Cooperation between women's NGOs and healthcare providers
A comparative study in the Western Balkans and Turkey

Women against Violence Europe Network (WAVE) is a European-wide network of more than 160 members (including women's NGOs, NGO networks and individual members) in 46 European countries, who are dedicated to addressing and preventing violence against women and girls. Since its foundation in 1994, WAVE has been working to promote and strengthen the human rights of women and children, and to enable women and their children to live free from violence, particularly through building and sustaining a strong European network of specialized support services, experts and survivors.

CREDITS

WAVE Executive Manager Stephanie Futter-Orel
WAVE Team Leader Anca Ciupa

Author Biljana Brankovic, International Consultant[1], Serbia

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Albania	Albanian Women's Empowerment Network
	Gender Alliance Development Centre
Bosnia and Herzegovina	Foundation United Women Banja Luka
Kosovo*	Women's Wellness Centre
Montenegro	SOS Hotline for Women and Children Victims of Violence- Niksic
North Macedonia	National Network to end VAW and DV – Voice against violence
Serbia	Association Fenomena
Turkey	Mor Çatı Women's Shelter Foundation

Graphic design Monika Medvey
WAVE Network Office Bacherplatz 10/6, 1050, Vienna, Austria
www.wave-network.org
https://cssplatform.org/
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[1] Biljana Brankovic is also a member of GREVIO. However, she authored this paper in her personal capacity as Independent Consultant, not in her official capacity as GREVIO member, so opinions expressed herein cannot not be attributed to GREVIO as a whole.

TABLE OF CONTENTS:

FOREWORD

Multi-agency work has been developed in many European countries over the past decades. Such partnerships are very important and have different forms and aims around improving the response to violence against women and domestic violence. It is common practice for such collaborations to work on a structural level; exchanging experiences, carrying out joint actions, offering trainings and activities to improve cooperation.

Multi-agency cooperation is an effective tool in reducing repeat victimization and improving survivor confidence in the services provided by ensuring that the victim is supported adequately by a women's support system. These partnerships must work together to include and engage survivors through their support services, and the process must be as empowering as possible for the woman. Her right to make decisions regarding her own life must be respected and no decisions must be made that may further endanger her.

As healthcare providers are a key and life-saving link in connecting women experiencing male violence with women's specialist services, the overall aim of the current project is to analyze how women's NGOs in the Western Balkans and Turkey assess the cooperation with healthcare providers, as such collaboration is instrumental in delivering quality support services. To increase the quality of specialist support services provided to victims of violence by healthcare providers and women's CSOs, referral pathways between these stakeholders need to be strengthened and where such connections do not exist, working cooperation needs to be built between women's CSOs and healthcare providers.

The COVID-19 pandemic impact on specialist services for victims and survivors of violence in the Western Balkans and Turkey has also affected multisectoral cooperation, specifically among healthcare providers and women's CSOs offering support to women victims of violence. Women's CSOs in the Western Balkans and Turkey have identified multisectoral cooperation as challenging during the pandemic, and its interruption has had a direct impact on women and girls, slowing down survivors' ability to access services and seek assistance. Multisectoral cooperation among women's CSOs and health care providers has already been challenging during normal times, and the pandemic has only exacerbated such issues. A lack of and/or precarious multiagency cooperation has been identified by all IPA beneficiaries supported by the UN Women program.

The present research assessment has been produced with the purpose of contributing to the development and/or increase in collaboration between women's CSOs and healthcare providers.
The present assessment was carried out as part of the EU/UN Women project "Strengthen multisectoral and interagency coordination mechanism, CSOs service providers online service delivery skills and youth roles in preventing violence across the Western Balkans and Turkey", as part of the UN Women region program on ending violence against women 'Implementing Norms, Changing Minds', funded by the European Union.

INTRODUCTION

Combating male violence against women and girls requires extensive multi-agency cooperation as part of an integrated approach – this is one of the most relevant principles of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, also known as the Istanbul Convention. In Article 18 (General obligations), the Istanbul Convention requires a multi-agency and comprehensive approach which means, *inter alia*, that there are appropriate mechanisms in place that provide effective cooperation among relevant state agencies as well as other relevant entities, in protecting victims of all forms of violence covered by the scope of

the convention. The term "mechanism", as highlighted in the Explanatory report to the convention (paragraph 113) refers to any formal or informal structure such as agreed protocols, round-tables or any other method that enables a number of professionals to cooperate in a standardized manner. Cooperation between different stakeholders in providing a comprehensive response to male violence against women has faced numerous obstacles across Europe, as relevant literature and GREVIO evaluation reports on the implementation of the Istanbul Convention clearly shows. This cooperation has become even more complicated in the context of the COVID-19 pandemic. Women's NGOs in the Western Balkans and Turkey have identified multi-sectoral cooperation as problematic during the pandemic, and its interruption has had a direct impact on women and girls, slowing down the process of providing assistance to women victims of violence.[2] Multisectoral cooperation among women's CSOs and healthcare providers has already been challenging during normal times, and the pandemic has only been increasing these issues.

As health care providers are a key and life-saving link in connecting women experiencing male violence with specialist women's services, the overall aim of the current project is to improve multisectoral cooperation between women's CSOs and especially women's CSOs and health care providers, as such collaboration is instrumental in delivering quality support services. To increase the quality of specialist support services provided to victims of violence by healthcare providers and women's CSOs, referral pathways between these stakeholders need to be strengthened and where such connections do not exist, working cooperation needs to be built between women's CSOs and healthcare providers.

As highlighted in international literature as well as in GREVIO Baseline reports on the implementation of the Istanbul Convention, the establishment of efficient multi-agency cooperation requires (apart from a sound legal base) clear procedures and clear division of responsibilities of each particular agency/organization that participates in multi-agency response. Such a clarity is best achieved through specific protocols that regulate all of the above. With this in mind, the cooperation between women's NGOs and healthcare providers should not be seen in "isolation" from other segments of the multi-agency approach. Although this study is focused on cooperation between women's NGOs and healthcare providers, this cooperation is assessed within the broader context of a multi-sectoral coordinated response which involves different relevant stakeholders, as required by the convention.

Challenges arising from the COVID-19 pandemic

Protection of victims became more challenging during the COVID-19 pandemic, as indicated in official statements and reports of monitoring mechanisms on women's human rights[3]. It is still difficult to determine the effects of the pandemic on the possibility to protect women victims of violence. As stated in the Second General Report on GREVIO's activities (2021)[4], GREVIO baseline evaluation reports published to date do not yet reflect the direct and indirect effects of the COVID-19 pandemic

[2] UN Women Report: https://www2.unwomen.org/-/media/field%20office%20eca/attachments/publications/2020/05/unw_covid-vaw_report_final.pdf?la=en&vs=5317

[3] GREVIO published a statement on 20 March 2020, calling on parties to the Istanbul Convention to uphold its standards during the COVID-19 pandemic as "restrictions on movement offer abusers additional power and control over the women and girls they live with", stressing how never before has the need been greater to ensure support services are available and that women and girls are informed of where to find help. On 14 July 2020, GREVIO joined the Platform of Independent Mechanisms on the Elimination of Discrimination and Violence against Women (EDVAW Platform), consisting of seven United Nations and regional expert mechanisms, in jointly calling upon all states and relevant stakeholders worldwide to ensure "peace at home" during the lockdowns related to the COVID-19 pandemic and to integrate the elimination of discrimination and gender-based violence against women in the COVID-19 recovery phase and beyond. The declaration underlines that as countries imposed lockdowns to fight the COVID-19 pandemic, the world saw dramatic increases in cases of domestic violence, including violence by intimate partners, sexual violence and femicide, requiring that states take urgent steps to combat this pandemic within a pandemic.

[4] GREVIO – Group on Experts on Action against Violence against Women and Domestic Violence (2021). *The Second General Report on GREVIO's activities, covering the period from June 2019 to December 2020*. Strasbourg: Council of Europe

on women and girls. This dimension is however highlighted in ongoing GREVIO evaluations and baseline evaluation reports. This notwithstanding, it is clear that restrictions on movement and social isolation measures adopted by governments as a result of the COVID-19 pandemic have by and large led to an exponential increase in violence against women, including domestic violence and sexual violence such as rape, as well as an increase in gender-related killings of women[5].

Some state parties have strived to quickly adapt to the challenges posed by the pandemic and ensure the continuation, as far as possible, of the provision of services to victims. Moreover, the COVID-19 pandemic has spurred in certain countries some positive and/or creative solutions in the area of specialist support services and provision of information. By way of example, some countries formally qualified emergency services and protection measures for victims of violence against women as fundamental priorities during the COVID-19 crisis[6]. Innovative ways of providing information to victims about services and assistance have also been deployed by a number of states, such as SMS helplines, the use of code words at pharmacies and an increase in online support services. Both France and Spain introduced a scheme allowing victims to use a code word in pharmacies and other stores to obtain advice and information on where to find help.

However, overall **the pandemic has shed light on pre-existing gaps already identified by GREVIO in the area of specialist services, magnifying them and/or giving rise to new shortcomings**. Based on submissions by Council of Europe Member States in response to a call for information by the Gender Equality Commission and the Committee of the Parties to the Istanbul Convention[7], it emerges that with regards to access to shelters, insufficient funding has been made available to help ensure that all victims are offered safe refuge throughout the pandemic. Also of particular concern has been the paucity of accommodation catered to the needs of women or children with disabilities. **The problems of insufficient funding for women's specialist services (WSS)** such as refuges and lack of available bed spaces for women and children fleeing from domestic violence have been quite substantial even before the pandemic. Unfortunately, although the pandemic led to an increasing need for these services, some governments (particularly those which are predominantly conservative or with right-wing political leaning) have simultaneously cut even more funding for WSS under the pretext that increased financial resources were needed to address the COVID-19 pandemic. This approach is however very short-sighted and clearly politically motivated, as WSS **are** essential health services.

Women's specialist services ensure the mental and physical health, and in many cases also the survival, of women and children experiencing violence, and ensure that they can exit these detrimental life-circumstances up to 8 times faster than through generic victim or state services. **Studies[8] from several countries (e.g. the UK, Italy and Denmark) have shown that WSS also effectively save states and overall society significant amounts of money every year i.e. for every €1 of funding invested in WSS, they give on average between €6-8 in social value back to society.** This is calculated in terms of saved costs for policing, social service interventions, emergency housing, hospital and secondary health care treatments due to injury, lost working hours to the economy due to injury or trauma, and above all the substantial human costs of suffering, trauma, injury and often life-long consequences of experiencing abuse and violence.

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[5] See Joint statement by the Special Rapporteur and the EDVAW Platform of women's rights mechanisms on COVID-19 and the increase in violence and discrimination against women, COVID-19 and increase in gender based violence and discrimination against women

[6] See Cristina Oddone: Expert on gender-based violence and research associate at the University of Strasbourg (2020). Violence against women and girls before, during and after COVID-19: the shadow pandemic that must be addressed, Synthesis report of the Council of Europe webinar on the Istanbul Convention held on 20 May 2020, France, p. 5, available at: www.coe.int/en/web/istanbul-convention/webinar.

[7] Available at www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights

[8] https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf

As is further stated in the Second General Report on GREVIO's activities (2021)[9], **an increase in the number of calls to helplines has also been reported during the pandemic**, in parallel with the deployment of novel online tools that allow victims to seek help discreetly. Such a surge in the number of requests for help has not, however, been matched by an increment in human resources that would allow civil society organizations that manage those helplines to effectively take the calls and help victims. Moreover, new online solutions are not readily available to all women, including elderly women or women with certain disabilities. Access to specialist health service provision has also been raised as a concern, particularly for victims of rape and sexual violence, exacerbating specific barriers that already existed for this group of victims before the pandemic. **Mental health services have been equally negatively affected**, as highlighted in the UN Women Rapid Gender Assessment measuring the impact of COVID-19 on violence against women in 13 countries[10]. More generally, civil society has pointed to insufficient funding for all types of specialist support services during the pandemic. Finally, access to health services for women, particularly sexual and reproductive health services, has also been affected which has negatively impacting maternal and child health.

Other sources also point to the consequences of the pandemic in the area of service provision. This issue was addressed in the webinar recently organized by the Council of Europe titled "Violence against women and girls before, during and after COVID-19: the shadow pandemic that must be addressed". The report of the webinar notes that restrictive measures taken in response to the pandemic have given rise to a number effects exacerbating existing forms of intersectional discrimination on the basis of gender, social condition, ethnicity, geographical location, age, and disability, among others. The report also highlights the negative impact that the pandemic has had on violence against women such as the rise of online and technology-facilitated violence, coupled with limited opportunities for victims to get immediate help and to report and a limited institutional response with regard to this type of violence.[11] Furthermore the report evokes states' obligations during the COVID-19 pandemic, while simultaneously recalling some positive institutional responses during the crisis such as the decision of certain states to designate some services and protection measures as priorities.

PURPOSE OF RESEARCH ASSESSMENT

The general purpose of this multi-country assessment is to analyze the **cooperation between women's NGOs and healthcare providers** (such as primary healthcare centers, hospitals, emergency wards, mental health centers, among others) in Albania, Bosnia and Herzegovina, Kosovo, Montenegro, North Macedonia, Serbia and Turkey, including the challenges arising from the pandemic. To be able to assess the cooperation between women's NGOs and healthcare providers, it is furthermore important to assess the capacity and quality of healthcare services for women survivors of violence. Assessing how survivors of violence are supported by healthcare providers is an important indication of the overall response to VAW and DV, but also to the overall prosecution of perpetrators. It should be further emphasized that the study relies on the perspective of women's NGOs and how they perceive the cooperation with healthcare services (medical professionals have not been included in the study). More specifically, the research aims to:

[9] op.cit.

[10] Available at: https://data.unwomen.org/sites/default/files/documents/Publications/Measuring-shadow-pandemic.pdf

[11] See: Cristina Oddone: Expert on gender-based violence and research associate at the University of Strasbourg, France (2020). Violence against women and girls before, during and after COVID-19: the shadow pandemic that must be addressed, Synthesis report of the Council of Europe webinar on the Istanbul Convention held on 20 May 2020, available at: www.coe.int/en/web/istanbul-convention/webinar

- **Analyze the quality of cooperation[12] between women's NGOs and healthcare institutions within a broader context of multi-sectoral response to violence as well as assess the response of healthcare providers** to VAW and DV, focusing on:
  a) **Referral pathways** – whether medical professionals use the opportunity to refer women victims to women's NGOs, so that victims may receive specialist support and help, and whether women's NGOs have signed protocols or other formal mechanisms of cooperation with healthcare institutions that might facilitate referral;
  b) **Cooperation with mental health professionals** (psychologists, psychotherapists, psychiatrists) and possibilities of women victims to receive longer-term psychological counselling in the public healthcare sector;
- **Examine what kind of protocols/guidelines are in place for healthcare providers** when supporting women victims of domestic and sexual violence[13];
- **Assess the implementation of such protocols** (where they exist) in practice, by:
  a) Analyzing the **experiences of women victims of domestic and sexual violence based on the support provided by healthcare professionals**;
  b) Assessing whether **doctors use standardized/prescribed forms to document injuries resulting from domestic violence** and how and under which conditions they provide forensic examination in cases of sexual violence. Understanding how standardized/prescribed forms are documented by healthcare providers contributes to potential legal support women's NGOs might offer to survivors of violence but also to potential aspects that women's NGOs can focus on when delivering trainings to healthcare providers;
  c) Examining whether **doctors in practice contribute to effective prosecution of sexual violence cases.** The analysis of the shortcomings in the implementation of the protocols is further aimed at identifying areas where women's NGOs might strengthen the cooperation with medical professionals and/or advocate for changes in the existing protocols. Moreover, these segments of the analysis are aimed at verifying if the important article of the Istanbul Convention is implemented in practice – Article 18, paragraph 4 prescribes that services to victims (including for example forensic examination), should be provided regardless of the willingness of victims to press charges or testify against any perpetrator.
- **Determine whether women's NGOs interviewed for this assessment have recorded an increase in the number of cases of violence reported to them in general during the pandemic** (in comparison to the period before the pandemic) as well as what types of support were provided to victims by these NGOs throughout the pandemic;
- **Identify any positive aspects** of cooperation between healthcare providers and women's NGOs in the areas specified above, **as well as any possible shortcomings**. Mapping (potentially) promising practices and shortcomings in the region will enable WAVE and CSSP partners to design activities and a strategy that can tackle identified shortfalls. In order to identify potentially promising practices and shortcomings, as well as to illustrate various aspects of collaboration with healthcare providers in the areas mentioned above, women's NGOs filling out the questionnaire were asked to write a brief description of cases of violence

[12] For the purpose of this research, the quality of cooperation was analysed through the lens of the general assessment of women's NGOs of such collaboration, based on the Likert Scale.

[13] To make the study feasible, we decided to focus on the experiences of domestic and sexual violence victims, rather than on all forms of violence covered by the Convention, taking into account that women's NGOs – national partners in the study mostly work with domestic violence victims, and occasionally, with sexual violence victims.

from their experience. Hence, some elements of qualitative methodology were used. These examples/brief descriptions of cases have been quoted throughout the present report.

Finally, in order to explore possibilities for improving the cooperation between women's NGOs and healthcare providers in the future, **two additional issues** are analyzed:

- Do women's NGOs possess the experience and capacity to organize **trainings** for medical professionals, and if so, whether these trainings may be used as basis for future cooperation;
- Do countries have systems of **data collection on access of victims to healthcare** (as the Istanbul Convention requires), and if so, whether such data may be used by women's NGOs for monitoring, shadow reporting and/or other advocacy purposes.

METHODOLOGY

For the purpose of this study, a questionnaire was developed by external consultant Biljana Brankovic and sent to national partners in the Western Balkans and Turkey, to ensure that data and information available was collected by partners based on a unified methodology, as well as to allow cross-country comparison. Indicators developed (see Annex of the present research) for the purpose of the questionnaire have been derived relying on the relevant provisions of the Istanbul Convention.

The questionnaire which was sent to the national partners in the seven countries included five parts, namely; cooperation between healthcare institutions and women's NGOs, experiences of victims of DV/SV in healthcare institutions, specific law on domestic violence and legal provisions about duties of medical professionals, General and/or Special Protocols regulating the duties of healthcare professionals in cases of DV/SV, and data about access to healthcare by DV and SV victims. Women's NGOs filling out the questionnaire were asked to answer in total 46 questions, some of which were open-ended. Certain elements of qualitative methodology have also been used; organizations responding to the questionnaire were asked to provide **examples of victims' experiences with healthcare services**, **i.e. to write brief stories** (small "case studies") describing such experiences.

In total, WAVE received answers from 14 women's organizations in all seven partner countries. The country distribution of women's NGOs participating in the survey was the following; seven organizations from Albania, one organization from BiH, 2 organizations from Kosovo, one organization from Montenegro, one organization from North Macedonia, one organization from Serbia, and one organization from Turkey.

RESULTS OF THE RESEARCH ASSESSMENT

A. Setting the scene: Assessing the cooperation between healthcare providers and women's NGOs within a broader context of multi-agency response to cases of violence

Women's NGOs who completed the survey were asked to assess on a scale from 1 to 5 (*1 indicating "very poor", 5 indicating "excellent")* the quality of cooperation between **their particular NGO** and different state agencies dealing with cases of domestic and sexual violence, such as the police, prosecution authorities, courts, educational institutions, healthcare institutions, as well as other relevant stakeholders (local governments, media, UN agencies, etc.). The chart below illustrates an average score, based on the responses of the 14 women's NGOs answering the questionnaire. Assessing the quality of cooperation (on a sale of 1 to 5) between women's NGOs and different stakeholders is the subjective assessment of the women's NGOs filling out the questionnaire; participants were invited to express their level of agreement with a specific statement, according to the Likert scale method. Consequently, women's NGOs were not only asked about the cooperation with healthcare institutions, the purpose of this part of the survey was to provide "an overall picture" regarding the cooperation between women's NGOs and all relevant state agencies/stakeholders

responsible for the protection of victims and prosecution of perpetrators. The cooperation between the NGOs involved in this project and healthcare providers should therefore be viewed **within the broader context of a multi-sectoral approach to cases of violence, which is crucial in the protection and support of victims.**

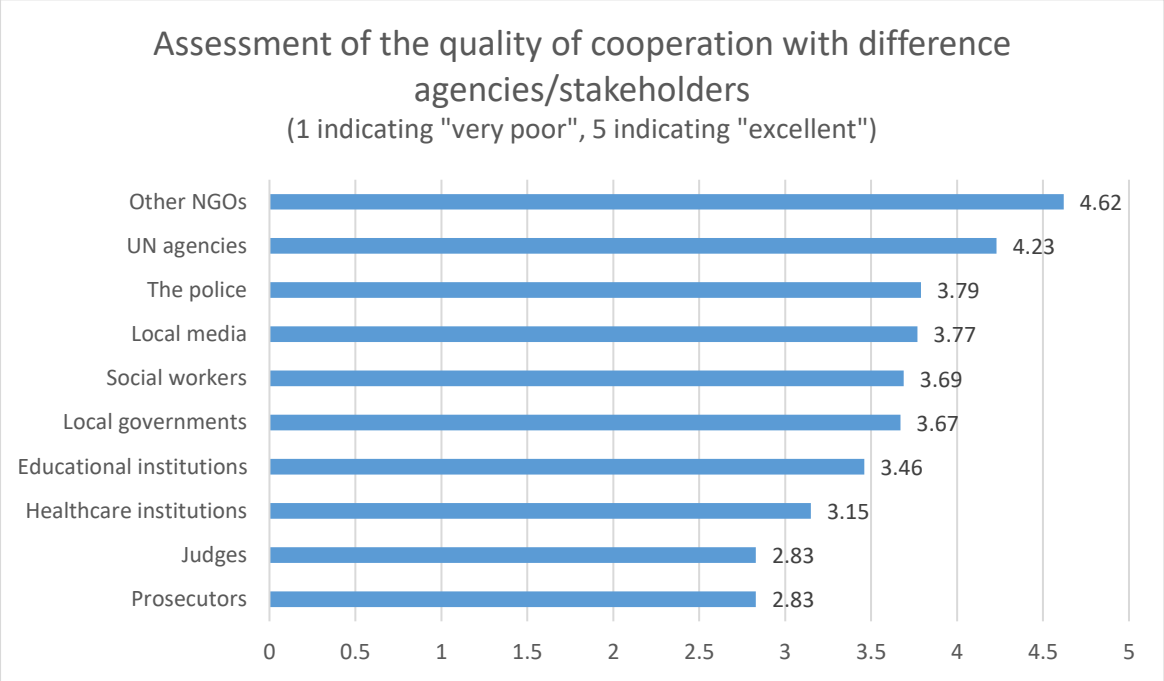

Chart 1: How women's NGOs assess the quality of cooperation between their particular NGO and state agencies/other stakeholders, on a 1-5 point scale (1 indicating "very poor", 5 indicating "excellent"), average scores

Participants were also asked, to their knowledge, to assess how **other NGOs in their country** cooperate with the indicated state agencies/stakeholders (See Chart 2).

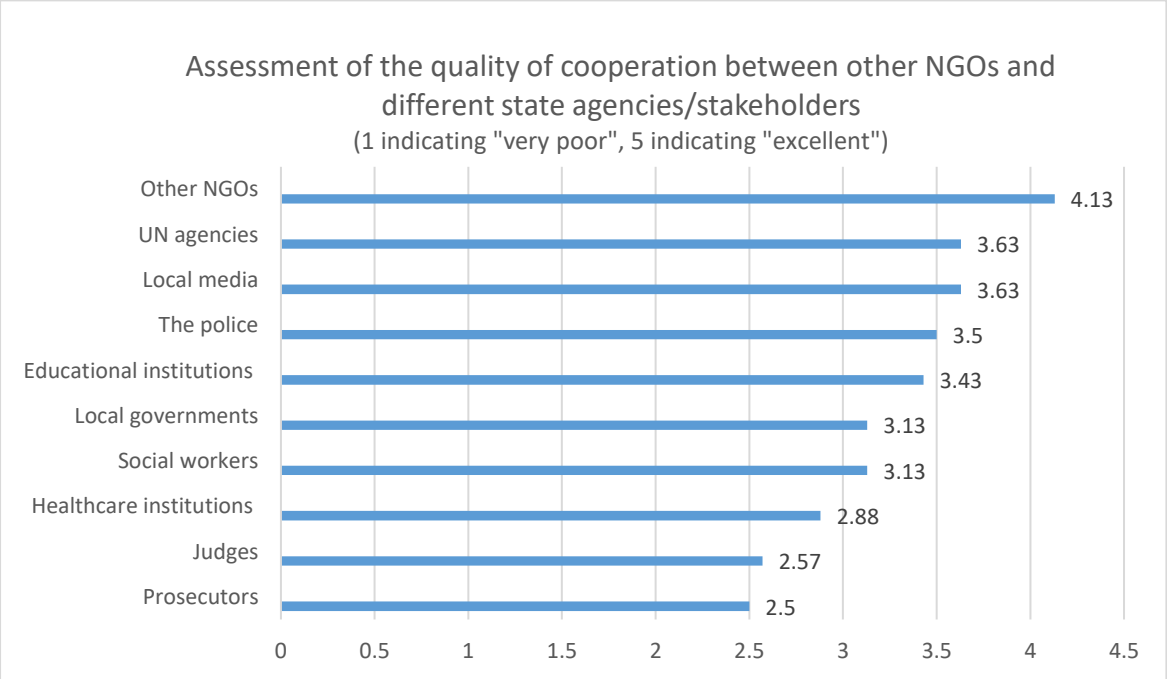

Chart 2: How women's NGOs assess the quality of cooperation between other NGOs in their country

and state agencies/other stakeholders, on a 1-5 point scale (1 indicating "very poor", 5 indicating "excellent"), average scores[14]

As can be seen in Chart 1, women's organizations assessed that their NGO cooperates very well with other NGOs (average score: 4.62) and UN agencies (4.23), while cooperation with the judicial system (judges and prosecutors) received the lowest average scores (2.83 and 2.83, respectively). Within this broader context of multi-sectoral collaboration, the quality of cooperation with healthcare providers received a modest average score (3.15), indicating **there is room for improvement in terms of this specific cooperation.** Qualitative analysis of responses to other questions in the questionnaire (provided in the following sections of this report) further indicate **which aspects of cooperation between women's NGOs and healthcare providers might be improved**.

The above-presented scores on the quality of cooperation with various institutional mechanisms are consistent with the findings of other recent multi-country reports in the region of the Western Balkans, which highlight that cooperation between service-providing NGOs and the judiciary has not been properly implemented in practice, i.e. that prosecutors and judges often represent the "weakest link" in the chain of collaboration, whereas cooperation between women's service providers and healthcare services received an average score that was somewhere in "the middle" (Brankovic, 2019[15]).

The story below highlights how domestic violence includes coercive control; violent men control all aspects of women's lives, including when and where they are "allowed" to see doctors. The beneficiary of the safe house run by Foundation United Women from Banja Luka (BiH) was a woman with disabilities who suffered violence from her husband, which unfortunately also included a neglect of her medical condition. With the intervention of the women's NGO and a good collaboration with medical professionals, this woman's case was prioritized in the local hospital and she was able to receive proper medical care. **Note that these institutions used the term "mental retardation" to determine her diagnose and describe her disability.**

Promising practice: Collaboration between women's NGOs and healthcare institutions during the pandemic: A "life-saving" intervention

The woman was exposed to all forms of violence by her husband for a long period of time, and she filed reports to the police. She belongs to a marginalized group of women, as she has a disability. The right side of the body is paralyzed, and she has been categorized as a person with "a light mental retardation". She was accommodated in the Safe House for Women and Children Victims of Violence in Banja Luka alone, as her children did not want to go with her. She never received adequate protection and the community perceived her as a helpless person who is incapable to live an independent life. She did not want to leave her children, and that was one of the reasons why she stayed in a violent relationship for a long time. After her husband forced her out of their home, she agreed to leave the children. Upon arriving to the Safe House in Banja Luka, she complained of breast pain. After she was checked by a specialist, she was diagnosed with breast cancer. Previously she asked her husband several times to take her to a doctor, but he refused, which led to a neglect of her health condition. Staff of the Safe House in Banja Luka contacted a social worker in a hospital, and she was scheduled for an examination the next day to determine the type and form of the

[14] As mentioned above, 14 partner organisations participated in this survey, which has impact on the reliability of the average scores. Yet, previous studies (based on far greater number of participating organisations; e.g., Brankovic, 2019) showed similar results.

[15] Brankovic, B. (2019). Violence against women in Western Balkans – Thematic report. In: Duhacek, D., Brankovic, B., Mirazic, M., *Women's rights in Western Balkans: Study for the FEMM Committee, European Parliament,* pp. 34-74. Brussels: European Parliament, Policy Department for Citizens' Rights and Constitutional Affairs. (in English), Available at European Parliament Website: http://www.europarl.europa.eu/RegData/etudes/STUD/2019/608852/IPOL_STU(2019)608852_EN.pdf

cancer, and to plan for the necessary treatment. Biopsy samples were taken the following day, and throughout the next days, the woman undertook all the necessary check-ups (that are complex and normally take longer periods of time to be undertaken). Considering these circumstances, if she would not have been accommodated in the shelter, this woman would have lost a lot of time to conduct all necessary investigations and further plan for the necessary therapy.

Story provided by Foundation United Women Banja Luka, Bosnia and Herzegovina, http://www.unitedwomenbl.org

B. Cooperation between women's NGOs and healthcare services: experiences with referral of victims to NGOs by healthcare services

Almost all (13 out of 14) questionnaire respondents assessed that **their cooperation with healthcare services remained the same during the pandemic as before**; only one NGO (from Albania) recording an improvement in such cooperation. Keeping in mind the importance of a multi-sectoral and comprehensive approach, as is emphasized throughout the Istanbul Convention, another issue examined through this assessment was **whether any referral pathways to women's NGOs exist**, i.e. if healthcare professionals, as "front-line workers", who often are the first point of contact for women experiencing violence, refer victims to women's specialist NGOs so that victims can receive psychological support and other types of assistance. If a multi-sectoral approach is functioning properly in practice, it is reasonable to expect that doctors and other medical professionals use the opportunity to refer victims to specialist NGOs in the local community.

In some countries (such as Albania), doctors have a legal obligation to refer victims to specialist services. therefore, It is essential to assess not only if medical professionals are identifying and supporting victims, but also if they use their unique position (as "front-line respondents") to refer victims to local sources of specialist support, including women's NGOs. Therefore, the following aspects were examined:

1) **Women NGOs' experiences with referral and whether healthcare services refer victims to their NGOs;**
2) Considering the above-mentioned importance of a formal or informal mechanism or structure of cooperation that enables professionals to cooperate in a standardized manner, **whether women's NGOs have signed protocols of cooperation/other formal mechanisms of cooperation with healthcare services or their cooperation with healthcare is based only on personal links.**

One of the most worrying findings of this study is that half of the NGOs report that healthcare institutions do NOT refer women victims of violence to their organization (see Chart 3). Consequently, it seems that there is a lot of room for improvement in this area. Furthermore, **those NGOs that responded that doctors mostly do not refer victims to them (with two exceptions) also highlight that they do not have a signed protocol with local healthcare providers**, i.e. that no formal mechanism of cooperation between their NGO and healthcare services exists at a local level. In addition, in response to the second question, **seven NGOs do NOT have a signed protocol at a local level or other formal mechanism of collaboration established with healthcare services** (see Chart 4). They state that their cooperation with healthcare institutions in their community is based only on personal links with medical professionals.

It could be therefore concluded that **the lack of a formal mechanism of cooperation is correlated with a lack of referral of victims to NGOs by healthcare providers. It can be further claimed that by**

signing a formal protocol at a local level or by establishing a more structured form of cooperation, referral pathways might possibly improve, and/or new referral pathways could be created where they do not exist.

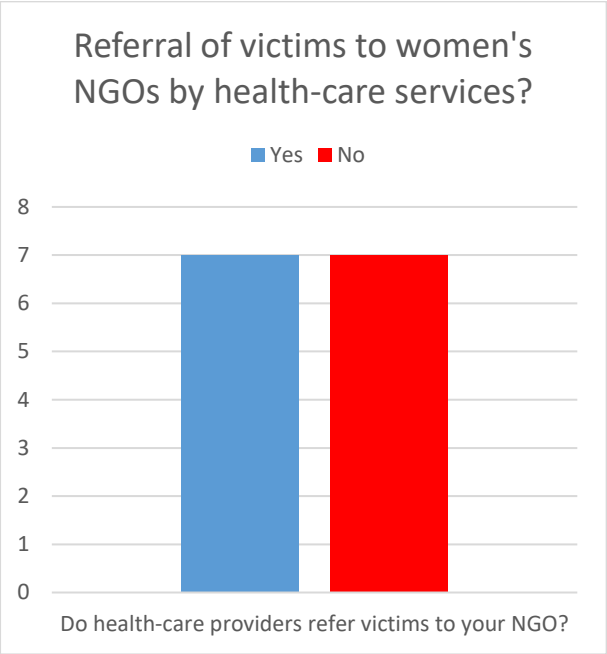

Chart 3: Referral of victims to women's NGOs by healthcare services

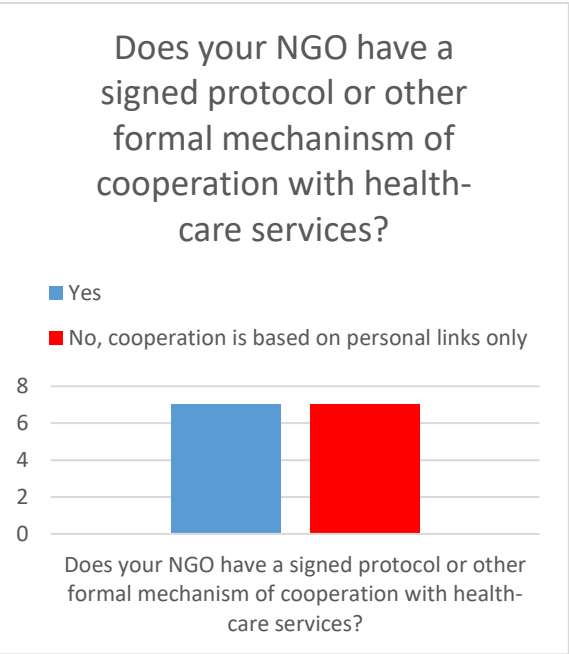

Chart 4: Signed protocols or other formal mechanisms for cooperation at a local level with healthcare services

Promising practices of cooperation identified by women's NGOs

To illustrate a possible promising practice, we quote here the response of the Bosnian partner, Foundation United Women from Banja Luka, which runs the safe house for women victims of violence. Based on the **Cooperation Agreement of Foundation United Women** and the Health Centre Banja Luka, established in 2010, upon arrival to the Safe House, a victim can receive free medical assistance in the local health center. The NGO further explains that, *"Sporadically, it happens that women victims are referred to the SOS helpline or other specialist services of Foundation United Women. Posters of the SOS helpline are placed in visible places in the local health centers, so that victims can be informed about such options. There were some cases of domestic violence being identified after women contacted their family doctors, and the doctors called the SOS helpline to get information on the possibilities to accommodate the women in the safe house."*

Problems identified in practice by women's NGOs

There are however examples where referral by healthcare professionals to women's specialist services encounter particular challenges, even though a formal mechanism (or other structure for cooperation) has been established to enable professionals to cooperate in a more standardized manner. Over a decade ago, Albania established the so-called Coordinated Referral Mechanism at the local (municipality) level. More information on how the **Coordinated Referral Mechanism (CRM)** is implemented in practice, based on the GREVIO report on Albania (2017), is provided in the section: *How multi-agency response to domestic violence works in practice: A case of Albania – analysis of GREVIO.*

As reported by Albanian NGOs, healthcare professionals are part of the CRMs and have a duty to be part of all technical meetings where cases of GBV/DV are handled[16]. However, despite the cooperation agreement between the institutions of the Coordinated Referral Mechanism, there is still a lack of referrals of victims from healthcare professionals, including psychiatrists, to women's NGOs or state agencies. This NGO further noted that women's NGOs are doing their best to increase the capacities of healthcare professionals in relation to the identification of victims of violence, their legal responsibilities to report such cases, and the importance of cooperation with other members of the CRM. The reasons for low levels of referral, according to the Albania NGO, include: health workers feel unprotected (for example due to possible retaliation from the perpetrator) and they are reluctant to report or refer cases. Other reasons might be related to the lack of information regarding their legal obligations and the continuous updates in legislation and regulations. Furthermore, women's NGOs also note that if doctors issue special medical reports for survivors of violence, which can be used in court, they will have to further testify in court proceedings. Some doctors are reluctant to testify in court proceedings because of fear of retaliation by perpetrators as well as the length of such court proceedings.

Collaboration between women's NGOs and medical professionals is commonly perceived in rather narrow terms. Such collaboration is typically associated only with referrals. While it is, without a doubt, important to examine referral pathways in more detail, brief stories provided by national partners include examples of various aspects of collaboration with doctors. In the following sections of the report, these different aspects will be explored in more detail. The next section is focused on cooperation with professionals working in the mental health sector.

C. Cooperation with mental health professionals, and provision of longer-term psychological counselling to survivors of violence within the public healthcare system

The recently published horizontal review of GREVIO reports (2021[17]) highlighted an important shortcoming in the implementation of the Istanbul Convention, **the insufficient provision of longer-term psychological counselling and support to victims of violence**. Across state parties that have been evaluated, GREVIO noted that long-term counselling was far less available than immediate medical and trauma care. Insufficient provision of long-term psychological counselling was noted (as an example) in Finland, France, Serbia, and Sweden. Generally, more support services appear to be available for recent episodes of sexual violence than past violence. GREVIO further emphasizes that such approach runs counter to the nature and dynamics of this form of violence, as a great deal of stigma, shame and guilt is still associated with it, and is one of the reasons why many victims do not immediately seek help but wait days, weeks, months and sometimes even years to report. Similar assessment about the inadequate possibilities for obtaining long-term psychological counselling has

[16] As per the Decision of the Council of Ministers which established the CRM. The organisation and functioning of the CRM was revised in 2021.

[17] GREVIO (2021). *Mid-term Horizontal Review of GREVIO baseline evaluation reports*. Strasbourg: Secretariat of the monitoring mechanism of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, Council of Europe

been identified in the evaluation reports of GREVIO on the implementation of the convention in Albania (2017[18]), Turkey (2018[19]), Montenegro (2018[20]) and Serbia (2020[21]).

Taking these assessments into account, specific objectives of this segment are to assess the quality of cooperation between women's NGOs and professionals working in the field of mental health (psychologists, psychotherapists and psychiatrists) in local communities, as well as to examine possibilities of women survivors of domestic and sexual violence to obtain longer-term psychological counselling in the public healthcare system.

Based on the responses received from the women's NGOs completing the questionnaire, it can be concluded that **women's NGOs note that they have established cooperation with psychiatrists, psychologists and psychotherapists who work in public healthcare centers in their local communities**, **but also identified numerous problems regarding such cooperation.** Furthermore, responses of women's NGOs indicate that **public healthcare systems in the Western Balkans and Turkey do not provide adequate possibilities for long-term counselling or psychotherapy for women survivors of domestic and sexual violence**, and/or that relevant professionals in the public mental healthcare systems sometimes express insensitive attitudes towards victims, or even, prejudices that can further contribute to their re-traumatization.

Promising practices of cooperation identified by women's NGOs

Cooperation agreements (formal/informal) with mental health professionals at a local level

In Albania, one organization notes that their cooperation with school psychologists has improved recently. Another organization further notes that they have had a good cooperation with psychologists and social workers employed in local hospitals, and occasionally refer women victims to them. A further NGO, which works with survivors across Albania (Counselling Line for Women and Girls), claims that such a cooperation has been quite good throughout the pandemic, making it possible to work with increased numbers of domestic violence survivors. Similarly, Psycho-social Centre Vatra from Vlora, Albania, reports that they refer women with mental disturbances to local psychiatrists, within the framework of the cooperation agreement with the Psychiatric Hospital "Ali Mihali" and the Community Centre. Yet another Albanian NGO assesses cooperation as good; social workers engaged in this NGO sometimes refer women victims to clinical psychologist in the local healthcare center, after creating individual follow-up plans for them. One more Albanian NGO reports that their NGO has maintained a good cooperation with experts in the field of mental health, such as psychologists and psychotherapists, as well as with the psychiatrists working in the Durres Polyclinic. Further, this NGO cooperates well with school psychologists in the Municipality of Durres, who refer women victims of

[18] GREVIO (2017). *GREVIO's (Baseline) Evaluation Report on legislative and other measures giving effect to the provisions of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention): Albania*. Strasbourg: Secretariat of the monitoring mechanism of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, Council of Europe

[19] GREVIO (2018). *GREVIO's (Baseline) Evaluation Report on legislative and other measures giving effect to the provisions of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention): Turkey*. Strasbourg: Secretariat of the monitoring mechanism of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, Council of Europe

[20] GREVIO (2018). *GREVIO's (Baseline) Evaluation Report on legislative and other measures giving effect to the provisions of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention): Montenegro*. Strasbourg: Secretariat of the monitoring mechanism of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, Council of Europe

[21] GREVIO (2020). *GREVIO's (Baseline) Evaluation Report on legislative and other measures giving effect to the provisions of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention): Serbia*. Strasbourg: Secretariat of the monitoring mechanism of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, Council of Europe

domestic violence to this NGO after identifying them through their children at school. During the pandemic, however, the latter was more difficult as schools switched to online learning and thus the number of referrals has decreased. This NGO further reports that for victims of domestic violence there is a procedure called "Green Counselling Line" which is a service provided by the Municipality of Durres; through this system, victims may receive free counselling services. Services of psychiatrists at the State Policlinic are free of charge. Cases of trauma caused by domestic violence are continuously monitored by the unpaid psychiatrist.

A women's NGO from Kosovo assesses that their NGO has an established formal cooperation with mental health professionals in the local hospital, who come to their center to provide services based on need, or they refer their users to such professionals.

One CSSP Partner from North Macedonia assesses cooperation as good, and further explains that some psychologists who work in the public healthcare system have been engaged by women's NGOs as individual consultants to provide psychological counselling. The partner also notes that these professionals are highly sensitized to the issue of violence against women. Consequently, the arrangement described by the national partner implies that victims who use women's NGO services are not referred to public healthcare services to receive free psychological counselling (under the condition they have health insurance); rather, selected professionals are engaged by women's NGOs to work in their premises.

In Serbia, several associations of mental health professionals and/or individual professionals have started to offer free psychological counselling to citizens in the beginning of the pandemic, including through the establishment of helpline(s). These forms of psychological support were, however, of a "general nature" (not specifically for women victims of violence). Within this context, some women's NGOs have used the opportunity to draw attention to the problems of violence which became more pronounced, especially during national lockdowns. As an example, one Serbian women's NGO working with women survivors of violence with disabilities reports that they have intensified the cooperation with providers of free psychological support in the local community in recent times. In their organization, the number of requests for psychological support increased significantly during the pandemic. For this reason, they worked more on the promotion of their free psychological support service for women with and without disabilities exposed to violence during this period. That is how they became members of the local network "Constellation of Support", which gathers providers of free psychological counselling on the territory of the city of Novi Sad. They also became members of the "Karika Mental Health Network" and in 2020, they actively participated in the Mental Health Festival organized by the Institute of Public Health of Vojvodina for six years in a row.

In Turkey, the women's NGO running the safe house for victims of domestic violence reports that throughout the pandemic, they have continued to refer their users to psychiatrists in public hospitals. They however noted problems prior to and during the pandemic, as described below.

Problems identified in practice by women's NGOs

<u>Limited provision of psychological counselling throughout the COVID-19 lockdowns and beyond</u>

One Albanian partner reports that they have no cooperation with psychotherapists in their local community, and also notes that throughout the lockdown imposed by the national government, psychological counselling provision was interrupted or had to be provided online for a limited number of women survivors, which was not effective in practice. Another organization states that the public healthcare service in their municipality has only one psychiatrist; he is the one who is supposed to provide long or short-term counselling to survivors based on their needs, but this is not sufficient. Another partner from Albania reports that victims can get free counselling sessions by psychiatrists,

but longer-term psychological counselling or psychotherapy is available only in private practice and thus is subject to fees.

A women's NGO from BiH, which runs a safe house for women victims of domestic violence reported that their beneficiaries had an increased need for psychological and psychiatric assistance during the pandemic. However, during the period of lockdown and most restrictive measures imposed by the government against COVID-19 in 2020, psychiatric and psychological counselling in the public healthcare system was not available. After lockdown restrictions were lifted, the waiting time for therapy were long, as disinfection measures increased the time between sessions and the number of clients per day was reduced. Therefore, women needed to wait longer to receive assistance. Due to the problems encountered in the public healthcare system, women beneficiaries relied on the services provided by the psychologist of the Safe House in Banja Luka. To bridge the gap between the needs of survivors and available psychological assistance, this NGO has also engaged a clinical psychologist as an external associate who conducts individual therapeutic sessions with beneficiaries of the Safe House on a needs-led basis.

The women's NGO from Turkey note that demand for psychological counselling has increased during the pandemic. Volunteer psychiatrists, psychologists, and psychotherapists provided online services in their organization, which remained available throughout the pandemic. At the same time, the local government reduced the provision of such services, or did not provide such services online. Therefore, demand for services from psychologists, psychotherapists and psychiatrists was supplied by women's NGOs. This NGO further reports that in general, and even before the pandemic, there are not enough therapists in hospitals so it is almost impossible to get long-term therapy in a hospital setting.

Short-term psychological counselling

One Bosnian NGO further highlights that according to available regulations, the duration of psychological counselling depends on the specificity of each case, and counselling can be long-term and continuous if there is motivation from the victim to continue the sessions. However, based on the experience of this NGO, women victims usually get just a few sessions in the public mental healthcare system, and very often, the treatment ends with a prescription for psychiatric medication.

A women's NGO from North Macedonia reports that women victims can go to a general practitioner in the primary healthcare practice and ask for referral to mental health specialists, but they have to pay a participation fee. In practice, there is no long-term counselling offered by mental health specialists.

In Turkey the services provided by the local government is not sufficient, and in most cases they do not provide long-term therapy, but only short-term psychological counselling. Psychological support at state hospitals is available depending on ones' health insurance; when a victim is not insured, in accordance with Turkish Law 6284, she can apply for temporary health insurance stating that she is exposed to domestic violence, however, this NGO claims that the latter provision has not been implemented in practice and women's NGOs sometimes cover these fees.

Lack of a gendered understanding when supporting survivors of violence

A Montenegrin women's NGO reports that professionals working in mental healthcare lack a gendered understanding of violence against women, so their interventions tend to further traumatize women survivors. Furthermore, this NGO notes that during the pandemic the services of such professionals were even less accessible than before, and in their opinion, these professionals have a "traditional" approach to domestic and sexual violence that contributes to the re-traumatization of the victim. When it comes to accessing longer-term counselling, this NGO reports that the length of treatment and the number of sessions depend on the victims' needs assessment, but the problem is that there

are no specialists (i.e. psychologists or psychotherapists) with sufficient and adequate knowledge who can work with victims of domestic violence, and there are no experts specialized in working with sexual violence victims.

Lack of cooperation with mental health practitioners

One NGO from Serbia reports that they have no direct cooperation with psychologists or other providers of services within the public centers for mental healthcare. Another NGO reports that women victims can go to their general practitioner and ask for a referral to a psychologist or psychiatrist, however, these specialists in the public healthcare system do not provide counselling; rather, the treatment includes only issuing a diagnostic and a drug prescription.

Bad practice example: Stereotypes encountered in the psychiatrist's report regarding a victim of sexual violence

"The young woman, a final year university student, lives alone in a rented apartment. Her family lives in a rural area. She survived rape by her former boyfriend. After the perpetrator was arrested, the public prosecutor decided that he should be released from pre-trial custody, although he knew where the young woman lives, and already had a criminal record. Because of her fear from repeated violence, the woman was accommodated in the Safe House in Banja Luka. During the procedure of reporting rape, she was referred to a psychiatrist in a hospital. The session was brief; the psychiatrist asked her only a few questions, without any interest in her actual psychological condition. In the medical report issued to the woman, the psychiatrist wrote that she had "a deep neckline", which automatically shifted the responsibility of rape to the victim, and could negatively influence the final outcome of the judicial proceedings. The survivor felt very bad due to the statement made by the psychiatrist. Throughout the procedure of reporting rape and medical examinations, she was exposed to re-traumatization, including denial of her problem and minimizing the consequences of the violence. This procedure is still ongoing."

Foundation United Women, Banja Luka, Bosnia and Herzegovina, http://www.unitedwomenbl.org

D. Protocols regulating duties and responsibilities of healthcare workers in cases of domestic and sexual violence

In assessing the quality of multi-sectoral cooperation, one of the crucial issues to be examined is: what kind of protocols are in place for healthcare providers when supporting women victims of violence?

As underlined in the horizontal review of GREVIO's evaluation reports (2021[22]), GREVIO highlighted the need to provide an adequate access to healthcare services, and positively noted that many **state parties are equipped with healthcare protocols including standardized care paths covering the identification of victims, screening, diagnostic, treatment, referral, documentation, as well as standardized forms to document the injuries experienced by victim** to the police, mainly in relation to intimate partner violence. Shortcomings have however been identified in the implementation of such protocols and minimum standards in state parties such as Albania and Portugal. GREVIO has also highlighted in its baseline evaluation reports on Albania and France a weak co-ordination of healthcare professionals based on existing referral mechanisms. Moreover, a lack of standardized protocols and guidelines that set clear procedures in the provision of treatment and care to victims of sexual violence

[22] GREVIO (2021). *Mid-term Horizontal Review of GREVIO baseline evaluation reports*. Strasbourg: Secretariat of the monitoring mechanism of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, Council of Europe

have been noted in GREVIO baseline evaluation reports, including those on Malta, the Netherlands, Serbia, and Spain.

The present research attempts to analyze the following:

- Whether countries have a **general protocol**, which clarifies the duties and responsibilities of **all relevant professionals**, such as the police, social protection services/centers for social work, the judiciary, educational institutions, and healthcare services. If yes, whether the document addresses all forms of violence covered by the scope of the Istanbul Convention or only domestic violence.

- Whether a **special** protocol for healthcare professionals exists, focused on the duties and responsibilities of **healthcare workers** in a more specific manner, including procedures for identifying, recording and documenting violence. If yes, whether the document covers domestic violence only or addresses sexual violence as well.

	Albania	BiH	Kosovo	Montenegro	North Macedonia	Serbia	Turkey
General protocol on all forms of VAW	No	No	No	No	No	No	No
General protocol on DV only	Yes + Protocol specific to the context of the pandemic	Yes (at the entity level: Republic of Srpska)[23]	Yes	Yes	No	Yes	No
General protocol on SV	Yes	No	No	No	No	No	No
Special protocol for healthcare providers	Yes + Protocol specific to civil emergency situations	No	No	No	No	Yes	No

Table 1: The overview of available General and/or Special Protocols in Western Balkans and Turkey, according to information received from women's NGOs filling out the questionnaire

According to the answers received to the questionnaire, a list of available protocols in the Western Balkans and Turkey is available in Annex I of the present assessment. These answers should be taken with caution, as they represent the information that is available to women's NGOs filling out the questionnaire.[24]

While some countries have protocols that include the terms "gender-based violence" or "violence against women" in their titles, such protocols only or primarily address domestic violence. According

[23] In the report of the national partner, there was no information about the another entity (Federation BiH)

[24] The questionnaire that was created for the purpose of this multi-country research assessment included questions about the content of each protocol (whether it is a general one, regulating duties and responsibilities of all relevant professionals, such as the police, social protection, education, health-care services, etc.) or special (regulating specific duties of health-care professionals); the legal status of the document (i.e. whether it is a by-law/mandatory or just represents a guideline/it is not obligatory); description of the main provisions; if there are any sanctions prescribed if the professionals do not respect it and if a particular NGO knows of any case that health-care professional was sanctioned for not respecting it; specification which procedures apply in cases of domestic violence and sexual violence. However, the answers provided by national partners were incomplete and/or not reliable.

to the information provided by the NGOs in North Macedonia and Turkey, these countries do not have either general or special protocols.

Although it was not in the scope of the present research, it is recommended that future analyses should assess in more detail the content of such protocols, and if such protocols include references to sexual violence. Based on the information provided by respondents in Serbia, the General Protocol includes a definition of sexual violence in intimate partner relations, under the section "Detecting violence"[25], but has no specific measures related to this type of violence. Interestingly, this document, adopted in 2011, includes a definition which firstly refers to lack of consent, and further to conditions that preclude a valid consent, and finally to "intimidation, blackmail and pressure". To this day, Criminal Law on rape in Serbia, has not been amended to meet the requirements of Article 36 of the Istanbul Convention. For this reason, GREVIO in its report on Serbia (2020), urged the Serbian authorities to speedily reform the Criminal Code provisions covering sexual violence to be based on the notion of freely given consent.

The current findings are consistent with the recent policy paper in the Western Balkans and Turkey, which was focused on the issue of sexual violence (Brankovic and Saidlear, 2021[26]) and revealed that protocols/guidelines for professionals related to providing support to sexual abuse victims are absent or insufficiently developed. The previous study also referred to a promising practice example; the guidelines[27] on sexual violence that were developed for medical and other professionals in Serbia in 2019, under the project implemented in the Autonomous Province of Vojvodina which prescribes procedures for medical and other professionals, and explains standards on which service provision should be based. Throughout 2020, three additional protocols were developed in Vojvodina which strengthened the capacities of NGOs and medical professionals to support sexual violence victims in light of the pandemic. The first protocol was drafted to ensure mandatory testing for infectious and sexually transmitted diseases for survivors of sexual violence; the second aimed to ensure improved coordination of the hospital working groups and groups for coordination and cooperation within the public prosecution office, while the third was drafted with primary healthcare centers and gynecological ambulances with the purpose of expanding the scope of healthcare institutions involved in providing direct assistance to women victims (ibid.).

Albania recently developed a document which specifically addresses sexual violence against adults, titled: 'Protocol for Management of Cases of Sexual Violence at the Local Level, through Multi-Sectoral Coordinated Approach', and adopted in March 2021. Furthermore, only Albania adopted a Protocol that addresses specificities of dealing with cases of domestic violence during the COVID-19 pandemic. As further explained by the above-mentioned Albanian NGO, these two protocols have to be adopted by the members of the Leading Committee of the Coordinated Referral Mechanism of cases of domestic violence at the municipality level (healthcare institutions are members of this Mechanism). The Albanian authorities also adopted a Special Protocol for healthcare providers, which is focused on "civil emergencies".

[25] The following definition is provided in the General Protocol in Serbia: Sexual violence is a sexual act without consent or the ability of the victim to choose to give consent, regardless of whether the act has been performed; sexual act or attempt of this act when a person is not in the position to consent or refuse participation due to illness, disability, influence of psychoactive substances, age, that is, because of intimidation, blackmail or pressure; painful and humiliating sexual act. Intimidation, blackmail or pressures to participate in the unwanted sexual act include using words, gestures, objects or weapons expressing intention to cause pain, injury or death.

[26] Op. cit.

[27] Todorov, D., Stevkovic, Lj., Veselinovic, I., Josimovic, S. (2019). *Guideline for conduct in cases of sexual violence within sexual violence referral centres in the Autonomous Province of Vojvodina*. Novi Sad: Provincial Secretariat for Health-Care of the Autonomous Province of Vojvodina and Centre for Support to Women, Kikinda (in Serbian)

E. Implementation of protocols regulating duties and responsibilities of healthcare workers

The present segment aims to analyze how the above-mentioned protocols have been implemented in practice, in light of victims' experiences with healthcare providers (as provided in the responses of the national partners).

E1. Experiences of victims in seeking help in healthcare institutions

Promising examples of the implementation of protocols identified by women's NGOs in Albania and BiH

One Albanian organization reports: "*Our organization is a member of the Coordinated Referral Mechanism in the Municipality of Durres and as such maintains a cooperation with all actors, and in particular, experts in the field of mental health, such as psychologists and psychotherapists. When the cases are identified and discussed during the meetings of this Mechanism, according to the needs presented, victims are referred to specialist examinations at the Durres Regional Hospital*".

A Bosnian NGO notes, "*Upon arrival to the Safe House, a victim can receive free medical assistance through accessing the healthcare center. This has been regulated through the Cooperation Agreement of Foundation United Women and the Health Centre Banja Luka, signed in 2010. There is a cooperation with the Health Centre of Banja Luka (responsible for primary health care and emergency wards) under which all women and children sheltered in the Safe House Banja Luka run by the Foundation United Women can receive medical assistance in the family medicine center close to the location of the Safe House. This applies to all women regardless of their previous place of residence. There is also a cooperation in place with a hospital in Banja Luka which provides free of charge specialist check-ups and examinations, prioritizing women and children beneficiaries of the Safe House. In accordance with the Law on Protection from Domestic Violence, all victims of violence have the right to free health examinations. Furthermore, due to the advocacy efforts of Foundation United Women at the Council for Combating Domestic Violence of the Republic of Srpska, in November 2020, the RS Government adopted the decision to grant free COVID-19 testing to victims of domestic violence prior to their accommodation in the safe houses in the Republic of Srpska.[28]*"

The following story illustrates how women survivors with disabilities are overlooked and neglected due to a poor institutional response, but also shows that interventions of women's NGOs can change a situation for better.

The woman with disabilities was abandoned by institutions, but women's NGO changed her fate

"*A woman with a physical disability was exposed to psychological violence and forced isolation by her husband for a long period of time. She was left locked in the locked while her husband was at work. She turned to the SOS telephone for help, due to the lack of response from the police and the Centre for Social Work to her reports of violence. The woman had previously approached institutions that did not respond to her calls, nor did they go out on the field to check the living conditions and circumstances in which she lived. The consultant of the SOS phone called the police and insisted that they should check her house. When police officers rang the doorbell, it turned out that the house was locked; the woman could not get up and open the door herself, so they concluded that she was locked inside. Due to the intervention of our organization, the woman was removed from her home*

[28] Decision of the Government of Republic of Srpska available at: https://www.vladars.net/sr-SP-Cyrl/Documents/Zakljucak%20o%20test%20zrtava%20nasilja%20u%20porodici%20prilikom%20smjestaja%20u%20sig%20kuce.pdf (on Serbian)

and accommodated in the Safe Women's House. Furthermore, during the pandemic, in the Health Centre in Vranje, a hydraulic gynecological table accessible to women with physical disabilities was placed in the red COVID-19 zone and doctors were not able to perform preventive and other examinations on this group of women. At the initiative of our cooperating organization (Human Rights Committee - SOS helpline Vranje), the gynecological table was moved from the red zone."

Iz kruga – Vojvodina, Organization for the Support of Women with disabilities, https://izkrugavojvodina.org/

Problems identified in the implementation of such protocols

While most of the countries in the Western Balkans and Turkey have been taking important initiatives to develop relevant documents on the duties of institutions, including public healthcare sector, as well as on inter-agency collaboration, the focus of this section is on identifying the challenges that emerged in the process of their implementation. **Women's NGOs identified the following shortcomings in the implementation of protocols, including some important aspects which occurred throughout the COVID-19 pandemic.**

One Albanian NGO noted that most medical staff are untrained in identifying cases of domestic violence or sexual abuse and in providing services to victims, as well as on referral. Furthermore, medical professionals avoid referral of cases due to "fear of being confronted with the perpetrators". During the pandemic, some victims of domestic violence were referred to hospitals by the Judicial Police Officers to conduct forensic examinations, but the regional hospital worked only with COVID-19 patients, and thus were not able to perform such examinations. Marginalized women, especially Roma women and women with disabilities, face obstacles in obtaining timely healthcare. This NGO further explained that despite the legal obligation arising from DCM no. 327 "On the Mechanism of coordination of work between the responsible authorities for the referral of cases of domestic violence, as well as its proceedings for the support and rehabilitation of victims of violence", dated 02.06.2021, referral of such cases is non-existent in their community.

A Bosnian NGO reports that, "in general, there is a lack of access to general services for women survivors of violence, especially during lockdown". Access to primary healthcare services was limited due to COVID-19 restrictions, and specialist medical check-ups were delayed. During the first few months after the pandemic outbreak, Foundation United Women experienced difficulties in providing accommodation to women and children in need due to lack of isolation premises, and lack of clear procedures for testing and access to testing for COVID-19.

One Kosovar NGO reported about the problems rural women face in healthcare centers. It seems that doctors sometimes avoid examining whether injuries were caused by domestic violence, since victims visit healthcare centers in the presence of members of the husbands' family; "Women in rural areas are not allowed to go to see a doctor alone, but usually a husband's family member is accompanying them. Doctors are aware of this issue and since they have no time or will to talk with women alone, they do not ask how the injury was inflicted, but focus only on prescribing a treatment. We had a case where the victim was injured by a knife and told the doctor that it was a dog bite, and the doctor wrote in the report that 'the injury was caused by a dog bite'". Another Kosovar NGO focuses on the problems of women who are, or might be, exposed to intersectional discrimination: "Based on our experiences, there are discriminatory practices in healthcare institutions towards women from Roma, Ashkali and Egyptian communities, as well as women with disabilities and lesbians. They receive poorer services and face a discriminatory approach by service providers".

A women's NGO from North Macedonia describes problems related to costs of medical treatment. According to Article 51 of the new Law on Prevention and Protection from Violence against Women and Domestic Violence, all healthcare institutions and healthcare workers must take protective measures to issue the necessary medical documentation to victims of VAW, and funds for these interventions are provided in the annual work program of the Ministry for Health. In practice, to get such documentation women must pay in advance and after receiving a confirmation certificate from the local Centre for Social Work that they are victims of VAW or DV, they can be reimbursed for the costs. In line with the Law on Social Protection, victims have the right to a one-off financial aid from the state budget covering the costs of medical treatment related to violence. Maximum financial aid for this purpose is 12.000 Macedonian denars (approx. 200 EUR). If they have no insurance, there is a Programme for Mother and Children, which is adopted by the Ministry of Health annually, but funds can cover only the costs of free examinations for victims of sexual violence.

A Montenegrin NGO points to the barriers women victims face in accessing healthcare services. "We cooperate well with healthcare institutions when there is an acute situation of violence, when the victim has injuries, and when a companion goes with her and the police to the ambulance. In such cases, everything is finished relatively quickly, without waiting. However, when additional check-ups are needed (for example, specialist examinations), women have to wait for hours. Only when individual doctors show empathy can the process be accelerated. Women victims of violence who are undocumented and foreigners do not have access to regular healthcare. In such cases, we lobby private medical centers to offer free specialist examinations, or offer at least their services for a smaller fee".

A Serbian NGO working with women with disabilities reported on the numerous obstacles this group of women face when seeking help in healthcare institutions: "Healthcare services are inaccessible, both in terms of architectural barriers and in terms of inadequate medical equipment (lack of hydraulic tables, inadequate instruments, etc.). Medical professionals are insufficiently trained to work with women with disabilities and we note problems such as social distance, communication barriers, ignorance of disability etiquette, and use of an offensive terminology. Women with disabilities are denied the right to choose their doctor or go to facilities that meet basic accessibility conditions. Under great risk are women with mental disabilities who receive birth control as part of regular therapy; they are not informed about their health choices, and are not generally informed about contraceptives (such as IUD placement). When it comes to women with hearing impairments, healthcare professionals do not call sign language interpreters, although this is a legal obligation and when a woman comes accompanied by an interpreter, it happens that they throw him/her out of the office. Healthcare professionals turn to personal assistants instead of the woman they provide the service to, or ask them to do tasks that are not within their competence (for example, to help the nurse get her on the bed)".

Examples of bad practice - Brief stories about the experiences of victims in healthcare institutions:

Who is responsible for forensic examination?

One Albanian NGO provided an example of a recent victim of domestic violence's experience. The case illustrates difficulties in the provision of medical services, such as forensic examination, which emerged during the pandemic. Since the usual referral pathways for providing forensic examination in cases of domestic violence were disrupted due to the pandemic, it became unclear which specific medical center was responsible for conducting a forensic examination. As a result, the woman did not receive the service she was entitled to, as a victim of domestic violence: "*The woman was a victim of domestic violence by her cohabitant. She reported violence one week after the violent*

incident. Since the first state agency she approached was the police, the police officer decided that she should be examined by a forensic doctor in the city X. However, due to the emergency situation during the pandemic, her case was referred to one shelter and she could not receive healthcare services in this city. In Vlora, this service was not provided since doctors claimed that her case was under the jurisdiction of the forensic doctor in the city X."

Vatra Psycho-Social Centre, Vlore, Albania, http://qendravatra.org.al/

Is the virus more dangerous than a head injury?

The NGO from Kosovo provided another bad example of the experiences of women victims during the pandemic: "*We supported a woman, mother of four children, who experienced domestic violence by her husband. She had a head injury, caused by her husband and went to a hospital, but due to the pandemic, doctors did not take her case seriously. They released her with an explanation that 'the virus is more dangerous than her injury'. She reported the violence to the police and they told her that, 'she cannot go to a shelter since she has four children'. A few months later her husband attacked her again, and she again reported violence to the police. This time, the police brought her to the safe house*".

Women Wellness Center, Kosovo, www.qmg-ks.org

A pregnancy resulting from rape

The Monitoring Network Against Gender-Based Violence, a network of Albanian NGOs, prepared the shadow report to the Committee of the Parties to the Istanbul Convention in 2021, related to the implementation of recommendations to Albania provided by GREVIO in 2017, and issued by the Committee of the Parties. The report includes a description of the ordeal of victims of sexual violence, including interventions of doctors related to pregnancies resulting from rape. They presented the case of a woman assisted by Lillium Centre, the center recently established in Albania to support victims of sexual violence.

"In December 2020, A.B. reported that she had been abused again by an unknown person. Another pregnancy was caused as a result of the sexual abuse, which was discovered by consultants at the town's psychiatric hospital. By that time, A.B. was 19 weeks pregnant. She expressed the wish to terminate the pregnancy on account of her not being able to care for the child. Her family refused to accept her back in the home and support her if the pregnancy was not terminated. Her safety was jeopardised. A.B. was accommodated in the Lilium Centre on 15 April 2021, together with her mother. She was assessed by the psychiatrist and received the necessary psychological support. She was also seen by an obstetrician-gynecologist. In the meantime, according to relatives, representatives of the social services and the state police, her brothers refused to allow her to return back home while pregnant. A.B. and C. D. insisted that the pregnancy had to be terminated because she felt she was at risk because of her brothers."

Article 11, of Law No. 8045, dated 7 December 1995, on the termination of pregnancy, states: *Termination of pregnancy for social reasons may be performed up until the 22nd week where a panel composed of three specialists – medical, social worker and legal – following an examination and deliberations, find that the pregnancy is the result of rape or another sexual crime, or where other social grounds are proven. The instruction on how to proceed in such cases and on the composition of the commission shall be adopted by the Minister of Health and Social Protection.* However, the relevant instruction which the competent institutions were required to issue, was never done. The local co-ordinator against domestic violence, the social services, and the police were informed and advised to pay a visit to the family in order to mediate A.B.'s return home. Their

efforts were not successful because her brothers categorically refused to allow her to return home pregnant. The agencies, however, insisted and made it possible for the pregnant girl to return home.

Centre for Legal Civic Initiatives, Tirana, Albania, quoting the following source: Monitoring Network Against Gender-Based Violence (2021). *Shadow report on the implementation of recommendations addressed to Albania by the Committee of the Parties to the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence 2018-2020*, https://rm.coe.int/albania-report-the-monitoring-network-against-gender-based-violence-co/1680a4681f

E2. Documenting the injuries in a domestic violence case

To explore the possibilities for women's NGOs to strengthen the cooperation with medical professionals in the future, this report further analyses how healthcare professionals fulfil their roles in protecting victims of violence. Such obligations entail also properly documenting the injuries of the survivor, as such documents can further contribute to the protection of the victim and punishment of perpetrators. This section analyzes how doctors' obligation to document injuries are implemented in practice, in order to a) identify areas where women's NGOs can concentrate their efforts on in the future (for example, by accompanying victims when they report injuries and reminding doctors of their obligation to use standardized forms for such reports) or b) to identify where changes in the existing protocols are needed (for example, to verify if the requirement of the Istanbul Convention, contained in Article 18, paragraph 4, is implemented in practice – whether services to victims are provided regardless of the willingness of the victims to press charges or testify against any perpetrator).

Healthcare professionals can provide a vital contribution to both the protection of victims and prosecution of perpetrators by documenting injuries in cases of domestic violence, preferably by relying on standardized forms. Such forms can be further used as evidence in court, for the purpose of criminal prosecution of perpetrators, as well as for obtaining compensation from the perpetrator and/or from the state (depending on the legal provisions that regulate compensation). **A sound, detailed and well-grounded description of injuries by medical doctors can greatly contribute to perpetrators' conviction in courts.** To achieve this, medical professionals need specific initial and/or in-service trainings. Protocols/guidelines that regulate duties of professionals in cases of violence (where such guidelines exist) include **standardized forms to document the injuries experienced by victims of violence.**

In the region, these documents are often called "medical certificates" and experiences of women's NGOs showcase that usually the **criminal prosecution of perpetrators of domestic violence heavily depends on such documents, which are used in courts as evidence**. Experience of women's NGOs in the region further illustrates that doctors sometimes avoid issuing such documents, due to lack of competence, or even the fear of a possible retaliation from the perpetrators. The absence of an appropriate medical documentation greatly reduces the chance of proving domestic violence in courts.

Keeping in mind the importance of appropriate medical documentation of physical violence injuries, the present report examines in more detail the experiences of women's NGOs with respect to this issue. The aim is to explore how procedures and regulations related to medical reports on injuries are applied in practice, whether such documents are free of charge, and which promising practices and problems can be identified across the Western Balkans and Turkey. The report also analyses in more detail **whether issuing such "certificates" is subject to certain conditions, such as, covering certain fees, or referral by responsible authorities** (such as the requirement that the victim needs to be referred to doctors by police or prosecutors). **The latter conditions, if they exist, should be thoroughly**

examined, taking into account the standards enshrined in the Istanbul Convention that services to victims, including for example forensic examinations, **should be provided regardless of the victim's willingness to press charges or testify against any perpetrator** (Article 18, paragraph 4 of the Convention).

All women's NGOs filling out the questionnaire confirmed that doctors in their countries issue such medical documents. However, there are variations with respect to the frequency of such documents and value as evidence in courts. Furthermore, answers also vary in situations where the issuance of documentation is subject to specific conditions, including fees paid by the victim, or the condition that the victim needs to be referred to medical professionals by the police or prosecutors. Based on the answers received, even though some promising practices can be highlighted, it can be concluded that there are a lot of problems encountered in practice when it comes to such medical documents. Lastly, in some countries issuing such documents is NOT free of charge.

Promising practices identified by women's NGOs

Injuries documented by doctors in a gender-sensitive manner

Albanian NGOs note that, as a rule, forensic doctors in Regional Hospitals fill out and issue certificates. Yet, one NGO from Tirana reports that, in addition to forensic doctors, some qualified and gender-sensitive family doctors also issue such certificates in cases of domestic violence. This partner also notes that the NGO Human Rights in Democracy Centre has managed to assist victims by using certificates in courts successfully as evidence.

National guidelines to document injuries

Similarly, one Bosnian NGO reports that as part of a resource package for healthcare and social protection professionals, developed by the Ministry of Health and Social Care[29], detailed forms and guidelines for issuing certificates have been provided to medical professionals. They further confirmed that certificates and injury lists are used as relevant evidence in courts.

In Serbia, a Special Protocol regulating duties of healthcare workers in cases of violence[30], adopted by the Ministry of Health (which has been in use for more than 10 years), includes a detailed, prescribed form for recording and documenting violence that doctors should fill in. However, two women's NGOs from Serbia have had different experiences regarding if doctors actually use the prescribed forms in practice (see section below).

Problems identified by women's NGOs

Medical certificates not always free of charge

The most worrying finding of this survey is: **medical certificates are not free of charge in all analyzed countries**. In some countries, there is a possibility to get such documents free of charge, but in others,

[29] Ministry of Labour and Social Protection of the Republic of Srpska and UNFPA (2015). *Resource Package for Response of Health-Care Providers in Republika Srpska to Gender Based Violence.* Banja Luka: UNFPA, https://www.vladars.net/sr-SP-Cyrl/Vlada/Ministarstva/MZSZ/Documents/UNFPA%20Resursni%20Paket%20Light%20FINAL2.pdf (in Bosnian-Croatian-Serbian), and High Judicial and Prosecutorial Council of Bosnia and Herzegovina (2018). *Handbook for Action in Cases of Gender Based and Sexual Violence against Women and Children for the Police, Prosecutors and Judges*, https://vstv.pravosudje.ba/vstv/faces/docservlet?p_id_doc=48586 (in Bosnian-Croatian-Serbian)

[30] The full title of the document is: *Republic of Serbia Ministry of Health - Special Protocol for The Protection and Treatment of Women Victims of Violence*; available in English at: https://www.rs.undp.org/content/dam/serbia/Publications%20and%20reports/English/UNDP_SRB_TirkizniTekst.pdf and in Serbian: https://www.rs.undp.org/content/dam/serbia/Publications%20and%20reports/Serbian/UNDP_SRB_TirkizniTekst.pdf

there are certain conditions victims of violence should meet in order to get such a document without having to pay a fee (for example in Albania and Kosovo). **There are (even) examples showing that victims have to pay a substantial fee in practice, despite legal regulations which prescribe that these documents must be issued free of charge.**

In North Macedonia, for example, the NGO reports that a certificate should be issued free of charge, in line with the Law on Health Insurance, but this provision is not actually implemented in practice. According to the information provided by the North Macedonian partner, in practice the price for issuing this document ranges from 1.500 to 6.000 Macedonian denars (approximately 25 to 100 EUR). In BiH, such certificates are currently free of charge for all victims of violence. When a victim accesses healthcare facilities for urgent medical assistance, a certificate is issued *ex officio* by doctors, and sent to the police or given to the victim. However, in earlier period, some health centers were charging 50 BAM (Bosnian Marks, approx. 25 EUR) for such document. Unfortunately, Foundation United Women Banja Luka records cases even presently, where some doctors are still charging victims as they are not informed about the change in regulations. For example, in 2020, doctors in Kotor Varos were unaware that such certificates should be free of charge, so staff members of the Safe House for Women and Children Victims of Violence had to send them the text of the current legal provision, to confirm that a fee cannot be charged.

As reported by the national partner in Turkey, doctors provide certificates if victims access a hospital, or are referred to hospitals by the police, and emergency wards issue certificates free of charge. Some Forensic Medicine Units in university hospitals in Turkey also provide such certificates or reports but they are not free of charge.

Medical reports are subject to certain conditions

Regulations in some countries imply that issuing a medical report is subject to certain conditions. In Albania, it is the forensic doctor who completes and issues the certificate, which is free of charge, but the victim needs to be referred by the relevant agencies. Forensic doctors in Regional Hospitals provide every victim of domestic violence with a forensic examination report upon referral of the Judicial Police Officers or the Prosecutors. As Albanian women's NGOs further explain, this document is not given to the victim of violence directly. After examining the victim, the report is compiled and sent to the responsible institutions. In such circumstances, the document is used and considered a substantive piece of evidence in courts. The problem identified in this context is that forensic doctors do not provide the victim with a copy of the forensic report. Activists of one Albanian NGO further note that police officers do not in all cases refer the victim to a forensic doctor for examination, which is an issue of particular concern. In addition, the availability of forensic doctors, i.e. those who are qualified to issue such documents, is insufficient in Albania. For example, one Albanian organization reported that a forensic doctor may be responsible for two districts, so it is often impossible to find an available doctor when the victim needs an immediate examination.

The Turkish NGO reports that general law enforcement or hospital police sometimes misinform or discourage victims from applying for a certificate. Furthermore, one national partner in Kosovo reports that doctors issue a certificate only if the victim is accompanied by the police, a social worker, or a women's organization; if the victim goes by herself, doctors will usually treat her like other patients, unless she informs them that she needs such a certificate.

Insufficient documentation of injuries

Women's NGOs in several countries indicate that often injuries have not been described sufficiently, or that doctors sometimes avoid issuing medical certificates in cases of domestic violence. Responses vary greatly with respect to the usage of certificates in courts and their value in judicial proceedings. One Montenegrin NGO highlights that certificates are usually very brief: the injuries are

not described in detail, or not all injuries are described. The partner from Montenegro further states that doctors do not include victim's statement that injuries are inflicted by the perpetrator; commonly it is written that, "The victim alleges that the injuries were caused by a third party." Some Albanian NGOs highlight the same issue.

A Serbian NGO working with women with disabilities reports that doctors rarely fill out the form (which is prescribed in the protocol that regulates the duties of medical professionals, as explained above), or do not describe the injuries in sufficient detail, which reduces the value of such certificates in court proceedings. Another Serbian partner claims that certificates are not commonly used as evidence in courts. The Turkish NGO reports that sometimes doctors do not listen to victims carefully, or do not check victims' complaints thoroughly, so the latter are not included in the reports.

Representatives of the NGO that works with victims across Albania (Counselling Line for Women and Girls) report that sometimes lack of a timely referral of victims to forensic doctors by the police has a negative impact on the quality of the forensic report, and consequently, its usefulness in judicial proceedings. In their experience, problems emerge when police officers do not refer the victim to a forensic doctor on time, or when a forensic doctor does not examine the victim on time (although an appointment has been scheduled); thus, examination is not done immediately after a violent act and evidence gathered may be less valuable.

E3. Contribution of healthcare professionals to the effective prosecution of sexual violence cases

In general, only a few cases of sexual violence are reported to the police. Many reported cases have been discontinued when the victim refuses to testify, and many criminal proceedings do not lead to conviction, due to "lack of evidence". Those victims who decide to testify are inevitably exposed to re-traumatization, since they have to repeat their testimony many times; firstly, when filing out the complaint to the police, then during investigation, and finally, before the judge. The story below does not follow this common pattern (*See Box: Promising practice in bringing perpetrators of rape to justice: Doctors can make a difference*).

In the recent policy paper on sexual violence in the Western Balkans and Turkey[31], the following details have been analyzed:

a) The procedures that apply when a victim reports the rape to law enforcement, as well as
b) Possibilities to obtain medical and forensic examination after rape, with the aim to assess whether the applicable procedures are in line with the **requirement of the Istanbul Convention, namely provision of services should not be dependent on the victim's willingness to press charges or to testify against any perpetrator (Article 18, paragraph 4).** While it turned out that it was not possible to offer a complete overview, responses of national partners indicated that **legal provisions or prescribed procedures (e.g. by-laws) regulating the work of state agencies have not been harmonized with the requirements of the convention to provide, for example, medical and forensic examination to all victims, regardless of their willingness to report the offence** (ibid.). Regulations in respective countries have been (mostly) restrictive; forensic examinations are subject to a request made by law enforcement agencies or prosecution offices. Therefore, forensic examination (mostly) depends on the prior report of the victim to the police or prosecution (ibid.).

[31] Brankovic, B. and Saidlear, C. (2021). *Promising practice of establishing and providing specialist support services for women experiencing sexual violence: A legal and practical overview for women's NGOs and policy makers in the Western Balkans and Turkey. V*ienna: Women against Violence Europe (WAVE), European Union, Civil Society Strengthening Platform and UN Women, https://wave-network.org/promising-practices-of-establishing-and-providing-specialist-support-services-for-women-experiencing-sexual-violence-a-legal-and-practical-overview-for-womens-ngos-and-policy-makers-in-the-w/

In the present assessment, the above-mentioned issue is further explored, as women's NGOs were asked to provide examples of recent experiences of victims of rape in obtaining healthcare services. No changes were identified to the situation described in the study above (ibid.). However, example obtained for the purpose of the current research is encouraging.

One of the women's NGOs described a brief case regarding a survivor of sexual abuse (by several perpetrators), which highlights that **a prompt and competent intervention by healthcare professionals can really make a difference.** The perpetrators were sentenced to prison, and the documentation provided by the doctors in the emergency ward played a crucial role in the trial.

Promising practice in bringing perpetrators of rape to justice: Doctors can make a difference

"*In April 2020, we were contacted by a girl who had been sexually abused by her partner for several years. We were the first organization to which she turned to for help. She disclosed that she experienced rape from her partner and two of his friends. With our support, she went to the emergency healthcare center and reported the rape. The doctor called the gynecologist on duty and all injuries were documented. The police was called and an urgent measure of detention for 24 hours was ordered for the perpetrators. The measure was extended for 30 days, thus, the perpetrators of the crime remained in detention. Criminal proceedings were issued against them. The girl refused to testify. The prosecutor used the medical records and continued the trial. The perpetrators were sentenced to prison*."

NGO Fenomena, Kraljevo, Serbia, www.fenomena.org

F. How multi-agency response to domestic violence works in practice: The case of Albania –GREVIO Baseline Evaluation Report

Albania can be regarded as a good practice example in the area of establishing structures for multi-agency collaboration. The authorities have established the so-called Coordinated Referral Mechanism at the local (municipality) level. GREVIO in its baseline report (2017) highlighted that, although the necessary structures for effective mechanisms for multi-agency collaboration have been envisaged in a proper manner, the gaps in their practical functioning are still visible, challenges are complex and numerous. One of the challenges identified by GREVIO was **the insufficient involvement of healthcare providers** in the functioning of the above-mentioned mechanism.

With this in mind, the **"lessons learned" in the process of establishing multi-agency cooperation in Albania can potentially be applicable to countries across the region of the Western Balkans, and for this reason, we quote below GREVIO's analysis.**

In its baseline evaluation report on the implementation of the Istanbul Convention in Albania, GREVIO estimated that available studies indicate that Albania is one of the few countries in the Central and Eastern European region that has set up a network for co-ordinated community intervention, and that Albania's achievements in this area are rightfully cited as an example of best practice of multi-agency cooperation in the region.

Albania started to pilot mechanisms for multi-agency cooperation in 2007 and later established a legal base for their functioning. The duties and responsibilities of professionals dealing with domestic violence cases are specified through amendments of the Law No. 9669 On Measures against Violence in Family Relations, which were adopted in 2011. Authorities also adopted legal regulations that

established the National Referral Mechanism for Cases of Domestic Violence operating at the local (municipal) level, composed of three structures: the steering committee, the technical team, and the local coordinator. Duties of the mechanism are to provide for co-ordinated actions of institutions and other actors, such as women's NGOs, in supporting victims of domestic violence.

GREVIO elaborates on the role of these structures and services/protection measures they provide: a steering committee is responsible for the political direction of the process, a multi-disciplinary technical team is tasked with case-management, while a local coordinator leads and co-ordinates the work of the technical team. Mechanisms are composed of representatives from municipalities, the police, the courts, including prosecutors and bailiffs, healthcare institutions, employment offices, educational offices and NGOs specialized in VAW. Whichever member of the mechanism the victim first contacts will set the process in motion by referring the victim to the local coordinator and/or the other members of the system. The mechanism provides services, both short-term-and long-term, such as healthcare support, shelter and protection (including procedures for protection orders), while long-term interventions include psychotherapy, assistance with children and with divorce procedures and reintegration in society. In assessing the functionality of these mechanisms (i.e. how the legal regulations on multi-agency collaboration are implemented in practice) GREVIO assesses, firstly, that local referral mechanisms are the centerpiece of Albania's co-ordinated multi-agency response to violence, as they bring together a wide array of representatives from the relevant authorities and civil society to put up a strong unified response to domestic violence, and also notes that NGOs and international donors have played a crucial role in establishing the existing mechanisms. Secondly, GREVIO commends the political leadership of those mayors who drove the process of creating referral mechanisms in their communities. While recognizing that establishing and sustaining such mechanisms is a complex process that requires several years, GREVIO identifies numerous gaps in their functioning:

a) Currently, referral mechanisms are established in only 29 out of the total of 61 municipalities in Albania[32]. As of 2021, the mechanism has been established in all 61 municipalities, but they function at varying degrees;
b) "Weak" links in the referral mechanisms affect the effectiveness and the quality of the inter-institutional response to VAW;
c) Frequent staff turnover, in particular following political elections, erodes their capacity;
d) Referral mechanisms lack a comprehensive set of services to offer victims and fail to meet their needs, as indicated in studies;
e) Multi-agency cooperation on forms of VAW other than domestic violence lacks a clear legal basis. The authorities indicate that the referral mechanism set up to deal with cases of domestic violence can also serve to tackle other forms of VAW, however, GREVIO was not in a position to verify that victims of stalking, sexual violence and rape or forced marriage have ever been directed to such a mechanism;
f) According to GREVIO's evaluation, the existing mechanism operates to varying degrees of effectiveness. The major weaknesses involve: the lack of proper enforcement by bailiffs of emergency barring orders and protection orders, inadequate responses from the courts' system and an insufficient implication of healthcare professionals, including forensic experts.

According to the Report on the Implementation of Recommendations addressed to Albania by the Committee of the Parties of the Council of Europe Convention on preventing and combating violence against women and domestic violence[33], the DCoM was substantially revised in 2021 to include measures taken to strengthen the referral mechanism after the GREVIO report. The Decision of the

[32] Note that this assessment by GREVIO was made in 2017, and changes in the number of referral mechanisms have occurred after this report.
[33] https://rm.coe.int/albania-report-on-the-implementation-of-the-reccomendations-from-cp-ic/1680a30d7f

Council of Ministers on the functioning of the Coordinated Referral Mechanism against domestic violence cases at national level was adopted in June 2021, which repeals the previous DCoM. The decision further emphasizes the need to prioritize tackling all forms of violence against women through a coordinated multi-sectoral approach.

In this context, a number of consultative roundtables were organized with key independent bodies such as the Ombudsperson, the Commissioner for Protection against Discrimination, the Bar Association, representatives of the academia and the civil society. There was, among others, a discussion on a new comprehensive law against violence against women. More specifically, at the local level, the responsibility for the prevention, protection, support and rehabilitation of victims of domestic violence rests with the Coordinated Reference Mechanisms (CRM), already established in all 61 municipalities in the country. The CRMs were set up pursuant to Law No. Albania: Implementation of the Recommendations addressed by the Committee of Parties 2018-2020 Submitted on 30 June 2021 32 9669/2006 "On measures against violence in family relations", as amended, which is underpinned by the principles of Istanbul Convention and other international conventions and treaties (Article 3/1). The new DCoM regulating the functioning of the CRMs contains more extensive references to the Istanbul Convention and addresses all forms of violence against women.

G. Has the COVID-19 pandemic led to the increase of domestic and/or sexual violence cases reported to women's NGOs?

The COVID-19 pandemic has had a wide-ranging impact on the protection of women and children victims of violence, as the previous analysis indicates. It should be further noted this assessment cannot respond to the question whether violence as such has increased in the context of the pandemic, but only addresses the question if this specific context led to an increase or decrease in the number of **reports** of violence to women's NGOs. An in-depth analysis of the impact of the pandemic should yet be concluded. Examination of diverse and complex aspects of this impact is beyond the scope of this study. However, the present research focuses on the following aspects:

- Did women's NGOs filling out the questionnaire record an increase or decrease in the number of domestic violence cases reported to their NGO in the last year and a half (since the beginning of the pandemic), compared to 2019?
- Did women's NGOs record an increase or decrease in the number of sexual violence cases[34] reported to their NGO in the last year and a half (since the beginning of the pandemic), compared to 2019?
- Did women's NGOs identify any specific problems that differ from their experience prior to the pandemic?

Almost all women's NGOs (12 out of 14), responded that they recorded an increase in the number of domestic violence cases reported to their NGOs during the pandemic (see Chart 5). With respect to an increase of sexual violence cases, responses differ. Only one NGO recorded an increased number of such cases; six NGOs did not record such an increase, and seven replied either that they do not work with sexual abuse survivors, or do not have complete data (see Chart 5). A Bosnian NGO responded that their NGO did not record an increase in the number of sexual violence cases reported to them; however, the Ministry of Interior of the Republic of Srpska stated in their Report on the Status of Security in 2020 that number of criminal offences against sexual integrity increased by 20,3% in 2020, compared to 2019.

[34] In the questionnaire that was developed for the purpose of this study, we included the question whether national partners recorded an increase or decrease in the number of sexual violence cases reported to their NGO. However, some of the NGOs – national partners **do not work with sexual abuse survivors**, **or do so only occasionally (or -** refer such cases to other agencies/organizations); hence, info related to sexual violence cases may be less reliable.

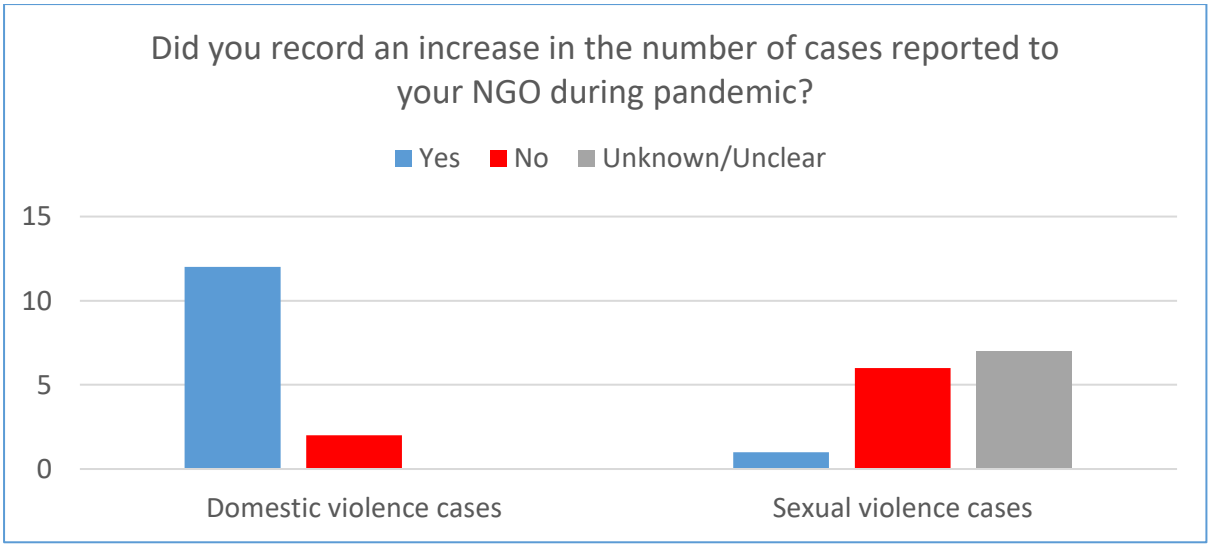

Chart 5: Distribution of responses to the question: Did you record an increase in the number of domestic, as well as sexual violence cases, reported to your NGO during the pandemic (in the last year and a half), compared to 2019?

Women's NGOs also provided explanations on the problems identified throughout the pandemic. Albanian NGOs reported that during the pandemic, victims were less inclined to report domestic violence to the police. In their opinion, the latter happened due to a variety of reasons, including: lack of alternative accommodation and restrictions of movement; limitations on public transport which affected women living in rural areas; state agencies/service providers were working in a "dysfunctional" manner or had reduced their working hours; an increased economic uncertainty made decisions to leave a violent partner even more difficult than in "normal" circumstances. Some of these NGOs noted they recorded more cases of psychological violence, or that domestic violence increased in its severity. One Albanian NGO specified that their records imply an increase in self-referred domestic violence cases, while the number of cases referred by the police decreased.

Responses of Bosnian, Serbian and Turkish NGOs (See: Box *Women's NGOs as the primary source of support during the pandemic: Examples from Bosnia and Herzegovina, Serbia, and Turkey*) indicated that access to general services was restricted, especially during the first phase of the pandemic. Healthcare services were overwhelmed with COVID-19 patients, and their availability for other patients was reduced, while social protection services reduced their working hours or stopped direct work with clients altogether. **Women victims of violence therefore turned to women's NGOs in a greater number, as these organizations have continued to offer support throughout the pandemic**. For these reasons, **some of the NGOs have significantly increased the number of services provided to victims.**

Based on the information provided by respondents to the questionnaire, **one of the most important conclusions of this survey is that women's NGOs, to the extent possible, compensated for the limitations in the provision of general services throughout the pandemic.**

Women's NGOs as the primary source of support during the pandemic: Examples from Bosnia and Herzegovina, Serbia, and Turkey

In the first two months of the pandemic (in March and April 2020), and when strict government measures were in place (lockdowns and restrictions of movement), **Foundation United Women Banja Luka** recorded a decrease in the number of calls to the SOS helpline. They also recorded a decrease in the requests for free legal aid and psychosocial assistance. But after that period

requests increased: SOS helpline recorded an increase in the number of calls, between 20% and 30% in comparison to the period before pandemic. This NGO provided 285 free legal aid services in 2019 and 437 such services in 2020; the number of women accommodated in the safe house was 40 in 2019, and 54 in 2020. This NGOs also noted that women experienced difficulties to access general services provided by Centres for Social Work, healthcare centers, and courts. The Centres for Social Work limited their field work and direct contact with beneficiaries, healthcare centers also had limited contact with patients, while courts processed only cases related to violation of measures introduced by the government during the pandemic.

A Serbian NGO that offers specialist services to women with disabilities, *Iz kruga/Out of Circle Vojvodina*, reported that they provided a higher number of services during the pandemic. They further reported that the problem of implementation of court decisions related to visitation rights was more pronounced, compared to the period before the pandemic. Since the beginning of the pandemic in 2020, compared to 2019, the number of services they provided has increased by 35%, and the number of women exposed to violence to whom they have provided these services has increased by 27%. A persistent problem, especially during the introduction of the state of emergency, was the implementation of court decisions regulating visitation rights of fathers. When children live with their mothers, it was expected that parents will themselves make a visitation rights agreement during hours when movement was not restricted. In cases where there was a history of domestic violence, it was significantly more difficult to reach an agreement that would be in line with the dynamics of visitation determined by the court. Another problem was also noted: when children live with elderly family members, their contact with other people outside the family increased the probability of transmitting the virus to elder family members and thus posed a serious health risk. Furthermore, as the regime of work in Centres for Social Work changed during the state of emergency, women victims of violence have found it even more difficult to obtain information and assistance.

Turkish NGO *Mor Cati* recorded an increase in the number of requests to support women victims. They specified that they have increased the number of staff in the period of the pandemic, to be able to meet the increased demand. They highlighted that younger women sent more applications than before (as they stayed with parents during the pandemic), and the number of applications sent by email also increased. As a general remark, this organization noted that since the situation in the state-run support mechanisms deteriorated during the pandemic, women were not able to reach them and as a result, they turned to women's NGOs more frequently than before.

Women's NGOs also provided brief stories, which illustrate experiences of victims during the pandemic. One particular story should be highlighted, as it showcases what happens when the victim is a medical worker, with additional work-related responsibilities during lockdown periods. Based on the described facts it seems that the hospital, in which both the victim and the perpetrator have been employed as medical workers, did not take any steps to support nor protect the victim.

Problems identified during the pandemic: What happens when both the victim and the perpetrator work in the same hospital?

"*A woman survived psychological and physical violence by her husband and his father. She reported the violence to the police and her husband was removed from the house for 48 hours, which was later extended to 30 days. She and her husband are medical workers and work in the same hospital. Due to the COVID-19 pandemic and the increased volume of work, they had a ban on using vacations, and there was no possibility to ask for sick leave. Therefore, there was the risk that they will see each other because they work together. Also, there is no one to take care of the children*

while she was at work. Although the protection measure was imposed in relation to the woman, but not in relation to the children, and there was no obstacle for the father to see and take care of the children, the problem identified is how to organize the "handover" of the children from the mother to the father, and consequently not to violate the measures of protection imposed. A possibility would have been to organize it through a third "neutral person", but the woman cannot organize something like that and there is no one to support her. Although the woman was protected by the measure, in practice it is impossible to apply it, and the woman had to be in contact with the abusive husband."

Iz kruga / Out of Circle – Vojvodina, Organization for the Support of Women with disabilities, https://izkrugavojvodina.org/

H. Trainings for healthcare professionals organized by women's NGOs: A solid base for strengthening future cooperation

The research assessment analyzes whether healthcare professionals have been sufficiently trained to respond to cases of domestic and sexual violence, and whether women's NGOs contributed to the delivery of these trainings. Therefore, information on previous trainings organized by women's NGOs may be seen as an indicator of their capacity. Furthermore, delivery of trainings may be also seen as a chance to improve communication and cooperation between healthcare providers and women's NGOs, and can therefore be regarded as a promising practice.

All women's NGOs who participated in this project assessed that healthcare professionals in their countries have not been sufficiently trained on the issues of violence against women, in particular, on a multi-agency coordinated response to domestic and sexual violence. To illustrate this, a response of the Serbian NGO is quoted below, "*In our opinion, healthcare workers are not sufficiently trained to work with women who have experienced domestic or sexual violence. Healthcare workers are not gender-sensitive, they do not have enough knowledge about different types of violence and the consequences each type of violence has on health. They are also overburdened with administrative tasks when providing healthcare services and have limited time to provide services, meaning they cannot devote enough attention and time to each patient even if they are trained*."

Similarly, the women's NGO in Turkey claims that trainings should be focused on changing attitudes of medical professionals, "*rather than lack of knowledge, the approach of these professionals constitutes the problem. We encounter examples where they blame, discourage, or misinform women victims of violence".*

Some of the NGOs from Albania clarified that health professionals need continuous training on legal regulations. One Albanian partner noted that medical professionals themselves have requested more meetings and trainings related to reporting cases of violence, the latest legal amendments, as well as on the "Standard operating procedures for the treatment of cases of domestic and gender-based violence by employees of health services". Another partner from Albania states that healthcare professionals mostly have not been sufficiently trained to identify cases of domestic and sexual violence and provide services to victims, and adds that trainings organized by women's NGOs have been often attended by only one or two representatives of medical centers, which is very low compared to the number of doctors working in local communities. Yet another partner from Albania claims that these professionals mostly need to be trained on a gendered understanding of violence and applying a gender-sensitive approach to victims.

It was further explored what kind of in-service trainings have been organized recently for these professionals by responsible authorities or NGOs, what was the content of such trainings and whether the trainings were mandatory or optional. Taking into account that a complete overview of in-service trainings for these professionals is outside the scope of this study, NGOs were asked only to provide **examples** of recent trainings.

Based on the responses provided, **it was not possible to obtain conclusive findings about the content of these trainings, which types of violence were covered and whether the trainings were mandatory or optional**. It should be emphasized that NGOs did not mention mandatory trainings, with only one exception. One national partner from Serbia, Association Fenomena from Kraljevo, reported (based on information provided by the Director of the healthcare center in Kraljevo) that all healthcare workers in this city attended a mandatory training on working with victims of domestic and sexual violence. On the other hand, another Serbian partner reported that trainings for healthcare providers are not mandatory; they are not obliged to undergo any training on domestic violence or sexual violence against women.

Two NGOs from North Macedonia and Turkey stated that National Action Plans in their respective countries make reference to mandatory trainings. More specifically, the Turkish NGO reported, *"National Action Plans always state the importance of in-service trainings, sometimes they are mandatory, but we never see what the impact of such trainings actually is. What we see is that trainings do not serve the purpose of changing the approach of healthcare workers".* Women's NGO from North Macedonia clarified that the National Action Plan (2018-2023), which aims at implementing the Istanbul Convention, established an obligation for mandatory trainings of professionals involved in the protection of victims of gender-based violence in the field of health, but there was no information whether the latter obligation has been implemented in practice.

Moreover, **there are some indications that previous trainings organized by responsible authorities, have been mostly focused on domestic violence, although the titles of the trainings may refer to gender-based violence**. To this regard, Foundation United Women from Banja Luka, BiH, highlighted this important issue, "*Foundation United Women believes that continuous training is necessary for all professionals in the healthcare system to be able to provide competent and sensitive support to victims of domestic violence and sexual violence. As we can see from available information provided by authorities to GREVIO in the State Report on the implementation of the Istanbul Convention, the training programs for healthcare professionals depend on occasional projects, are not sufficiently institutionalized, and it is not clear if they are mandatory. Furthermore, available information indicate that trainings conducted so far predominantly focus on the issue of domestic violence, although resource materials produced by relevant entity ministers refer to gender-based violence*."

Examples of recent trainings for healthcare professionals in BiH and Serbia

One women's NGO from Bosnia and Herzegovina provided interesting information on the trainings organized for healthcare professionals, including recent initiatives of the governments at the entity level to increase their capacities.

Recent State Report of BiH to GREVIO indicates that in the Federation BiH, 11 healthcare workers and associates completed training of trainers (ToT) in 2016, conducted in line with the resources and training package "Strengthening the response of Federation BIH Health Care system to Gender-Based Violence". In the period 2016–2018, 140 healthcare workers and associates attended trainings in the frame of this project. In 2017, training of trainers was conducted in line with the document entitled "Rendering Psychosocial Services to Victims of Gender-Based Violence" and 15 mental health professionals and those working in Centres for Social Work attended. In the period of 2017–2018, the education of healthcare professionals was conducted pursuant to the module

"Rendering Psychosocial Treatment of Victims of Sexual Violence and Torture in Times of Conflict" with 96 healthcare workers and associates attending. The State Report of BiH to GREVIO also indicates that 28 education sessions in 28 healthcare institutions for 895 employees of healthcare institutions were conducted earlier in Federation BiH in line with another training program for healthcare workers.

In Republika Srpska, in 2017 the Ministry of Health and Social Protection of RS drafted a number of publications and organized education sessions for professionals in social protection and healthcare on domestic violence as a social problem, which were focused on "Strengthening the response of healthcare providers to gender-based violence". The following publications were drafted (adapted): the training manual 'Training of Trainers for Psychosocial Treatment of GBV Perpetrators' and the training module 'Psychosocial Treatment for GBV Violence Perpetrators'. Professionals in RS participated in an education session held in Banja Luka related to the psychosocial treatment of gender-based violence perpetrators. A training package was also prepared under the title 'Minimum Standards for Prevention of and response to GBV'. Additionally, the State Report to GREVIO indicates that RS Ministry of Health and Social Care prepared a resource package to improve the response of healthcare and psychosocial assistance professionals in Republika Srpska to GBV, and that trainings are planned based on this package. There is no information in the State Report to GREVIO if these trainings are mandatory and part of the regular and systemic institutional practice. The latest 6th Periodical CEDAW Report of BiH (covering the period 2013-2016) does not contain specific reference to training of healthcare professionals in BiH on domestic violence or sexual violence against women.

Foundation United Women from Banja Luka, BiH, http://www.unitedwomenbl.org

The women's NGO from Serbia reported as follows, "*Sporadically, trainings for healthcare workers have been organized by responsible authorities, such as: the Provincial Secretariat for Health, implementing the project "STOP-PROTECT-HELP a stronger institutional response to gender-based violence in the Autonomous Province of Vojvodina", which organized in several health centers in Vojvodina an accredited three-day training "Effective response of the health system in protecting women victims of violence in the family and gender-based violence" in order to improve the prevention and early detection of violence*".

Iz kruga – Vojvodina, Organization for the Support of Women with disabilities, https://izkrugavojvodina.org/

Almost all NGOs have previously organized in-service trainings for healthcare workers in their local communities, some of which were described in greater detail. **It can be therefore assumed that women's NGOs in the region of the Western Balkans and Turkey possess the capacities, expertise and motivation to (continue to) provide trainings for healthcare professionals in the future**. **This may be viewed as an encouraging finding of the assessment. Under the condition that governments and/or UN agencies provide funds for such trainings in the future, it can be expected that cooperation between women's NGOs and medical professionals may be improved, including referral, to the benefit of women victims**.

In this context, we should be reminded that in other segments of this study it was revealed that medical professionals, regretfully, rarely use an opportunity to refer victims to women's specialist services. Therefore, a lot needs to be improved this area, and trainings may contribute to strengthening a multi-sectoral coordinated response to violence, including referral.

In planning (possible) future trainings for medical professionals, it is important to note that some women's NGOs in the region, in particular, those working in Serbia, have been faced with certain requirements when they intend to organize such trainings. As reported by the Serbian partner, "*Non-governmental organizations cannot independently submit a request to the Health Council of Serbia for approval for conducting trainings for medical workers, but must do so in cooperation with medical institutions (Medical Faculty, Association of Nurses and Technicians, Institute of Public Health, etc.). The Center for Support of Women from Kikinda, in cooperation with the Medical Faculty of the University of Novi Sad and the Center for Continuing Medical Education, accredited the program with the Health Council of Serbia (Decision No. 153-02-01202/2020-01 of 16.11.2020). The program is intended for health workers - doctors, nurses, technicians, as well as associates in healthcare institutions - psychologists, social workers, special educators, but also for non-medical workers in healthcare centers where a victim of violence may show up. The goals of the program are to improve: knowledge and skills of professionals for the efficient provision of services to women victims of gender-based and domestic violence; knowledge and skills for documenting and recording cases of violence against women, especially cases of sexual violence; cooperation and communication of health institutions with other institutions in multi-sectoral work on cases of violence against women in the family and gender-based violence; cooperation with centers for victims of sexual violence* (https://edukacije.cpz.rs/o-programu/)."

I. Access of victims to healthcare: what data can tell us and how data can be used by NGOs

Preventing and combating violence against women, including domestic violence, requires evidence-based policy-making. The collection of systematic and comparable data from all relevant administrative sources is crucial in this regard. Data on access of victims to healthcare are relevant for the assessment whether medical professionals are fulfilling their intended (and often, legally prescribed) roles.

In this context, it is important to highlight; **if data on violence is collected by healthcare institutions and made available to the public (as the Istanbul Convention requires), if women's NGOs could use this data for monitoring, shadow reporting and advocacy purposes, and to assess whether medical professionals meet their obligations as "first responders**". **This may include monitoring if doctors fulfil their duties related to referral (including referral to specialist services, if laws and/or protocols oblige them to do so).** GREVIO reports on Albania (2017), Montenegro (2018), Turkey (2018) and Serbia (2020), identified shortcomings in collecting data on violence by public healthcare institutions.

As an example, in GREVIO's report on Albania (2017), it is stated that the law on domestic violence in Albania stipulates that victims are entitled to receive medical and psychological support and should be referred to specialist support services; domestic violence cases are to be recorded and communicated to the Ministry of Health using the appropriate templates approved by the ministry, and that victims are entitled to receive documentation illustrating any injury sustained as a consequence of violence. However, the implementation of these provisions is insufficient and hampered by healthcare professionals' reluctance to report cases of domestic violence, partly out of fear of exposing themselves or the victims to retaliation by the perpetrators. Thus, actors in the field acknowledge that data generated by healthcare are largely a substantial under-representation of real figures. There are no equivalent obligations to collect data regarding other forms of violence against women, such as sexual violence. As a result, information on the number of victims identified by medical professionals and on the treatment they receive is rather scarce. Thus, it is impossible to evaluate the impact such support services have where they are provided, and whether they fulfil their intended role.

In its report on Turkey (2018), GREVIO commended the authorities for their data collection efforts in the health sector, but also noted a considerable decrease in the numbers of domestic violence cases identified. Namely, healthcare professionals in Turkey receive training allowing them to recognize and detect signs of violence and requiring that they record cases of violence against women by using the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD 10 Codes), developed by the World Health Organization. They are under an obligation to report any recognized or suspected case of violence, and face criminal liability in case of any failure to report it. GREVIO welcomes the authorities' ongoing initiatives to develop an infrastructure for systematic data collection in the health sector, and to improve the capacities of healthcare professionals, including general practitioners and emergency services, to identify and record cases of violence. It also stresses the importance of current efforts to train all personnel in primary healthcare, while recognizing that such an endeavor is both necessary and costly, based on the size of the country. According to statistics by the Ministry of Health, there were 20.895 such cases in 2015 and 1.094 in 2016. The sharp decrease in the number of recorded cases would require identifying the reasons for this phenomenon. Moreover, GREVIO notes that this data does not appear to comprise statistics on violence affecting girls, such as data kept by Child Protection Centres in cases of sexual assault against minors or the numbers of sexual assaults involving minors recorded in obstetrics wards in cases of child delivery.

As far as Montenegro is concerned, the GREVIO report (2018) noted that the public healthcare sector does not have an electronic data collection system. The health sector manually collects data on the basis of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10 Codes) developed by the World Health Organisation. Medical staff are trained to identify victims of domestic violence, including victims of psychological violence, and have the duty to report any suspicion of a crime to law enforcement agencies.

In the GREVIO report on Serbia (2020), it is assessed that tools have been developed for healthcare professionals to identify and support victims of domestic violence, and records are kept by the Institute of Public Health on the number of identified victims and case referrals (reports) to police and social welfare centers. It is disaggregated by geographical location, which shows stark differences in approaches. While in 10 of the 26 administrative districts of the Republic of Serbia all identified cases of domestic violence are reported to another authority (police, prosecution or social welfare center), in other districts a large number go unreported (10-40%). The records kept also identify the percentage of women with disabilities, pregnant women and elderly women – but not their relationship to the perpetrator.

GREVIO reports, therefore, clearly indicate that public healthcare systems in these four countries do collect data on violence, and that analyses of such data reveal serious shortcomings in the response of the healthcare sector to violence against women. However, some respondents to the questionnaire answered that they are unaware of national-level data on access of victims of domestic and sexual violence to healthcare services (for example, the annual number of victims who asked for help in healthcare institutions), or on the services to victims provided by healthcare professionals. This surprising finding seems to imply that **women's NGOs in the Western Balkans and Turkey miss the opportunity to use data on access of victims to healthcare for the purpose of monitoring, shadow reporting and advocacy.**

Only two national partners reported on available data on access of victims to healthcare, one from Kosovo, and one from BiH. Women's NGO in Kosovo*reported that when women victims of domestic or sexual violence approach a primary healthcare center and report violence, doctors are obliged to fill in the form of reporting cases of domestic violence. The forms completed by doctors are sent to a special office in the Ministry of Health, which monitors and collects data on cases of domestic violence reported to each ambulance/ healthcare center/ hospital in Kosovo. However, as reported by the partner, this data is not available to public. An NGO from BiH reported about recent considerable

changes in data collection on cases of domestic violence by healthcare institutions (which are legally prescribed and specified in respective by-law). **These relevant changes explained below can be very interesting to women's NGOs in the Western Balkans and Turkey and their advocacy efforts in the future.**

Promising practice: Improvements in the system of data collection on domestic violence cases in healthcare institutions in Republic of Srpska, BiH

The Bosnian NGO reported about a considerable improvement in data collection on domestic violence by healthcare institutions in one entity of BiH (Republic of Srpska). It should be highlighted that data are publicly available.

"*Based on the Law on Protection from Domestic Violence of Republic of Srpska, the Ministry of Family, Youth and Sport is collecting statistical data on domestic violence cases that were identified/processed from all institutions that are recognized as subjects of protection, including healthcare institutions. Data is collected on predetermined methodology defined through the By-law on Content of the Evidence and Reports on Domestic Violence, adopted on 12 May 2021 (after the latest changes and amendments of the Law on Protection from Domestic Violence in Republic of Srpska entered into force)*[35]*. Data is collected semi-annually and is publicly available on the webpage of the Ministry. Type of data collected by healthcare institutions are defined in the Article 9 of the By-law, as follows:*

The records kept by healthcare institutions shall contain information on:
1) the number of victims according to gender, age, disability and the victim's relationship with the perpetrator,
2) diseases and injuries caused by domestic violence and referral for treatment,
3) protection of the mental health of victims of domestic violence in healthcare institutions,
4) number, gender and age structure of perpetrators of violence in the family referred to compulsory psychosocial treatment,
5) number, gender and age structure of perpetrators of violence in a family referred to compulsory addiction treatment.
(2) The data referred to in paragraph 1 of this Article shall be recorded by all healthcare institutions where admission, processing and treatment of persons, victims of domestic violence and perpetrators of domestic violence have been conducted."

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CONCLUDING REMARKS

The present research reveals that women's NGOs have established cooperation with healthcare providers, including with professionals working in the field of mental health, which remained at the same level during the pandemic. It seems that none of the NGOs have assessed that this cooperation has deteriorated during the pandemic, and such finding can be seen as encouraging. The NGOs were asked to assess the quality of cooperation with medical professionals within a wider context of the multi-agency response (which includes healthcare providers, but also other stakeholders, such as the police, prosecutors, judges, social workers, teachers, media, among others). It turns out that NGOs are moderately satisfied with the quality of cooperation, which is consistent with the findings of some

[35] Official Gazette of Republika Srpska, no. 58/2021, available (in Serbian language), at the web page of the Ministry of Family, Youth, and Sport: https://www.vladars.net/sr-SP-Cyrl/Vlada/Ministarstva/mpos/Documents/Правилник%20о%20садржају%20евиденције%20и%20извјештаја%20о%20насиљу%20у%20породици%20СГ%2058%2021_230602192.pdf

previous multi-country studies conducted in the Western Balkans (Brankovic, 2019[36]). This section highlights the relevant aspects of cooperation that can be more encouraged in the future, including any NGO "strategies" which can represent a source of inspiration to other women's NGOs in the region.

Referral mechanisms represents a "weak point" in multi-agency cooperation. As medical professionals are often the first professionals with whom victims get in contact with, they may use such opportunity to refer the victims to women's specialist services (and in some countries, such as Albania, are even obliged to); however, this seems to be a "missed opportunity". Referral to specialist NGOs by doctors works better where women's NGOs have signed protocols or other structured/formalized forms of cooperation with respective healthcare institutions in their local communities, whereas some NGOs rely on "personal links" with medical professionals, when other formal mechanisms cannot be used. It can be therefore concluded that by encouraging the conclusion of formal protocols or other structured mechanisms of cooperation at local level, it would furthermore contribute to the improvement of referral pathways, and/or establishment of such pathways where they do not exist (although exceptions can be noted to this general remark).

In establishing strategies on how to improve the cooperation with medical doctors in the future, one of the areas where women's NGOs may focus their advocacy efforts on is the content and quality of medical reports documenting injuries in cases of domestic violence (in the region, these are often referred to as "medical certificates"). The issuance of such medical documentation is not free of charge across the region: in some countries, victims should pay (even substantial) fees, or can get such documents for free only under certain conditions (if they are referred to doctors by the police or prosecutors). Keeping in mind that the Istanbul Convention stipulates that services to victims including, for example, forensic examination, should be provided regardless of the victim's willingness to press charges or testify against any perpetrator (Article 18, paragraph 4 of the Convention), these worrying findings imply a need to advocate for changes in laws/regulations. There are even examples where such regulations do exist, but are not implemented in practice or, where doctors are not aware that (recently-amended) regulations prescribe that victims cannot be charged for such "certificates". In the latter case, one NGO from BiH has managed to advocate successfully for free-of-charge certificates, on behalf of victims. The research further indicates that doctors often do not describe injuries in their reports in sufficient detail, do not listen to victims' complaints, or do not use the forms that are prescribed for documenting injuries (in protocols/guidelines for medical professionals, where they exist); therefore these documents cannot be successfully used in courts as evidence, in order to contribute to convictions. Through establishing close links with doctors at a local level, and improving their understanding of the issue of violence against women through trainings, women's NGOs might contribute to a successful use of "certificates" in courts; one Albanian NGO has done so, which possibly may inspire other NGOs in the region.

When it comes to the assessment of applicable procedures regulating provision of forensic examination after rape, the findings of the current assessment confirm the conclusions of the recent multi-country study conducted in the Western Balkans and Turkey, and the policy paper[37]. Namely, legal provisions or prescribed procedures (e.g., by-laws) regulating the work of state agencies are not harmonized with the requirements of the convention to provide, for example, medical and forensic examination to all victims, regardless of their willingness to report the offence (ibid.). Rather, forensic examinations are subject to a request made by law enforcement agencies or prosecutors and thus (mostly) depend on the prior report of the victim to the police or prosecution (ibid.). On the contrary, an example provided by the Serbian NGO highlights that doctors' examination in the emergency ward and corresponding documentation proved to be highly valuable in court, which indicates that it is

[36] op. cit.
[37] op. cit.

worth trying to strengthen cooperation with doctors at the local level. The lesson learned based on their experience can be: although doctors in local hospitals may not possess specialization and expertise to perform high-quality forensic examinations in cases of rape, they can still contribute to the effective prosecution of sexual violence cases, if "prompted" by women's NGOs to undertake timely and well-documented examination.

Responses of women's NGOs in the Western Balkans and Turkey further imply that public mental health systems provide limited possibilities to victims of violence to get long-term psychological counselling. Furthermore, relevant professionals often lack a gendered understanding of the phenomenon of violence against women, and/or are inclined (or pressured, due to large number of clients) to prescribe just a "drugs prescription", rather than prescribe (longer-term) psychological counselling. These shortcomings became even more pronounced throughout the pandemic. However, it is revealed that these NGOs have come up with innovative strategies to address such shortcomings. The strategies, which could be possibly replicated across the region are:

a) Strengthening the cooperation with relevant public mental healthcare centers (using formal mechanisms of cooperation at the local level or "creating" referral pathways relying on "personal links" with such professionals);
b) Hiring mental health professionals (experienced and sensitized to meet the needs of women victims of violence) as individual consultants, to provide psychological counselling in NGO premises based on actual needs;
c) Engaging such professionals (again, under condition that they approach victims in a gender-sensitive manner) as volunteers;
d) Networking, including intensifying cooperation with existing associations of psychologists, and other specialists who offer free psychological counselling.

While these strategic efforts of NGOs can be viewed as inspiring, it must also be emphasized that they are unfortunately project-based. In the context of the pandemic, these "models" have proven to be practical and useful, as they enabled women's NGOs to compensate for the lack of services in the public healthcare system. Women's NGOs have demonstrated skills and creativity in developing strategies to overcome shortcomings in the public healthcare system, which became more pronounced during the pandemic. Due to reduced availability of general services survivors of domestic violence turned to women's NGOs in greater numbers than before[38]. As a result, the number of services provided by these NGOs have significantly increased. It is therefore intriguing that women's NGOs, which are often under-staffed and under-funded, have managed to compensate, to the extent possible, for the limitations in the provision of general services that occurred throughout the pandemic. Examples provided by NGOs from BiH, Serbia and Turkey showcase that, to some victims, the NGOs became the primary (or sometimes only) source of support. By hiring external associates, engaging volunteers, and/or developing and promoting online services, NGOs could meet the increased demand. Has one of the greatest challenges experienced by humankind in this century had to happen so that state agencies can recognize how important women's NGOs are?

Finally, the research implies there are several additional areas on which women's NGOs can concentrate their efforts on:

[38] As explained in more detail in the survey, numbers of cases of sexual violence, which were reported to women's NGOs during the pandemic, especially its first phase, have not increased; however, this finding is not conclusive and reliable, having in mind that NGOs included in the survey primarily work with victims of domestic violence, and only occasionally with sexual violence survivors.

- Organizing trainings for healthcare professionals with the aim to improve their sensitivity and gendered understanding of violence against women, and to establish a closer cooperation with them at a local level;
- Advocacy for the adoption (or amendment) of protocols regulating duties of medical professionals that should be fully harmonized with the standards of the Istanbul Convention, as well as for (more) efficient implementation of such protocols in practice (since the assessment indicates shortfalls in the implementation and a need to conduct additional, in-depth assessment) and;
- Using national-level data on access of victims to healthcare (some of which have been analyzed in recent GREVIO reports) for the purpose of monitoring, shadow reporting and advocacy.

In order to reach the goals mentioned above, women's NGOs in the region would need the support of UN agencies, and/or national governments. Such a support is important as the achievements of NGOs during the pandemic have confirmed a simple truth – women's NGOs, due to the flexibility in adapting their models of work to new circumstances and a dedication to principles of work with victims (that are developed by women's movement and enshrined in the convention), are an invaluable source of support, throughout crisis situations and beyond. Finally, women's NGOs are the primary providers of specialist services but given that most of them are not specialized in monitoring, there is a need to further develop their capacities for monitoring and evaluating governments' polices, as well as for shadow reporting.

ANNEX:

I. Protocols available in the Western Balkans and Turkey[39]:

Albania:
Protocol for Management of Cases of Domestic Violence at the Local Level, through the Coordinated Referral Mechanism (CRM)[40];
Protocol for managing cases of domestic violence at the local level, through Coordinated Referral Mechanism during the situation of COVID-19;
Standard Action Procedures on Treatment of Domestic Violence and Gender-Based Violence by employees of Healthcare Services in the Framework of Cooperation as Members of Coordinated Referral Mechanism;
Protocol for Management of Cases of Sexual Violence at the Local Level, through Multi-Sectoral Coordinated Approach, adopted in March 2021;
Standard Action Procedures for the Workers of Healthcare Services to Reduce the Risk of Experience of Domestic Violence and Gender-Based Violence in Civil Emergency Situations

Bosnia and Herzegovina:
General Protocol on the Procedure in Cases of Domestic Violence in the Republic of Srpska (at the entity level)[41], adopted on 25 November 2013, entered into force on 1 April 2014. It has a status of by-law and it is legally binding. Note: As sexual violence is recognized as a form of domestic violence by the Law on Protection from Domestic Violence in the Republic of Srpska, all procedures regulated by the General Protocol apply in these cases as well. It should be also added that, as recorded in the recent multi-country study in Western Balkans and Turkey, in this entity of BiH, resource materials[42] were developed, which include instructions to professionals who provide protection and support to victims of different forms of violence, including sexual violence (the police, prosecutors, judges, healthcare professionals).

Kosovo:
Standard Operating Procedures for Protection from Domestic Violence in Kosovo, (based on Programme of Kosovo against Domestic Violence and National Action Plan 2011-2014), adopted in 2013[43]

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[39] Disclaimer: According to the answers received to the questionnaire, the following protocols exist in the Western Balkans and Turkey. These answers should be taken with caution, as they represent the information that is available to women's NGOs filling out the questionnaire. Therefore, some protocols might be missing from the following lists.

[40] Available in Albanian:
https://www.al.undp.org/content/dam/albania/NewPublications/Protokoll_Menaxhimit_Rasteve_MKR.pdf

[41] Protocol is published in the Official Gazette of Republika Srpska no. 104/13, available in Bosnian-Croatian-Serbian:
https://www.vladars.net/sr-SP-Cyrl/Vlada/Ministarstva/mpos/Documents/Општи%20протокол%20о%20поступању%20у%20случајевима%20насиља%20у%20породици%20Републике%20Српске_241528621_188093949.pdf

[42] Ministry of Labour and Social Protection of the Republic of Srpska and UNFPA (2015). *Resource Package for Response of Health-Care Providers in Republika Srpska to Gender Based Violence.* Banja Luka: UNFPA, https://www.vladars.net/sr-SP-Cyrl/Vlada/Ministarstva/MZSZ/Documents/UNFPA%20Resursni%20Paket%20Light%20FINAL2.pdf (in Bosnian-Croatian-Serbian), and High Judicial and Prosecutorial Council of Bosnia and Herzegovina (2018). *Handbook for Action in Cases of Gender Based and Sexual Violence against Women and Children for the Police, Prosecutors and Judges*, https://vstv.pravosudje.ba/vstv/faces/docservlet?p_id_doc=48586 (in Bosnian-Croatian-Serbian)

[43] Available in Albanian, Serbian and English: https://abgj.rks-gov.net/assets/cms/uploads/files/Publikimet%20ABGJ/Procedurat%20Standarte%20t%C3%AB%20Veprimit%20p%C3%ABr%20Mbrojtje%20nga%20Dhuna%20n%C3%AB%20Familje.pdf

Montenegro:
Protocol on Action, Prevention of and Protection from Violence against Women and Domestic Violence, adopted on 1 January 2019

Serbia:
General Protocol for Action and Cooperation of Institutions, Bodies and Organisations in the Situations of Violence against Women within the Family and in Intimate Partner Relationship[44], adopted in November 2011[45];
Republic of Serbia Ministry of Health - Special Protocol for The Protection and Treatment of Women Victims of Violence[46], adopted in June 2010

II. Questionnaire prepared by Biljana Brankovic to gather data for the present research assessment:

- Name of the women's NGO that completed the questionnaire:
- Website of the NGO:
- Name(s) of the person(s) who completed the questionnaire:
- E-mail(s) of the person(s) who competed the questionnaire:

Cooperation between healthcare institutions and women's NGOs (including your organization)

1) How would you assess the quality of cooperation between **YOUR NGO**, as well as **all other women's NGOs in your country** with the following institutions, on 1-5 scale (*1 indicating "very poor", 5 indicating "excellent" – underline one of the answers for each institution/organization)*

	YOUR NGO					WOMEN'S NGOs in your country				
The police	1	2	3	4	5	1	2	3	4	5
Social workers	1	2	3	4	5	1	2	3	4	5
Healthcare workers	1	2	3	4	5	1	2	3	4	5
Educational institutions	1	2	3	4	5	1	2	3	4	5
Prosecutors	1	2	3	4	5	1	2	3	4	5
Judges	1	2	3	4	5	1	2	3	4	5
Local governments	1	2	3	4	5	1	2	3	4	5
Local media	1	2	3	4	5	1	2	3	4	5
UN agencies	1	2	3	4	5	1	2	3	4	5
Other women's NGOs	1	2	3	4	5	1	2	3	4	5

2) Do doctors in your country issue certificate of injuries in cases of DV? If so, are these certificates used in courts, as evidence? Are certificates free of charge? Which problems did you notify in relation to certificates?

3) Is there an increase of cases of DV reported to your NGO in the last year and the half (since the beginning of the pandemic), in comparison to the year 2019? Yes No

[44] Available in English, https://www.rs.undp.org/content/dam/serbia/Publications%20and%20reports/English/UNDP_SRB_LjubicastiTekst.pdf and Serbian: https://www.rs.undp.org/content/dam/serbia/Publications%20and%20reports/Serbian/UNDP_SRB_LjubicastiTekst.pdf
[45] The text of General Protocol is published in Official Gazette of Serbia, 027/2011 (in Serbian)
[46] Special Protocol is available in English at: https://www.rs.undp.org/content/dam/serbia/Publications%20and%20reports/English/UNDP_SRB_TirkizniTekst.pdf and Serbian: https://www.rs.undp.org/content/dam/serbia/Publications%20and%20reports/Serbian/UNDP_SRB_TirkizniTekst.pdf

If "yes", *please describe which specific problems did you identify that differ from your experience prior to the pandemic*:

4) Was there an increase of cases of SV? Yes No We don't work with SV

If "yes", *please describe:*

5) Does it happen that healthcare institutions in your city refer the victims to your NGO or any other NGO?Yes-No If "yes", *pls. say how often and describe*:
6) Does your NGO have a protocol or other formal mechanism for referring victims of DV and/or SV to healthcare services? Yes No, cooperation is based on personal links only

   If yes, *please specify in more detail*.

7) Can you describe in more detail the **current** cooperation of your NGO and healthcare professionals in your city (in primary healthcare, hospitals, emergency wards, etc.), including which problems your NGO experienced?

8) Did you identify some specific/new problems during pandemic? Yes No

   If yes, *pls. describe*:

9) In comparison to the time before pandemic, is your cooperation with them (*underline*): a) better b) worse c) the same

10) Can you describe in more detail the **current** cooperation of your NGO and psychiatrists, psychologists, psycho-therapists, including which problems your NGO experienced? Are there any new issues during pandemic?

11) Do psychiatrists/psychologists who work as expert witnesses in courts use the term "parental alienation syndrome", referring to divorced victims of DV who are supposedly trying to turn the children against their violent father? Yes No

    If yes, *please describe.*

12) Have you organized trainings on DV or SV for healthcare professionals? Yes No

   If yes, *please describe your experiences.*

13) Can you provide information on trainings on DV and SV for healthcare professionals in your country, including if trainings are obligatory or optional, what is the content (*use, for example, recent report to CEDAW*)?

14) In your view, are medical professionals in your country sufficiently trained to provide competent and gender-sensitive support to victims of DV and SV? *Please describe*

<u>Experiences of victims of DV/SV in healthcare institutions - Good and bad examples</u>

1) Do victims of DV have to pay participation/fee for any health-service, when they openly declare they are exposed to DV? (*answers depend on the health insurance system in the country, so make a distinction between the situation when a) the victim has health insurance and b) when she does not – are there special regulations granting free medical service for DV victims, even*

when they are not insured? Do special regulations apply to emergency situations – when victim has visible injuries and needs an urgent medical help?)

2) Can victims of DV/SV get free-of-charge counselling by psychiatrists, psychologists, psychotherapists in public healthcare system? Yes No

Can counselling be longer-term, or they can get just a few sessions? Please detail.

3) Do victims that belong to marginalised groups (minorities, especially Roma, migrants, women with disabilities, lesbians, asylum-seekers, etc.) experience specific problems when they approach healthcare in your country?

Pls. describe problems of victims (of any of mentioned groups) – provide examples from experience of your NGO

4) Please write a BRIEF STORY (approximately few paragraphs) about the case of **domestic or sexual violence** from the experience of your NGO (or experience or other women's NGO) during pandemic that illustrates a **GOOD EXAMPLE** of interventions/support provided to the victim.

5) What about **BAD EXAMPLE** of interventions/support provided to the victim during pandemic by healthcare?

(*Please include in BOTH stories basic info about the case: when the victim reported DV or SV to your NGO, for how long violence lasted before she reported it to you, did she asked other institutions/organizations for help and if so, which ones, how she described experience with doctors/other medical professionals, was any judicial process involved, and if so, was doctor's report included as evidence, and what was the outcome. Pay attention not to disclose any personal details about the victim*).

<u>Specific law on domestic violence and legal provisions about duties of medical professionals</u>

1) Is there a specific law on DV in your country? (*underline*): Yes No

If "yes" Include the link to the document, if exists in English:

2) Include the link to the document, in local language:

3) When it was adopted (*write the date*):

4) *Write info* about the Official Gazette where it was published:

5) Does it include definition of VAW? Definition of DV? *(Please QUOTE definitions and specify - if these make reference to international documents or are based on domestic laws only):*

6) If this law also has provisions related to sexual violence in the family, or about sexual violence in general, please *describe and QUOTE these provisions here*:

7) Does it include any reference to gendered understating of VAW/DV? *(specify if it does; if not, clarify that it is gender-neutral and specify provisions reflecting gender-neutrality):*

8) **Describe and QUOTE the main provision of this law**, including (possible) provisions specifically focused on duties of doctors/ medical professionals (*pls. include info on the following*):

Does it include specific provisions related to medical professionals? Yes No
If yes, describe
Does it include specific provisions on inter-institutional cooperation? Yes No
If yes, describe
Does it include any reference to specialist women's organizations? Yes No
If yes, describe
Does it have provisions on inter-institutional cooperation? Yes No
If yes, describe, in particular, is cooperation obligatory and how it is specified)
Does it describe principles of protection of victims, referral mechanisms? Yes No
If yes, describe

How is this law implemented in practice: did it brought any positive changes, and which main problems exist, in your view (*describe and clarify*):

General and/or Special Protocols regulating the duties of healthcare professionals in cases of domestic violence (DV) and sexual violence (SV)

1) Does your country have a **GENERAL protocol/guideline/instruction that regulates duties and obligations of all relevant professionals** (the police, healthcare professionals, judiciary, social workers, etc.) who deal with cases of VAW/DV and/or a **SPECIFIC protocol describing responsibilities and duties of healthcare professionals** in cases of VAW/DV? (*underline*):

GENERAL protocol on all forms of VAW: Yes No It is in a process of drafting/adoption

GENERAL protocol on DV only: Yes No It is in a process of drafting/adoption

SPECIFIC protocol for healthcare: Yes No It is in a process of drafting/adoption

If there is a specific protocol for health care: specify which forms of VAW it covers:

GENERAL Protocol (if your country has it, describe the following):

1) Please write the **full title** of the document (*write*):
2) Include the link to the document, if exists in English:
3) Include the link to the document, in local language:
4) **When it was adopted** (*write the date*):
5) **Which professions are included** *(specify, for example, police, healthcare workers, teachers, etc.):*
6) What is the **legal status** of the document: **is the document obligatory/legally-binding or it is just a guideline/ not obligatory**? (*describe the legal status, for example, a) the document is a by-law, and it is obligatory; or: b) it is include in the law- indicate TITLE of the law and the articles that cover duties of professionals, including medical ones, so, it is obligatory, c) its legal status is unclear, and it is not legally-binding*):
7) Are there any sanctions specified in the document if the professionals (listed in the document) do not respect it?

Yes No *(if yes: describe which sanctions):*

8) **Describe and QUOTE** the main provisions of this document, focusing on the procedures that apply in cases of

- **DV**
- **SV**

9) Are there specific provisions related to health care professionals? Yes No

If "yes", *describe how are their duties/obligations defined*:

- **which procedures they apply in cases of DV**?
- **Which procedures they apply in cases of SV**?

(for example, is the procedure for issuing a medical certificate on injuries specified; are doctors/medical professionals obliged to issue a medical certificate on injuries; are doctors/med. professionals instructed to ask pro-actively about DV when they suspect it (for example, to ask specific questions about DV, although the victim claims she fell on stairs); does the document include procedures for cooperation between doctors and other professionals, such as the police, and if so, which professions; are procedures on cooperation clearly specified, are they obligatory; are there provisions that deal with confidentiality and privacy of victim's data; is VAW/SV/DV defined and if so, are these definitions from domestic laws or international documents – quote; does it make reference to Istanbul Convention or other international documents, and if so, which ones; is there a procedure for referral of victims to NGOs – are doctors instructed to refer victims to women's NGOs; are doctors obliged to report DV or rape/sexual assault to the police; is forensic examination in cases of SV described).

10) Do you know of any case in practice that healthcare professional was sanctioned for not respecting the Protocol? Yes No

If "yes"*, describe*

11) How is this Protocol implemented in practice? *Specify positive sides, and problems/shortcomings*.

Special protocol on DV - *if your country has such a protocol, COPY-PASTE the list of 11 questions mentioned above (in relation to General protocol), and respond to them*

Special protocol on SV - *if your country has such a protocol, COPY-PASTE the list of 11 questions mentioned above (in relation to General protocol, and respond to them)*

Data about access to healthcare by DV and SV victims in your country

1) Does your country have data (collected at the national level) on the number of DV/SV victims who asked for help in healthcare institutions and/or on the number and type of healthcare services provided to DV/SV victims (such data should exist, in line with the Istanbul Convention, Art. 11)? Yes No
2) If **any data exist**, please *describe – which type*
3) If **any data exist**, are they publicly available? (*for example, on official websites*)? Yes No
4) If "yes", please provide data on DV for the years 2019 and 2020
5) If "yes", please provide data on SV for the years 2019 and 2020
6) If "yes", are such data disaggregated by (*underline all that applies*):

a) sex of the victim b) sex of the perpetrator c) age of the victim d) age of the perpetrator

e) victim-perpetrator relationship f) none of the above

7) If data are not publicly available, can you quote **any data related to access to healthcare by DV/SV victims** from other sources: state reports to CEDAW and other international bodies, reports of international organizations, etc.?