assumed that the people who chose to answer the survey have a in average a higher interest into the topic and were already exposed to trainings on the topic as a large number of the respondents were participating in trainings hold by the AMI. Therefore, the results are relevant for initial explorative research and we recommend a more in-depth survey with a

representative sample of respondents on this matter including medical doctors.

Last but not least, it has to be noted that a relevant baseline for understanding current practices, experiences and capacity-building needs was provided, prior to the present research, by the discussions and the feedback received during the training sessions on GBV and PSEA held by the Association of Independent Midwives (and the author of the present report) to over 240 healthcare professionals - mainly nurses, community nurses, midwives and medical doctors with specialty in family medicine, emergency medicine and gynecology & obstetrics and neonatology. The training sessions were part of a larger training project named Care for Mothers Network, organized with support from UNICEF and held between January – April 2023 in 6 different counties of Romania. Since the training sessions were held in an interactive approach, we were able to receive relevant insights from the healthcare professionals. The respective training notes were used for this report.

Access to the healthcare system and identification of the victims

According to Romanian legislation, victims of domestic violence have **free access to emergency healthcare support and care**. 29.7% of the respondents of the questionnaire consider that the victims do not access the healthcare system, while 33.5% of the respondents consider that the victims access the healthcare system but do not disclose incidents, 15.9% say they cannot answer on these issues.

When asked how often they encountered cases of domestic violence/ gender-based violence in the last year, 46.1% of the respondents said they had no case and 35% said they had less than 5 cases. 7.2% of respondents shared that they encountered between 5 and 20 cases and 11.4% of respondents answered that they do not know, cannot answer. Considering the prevalence of GBV, disclosures of incidents remain low based on the feedback from the respondents. Considering how widespread the phenomenon of gender-based violence is, and that most of the respondents are healthcare workers interacting with a large number of people, it is **more plausible that people who experienced violence were not identified or that there were barriers for survivors to address healthcare services.**

The discussions during the focus groups indicate that the following healthcare sectors are addressed by the victims/ have the capacity to identify and assist people who experienced gender-based violence: family, emergency, pediatrics, forensic medicine, gynecology and obstetrics. The NGOs working on a grassroots level with victims of gender-based violence indicate that they very often cooperate with community nurses and Roma health mediators. Community nurses and Roma health mediators interact with large communities, have the capacity to build good relations with the community and hence a better capacity to identify cases of gender-based violence. School doctors and nurses are another category of healthcare professionals that have a similar potential impact and capacity to interact with large communities but were not yet involved in addressing GBV.

In the training discussions focused on gender-based violence (GBV) held by AMI with healthcare professionals, numerous instances were recounted by participants, in which patients exhibited visible lesions strongly suggesting potential abuse but no formal identification process or specialized care was provided in these cases. A high concern is that abuse on children is also not identified and not reported, even in cases of pregnancies for girls under 14 years old with partners over 20 or 30 years old.

In some cases, even if victims address the healthcare system and disclose their experience and even the immediate danger, they do not receive any support:

> *We had a case when a lady wanted to be hospitalized, her husband at the door [she felt threatened]. The doctor told her that there was no reason to hospitalize her and told her that "problems of violence you need to solve yourself at the police". No one offered to call the police for her* (Medical nurse).

The low level of case identification and GBV support is due to a combination of reasons:

(1) violence is often normalized and not identified as harmful and a breach of human right;
(2) violence is identified but is minimized by healthcare professionals (they see it as a normal result of patriarchal societal norms and traditions);

(3) lack of information/ awareness/ procedures in healthcare institutions and professionals that GBV is a matter of public health, and they have responsibilities on addressing it:

> *Many people do not know that there is a law on domestic violence, that there is a protection order, they do not call the police when there is abuse. They have the principle to not use the resources from the state and they "forget" to do their duty and there should be someone to remind them about this. I am sure there are many minors who go through abuse; they get into hospitals, and no one is informed*. (Representative of NGO working on GBV)

(4) lack of training of healthcare professionals in addressing and managing cases of gender-based violence.

> *We had a case when the community nurse was the only one who could meet the victim in person, the rest of us were providing support only by phone. Because the community nurse did not have enough information about GBV and legislation, we lost some important stages in supporting the victim, and finally, we lost the connection with the victim. That person could not benefit from assistance. We should not blame her [the community nurse] because she had limited knowledge.* (Representative of NGO working on GBV)

(5) lack of methodologies, procedures, and protocols as well as low implementation of the existing legislation.

Moreover, effectively responding to gender-based violence (GBV) requires an inclusive approach. Underserved and minority groups - such as living in rural areas/small towns, Roma ethnicity, LGBTQI+, refugees, migrants, institutionalized teenagers or with parents living abroad - make access to services even more difficult.

> *I always say that it is very important that people who work in small and rural communities be informed and trained. Laws get changed, like for domestic violence, many things are changed, but everyone who creates the change and sits at the decision-making table, they think from the perspective of privileged people who have access to services, and resources – like access to a smartphone. They do not think from the perspective of the most underprivileged - laws should be made for them, too.* (Representative of NGO working on GBV)

Gender-based violence is a public health concern. Attitudes of healthcare professionals

There is a low level of awareness among healthcare institutions and professionals concerning their responsibility in addressing GBV. They are not aware that addressing GBV is a matter of public health:

66.5% of the respondents consider that, as healthcare professionals have the responsibility of addressing gender-based violence/ violence against women. 12.3% consider they do not have such a responsibility and 21.3% do not know/ cannot answer.

A lower proportion, only 57.8% of respondents, consider the healthcare system to be responsible for preventing, combating, and managing gender-based violence/ violence against women.

Recommendations:

- Awareness raising on the role and responsibility of healthcare systems to address GBV among health care professionals
- Training programs for community nurses, Roma healthcare mediators, school doctors and other healthcare professional working with large communities on prevention and response of GBV;
- Provide community nurses, Roma healthcare mediators, and family medicine in rural and underprivileged areas with a professional advice support system for case management.

Service Provision & Addressing Gender-based Violence in Healthcare

Identifying the victims and addressing gender-based violence is not a common practice in

healthcare even when there are evident signs. Only 60% of the respondents say that they ask the victim about experiencing abuse when they suspect it.

When asked what are the actual services that victims benefit from in the healthcare units where they are working, 56% of respondents indicated that first-line support is provided in their facility. Only 35.9% of respondents indicated that medical examination and treatment are provided in the healthcare system. Social assistance, legal consultation, and referral to police are services indicated to be offered to the victims by more than 35% of the respondents. Report to the police/ social services of abuses with minor victims register lower rates of 31.4%.

Psychological consultation is indicated to be offered as a service only by 25.4% of the respondents. In comparison, referral to forensic institutes is indicated as an available service only by 12% of respondents.

What are the services that victims of gender-based violence/ domestic violence (physical and/or sexual) can receive in the health care facility where you work?

- Medical examination and treatments 35,9%
- First-line support (listening to the victim, inquiring about their needs and concerns, validation, enhancing safety, providing support, informing about available services for them) 56,6%
- Medical history and examination of victims of physical and/or sexual violence 21%
- Documentation of the physical and / or sexual abuse in the medical documents 13,2%
- Forensic examination and/or collection of biological samples 9.6%
- Emergency contraception 6%
- Termination of pregnancy resulting from sexual abuse 4.2%
- Post-exposure prophylaxis against sexually transmitted infections 7.8%
- Post-exposure prophylaxis for HIV 4.8%
- Psychological counseling 25,4%
- Legal counseling 4,8%
- Social assistance 36.5%
- Refral to psychological counselling/ support groups 13.2%
- Referral to DGASPC 21%
- Referral to an intervention center that offers support services for victims of sexual violence 13,5%
- Referral to non-governmental organizations that offer support services for victims 6.9%
- Referral to an institute of forensic medicine 12%
- Referral to police 38%
- Report to DGASPC/ Police if the victim is a minor 31.4%
- None of these services 2.4%
- Do not know 8.1%

The results of the questionnaire show a considerable gap between the reality of service provision for the survivors of gender-based violence in Romania and the international clinical and policy guidelines. The focus group discussions with NGOs and the discussions during the training with healthcare professionals indicate that GBV victims are not provided with the necessary services and referrals beyond initial examination and medical treatment:

> *As healthcare professionals, we treat the lesions, but no one, due to mentalities, wants to deal with such situations.* (Medical nurse and member of an NGO working on GBV)

Another aspect that prevents victims from benefiting from specialized services, even the ones who access the emergency centers of intervention for victims of sexual violence, is the different services cannot be accessed in the same place, and often they are located at a significant distance one from another (e.g. different sides of a city) which makes the services even less accessible for the victims who just went through a traumatic event and cannot afford the transportation. Another limitation is that the different services are not accessible on a 24/7 basis, they are located only in the capital of the counties, so the victims may need to travel considerable distances. Still, the victim must be able to access this service without delay.

> *There is the need to have one person in medical facilities who can tell a victim: <<you can go to this institution and ask for this>>. We have women [survivors] and they say they were not told by the hospitals that they can get a certificate after forensic examination, or that they can go to the police; if they say they were aggressed, they are treated just for the lesions, from the medical point of view, so to say, there would be good to have in every healthcare unit a person who is in charge of that and would guide the victim to know what she can do. I understand doctors may be busy, and tired, but to refer to the victim [to needed services] is something that can be done.* (Member of NGO working on GBV)

Similarly, the social worker of a hospital (when there is one) is not accessible 24/7. Usually, the social worker assistant has the role of assisting many cases at the county level emergency hospital. Therefore, the social worker assistant does not necessarily have the capacity to provide support to the victim.

In order to have the capacity to refer a victim to the needed services, it is important to create coordination mechanisms at the local level between institutions. As previously discussed, the legislation mandates local institutions, healthcare institutions, police, social services, and other stakeholders to create multidisciplinary teams. The results of the qualitative research show that functional multidisciplinary teams or/and networks between professionals exist only at the initiative and with the support of non-governmental organizations:

> *The healthcare professionals do not know one another [other institutions] even*

> *in small towns, they do not know where to advise the victim to go. At the local level, there is no network of referral paths, and they do not know one another even in the same place.* (Representative of NGO working on GBV)

The healthcare system in Romania rarely manages to be, as recommended, a gateway for the victims to access social services, justice, or police. Furthermore, not providing certain services such as prophylaxis against sexually transmitted infections & HIV and emergency contraception can have severe and long-term consequences for victims' health and also block survivors' rights to justice.

Barriers to healthcare professionals in addressing gender-based violence

The respondents identified a combination of barriers that limit the capacity of healthcare professionals to provide support to the victims:

Do you consider that health professionals face barriers to being able to provide care and support services to victims of gender-based violence/violence against women? If yes, which of these do apply?

- Lack of time (17.1%)
- Lack of education and training (33.5%)
- Lack of information on referral pathways (35%)
- Institutional barriers (15.3%)
- Absence of a reporting system (17.7%)
- Lack of procedures and standards (24%)
- Fear of the aggressor's vengeful actions against healthcare staff (25.4%)
- There are no barriers (10.2%)
- Do not know, cannot answer (19.5%)

This shows that healthcare professionals would provide better care and support for victims if they receive better institutional support (through guidelines, protocols, and procedures), allocation of more human resources, and training - complemented by a monitoring system.

The focus group discussions and the discussions during the training gave an important insight: if the nurses, midwives, and young doctors perceive that the more experienced medical doctors, heads of departments, or the hospital manager do not consider addressing gender-based violence, they should not do it either. This perspective was shared even by healthcare professionals who are well- informed on GBV but they say they are afraid of their hierarchical superiors for acting beyond their professional responsibility.

> In the focus groups one respondent that is both healthcare professional and also active in an organization working on supporting GBV survivors shared a

situation that took place in the hospital when a victim was in an emergency situation being threatened and followed by their partner but the doctor in charge told the victim to leave the hospital without providing any further support. The respondent felt that could not intervene further and provide information to the victim or report the case to the police: *As a medical nurse, according to my job description (fișa postului) I cannot cross over what the doctor says. I have no decision power without the agreement of the doctors.* (Medical nurse and member of NGO working on GBV)

Moreover, healthcare professionals that we discussed with, both in the training and in the focus groups, shared the perception that institutional hierarchies act stronger than even national legislation i.e. although legislation states that any suspicion of child abuse has to be reported many healthcare professionals perceive that they need to receive approval from their superior before filing a complaint. Furthermore, procedures on referral pathways are indicated to be followed at a high or very high level only by 15% of the respondents, while procedures concerning the obligation to report abuse against minors are indicated to be followed to a high or very high degree by 27% of the respondents.

Considering the existing authoritative leadership approach present in Romanian public institutions, the absence of a functional mechanism for reporting medical errors by colleagues or superiors, and the concerning prevalence of mistreatment towards women, including obstetric-related violence and the mistreatment of female healthcare professionals within lower hierarchical tiers, particularly midwives and nurses - there is the need the need to create and enforce procedures and train staff at all levels including management for ensuring that victims get access to the necessary services.

Recommendations:

- Ensure that all victims, without any discrimination, receive immediate and comprehensive assistance provided by a coordinated, multidisciplinary and professional team, whether or not they file a complaint, including medical and forensic medical examination and treatment, together with post-traumatic psychological and social support as well as legal assistance; these should be provided on a confidential basis, free of charge and be available 24/7;
- Include responsibilities for addressing gender-based violence in the job descriptions of healthcare professionals as well in the job descriptions of other professionals working in the healthcare system that have responsibilities in GBV: i.e., social assistant, psychologist;
- Implementation of referral pathways for primary, secondary and tertiary level of care;
- Create effective mechanisms to increase human resource capacity. i.e., ensure every emergency hospital have a responsible person to address GBV cases 24/7;
- Ensure funding for implementation.

Training needs

As previously discussed, providing health care professionals with training is essential. Considering that today's healthcare practitioners did not benefit from such a training in their initial professional training, efforts should be made to create training programs for continuous training.

When given the opportunity to choose **the top three priority training topics** for them, the respondents had the following choices:

- **Measures of prevention against GBV (65.9%)**
- **Screening and identifying victims of domestic violence/GBV (54.2%)**
- **First-line support (61.7%)**
- Medical history and examination of the victim (12.6%)
- Documentation of the physical/ sexual abuse in the medical data (11.7%)
- Forensic examination (5.1%)
- Emergency contraception (8.1%)
- Referral pathways to available support for the victim - legal, social assistance, psychological support, shelter (25.4%)
- Prophylaxis against sexually transmitted infections (8.7%)
- Prophylaxis against HIV (7.2%)
- Case management and inter- and intra-institutional coordination for providing support to victims (18.3%)

Considering their low level of awareness and existing current gender stereotypes at societal level, it is essential that healthcare professionals receive information on gender-based violence, measures of prevention, identification of the victim, first-line support, and basic information on referral pathways. Adapting to their specialization, healthcare professionals in gynecology and obstetrics and emergency should be trained in documentation, prophylaxis against sexually transmitted infections & HIV, and emergency contraception.

Due to the low level of expertise on the matter, it is highly important that such training programs be developed in cooperation with healthcare institutions at the national level and experts in gender-based violence. Representatives of NGOs shared in the focus group that healthcare professionals are one of the hardest-to-reach professional groups when compared with other sectors such as security, justice, social work, or education. Furthermore, a system of mandatory regular participation in these training programs on addressing GBV should be established - i.e. every 3 years. Last but not least, GBV experts highlighted the need for a minimum standard for organizing such training.

Recommendations:

- The training programs for healthcare professionals should be created as a cooperation between institutions with responsibilities in healthcare at the national level and GBV experts;
- Trainings on strengthening the response to GBV in the healthcare system should be provided for decision-makers and managers of healthcare institutions at the national level, professional medical colleges, hospital managers, and heads of hospital departments;
- Pre-service training on GBV should be included in the formation curriculum for doctors, nurses, and midwives;
- Advanced training in residency programs for professionals in family medicine, emergency, pediatrics, school doctors and nurses, forensic medicine, obstetrics and gynecology;
- Continuous refreshers and trainings should be provided to healthcare professionals on a mandatory and regular basis, i.e., every 3 years.
- Training shall include general notions on gender-based violence, identification of victims, first-line support, and documentation.
- Ensuring that the training content is coherent with international standards and that the trainers have proven expertise on the subject matter.

Conclusions

Romanian authorities are responsible for ensuring access to the healthcare system without any discrimination. GBV survivors must receive immediate and comprehensive assistance provided by a coordinated, multidisciplinary, and professional team, whether or not they file a complaint, including medical and forensic medical examination and treatment, together with post-traumatic psychological and social support as well as legal assistance; these should be provided on a confidential basis, free of charge and be available around the clock. This is not yet a reality in most healthcare facilities in Romania.

Considering the findings of this report, improvement needs to start by prioritizing GBV response into the agenda of healthcare institutions. Furthermore, training and sensibilization of professionals and decision-makers need to be supported by capacity-building efforts and effective institutional mechanisms as well as by mobilizing the necessary resources.

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Annex 1. List of participants to the Focus Groups

	Organization	**Location**
1	A.L.E.G.	Sibiu
2	ANAIS	Bucharest
3	ANES – National Agency for Equality of Chances	national
4	Centrul de Mediere și Securitate Comunitară	Iași
5	Centrul de victime violență în familie	Covasna
6	East European Institute for Reproductive Rights	Mureș
7	Fundația Sensiblu	București
8	Fundația VIS	Constanța
9	Pas Alternativ	Brașov