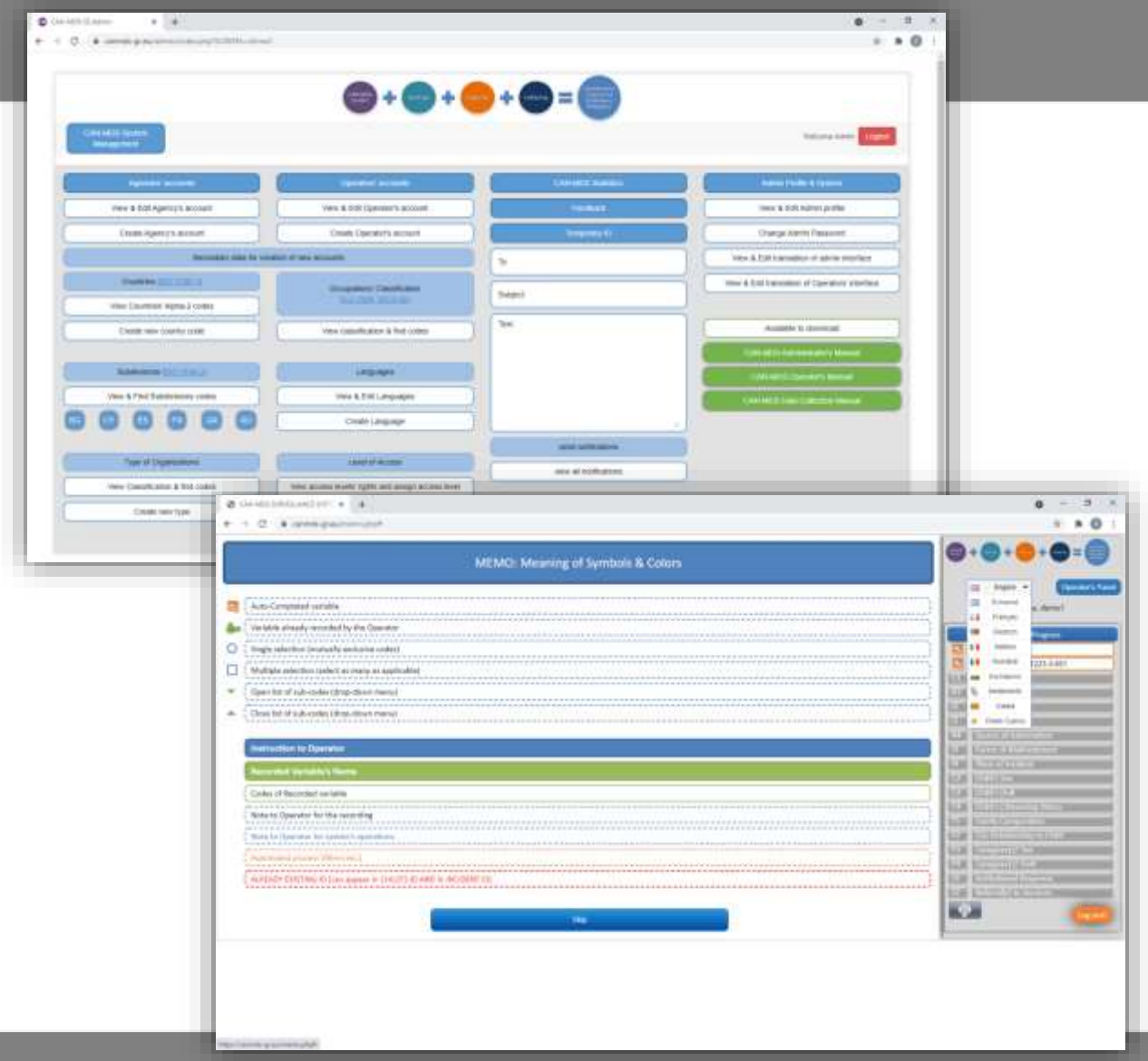
Co-funded by EU REC Programme 2014-2020

D4.5

EVALUATION OF CAN-MDS PILOT IMPLEMENTATION AT INTERNATIONAL LEVEL



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" [REC-RDAP-GBV-AG-2017/ 810508]

Action's Identity

Title	Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice* (CAN-MDS II)
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Work package	4 Piloting of CAN-MDS System, Monitoring & Reporting
Activity	Activity 4.5: Reporting on CAN-MDS Pilot Implementation at National Level and comparative evaluation of National results
Deliverable No.	D4.5
Drafted	A. Ntinapogias, G. Nikolaidis
Deliverable title	Evaluation of CAN-MDS Pilot Implementation at International Level
Target group	Project Leader & Coordinator (ICH-MHSW-GR); External Evaluator; Expert on Ethics; National coordinators from SWU-BG; SACP-BG; SWS-MLSI-CY; HFC-CY; ONPE-FR; BBU-RO; FONCP-RO; DASM-RO; AROA-ES); National Intersectoral Boards; National Administrators; all relevant stakeholders.

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Project's Website: www.can-via-mds.eu

This Report was prepared in the context of the Action "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"

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Contents

Evaluation of CAN-MDS Pilot Implementation at International Level

Initial planning

Work Package 4 "Piloting of CAN-MDS System" aimed at the transition from the planning of the CAN-MDS system to putting the system to operate in practice. The objective of this work package was to test and monitor the CAN-MDS System in real settings, in the 6 EU countries participated in the Action CAN-MDS II, following customized pilot plans (at different geographical levels, involving stakeholders deriving from multiple disciplines and working in multiple sectors with or for children) in terms of effectiveness, applicability, and usability.

Customized National CAN-MDS Pilot Plans were drafted for each country taking into account the following aspects: level of piloting (national, regional or local level and, if regional or local, which area/ municipality/ city and approximately minors' population covered); sectors to be involved (where not feasible for all eligible sectors to be involved, specification); number of professionals to be involved as operators (estimation depending on the level of piloting); the identity of the national Administrative Authority (satisfying the predefined criteria see CAN-MDS Policy & Procedures Manual, p. 14), namely the authority that would support the effort, as well as of the key-stakeholders from relevant sectors (Ministries, Governmental Authorities, Independent Authorities and relevant NGOs) to be invited to participate as members of national inter-sectoral Boards to support the piloting and.

On the basis of the information collected through the nationally customized piloting plans, CAN-MDS piloting at EU level was planned following on a design 6X2X6 (country X national/regional/Local piloting X number of sectors [& professionals] to be involved), as it is presented below. In all countries CAN-MDS Registry has to be used as means of data collection.

Country	Level of piloting	Sectors (& professionals) to be involved
Bulgaria	Regional (3 regions)	ALL sectors (122)
Cyprus	National	ALL sectors (86)
France	National/sampled areas	ALL sectors (26)
Greece	National	ALL sectors (400)
Romania	Regional (4 regions)	ALL Sectors (95)
Spain	Regional (3 areas)	ALL Sectors (150)

Below the draft national pilot plans are presented:

BULGARIA (South-West University-SWU & State Agency for Child Protection -SACP)	
Piloting level	**Regional and local:** 3 regions (21 municipalities): **Veliko Tarnovo** (6 municipalities, total population of children 40,971*); **Sofia town** (9 municipalities, total population of children 235,634*); **Blagoevgrad** (6 municipalities, total population of children 58,947*) **National Statistics Institute (2015)*
Sectors	**Social system** [State Agency for Child Protection-SACP (at national level) and **Child Protection Departments** (at local level)], **Municipalities**, **Police** departments, **Regional health inspections**, **Regional education inspections**, **NGOs**
Operators	**Total expected number of professionals to be as system's operators: 122** **Sofia Town (34):** 2 SACP representatives, 18 SWs, 9 police officers, 1 health & 1 education inspector, 1 municipality representative; 2 NGOs; **Veliko Tarnovo (44):** 24 SWs, 12 police officers, 2 health & 2 education inspector, 2 municipality representative, 2 NGO; **Blagoevgrad (44,** identical as in Veliko Tarnovo)
Stakeholders	SACP will undertake the leading role (National Administrator). The stakeholders from the key sectors to participate in the Inter-Sectoral Board are representatives from the Agency for Social Assistance and local coordinators from the chosen regions, representative from the Chief Directorate "National Police", Ministry of Interior, representatives from the Ministry of Education and Science and Ministry of Health.

CYPRUS (Social Welfare Services, Min of Labour, Welfare & Social Insurance & Hope for Children)	
Piloting level	National
Sectors	Social Welfare Services; Ministry of Health (e.g. Health Services, Mental Health Services), Ministry of Justice and Public Order; Police; Attorney General; Ministry of Education and Culture; NGO (Children`s House operated by Hope for Children CRC Policy Center)
Operators	**Total expected number of professionals to be as system's operators: 86** Social Welfare Services (15), Ministry of Health (15), Ministry of Justice and Public Order (2), Police (40), Attorney General (2), Ministry of Education and Culture (10), NGO (2)
Stakeholders	**National inter-sectorial board**: Social Welfare Services, Police, Ministry of Health, Ministry of Education and Culture; **National Administrator of the System:** Social Welfare Services

FRANCE (ONPE)	
Piloting level	**National:** 10 Unité d'accueil Médico-Judiciaires pédiatriques (UAMJP) in 10 *départements*
Sectors	Health-general & mental h.; Medico-Judiciary; Social Work; NGO; Justice; law enforcement
Operators	**Total expected number of professionals to be as system's operators: min 26** Presumably 10 from a health/mental health background, 10 from a social work background, 2 from NGOs and 1 from law enforcement. Persons involved in the process altogether (professionals benefiting from some form of presentation/advice): 100 (co-workers and supervisors of the operators) would be a fairly solid guess.
Stakeholders	ONPE will pilot the implementation of the CAN-MDS system in France in 10 different UAMJPs in France. The 10 locations for the UAMJP will be chosen with the NGO that runs them, La Voix de l'Enfant, so they can represent as much as possible the geographical and demographic diversity of France (rural/urban zones, North/South and East/West repartition, types of population).

GREECE (ICH-MHSW)	
Piloting level	National
Sectors	Welfare; Health & mental health; Justice; Law enforcement; Education; NGOs
Professionals-Operators	**Total expected number of professionals to be as system's operators: 400** Starting point would be all professionals already trained in 2015 for using the national CAN registry ("ESA KaPa-P", see below); their allocation in the five involved sectors is widespread with some fluctuations in

	between them in virtue of the role of its sector in first line management of CAN cases and thus CAN data collection.
Stakeholders	Ministry of Labour, Social Insurance and Social Welfare which is responsible for a number of social services nationwide will support the implementation of the project. ICH-EL has already been developing a national multi-sectorial CAN surveillance system "ESA-KaPa-P" within the context of the Greek NSF program where 400 professionals from all relevant sectors were trained to its use in all regions of Greece and memorandums of collaboration were signed between ICH and a few hundred agencies all over Greece.

ROMANIA (Babes-Bolyai University, DASM Cluj & FONCP)	
Piloting level	Regional 4 regions: Bucharest, Cluj, Satu-Mare, Covasna; total children population ~150000 in Bucharest Region and ~80000 in Transylvania Regions (Cluj, Satu-Mare, Covasna)
Sectors	Bucharest region: Central and national authorities: child protection, justice, education and health system, local authorities: general direction for child protection in 6 Bucharest district, NGOs. Now, the Federation has 87 NGOs members active in almost all the counties and in Bucharest. Transylvanian regions: Local child protection authorities, county child protection directorates, paediatric outpatient and inpatient psychiatry/mental health, one Roma NGO.
Operators	Total expected number of professionals to be as system's operators: 95 In Bucharest region (45): 14 CP professionals; 6 psychologists/SWs from the health sector, 6 professionals from the educational sector: school counselors, school mediators or social workers, 4 professionals from justice sector working with children, 15 form NGOs. In Transylvanian regions (50): 15 CP professionals; 10 psychologists/SWs from the health sector, 10 professionals from the educational sector: school counsellors, school mediators and school social workers, 15 community workers in NGOs.
Stakeholders	The Federation will involve organizations and authorities activated in all relevant sectors: welfare, social, health, justice, education, as well as NGOs. FONPC is the main interlocutor of the state specialized in developing and redefining policy for child welfare from a child's rights perspective, using and developing a coherent and comprehensive experience and expertise of its members. In order to achieve its objectives, FONPC is working in close partnership with donors, funders, local authorities and national NGOs, international organizations, European institutions, civil society, the community and other stakeholders in promoting children's rights. Plan to create local networks in each of the localities involved, with the local authorities and NGO's that supported the application. The local networks with be comprised of representatives of all the sectors involved with child abuse and neglect cases, one person for each sector, in all the areas of Transylvania: Cluj-Napoca, Satu-Mare and Sfantu Gheorghe, and one or several in Bucharest. The Bucharest network will function in a similar way. The FONPC will build in Bucharest a network for this project involving representatives of all the sectors involved with child abuse and neglect cases, including those that signed partnerships with the Federation and other interested parties, in order to build a strong intersectoral network with actors who can collaborate effectively (at least 10 stakeholders from CP, health, education, justice sectors, NGOs). Also, UBB and DASM will manage to do a similar network in Covasna and Satu Mare counties, respectively in Cluj-Napoca. The three networks will collaborate and ensure a part of sustainability (at least 20 stakeholders from CP, health, education, justice sectors, NGOs from the 4 regions). We shall have a common board, that will be mixed as per professions and institutions from all the relevant sectors (CP, health, education, justice sectors, NGOs) Due to the fact that The National National Authority for child protection, adoption and persons with disabilities from Romania and the Directorates of CP signed the protocols and agreed to be part of the Intersectoral National Board, but none of them decided to take the role of Romanian National Authority, FONPC is taking the role of the National Administrative

	Authority and so in January the Federation hired an administrator of the system, with experience in working with databases and analysis. The National Authority for child protection, adoption and persons with disabilities from Romania will support the training and the piloting and be an institutional partner.The Romanian partners will invite the National Authority for child protection, adoption and persons with disabilities to take over the CAN-MDS system at the end of the project.

SPAIN (Fundacio AROA)	
Piloting level	**Local:** Barcelona County, 3 areas (Minors' population covered: 543,796)
Sectors	Welfare, Health, Mental Health, Education, NGOs, Justice, Security Corps (Justice and Security Corps added but in the current situation Health, Justice and Security Corps have drop off the participation; partners are working at political level for their re-engagement)
Operators	**Total expected number of professionals to be as system's operators: 150** Welfare: 40; Health: 30; Mental Health: 10; Education: 20; NGOs: 15; Justice: 20; Security Corps: 15
Stakeholders	The following stakeholders from key sectors are going to be invited to participate in an inter-sectoral board: General Directorate of Children and Adolescence Support (Government of Catalonia), Social Welfare Services Department (Barcelona Provincial Council), Barcelona Social Services Consortium (Government of Catalonia and Barcelona City Council), Catalan Institute of Health, Barcelona Health Consortium, Children and Family Department (Barcelona City Council), Direction of Feminisms and LGTBI - Area of Rights of Citizenship and Transparency (Barcelona City Council), Municipal Institute of Social Services, Education Department (Government of Catalonia), Barcelona Education Consortium, ABD Foundation, Cooperativa EDUVIC, University of Barcelona, Justice Department (Government of Catalonia) Mossos d'Esquadra (security corps of Catalonia) and Guardia Urbana (Barcelona police), IRES Foundation, Vickyi Bernadet Foundation, Family and Community Foundation, Pompeu Fabra University and University of Barcelona. The national administrator of the system could be either the General Directorate of Children and Adolescence Support (Government of Catalonia) or the Barcelona Social Services Consortiu. The Social Welfare Services Department (Barcelona Provincial Council) and the Direction of Feminisms and LGTBI - Area of Rights of Citizenship and Transparency (Barcelona City Council)will support the effort providing a letter of support.

Under the WP4 a set of activities were also included that were relevant to pilot implementation, common for all partners; specifically, continuous monitoring of system's operation by each National CAN-MDS Administrator with the support of Local coordinators (including communication with national operators, when needed, asking for their feedback, extraction and checking of anonymized data collected and collection of evaluation data via evaluation tools). Piloting results had to be presented to national Boards periodically and progress to be discussed during the National Board meetings twice (every 3 months). Moreover, during the pilot phase support had to be provided to all National Boards and administrators by the Coordinating organization (including one in situ monitoring visit) as well as a series of 4 bilateral skype meetings (every 3 months) with each one of the implementer countries, where apart from the local coordinator, the national administrator and the coordinating team, the External evaluator and the expert on ethics will also participate. The last activity under WP4 concerns reporting on CAN-MDS pilot implementation at a national level and comparative evaluation of national trainings.

The results of all the above additional activities are included in distinct deliverables, already available, namely:

D4.1 CAN-MDS National Board Meetings

D4.2 Monitoring of Pilot implementation - bilateral online meetings

D4.3 Monitoring of Pilot implementation - bilateral monitoring visit

D4.4 Reporting on CAN-MDS pilot implementation at a national level

Overview of the results of CAN-MDS System Piloting in real settings

Planned vs Achieved Piloting results per country:

BULGARIA (South-West University-SWU & State Agency for Child Protection - SACP)		
Planned		Achieved
Piloting level	**Regional and local:** 3 regions (21 municipalities): **Veliko Tarnovo** (6 municipalities, total population of children 40,971*); **Sofia town** (9 municipalities, total population of children 235,634*); **Blagoevgrad** (6 municipalities, total population of children 58,947*) **National Statistics Institute (2015)*	**1 region** Blagoevgrad (6 municipalities)
Sectors	**Social system** [State Agency for Child Protection-SACP (at national level) and **Child Protection Departments** (at local level)], **Municipalities**, **Police** departments, **Regional health inspections**, **Regional education inspections**, **NGOs**	**13 Agencies**; Health, Mental Health, Education, Education/Health, Social Welfare/Social Services
Operators	**Total expected number of professionals to be as system's operators: 122** **Sofia Town (34):** 2 SACP representatives, 18 SWs, 9 police officers, 1 health & 1 education inspector, 1 municipality representative; 2 NGOs; **Veliko Tarnovo (44):** 24 SWs, 12 police officers, 2 health & 2 education inspector, 2 municipality representative, 2 NGO; **Blagoevgrad (44,** identical as in Veliko Tarnovo)	**21 trained professionals to become operators** psychologists; social workers; nurses; preschool teachers; nursery teachers
Stakeholders	SACP will undertake the leading role (National Administrator). The stakeholders from the key sectors to participate in the Inter-Sectoral Board are representatives from the Agency for Social Assistance and local coordinators from the chosen regions, representative from the Chief Directorate "National Police", Ministry of Interior, representatives from the Ministry of Education and Science and Ministry of Health.	**National Administrator:** National Agency for Child Protection **Inter-Sectoral Board:** State Agency for Child Protection South-West University Ministry of Labor and Social Policy Prosecutor's Office of the Republic of Bulgaria Ministry of Interior National Center of Public Health and Analyses Regional department of Education - Sofia Commission for Personal Data Protection National Statistical Institute UNICEF Bulgaria Ombudsman

CYPRUS (Social Welfare Services, Min of Labour, Welfare & Social Insurance & Hope for Children)		
Planned		Achieved
Piloting level	National	National
Sectors	Social Welfare Services; Ministry of Health (e.g. Health Services, Mental Health Services), Ministry of Justice and Public Order; Police; Attorney General; Ministry of Education and Culture; NGO (Children`s House operated by Hope for Children CRC Policy Center)	6 agencies Social Welfare Services; Ministry of Justice and Public Order; Police; NGO (Children`s House operated by Hope for Children CRC Policy Center)
Operators	Total expected number of professionals to be as system's operators: 86 Social Welfare Services (15), Ministry of Health (15), Ministry of Justice and Public Order (2), Police (40), Attorney General (2), Ministry of Education and Culture (10), NGO (2)	34 operators (89 trained professionals) Psychologists; social workers; administration professionals; police officers; child care workers
Stakeholders	National inter-sectorial board: Social Welfare Services, Police, Ministry of Health, Ministry of Education and Culture; National Administrator of the System: Social Welfare Services	Administrative Authority Ministry of Labour, Welfare and Social Insurance, Social Welfare Services Inter-Sectoral Board: (and possible members) Law Office of the Republic of Cyprus Ministry of Justice and Public Order Ministry of Health Cyprus Police Cyprus Pedagogical Institute Children's House Social Welfare Services 'Hope For Children' CRC Policy Center Association for the Prevention and Handling of Violence in the Family (SPAVO)

FRANCE (ONPE) – No piloting took place	
Piloting level	National: 10 Unité d'accueil Médico-Judiciaires pédiatriques (UAMJP) in 10 *départements*
Sectors	Health-general & mental h.; Medico-Judiciary; Social Work; NGO; Justice; law enforcement
Operators	Total expected number of professionals to be as system's operators: min 26 Presumably 10 from a health/mental health background, 10 from a social work background, 2 from NGOs and 1 from law enforcement. Persons involved in the process altogether (professionals benefiting from some form of presentation/advice): 100 (co-workers and supervisors of the operators) would be a fairly solid guess.
Stakeholders	ONPE will pilot the implementation of the CAN-MDS system in France in 10 different UAMJPs in France. The 10 locations for the UAMJP will be chosen with the NGO that runs them, La Voix de l'Enfant, so they can represent as much as possible the geographical and demographic diversity of France (rural/urban zones, North/South and East/West repartition, types of population).

GREECE (ICH-MHSW)		
	Planned	Achieved
Piloting level	National	National
Sectors	Welfare; Health & mental health; Justice; Law enforcement; Education; NGOs	59 agencies Independent Authorities; Welfare (Municipal Social Welfare Services); Health; Mental Health; Education; Socio-Medical Services; Research and other Relevant Organizations; NGOs
Professionals-Operators	Total expected number of professionals to be as system's operators: 400 Starting point would be all professionals already trained in 2015 for using the national CAN registry ("ESA KaPa-P", see below); their allocation in the five involved sectors is widespread with some fluctuations in between them in virtue of the role of its sector in first line management of CAN cases and thus CAN data collection.	112 Operators medical doctors; nurses; health associate professionals; teaching professionals; special needs teachers; lawyers; sociologists; psychologists; social workers; health visitors
Stakeholders	Ministry of Labour, Social Insurance and Social Welfare which is responsible for a number of social services nationwide will support the implementation of the project. ICH-EL has already been developing a national multi-sectorial CAN surveillance system "ESA-KaPa-P" within the context of the Greek NSF program where 400 professionals from all relevant sectors were trained to its use in all regions of Greece and memorandums of collaboration were signed between ICH and a few hundred agencies all over Greece.	National Administrator: Institute of Child Health, Dept of Mental Health and Social Welfare Inter-Sectoral Board: National Commission for Human Rights The Greek Ombudsman, Children's Rights Ministry of Education and Religious Affairs Ministry of Health Ministry of Justice Ministry of Labour & Social Affairs Ministry of Citizens Protection, Hellenic Police National Center for Social Solidarity-EKKA, SOS Line 1107 National Union of Municipalities of Greece The Smile of the Child, SOS Line 1056 ELIZA – Prevent & Identify Child Abuse UNICEF Greece Country Office

ROMANIA (Babes-Bolyai University, DASM Cluj & FONCP)		
Planned		Achieved
Piloting level	**Regional** 4 regions: Bucharest, Cluj, Satu-Mare, Covasna; total children population ~150000 in Bucharest Region and ~80000 in Transylvania Regions (Cluj, Satu-Mare, Covasna)	**Regional,4 Regions** Bucharest, Cluj, Satu-Mare, Covasna
Sectors	**Bucharest region:** Central and national authorities: child protection, justice, education and health system, local authorities: general direction for child protection in 6 Bucharest district, NGOs. Now, the Federation has 87 NGOs members active in almost all the counties and in Bucharest. **Transylvanian regions:** Local child protection authorities, county child protection directorates, paediatric outpatient and inpatient psychiatry/mental health, one Roma NGO.	**42 agencies** social services/child protection services/ social assistance; justice; law enforcement; education; health/mental health; NGOs
Operators	**Total expected number of professionals to be as system's operators: 95 In Bucharest region (45)**: 14 CP professionals; 6 psychologists/SWs from the health sector, 6 professionals from the educational sector: school counselors, school mediators or social workers, 4 professionals from justice sector working with children, 15 form NGOs. **In Transylvanian regions (50)**: 15 CP professionals; 10 psychologists/SWs from the health sector, 10 professionals from the educational sector: school counsellors, school mediators and school social workers, 15 community workers in NGOs.	**146 operators** (171 trained professionals) teaching professionals; legal professionals; IT technicians; managing directors; medical doctors; social and religious professionals; researchers; social welfare managers; education managers; psychologists; sociologists; social workers; medical assistants; police officers
Stakeholders	The Federation will involve organizations and authorities activated in all relevant sectors: welfare, social, health, justice, education, as well as NGOs. FONPC is the main interlocutor of the state specialized in developing and redefining policy for child welfare from a child's rights perspective, using and developing a coherent and comprehensive experience and expertise of its members. In order to achieve its objectives, FONPC is working in close partnership with donors, funders, local authorities and national NGOs, international organizations, European institutions, civil society, the community and other stakeholders in promoting children's rights. Plan to create local networks in each of the localities involved, with the local authorities and NGO's that supported the application. The local networks with be comprised of representatives of all the sectors involved with child abuse and neglect cases, one person for each sector, in all the areas of Transylvania: Cluj-Napoca, Satu-Mare and Sfantu Gheorghe, and one or several in Bucharest. The Bucharest network will function in a	**National Administrator:** – Federația Organizațiilor Nonguvernamentale pentru Copil – **Inter-Sectoral Board:** – ANDPDCA – Autoritatea Națională pentru Drepturile Persoanelor cu Dizabilități, Copii și Adopții – Asociația Medicilor de Familie - București – Asociatia STEA – Asociatia Umanitara Concordia – Avocatul Copilului (Instituția Avocatul Poporului) – Centrul Municipiului Bucuresti de Resurse si Asistenta Educationala – Colegiul National al Asistenților Sociali – Directia de Asistenta Sociala si Medicala Cluj Napoca – Direcția Generală de Asistență Socială și Protecția Copilului Cluj – Direcția Generală de Asistență Socială și Protecția Copilului Covasna – Direcția Generală de Asistență Socială și Protecția Copilului Satu Mare – Direcția Generală de Asistență Socială și Protecția Copilului Sector 1

similar way.

The FONPC will build in Bucharest a network for this project involving representatives of all the sectors involved with child abuse and neglect cases, including those that signed partnerships with the Federation and other interested parties, in order to build a strong intersectoral network with actors who can collaborate effectively (at least 10 stakeholders from CP, health, education, justice sectors, NGOs). Also, UBB and DASM will manage to do a similar network in Covasna and Satu Mare counties, respectively in Cluj-Napoca. The three networks will collaborate and ensure a part of sustainability (at least 20 stakeholders from CP, health, education, justice sectors, NGOs from the 4 regions). We shall have a common board, that will be mixed as per professions and institutions from all the relevant sectors (CP, health, education, justice sectors, NGOs)

Due to the fact that The National National Authority for child protection, adoption and persons with disabilities from Romania and the Directorates of CP signed the protocols and agreed to be part of the Intersectoral National Board, but none of them decided to take the role of Romanian National Authority, FONPC is taking the role of the National Administrative Authority and so in January the Federation hired an administrator of the system, with experience in working with databases and analysis. The National Authority for child protection, adoption and persons with disabilities from Romania will support the training and the piloting and be an institutional partner.The Romanian partners will invite the National Authority for child protection, adoption and persons with disabilities to take over the CAN-MDS system at the end of the project.

București
- Direcția Generală de Asistență Socială și Protecția Copilului Sector 1 București
- Direcția Generală de Asistență Socială și Protecția Copilului Sector 2 București
- Direcția Generală de Asistență Socială și Protecția Copilului Sector 3 București
- Direcția Generală de Asistență Socială și Protecția Copilului Sector 5 București
- Direcția Generală de Asistență Socială și Protecția Copilului Sector 6 București
- Federația Organizațiilor Nonguvernamentale pentru Copil
- Fundatia Internationala pentru Copil si Familie Dr. Alexandra Zugravescu
- Fundatia pentru Dezvoltarea Popoarelor Cluj
- Hands Across Romania (HAR)
- Inspectoratul Județean Cluj
- Ministerul de Justitie- Direcția de Prevenire a Criminalității
- Parchetul de pe lângă Curtea de Justiție și Casație/Ministerul Public
- Universitatea Babes-Bolyai, Departmentul de Sociologie si Asistenta Sociala
- Universitatea din București- Facultatea de Sociologie si Asistenta Sociala

SPAIN (Fundacio AROA)		
Planned		Achieved
Piloting level	**Local:** Barcelona County, 3 areas (Minors' population covered: 543,796)	**Local**
Sectors	Welfare, Health, Mental Health, Education, NGOs, Justice, Security Corps (Justice and Security Corps added but in the current situation Health, Justice and Security Corps have drop off the participation; partners are working at political level for their re-engagement)	**27 agencies** education; health; mental health; social welfare; NGOs
Operators	**Total expected number of professionals to be as system's operators: 150** Welfare: 40; Health: 30; Mental Health: 10; Education: 20; NGOs: 15; Justice: 20; Security Corps: 15	**45 operators** (59 trained professionals) psychologists; social workers-social work associate professionals; health professionals; education method specialists;
Stakeholders	The following stakeholders from key sectors are going to be invited to participate in an inter-sectoral board: General Directorate of Children and Adolescence Support (Government of Catalonia), Social Welfare Services Department (Barcelona Provincial Council), Barcelona Social Services Consortium (Government of Catalonia and Barcelona City Council), Catalan Institute of Health, Barcelona Health Consortium, Children and Family Department (Barcelona City Council), Direction of Feminisms and LGTBI - Area of Rights of Citizenship and Transparency (Barcelona City Council), Municipal Institute of Social Services, Education Department (Government of Catalonia), Barcelona Education Consortium, ABD Foundation, Cooperativa EDUVIC, University of Barcelona, Justice Department (Government of Catalonia) Mossos d'Esquadra (security corps of Catalonia) and Guardia Urbana (Barcelona police), IRES Foundation, Vickyi Bernadet Foundation, Family and Community Foundation, Pompeu Fabra University and University of Barcelona. The national administrator of the system could be either the General Directorate of Children and Adolescence Support (Government of Catalonia) or the Barcelona Social Services Consortiu. The Social Welfare Services Department (Barcelona Provincial Council) and the Direction of Feminisms and LGTBI - Area of Rights of Citizenship and Transparency (Barcelona City Council)will support the effort providing a letter of support.	**National Administrator:** DGAIA (Governmental Agency) **Inter-Sectoral Board:** Directorate General for Childhood and Adolescence Support ABD EDUVIC Social Services Barcelona CityHall Aroa Foundation

Summarizing, **5 organizations** undertook the role of the **National CAN-MDS Administrative Authority**, 4 public organizations (Ministry of Labour, Welfare and Social Insurance, Social Welfare Services-Cyprus; DGAIA-Catalonia, Spain; Institute of Child Health, Dept of Mental Health and Social Welfare-Greece; National Agency for Child Protection-Bulgaria) and 1 NGO (Federația Organizațiilor Nonguvernamentale pentru Copil-Romania).

Moreover, a total of **69 organizations** were participated through representatives in the 5 **national inter-sectoral boards** (Bulgaria: 6; Cyprus: 10; Greece: 14; Romania: 27; Spain 6), as follows:

Independent authorities (Commission for Personal Data Protection, Bulgaria; National Commission for Human Rights, Greece; National Statistical Institute, Bulgaria; Ombusman, Bulgaria; The Greek Ombudsman, Children's Rights, Greece; Avocatul Copilului -Instituția Avocatul Poporului, Romania)

Ministries (Ministerul de Justitie- Direcția de Prevenire a Criminalității, Romania; Ministry of Citizens Protection, Greece; Ministry of Education and Religious Affairs, Greece; Ministry of Health, Cyprus; Ministry of Health, Greece; Ministry of Interior, Bulgaria; Ministry of Justice, Greece; Ministry of Justice and Public Order, Cyprus; Ministry of Labor and Social Policy, Bulgaria; Ministry of Labour & Social Affairs, Greece; Ministry of Labour, Welfare and Social Insurance, Social Welfare Services, Cyprus; Parchetul de pe lângă Curtea de Justiție și Casație/Ministerul Public, Romania)

National Level Authorities/ Services (ANDPDCA – Autoritatea Națională pentru Drepturile Persoanelor cu Dizabilități, Copii și Adopții, Romania; Centrul Municipiului Bucuresti de Resurse si Asistenta Educationala, Romania; Cyprus Pedagogical Institute, Cyprus; DGAIA, Spain; Directorate General for Childhood and Adolescence Support, Spain; Inspectoratul Județean Cluj, Romania; Institute of Child Health, Dept of Mental Health and Social Welfare, Greece; Law Office of the Republic of Cyprus, Cyprus; National Agency for Child Protection, Bulgaria; National Center for Social Solidarity-EKKA, SOS Line 1107, Greece; National Center of Public Health and Analyses, Bulgaria; National Union of Municipalities of Greece, Greece; Prosecutor's Office of the Republic of Bulgaria, Bulgaria; Social Services Barcelona CityHall, Spain; Social Welfare Services, Cyprus; State Agency for Child Protection, Bulgaria; Cyprus Police, Cyprus; Hellenic Police, Greece)

Regional Level Authorities/ Services (Children's House, Cyprus; Directia de Asistenta Sociala si Medicala Cluj Napoca, Romania; Direcția Generală de Asistență Socială și Protecția Copilului Cluj, Romania; Direcția Generală de Asistență Socială și Protecția Copilului Covasna, Romania; Direcția Generală de Asistență Socială și Protecția Copilului Satu Mare, Romania; Direcția Generală de Asistență Socială și Protecția Copilului Sector 1 București, Romania; Direcția Generală de Asistență Socială și Protecția Copilului Sector 1 București, Romania; Direcția Generală de Asistență Socială și Protecția Copilului Sector 2 București, Romania; Direcția Generală de Asistență Socială și Protecția Copilului Sector 3 București, Romania;

Direcția Generală de Asistență Socială și Protecția Copilului Sector 5 București, Romania; Direcția Generală de Asistență Socială și Protecția Copilului Sector 6 București, Romania; Federația Organizațiilor Nonguvernamentale pentru Copil, Romania; Federația Organizațiilor Nonguvernamentale pentru Copil, Romania; Fundatia Internationala pentru Copil si Familie Dr. Alexandra Zugravescu, Romania; Fundatia pentru Dezvoltarea Popoarelor Cluj, Romania; Regional department of Education - Sofia, Bulgaria)

Universities (Colegiul National al Asistenților Sociali, Romania; South-West University, Bulgaria; Universitatea Babes-Bolyai, Departmentul de Sociologie si Asistenta Sociala, Romania; Universitatea din București- Facultatea de Sociologie si Asistenta Sociala, Romania)

Non-governmental organizations in the field of child protection (ABD, Spain; Aroa Foundation, Spain; Asociația Medicilor de Familie - București, Romania; Asociatia STEA, Romania; Asociatia Umanitara Concordia, Romania; Association for the Prevention and Handling of Violence in the Family (SPAVO), Cyprus; EDUVIC, Spain; ELIZA – Prevent & Identify Child Abuse, Greece; Hands Across Romania (HAR), Romania; 'Hope For Children' CRC Policy Center , Cyprus; The Smile of the Child, SOS Line 1056, Greece; UNICEF Bulgaria, Bulgaria; UNICEF Country Office, Greece)

Lastly, more than 150 agencies were involved in the piloting and more than 450 professionals in piloting and /or the CAN-MDS training (Details are available in D2.8)

In the next pages information is provided based on the national piloting reports prepared by partners per country.

Bulgaria

[from D4.4 Bulgarian Report on CAN-MDS Piloting]

Administrative authority and Inter-Sectoral Board

Within the project, the SACP took over the function of an **administrative body.** Since 2002, SACP collects and summarizes the number and profiles of children-victims of violence. Under the Child Protection Act, art. 17a, para. 1, p. 9, SACP established and maintains a national system for children at risk, some of which are children, victims of violence.

On May 4, 2020, a National CAN-MDS Administrator was elected, who subsequently underwent a special training course organized by the coordinating organization-ICT.

In June 2020, a national **Inter-sectoral Board** was formed, which includes representatives of the following institutions: State Agency for Child Protection, Ministry of Labor and Social Support, SWU, National Center for Public Health, Ministry of Interior - Police Directorate, Ministry of Education - Regional Education Office, Sofia; Supreme Cassation Prosecutor's Office; National Statistical Institute; Commission for Personal Data Protection; UNICEF, and Ombudsman.

The first meeting was held in July 2020, during which the project activities were presented. The members also got acquainted with the schedule for the implementation of the project and discussed current issues. The participants in the meeting agreed on the fact that the information systems that currently exist are not coordinated and do not exchange enough data with each other. In Bulgaria, no institution has real and complete data on these children. Practice and experience show that professionals do not communicate with each other - social workers with health professionals, with local authorities - the municipality or social service provider. There is also no data-based policy on the number of children who have experienced violence, including neglect. Within the project, periodic communication was carried out with some of the board members on certain issues. The details of the project and problems with GDPR was discussed with board member-expert in the Commission for Personal data protection additionally (Meeting in SACP; Meeting in Commission for Personal Data Protection, September 2020, Vaska Stancheva-Popkostadinova on behalf of project's team; and online meeting between the partners and the expert).

Communication with Agency for Social Assistance and other authorities

In connection with the implementation of the project and communication between the project partners with various institutions, official written communication was carried out between South-West University and Agency for Social Assistance (ASA), State Agency for Child Protection (SACP) and ASA. In connection with an invitation for data entry by ASA employees, a response was received on 27.11.2019 that participation of ASA is inappropriate. It was pointed out that an integrated information system has been put into operation in the ASA, which is centralized, web-based, with a single database. According to the Agency, inclusion in the system would lead to duplication of commitments and additional staffing.

The existing system has 3 modules, one of which is "Child Protection", but it does not include all the elements contained in the CAN-MDS system. The application of CAN-MDS would enrich the existing system of ASA, and this was explained several times.

At the same time, meetings were held between the management and employees of SACP, SWU and ASA. A letter from the SACP to the ASA dated 13 July 2020 reiterated the importance of support from the Social Assistance Agency for the successful implementation of the project, including the appointment of representatives of the institution to participate in the training in the three areas. It is emphasized that the data collection and processing system, which remains for use by each project partner country, will enable the receipt of information from reliable sources and its analysis, as well as will support the national efforts to create a single database for children, victims of violence and neglect.

In response to the letter of August 2020, the ASA informed that as a public response it may receive personal data within the legally defined powers, therefore it is not treated as a "recipient", and the processing of such data complies with the applicable rules for data protection according to the purposes of processing. With regard to personal data, the ASA requested additional information on the specific and legitimate purposes for providing data for children; the legal grounds for disclosing personal data of children and in connection with Regulation (EU) 2016/679 on data protection; who will process the data of children after their disclosure/provision; which subjects will have access to data, in what period of time they will be processed, as well as for the respective guarantees for the exercise of the rights.

In this regard, a consultation was held with the board member of the CPDP, as well as with the leading Greek organization. The leading Greek organization confirmed the feasibility of the project, as well as detailed information regarding personal data. This information was also provided to the ASA. In response from October 2020, the SACP stated that the first project examined the available information systems in each of the partner countries. For Bulgaria, a legislative framework has been established, and weaknesses have been identified, namely the coordination between the different protection bodies, as well as the need to improve the signaling. It is reiterated that, in line with the 2016 recommendations of the Committee on the Rights of the Child, it is crucial to ensure effective cooperation, coordination and data exchange between the various systems, namely between child protection services, and the government on the other hand – especially the police and the justice system.

It is specified that personal data is processed lawfully, fairly and in a transparent manner with regard to the data subject. A detailed answer was given to all questions raised by the ASA.

In a letter from the ASA dated 19 October 2020, the Agency expressed its concerns related to the provision of personal data of children at risk under Art. 7, para 1 and special personal data of children at risk in the sense of art. 9, §1 of Regulation (EU) 2016/679 on data protection, which data to be collected, generated, stored and processed through the "CAN-MDS II" system. Concerns are shared that the data will be shared with partners in different countries.

It is alleged that the ASA, as the primary controller of personal data, has no legal basis to provide personal data to children at risk/children who have been abused. Their disclosure on a contractual basis is not applicable to a public institution, such as the ASA, as it collects and processes data of children in the performance of their competencies, described in the Child Protection Act. The ASA states that it can support the project by providing data within the statistics: number of children affected by violence, gender, age, by districts, as well as protection measures taken.

In the meantime meeting with UNICEF, Police and some NGOs were made concerning possibilities for piloting CAN-MDS and involving respective professionals in the training. After the meeting with a representative of the Ministry of Interior it was clarified, that according to the regulations their employees are not allowed to submit information to a system, other than their own.

Consultation with Commission for Personal Data Protection

In its letter of December 2020, the SACP sent an inquiry to the Commission for Personal Data Protection. SACP informed the Commission that pseudonymization is used (the child's personal data are not presented), and the key to this data is stored on paper (offline forms from the SACP), as the National Control Authority of the system, under the relevant requirements.

The SACP states that when the ASA fills in a specific case in the system, the identification data will be shared only between the ASA and the SACP. According to the relevant legislation, namely Art. 7, para. 1 of the Child Protection Act, a person who becomes aware that a child needs protection is obliged to immediately notify the Social Assistance Directorate, the State Agency for Child Protection or the Ministry of Interior in order to take measures of competence. The three agencies are the competent authorities for providing this protection, whether individually or jointly, and may exchange data with each other in this regard.

An opinion was requested on the following issues:

1. When processing personal data of children at risk, should the explicit consent of the parents/bearers of parental responsibility be required, as well as of the child, upon reaching a certain age?
2. Does the Child Protection Act constitute a legal basis under Regulation 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data and on repeal of Directive 95/46/EC (General Data Protection Regulation), according to which the ASA should provide the SACP with personal data of children at risk/children who have been abused?
3. With regard to the processing of personal data of children at risk, can Art. 26 of Regulation 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data and repealing Directive 95/46/EC (GDPR), namely the role of joint administrators of SACP and ASA in relation to the provision of personal data to children for the purposes of the CAN-MDS system?

Answers from the Commission for Personal Data Protection

In relation to this the role of the designated persons for personal data protection in each of the the administrations should be stated. Their role is to supervise the processing activities and to inform and consult the administrators/mutual administrators and the staff who process the data about their obligations according to the GDPR and other regulations on personal data protection on EU and Member State level. The staff may also perform additional duties and in the exact case in the context of the project implementation their opinion could be required on the impact assessment over the personal data according to Art. 35 of the GDPR.

This statement is of only clarifying nature on the implementation of the norms stated without any rights or obligations for each party. According to the GDPR the personal data administrator alone or together with another administrator states the rules and procedures for data processing which have to be in accordance with the applicable law.

Statement, made by the Commission for Personal Data Protection:

1. The Implementation of the CAN-MDS II Project does not require the consent of persons under the Art. 11a from the Child Protection Act. The reason for data processing under the project should be found in Art.9, par.2 from the GDPR in accordance with the special legislation regulating the functions and rights of the project participants.
2. When there are one or more reasons according to Art.9, par.2 from the GDPR in connection with Art. 6a from the Child Protection Act, the Agency for Social Assistance can provide data to the State Agency for Child Protection for the project purposes.

Following the reply from the Commission for Personal Data Protection, the reply was forwarded to the ASA, along with draft agreement between the State Agency for Child Protection and the Agency for Social Assistance for joint data controllers.

Even the positive statement for the implementation of the Project, given by the Commission for Protection of Personal data, Agency for Social Assistance put some additional requirements and stress that may participate with simulated data (March 2021).

Communication with ICH - coordinating organization

During this phase, permanent support was provided to our teams by the Institute of Child Health: series of 4 bilateral meetings (Skype, mails, Viber, phone calls).

Communication with Coordinator of the project at this stage was intensive and concern difficulties for starting implementation, and discussion of alternatives for training and piloting (5 bilateral meeting were held through Viber, 2 via phone, and couple of E-mails.

An official letter was sent to ICH in July 2020 related to the project implementation issues.

Challenges

The implementation of the project activities took place in the conditions of continuous and unproductive communication with and between the main responsible institutions and logistical constraints as a result of the epidemiological situation. There were hesitations and increased caution regarding the exchange of information based on specific cases, which raised sensitive issues with the protection of personal data. This problem, obvious from the time of development of the CAN-MDS system, has been satisfactorily solved by introducing (a) pseudonymisation of all information to be stored in the system; and (b) mechanisms for maintaining case-based data communication between different countries using the system (i.e. using the methodology and CAN-MDS programs). In other words, such considerations have already been addressed, and the fluctuations for precisely these reasons are due to misconceptions on the issue and technical solutions already applied.

In our trials for arrange piloting CAN-MDS we faced many challenges. There were some delays during the preparatory phase and organizational issues. There was staff turnover within the State

Agency for Child Protection, including change of the Chairperson. The current staff of the project (SACP) started the real work in 2020.

Our main concerns were about GDPR and legislation related issues, difficulties in communication with Agency for Social Assistance. Agreements with the state authorities, communication with various organizations and professionals were time consuming processes.

COVID condition were leading to delays and change of initial plans. The declared state of emergency and epidemic situation and the introduced restrictive measures in the Republic of Bulgaria, in connection with COVID-19, have created a number of difficulties and challenges for children and young people, as well as for professionals. The social isolation and distance, the remote form of work, the observance of strict sanitary anti-epidemic measures prevented the full work on the project. Personal contacts as well as meetings were limited, and the workload increased many times over.

There were recent governmental elections, followed by unsecure political situation. This situation lasted for a long time and hindered some of the important processes related to the project - especially agreement for piloting. After long communication efforts with Agency for Social Assistance, meeting with representatives of State Agency for Child Protection and Agency for Social Assistance, was organized by Vice-Minister of Ministry of Labor and Social Policy, but this was canceled, due to the change of government.

Actions taken to deal with the challenges: extension was asked; the trainings were reorganized to take place online; new experienced staff was recruited (SACP); consultations with GDPR experts were held. During implementation of project-especially preparation for piloting phase, many lessons were learned more negative, but also and some positive. It was difficult to convince some of the relevant third parties to commit to such a target in such a short period (as the project's duration); they were also overloaded with work and COVID-19 unpredictable conditions made it even harder. Some overlap in responsibilities regarding CAN management at national level, communication problems, and leadership issues. *Among the "positive" lessons* were that some of the stakeholders were very supportive when they gained understanding of the need for data collection on CAN and how the CAN-MDS could contribute to this (especially as it relates to children). During the project strong network of professionals for CAN prevention was built at local, regional and international level.

Conclusion

Despite the efforts of the project teams, the piloting of the system CAN-MDS did not take place in Bulgaria. The reasons for this were multifaceted.

To introduce and maintain CAN-MDS as a permanent operation/service needs time and more awareness and joint efforts by the respective authorities. We hope that even though we didn't succeed with piloting the system CAN-MDS, strong basis for its future implementation in Bulgaria was made in the frame of CAN-MDS-II project. We are continuing our efforts for encouraging professionals, and lobbing for implementation of CAN-MDS, in order to create effective system for registration and monitoring cases of child abuse and neglect and build fruitful inter-sectoral collaboration in the field of child protection.

Cyprus

[from D4.4 Cypriot Report on CAN-MDS Piloting]

Context

In the framework of the CAN-MDS II project, "Hope For Children" CRC Policy Center was responsible for organizing and delivering the trainings to professionals working in different agencies and institutions in Cyprus regarding the platform.

For the purpose of the implementation of the platform, Hope For Children CRC Policy Center together with Social Welfare Services presented the project and the objectives of CAN-MDS II: Joining forces to more effectively protect children from abuse and neglect' (www.can-via-mds.eu). The program aims to provide case-level follow-up, including services to children to prevent repeated victimization.

Inter-Sectoral Board

The organizers then presented the role of the Inter-sectoral Board (representing services/sectors, providing information and supporting the piloting of the CAN-MDS system). It was clarified that the CAN-MDS Board members are not directly responsible for managing any aspects of the System but for providing support and sectoral guidance to the National Administrative Authority. It is worth noting that the terms of reference proposed by the organizers for signature are not legally binding but represent values, approaches and objectives related to children's rights and their protection from all forms of violence.

At the end of the meeting, the stakeholders and agencies requested time to discuss with their agencies the possible signing of the terms of reference for the establishment of the Inter-sectoral Board.

One more inter-sectoral meeting is planned to be delivered in a later stage, as the platform will be implemented in the following months after the end of the project, in a total of 6 months, as agreed with project's coordinators. In the following meeting is planned to discuss about the potential problems.

A skype meeting scheduled and delivered with the project coordinator's, involving the local coordinator and the technical staff in order to support the national team in regards of the platform technical issues while the piloting phase.

Professionals involved

From the professionals trained, 34 accounts were created from the national coordinator for the professionals of HFC in order for the piloting phase to start. After their accounts were created, each one receive their credentials along with further instructions in order to start adding their new cases on the platform.

All the professionals added again some mock cases in the guidance of the HFC project's team as their trainings were delivered online. In continuation, three cases were added to the platform, for three different child IDs.

The first case added in the platform on 23/06/2021 referring to "A "distinct" event took place – Not continuous maltreatment". The second case added on 28/06/2021, referring to "Continuous maltreatment – including distinct event(s)" and the third cases added on 30/06/2021, referring to "A "distinct" event took place – Not continuous maltreatment".

Piloting phase

Even though the piloting phase started in a national level, the cases added by now are from Nicosia regional offices.

The sectors involved in the piloting phase are the Children's House, which handles the investigation of cases of children sexual abuse, with therapy included, and the Foster department which deals with the home replacement of children.

In regards to the system and its understanding of the professionals, even though not all of them had real cases to add, they tried to navigate in the platform using mock cases (taking into account their previous cases) in order to be able to give their feedback. They said that at the beginning it was a bit confusing as some of the choices were not translated or were placed twice using different terms. However, on that we informed the project's coordinators and they work on that.

Moreover, they found that there are many options under each category and they mentioned that even though at this point it seems confusing, they believe that once they learn the platform this would be very helpful on extract exact data as the professionals don't need to write something, thus won't use different terms for the same issue.

Added to that, they said that the platform is easy to navigate as it's step by step and it's not confusing.

They mentioned the importance of the Operator's Manual as this helped them to understand the terms were written solving any confusions.

About any technical problems they didn't face any of them by now, but they said that this might be because the platform is not overloaded yet and they share their concerns on that regarding the host proxy. This is something we keep in mind for the future.

After the piloting phase, the project team plans to continue with the comparison of the data and to collect the feedback of the professionals through focus groups in order to fix any issue.

Overall, the professionals involved in the piloting phase of the CAN-MDS II platform were particularly satisfied of this initiative and interested to see the results of this new reporting mechanism built within the framework of the project.

Conclusion

The pilot implementation of the CAN-MDS II project in Cyprus proved to be both challenging and stimulating. The feedback provided by the professionals that participated in the different stages of the project will serve as a guide to improve the current mechanism. Yet, as the piloting phase did not finish due to the delay of the situation with the pandemic, the project team engaged with the professionals to continue the piloting phase in a total of six months.

France

Piloting of CAN-MDS System in France was not realized.

Information provided by ONPE-FR

1-Risks not anticipated at the start of the project

a) Early 2020 - the "covid 19" pandemic

For WP1, the rule being teleworking, contacts took place by video, phone, SMS between the administrator/operators; contacts with consortium members were also implemented as often as necessary by mail, phone or video.

In addition, GIPED/ONPE were confronted with another important difficulty, less directly related to the pandemic, but nevertheless strongly amplified by the covid.

In January 2019, the government created a State Secretariat for the Protection of Children and Adolescents, which decided to revise in depth the child protection plan in force in France, leading to a proposal for a new law to be submitted to Parliament this month (June 2021). After the diagnosis, from September 2019, the consultations of many actors in the broad field of child protection have profoundly modified the priorities set to Giped/ONPE by the supervisory authorities. Without covid, it would have been possible to carry out at the same time CAN-MDS 2 and other missions. In order to achieve the objectives of the project the operators had to intervene in about ten paediatric reception units for children at risk (UAPED) spread across France, but the acceleration of the needs of the authorities combined with the difficulties of availability of actors in the UAPEDs have made it impossible to implement the training of professionals and experimentation in the UAPEDs.

By the end of 2019 and into 2020, the person responsible for CAN-MDS 2 warned ICH that achieving the objectives would be difficult, if not impossible. Numerous exchanges testify to this. After the request for an extension of the project until the end of June 2021 and the confirmed unavailability of professionals in the UAPEDs, the structure decided to present the difficult situation of the CAN-MDS 2 project to the Giped Board of Directors at the beginning of 2021. This board took place at the beginning of March (date postponed due to the health situation) and took the decision to submit to ICH, for transmission to the commission, a request for the withdrawal of the European project CANMDS 2 from the signed agreement.

b) In direct relation to the project

During the implementation of the project in 2018, the decision-makers and professionals of the ONPE who had participated in the setting up of the project were no longer present in the structure, which caused misunderstandings during its operational launch by the new management and the operator dedicated to the project, mainly in the distribution of the schedule. The project operators expected to be operational in the UAPEDs from September 2019, which was not the case.

2-Description of the actions

Preparatory phase: 2019

"The project summary" foresees a duration of 12 months (between December 2018 and December 2019), however, the French team always thought that it could start to be operational in September 2019; misunderstanding when transmitting the project information? Misunderstanding during the KOM seminar? The planning of the ONPE had foreseen a full-time intervener for this period, who in fact intervened much less.

In January 2019, the CAN-MDS 2 interveners contacted the federation "La Voix De L'Enfant", which initiates and accompanies the UAPEDs in France and abroad, to define the most relevant criteria for choosing the UAPEDs that would be asked to participate in CAN-MDS 2. A list was drawn up and the following UAPEDs were selected: Angers - Carpentras – Chalon-sur-Saône - Clermont-Ferrand - Dunkerque - Limoges - Nantes - Niort - ST Denis de la Réunion - St Malo .

All these UAPEDs were contacted by telephone, video; some were visited by 2 members of the project team. The project was explained to the managers and documents were sent to them so that they could discuss it with their teams. All agreed in principle to work with the project from September 2019.

Unfortunately, the delay caused by the impossibility of starting work in this last quarter of 2019, which would have been easily recoverable in normal circumstances, was irrecoverable in 2020 due to the elements described in point 1 of this report "unidentified risks".

In December 2019, A. Gindt-Ducros and A-L Stephan participated in the consortium meeting and director training organised by ICH in Athens. In the first quarter of 2020, in addition to the difficulties generated by the first lockdown, A-L Stephan left the ONPE, she passed on to her replacement Linda Marti the state of play of the project and what remained to be done, but despite various attempts the training of operators could not be achieved.

During this year 2019 the ONPE communicated on the project both through publications initiated by the structure and distributed widely, including via the internet, to actors in the field of child protection and during the many meetings that took place for the reworking of the national child protection plan. Contacts for the constitution of the national steering group were made with the people concerned, no difficulties were encountered at this level, but it was not operational, pending consultation on implementation.

Year 2020: training and operationality

An attempt was made to get around the difficulty of training at least one operator per UAPED selected for the project, i.e. 10 operators, but it did not succeed; the idea was to start with 1 or 2 UAPEDs, with the aim of increasing the number of potential "trainers" with support/tutoring from the ONPE. Throughout the year, there were many discussions within the project team to find a solution, to ask for a delay, but because of the evolution of the health crisis and the missions requested of the ONPE by its governing bodies, there was no certainty that an extension would be sufficient to achieve the objectives and, moreover, it penalised all the members of the consortium.

In view of A. Gindt-Ducros' repeated warnings about the delay in the project and the impossibility of making up for it under the circumstances at the end of 2020, it was decided to put the future of the project on the agenda of the next GIPED Board meeting.

The Board meeting took place on 4 March 2021 and decided to request ICH to withdraw from the agreement co-signed by the EU, ICH and all consortium members for transmission to the relevant EU services. This request was sent on 9 March 2021, by letter A/R and an extract of the minutes of the Board of Directors concerning this decision was enclosed. Upon receipt of this letter, G. Nikolaidis and Sakis Dinapogias contacted the ONPE by video to try to find a solution. Unfortunately, the proposal from the ONPE took time (about 2 weeks) to be validated and sent to Greece; moreover, it did not really seem satisfactory to the project leaders and the situation having simultaneously evolved unfavorably at the ONPE, the departure of the two directors from the GIPED/ONPE structure was decided and effective on 8 June 2021. The ONPE professionals involved in this project continue to believe that this project was well constructed, very useful and that its potential results are expected by professionals in the field. The very particular circumstances of 2020-2021 have had a major impact on the world of child and adolescent protection, shifting the priorities to be implemented.

Greece

[from D4.4 Greek Report on CAN-MDS Piloting]

CAN-MDS System Piloting

For the evaluation of the CAN-MDS System operation in real conditions in Greece, the following indicators were applied (as it was discussed during the 1st Managerial Meeting, 2-3 Dec 2019, see presentation *"Development of the evaluation methodology & tools for assessing piloting results at national level"*):

Involved parties (before piloting)

- Representation of relevant sectors in the National Inter-Sectoral Board
  - Number of Sectors invited/accepted the invitation and participate in the Board
  - Number of meetings and participation rate in the meetings
- Number of agencies participating in the piloting as data sources
  - Rate of invited/accepted invitation
- Number of professionals participating in the training to become operators
  - Rate of invited/accepted invitation to be trained
- Number of professionals participating in the piloting as operators
  - Rate of trained/participated in piloting

Monitoring process

- National Inter-sectorial Board Meetings where progress assessed, potential problems and ways to overcome were discussed
- Online Consortium meetings involving local coordinators, national administrators, project leader and coordinator, external evaluator and experts on ethics and IT

Piloting – indicators for evaluation

- Deviations from the national plan in terms of
  - Level of piloting (national, regional or local)
  - Sectors to be involved
  - Number of professionals to be involved as operators
- Number of cases recorded
  - Totally
  - Geographically (per region)
  - Per sector
  - Per professionals' group
- Number of inter-sectoral cooperation via system (referral to services)
- Completeness of records (concerning data elements)
- Problems faced with the methodology (misunderstandings etc)
  - Periodic group discussion with Administrators in 6 countries (bimonthly)
- Technical problems faced with the system
  - Log recorded by the system

Involved parties

By design the CAN-MDS System aims to involve as much as possible potential stakeholders in order to widening the data sources of CAN reports, namely eligible professionals having various professional specialties and backgrounds working with or for children in organizations and services activated in relevant sectors (justice, law enforcement, social welfare, health, mental health, education, hotlines, governmental and NGOs). Involvement of various stakeholders in the context of CAN-MDS Piloting took place at three levels: the National CAN-MDS Inter-Sectoral Board; the cooperating Agencies (who signed bilateral relevant Memoranda of Collaboration) and the participating Professionals (who declared their willingness to participate in both, the required training and the piloting of the system signing also the necessary informed consent).

Inter-Sectoral Board

To promote data collection on child abuse and neglect and support the piloting of the CAN-MDS system in Greece, a National Inter-sectoral Consultative Committee was formatted where **ALL relevant sectors are represented**. Currently 13 Authorities, Ministries and Organizations are participating (see also D2.7).

Number of Sectors invited/accepted the invitation and participate in the Board

In December 9, 2020 ICH-MHSW sent out a total of 15 invitations to Authorities/Organizations according to the customized pilot plan. Out the 15 Authorities 12 eventually replied positively that they are willing to cooperate and to support the piloting of the CAN-MDS System. Two Authorities, Ministry of Citizens Protection and Hellenic Police, are represented in common by 3 members in the Committee; Prosecutor's Office replied that due to some specific rules they are not able to participate while the Ministry of Digital Governance and the General Secretariat of Information Systems didn't replied in the invitation (and reminders) at all. While the Committee was under formation, Eliza –an Association against Violence against Children was also invited to participate in the Committee. The Committee decided to approach again the Prosecutors' Offices as there was probably a miscommunication of the information and typically there is no obstacle for them to participate in the effort. The process is ongoing. General Secretariat for Information Systems informed the ICH that another General Secretariat called IDIKA is more appropriate for health related issues (including also the hosting of the CAN-MDS system in the governmental cloud). Invitations sent to IDIKA along with request for hosting the app (see Annex 2) and the process is also ongoing.

Number of meetings and participation rate in the meetings

1st Meeting: April 5, 2021; 15 participants / 13 Authorities-Organizations
2nd Meeting: May 10, 2021; 14 participants/ 11 Authorities-Organizations
3rd Meeting: June 16, 2021; 12 participants/ 10 Authorities-Organizations
(For more details such as agendas and minutes, see also D4.1)

It is of note that during the 3rd Meeting of the Inter-Sectoral Board (that was the last one according to the initial plan and the ToR), ICH-MHSW suggested the continuation of the operation of the Committee/Board along with the continuation of the piloting of the system and the training activities for at least the next period until the end of December 2021 (over and beyond of the project). All present members were positive to such a development and many of them already agreed and committed to continue to work according to the ToR while for some others (such as the Police) the decision has to be made by the hierarchy. In addition, a number of members of the Committee suggested during the same period to take action towards the preparation of the appropriate legal framework for the operation of the system (probably in the context of an Inter-Ministerial Decision) (see also Minutes of the 3rd Meeting).

Agencies participating in the piloting as data sources

The process for recruiting agencies to participate in the piloting of CAN-MDS has as follows:

Steps
1. Informational material and Invitations sent out to relevant Organizations/Services along with a bilateral Protocol of Collaboration to be signed; Invitations sent either by the ICH or by other Members of the Inter-Sectoral Committee (up to now by EKKA, Ministry of Health and Eliza)
2. When a Protocol of Collaboration was signed, an individual account was prepared for the Agency in the CAN-MDS System (according to the instructions in the Step by Step Guide for the Administrator) At the same time, informational material and invitation sent to Professionals working in the specific Organization/Service along with a form to be filled in and returned to Administrator where the Professionals declare their willingness to participate in the training and to become CAN-MDS System's Operators as well as written informed consent that their data will be used in the system

Since May 10, 2021 59 organizations signed the bilateral Protocol of Collaboration and nominated professionals to participate in the CAN-MDS, as follows:

Code	Type of Organization/ Sector	N (59)	%
SWS	Social Welfare Services (SWS)	*39*	*66.1*
MHS	Mental Health Services (MHS)	*5*	*8.47*
NGO	Non-Governmental Organization (NGO)	*5*	*8.47*
ORS	Other related Services (ORS)	*3*	*5.08*
THC	Tertiary Health Care Services (THC)	*2*	*3.39*
CPS	Child Protection Services (CPS)	*1*	*1.69*
IAU	Independent Authorities (IAU)	*1*	*1.69*
PHC	Primary Health Care Services (PHC)	*1*	*1.69*
ROI	Research Organizations (ROI)	*1*	*1.69*
SMS	Social and Medical Services (SMS)	*1*	*1.69*

Geographic Coverage

At least one participating agency is located in 7 out of the 13 peripheries (most of them in Attica); none agency is still participating in the remaining 6. Once invitations will be sent by Ministry of Education, Ministry of Justice and KEDE this expected to be improved.

Professionals' involvement

Professionals participating in the training to become operators and Professionals participating in the piloting of the CAN-MDS as Operators

The process for recruiting professionals to participate in the piloting of CAN-MDS has as follows:

Steps
As it was mentioned above, informational material and Invitations sent out to relevant Organizations/Services along with a bilateral Protocol of Collaboration to be signed; Invitations sent either by the ICH or by other Members of the Inter-Sectoral Committee
After a Protocol of Collaboration was signed, informational material and invitation sent to Professionals working in the specific Organization/Service along with a form to be filled in and returned to Administrator

where the Professionals declare their willingness to participate in the training and to become CAN-MDS System's Operators as well as written informed consent that their data will be used in the system	
When a completed form received by the Coordinator, an account for the CAN-MDS e-learning platform was prepared per professional and individualized message sent back to each professional providing information for the procedure (namely first about the completion of the pre-questionnaire and next for the online training).	
When one Professional trainee completed the nine first sections, s/he communicated with the Administrator (according to written instructions within section 10) providing necessary (mock) information for the pseudonymization and asking for a pseudonym.	
Upon the receipt of the required information (and check of their correctness) individualized communication followed with each professional providing either further instructions (when information wasn't the expected) or the pseudonym for the recording of the mock incident in the system. At the same time individual account was prepared per professional for the CAN-MDS System (according to the instructions in the Step by Step Guide for the Administrator)	An email account was created for this aim (canmds.ich@gmail.com; currently the emails related to the Greek Inter-Sectoral Board, the professional-Operators & the Conference includes >1350 messages)
When a Professional complete the recording of the mock case and the replacement of the temporal ID with the Pseudonym, s/he receives an individualized message by the Administrator including the instructions and link for the post-training evaluation, the Certificate of successful Attendance of the training and a certification that s/he is an operator of the CAN-MDS system (along with final username/ password for entering in the system).	See also D3.7 and D2.8 for the current list of Operators.

Since May 10, 2021 112 professionals sent completed declaration of interest form and signed consent form for the use of their personal data (name, surname, contact details).
According to the initial plan CAN-MDS Operators' seminars would include 16*2-day seminars x 25 participants (400 trainees-operators) nationwide. Conduction of seminars had been scheduled to start during March 2020; due to the restrictive measures, however, that adopted because of the COVID-19 pandemic on March 5, 2020, an amendment was submitted to the EU in order for the seminars to take place online (instead of in person). EU accepted the amendment on Oct 2020. According to the revised plan it was decided to be used asynchronous e-learning methodology (based on the talentlms.com platform) with the aim to involve at least 400 trainees (as it was initially planned). Due to delays, recruitment of professionals started in April 2021 (see also comments about Agencies above).

Concerning their Professional specialties, the distribution has as follows:

Profession	ILO 2008, ISCO-08 Code	N (112)	%
Social Work associate professionals	3412	81	72.3
Psychologists	2634	16	14.3
Medical doctors	221	4	3.6
Health associate professionals	32	2	1.8
Nursing professionals	2221	2	1.8
Counselling professionals	2635	2	1.8
Teaching professionals	23	1	0.9
Software and applications developers and analysts	251	1	0.9
Special needs teachers	2352	1	0.9
Lawyers	2611	1	0.9
Sociologists, Anthropologists and related professionals	2632	1	0.9

As regards the sectors where the 112 professionals work, the distribution has as follows:

Sector	Code	N (112)	%
Social Welfare Services	SWS	77	68.8
Research Organizations	ROI	9	8.0
Mental Health Services	MHS	6	5.4
Primary Health Care Services	PHC	6	5.4
Non-Governmental Organization	NGO	5	4.5
Other related Services	ORS	3	2.7
Independent Authorities	IAU	2	1.8
Tertiary Health Care Services	THC	2	1.8
Child Protection Services	CPS	1	0.9
Social and Medical Services (SMS)	SMS	1	0.9

Rate of trained professionals / participated in piloting

Stage in the process (since May 10, 2021)	N=112 professionals	%
Sent signed declaration of interest & consent form	112	100.0
Started the training	112	100.0
Completed the training	71	63.0
Recorded one at least mock case in the System (60 mock cases)	63	56.7
Active Operators:	63	100.0
Active Operators (that not recorded real case yet)	52	82.5
Active Operators who recorded one at least REAL case in the System (38 real cases)	11	17.5

As it was noted above, because of these delays in the training and the piloting phase of the system, the National Inter-Sectoral Board made the decision to support the training and the piloting of the project for at least the next 6 months (until December 2021), over and beyond the CAN-MDS II Action. In this context, Board Member Authorities/Organizations will continue the recruitment of Agencies and Professionals from ALL sectors to participate in the piloting and, afterwards, in the normal operation of the system while ICH undertook the responsibility to coordinate both, training and piloting for this period.

Evaluation of CAN-MDS Operability via Simulation (working with Mock Cases)

What was evaluated regarding the use of the e-app to perform the practice tasks?

1. Correctness of record based on a mock case (64 records)
2. Completeness of record based on living cases the trained operators entered in the system (38 cases)
3. Correctness of the procedure for the pseudonymization

Mock case (along with instructions for the referee)	Data to be recorded and/or auto-calculated
RECORD (DE_R1-DE_R4)	Operator's id (auto-completed) Agency's ID (auto-completed) Date of Record (auto-completed) Information provided by:
Child (alleged) victim (DE_R1-DE_R4)	ID: Sex: Date of birth: Citizenship status:
Family and Caregiver(s) (DE_R1-DE_R4)	Type of family: Family's member(s): Primary caregiver(s): 1st caregiver: 2nd caregiver:
Incident (DE_R1-DE_R4)	Incident ID: Date of incident: Form(s) of maltreatment: Place of incident:

Working with Mock case - Simulation Results

AXES	DATA ELEMENTS	Correct info	Correct record	Notes
RECORD (DE_R1-DE_R4)	Operator's ID	Per case	Auto-completed	
	Agency's ID	Per case	Auto-completed	
	Date of Record	Per case	Auto-completed	
	Source of Information	Personnel working in Health services	53/64 (82.6%)	In 2 cases the Operators recorded "identified via routine screen" (that's no valid) and in 9 cases "Other" (operators did not identify the correct pre-coded value and considered that the source of referral was not among the predefined list)
Child (alleged) victim (DE_C1-DE_C4)	ID:	Per case	64/64 (100.0%)	All operators' contacted by email the Admin, provided all necessary information for the off line database correctly, asked and received the child's pseudonym. Documentation (relevant files and emails) are available. Some operators used the TEMP ID option (12/63) but in their majority the proceeded with the record after receiving the Child's ID (pseudonym).
	Sex:	Female	64/64 (100.0%)	
	Date of birth:	Exact date 2008-03-03	57/64 (89.1%)	
		Exact Year (YYYY)	60/64 (93.7%)	
		Exact Month (MM)	57/64 (89.1%)	Wrong selection from the dropdown list for DD (13; 31 instead of 03)
		Exact Day (DD)	57/64 (89.1%)	Wrong selection from the dropdown list for MM (04; 05 instead of 03)
		Under 18	4/64 (6.2%)	This is correct also but not exact
	Citizenship status:	Child is a citizen	64/64 (100.0%)	
		with ID	62/64 (96.8%)	In 2 cases operators recorded "not known"
Family and Caregiver(s) (DE_F1-DE_F4)	Type of family:	Child lives with his/her family (including biological/ adoptive)	64/64 (100.0%)	
	Family's member(s):	Identity: Parents	64/64 (100.0%)	
		Number/identity: Parents 2	64/64 (100.0%)	
		Total Family Members: 3	64/64 (100.0%)	
		[2 Parents+ the specific Child]		
	Primary caregiver(s):	1st - Parent	64/64 (100.0%)	63 (all) operators consider at least one parent as primary caregiver
		2nd - Parent	38/64 (63.5%)	38 of the Operators record the 2nd parent as primary caregiver; this is also correct (1 primary caregiver is enough); however the information here could be more completed
				Specifically: 34 operators (53.1%) recorded both parents as primary

				caregivers when the incident took place; 19% recorded only fathers; 19% recorded only mothers; in 5 cases the identity of caregivers noted as "unknown"
	1st caregiver:	Relationship to child: parent	59/64 (93.7%)	5 cases "not known"
		1st Caregiver's Sex (male or female)	59/64 (93.7%)	Male or Female; both correct (depends on the subject, father or mother)
		Date of birth (estimated based on age '80s (~30-35) and '90s (~25-30)	38/64 (63.5%)	9 (14.2%) cases inserted age instead of decade; 17 (26.9%) "not known"
	2nd caregiver:	Relationship to child: parent	38/38 (100.0%)	5 cases "not known"
		2st Caregiver's Sex (male or female)	38/38 (100.0%)	Male or Female; depends on the subject, father or mother; 26 cases with no answers
		Date of birth (estimated based on age '80s (~30-35) and '90s (~25-30)	26/38 (68.4%)	6 (15.8%) cases inserted age instead of decade; 5 (13.2%) "not known"
Incident (DE_I1-DE_I4)	Incident ID:	Per case	Auto-completed	
	Date (and type) of Incident:	Type: Continuous maltreatment – including "distinct event(s)"	47/64 (73.5%)	7 operators recorded correct type *Continuous maltreatment – including "distinct event(s)"* and that the last event took place *during the last 12 months* (which is also correct but not as much precise as possible)
		Date of event: 2021-04-18 (or 19 or 20)	45/64 (70.3%)	
		Previous event (~ five months before)	17/47 (36.2%)	10 operators recorded "a distinct event took place" (with correct date); 2 operators recorded "unknown information" and 2 operators recorded "*Continuous maltreatment - No "distinct event" took place*".
	Form(s) of maltreatment:	**[I3_A_2] Physical violence acts committed**	**64/64 (100%)**	Main form of CAN (physical violence) was identify by all professionals, regardless of professional background and sector where they are working. More specific forms of physical violence, such as corporal punishments practices, were also recognized (>80% of operators) and in many cases even more specific sub-forms of corporal punishment. Many operators also recognized harmful practices (e.g.~77% recorded "forcing to ingest spicy food"). Secondary main types of violence were also recognized and recorded by almost 6 out of the 10 professionals (e.g. psychological violence acts with or without consequences or without specific information). Lastly, regarding neglectful parental behaviour, although no clear suspicion and/or information was provided almost 65% of the operators recognized and recorded 1 to 3 specific forms (in the 9/10 of cases medical neglect related omissions, delay in seeing medical needed care or refusal to provide preventive health care such as vaccinations) and in 4/10 cases risk exposure related omissions and inadequate supervision related omissions).
		[I3_A_2.1] corporal punishment/"disciplines"	***52/64 (81.25%)***	
		[I3_A_2.1.03] spanking	25/52 (48.1%)	
	Basic form	[I3_A_2.1.07] hitting with an object	45/52 (86.5%)	
	Sub-form 1	***[I3_A_2.2] violent acts/ harmful practices***	***49/64 (76.6%)***	
	Sub-form 2	[I3_A_2.2.02] forcing to ingest spicy food	45/49 (91.8%)	
		[I3_A_4] Psychological violence acts	**37/64 (57.8%)**	
		[I3_A_4.1] with/no obvious consequences	21/37 (56.8%)	
		[I3_A_4.1.15] terrorization / scaring	11/37 (29.7%)	
		[I3_A_4.88] no specific info /suspected I3_A_4	24/37 (64.9%)	
		[I3_B] OMISSIONS	**41/64 (64.1%)**	
		[I3_B_3] medical neglect related omissions	***37/41 (90.2%)***	
		[I3_B_3.01] refusal to provide preventive health care (vaccinations, vision, dental care)	30/37 (81.1%)	
		[I3_B_3.03] unjustified delay to seek med care	29/37 (78.4%)	
		[I3_B_5] risk exposure related omissions	***18/41 (43.9%)***	
		[I3_B_6] supervision related omissions	***16/41 (39%)***	
	Place of incident:	Child's Home (possibly)	29 (48.4%)	52/64 (87.5%) recorded Child's Home and/or street/surrounding area

	Street/ Surrounding area (possibly)	23 (39.1%)	(both are correct in the specific incident); 23 operators recorded "unknown"; 3 operators recorded other place

Summarizing:

The last two data elements related to services' involvement (DE_S1. Institutional Response and DE_S2: Referral(s) to Services) were not assessed as it wasn't expected from trainees to reply in a specific-predefined way. Concerning the remaining 16 data elements:

C1 (Child's ID)

100% correct completion, after the provisioned process for acquiring the child's pseudonym

C2 (Child's Sex)

100% correct completion

C3 (Child's Date of Birth)

89.1% Exact full date (YYYY-MM-DD)
93.7% Exact Year (YYYY)
89.1% Exact Month (MM)
89.1% Exact Day (DD)
100% Under 18

C4 (Citizenship status)

100% correct completion of whether the child is a citizen or not
96.8% correct completion on whether the child has an ID or not

F1 (Family Composition)

F1A (Type of family)

100% correct completion

F1B (Family composition) – IDENTITIES (relationship to the child) of Family Member(s)

100% correct completion

F1B (Family composition) – NUMBER of Family Member(s) per IDENTITY of Family Member(s)

100% correct completion

F1_C (Definition of Primary Caregivers)

100% completion (of at least 1 primary caregiver); 63.5% of the 2nd Primary Caregiver

F2 (Relationship of the child with the Primary Caregiver(s) when the incident took place)

93.7% correct completion for the 1st Caregiver; 100% for the 2nd Caregiver (where defined)

F3 (Primary Caregiver(s) Sex)

93.7% correct completion for the 1st Caregiver; 100% for the 2nd Caregiver (where defined)

F2 (Primary Caregiver(s) Date of Birth based on relevant information or based on the reported age, real or estimated)

63.5% correct completion for the 1st Caregiver; 68.4% for the 2nd Caregiver (where defined)

I2 (Date and Type of Incident)

70.3% correct completion of the type of CAN case (continuous or not with distinct events or not) **73.5%** correct completion of the date of the event

I3 (Form(s) of maltreatment)

Main Form of CAN: 100%

Specific Sub forms of violence under the main form of CAN: 81.3%; 76.6%

Specific types (violent acts or omissions in care): 91,8%; 86,5%; 48,1%

Secondary (concurrent) main form(s) of CAN: *64,1%; 57,8%*

Specific sub forms of violence under the secondary main forms of CAN: 90,2%; 43,9%

Specific types(violent acts or omissions in care): 81.1%; 78.4%; 64.9%; 56.8%; 29.7%

I4 (Location of Incident)

87.5% correct completion

4 out of the 18 data elements were auto-completed and by definition the completion is full and correct (R1, R2, R3, I1)

Conclusion

In the table above completeness and correctness of the records of a specific mock case by trained professionals are presented; the mock case was provided as a written script to 64 professionals of various specialties that work in various Agencies in sectors relevant to child protection and child wellbeing in the context of an online asynchronous e-learning seminar. This was the first time that the 64 professionals used the CAN-MDS tool. As for the inaccurate information in specific data elements, in most of the cases after a very short bilateral discussion or written comment professionals-operators understood exactly what was the misunderstanding led them to insert a non-precise information.

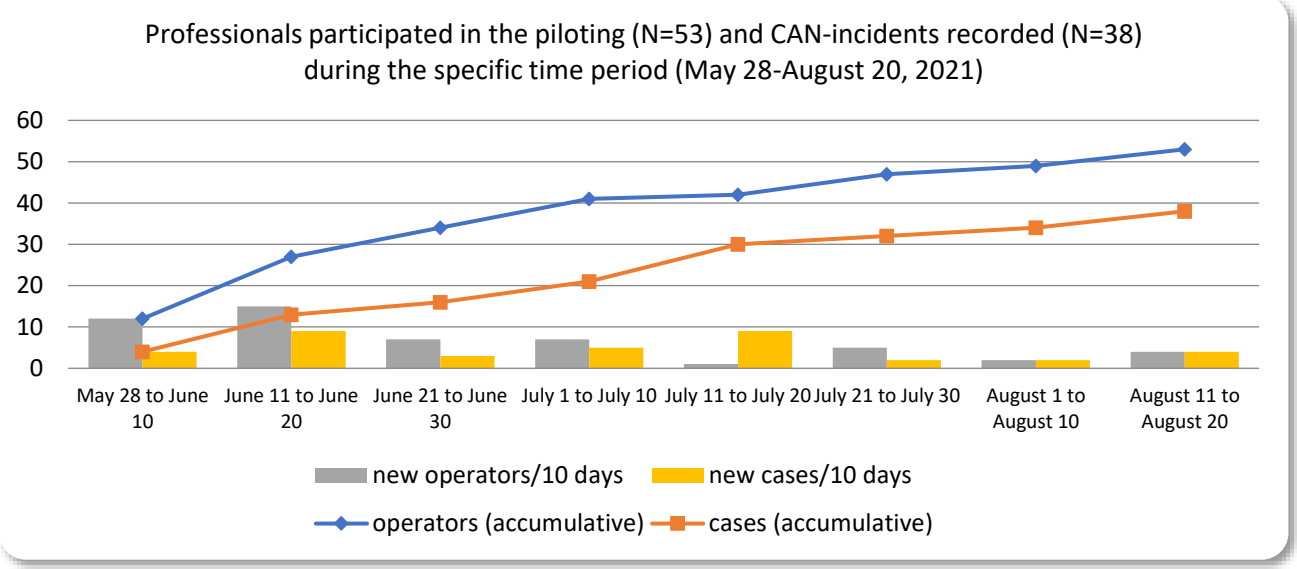
It is expected that after some more practice and familiarization of the professionals with the toolkit and the electronic tool the records will be even more complete and correct (regardless of the professional specialties, sectors or other characteristics of the operators)

Professional's assessment of e-app: In terms of the application itself, it is very easy to use and helps the professional in capturing the data and to approach the incident in many ways and make a more complete presentation.

Living Cases Data Collection through CAN-MDS during piloting phase in Greece

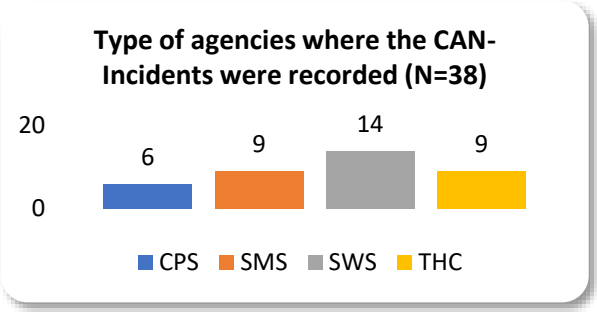
Pilot operation of the CAN-MDS System in Greece started in May 28, 2021 initially with a group of 10 professionals who completed their training (since May 10, 2021). The data that will presented below were collected during the period May 28 to August 20 from 11 operators out of a group of 53 professionals who gradually entered in the piloting phase of the system (after the completion of the mock case recording). A total of 38 CAN incidents were entered in the system.[1]

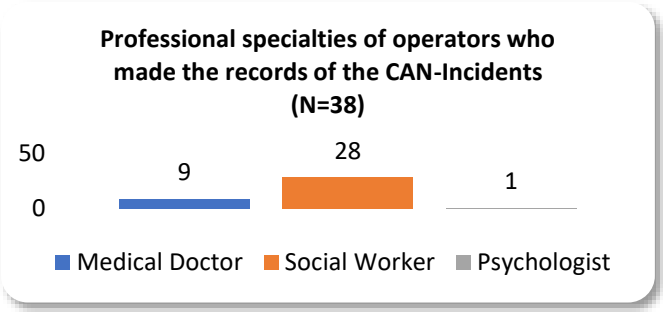
Professionals participated in the piloting and CAN-incidents recorded during the specific time period



From the figure above it seems that the number of new operators during the period July 10 to August 20 was lower than in the previous period (May 28 to July 10), probably because of summer vacations; number of new CAN-incidents recorded in the system, however, seems to have a similar distribution during the above periods. In both cases, of course, the cumulative number of both, operators and recorded CAN-incidents increases over the time in a more or less similar way (as it was expected).

All 38 records of incidents in the system made by 11 different operators (from now on "*active*"), 9 of them working in 7 Agencies located in Attica and 2 in 2 Agencies located in Thessaloniki. Detailed information follows:





[1] No data are available from other sources for the same or similar period (of past year, for example) in order to proceed in comparisons.

AXIS: RECORD

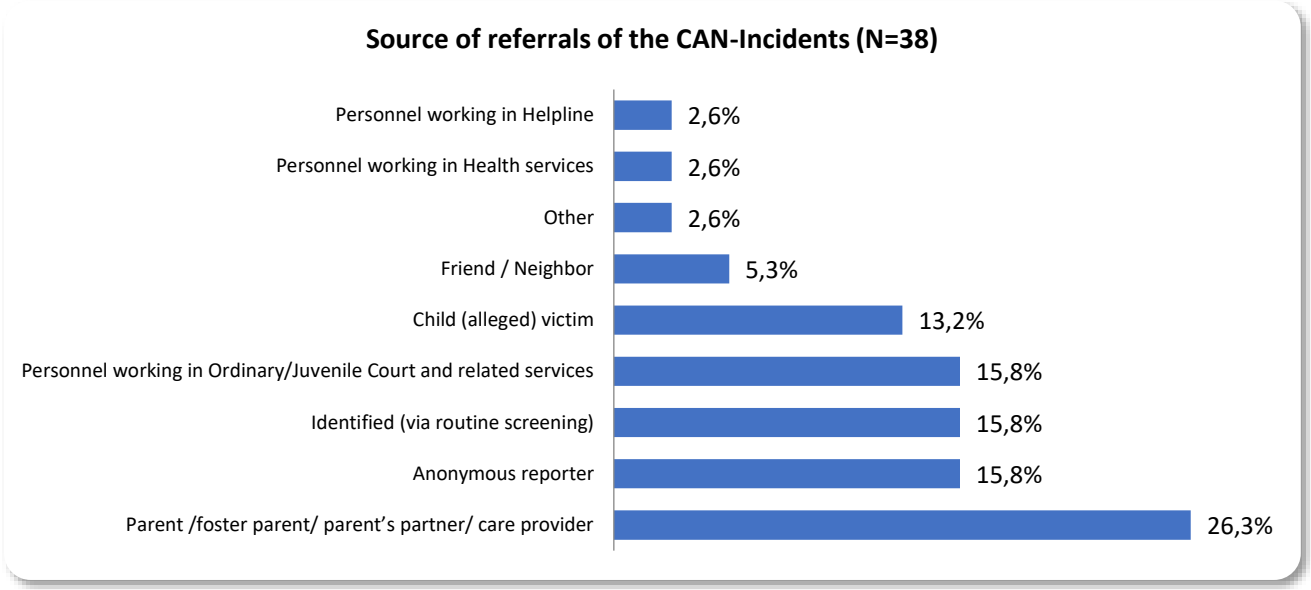
DE_R1 AGENCY's ID DE_R2 OPERTOR"S ID DE_R3 DATE OF RECORD

The above information were extracted by the auto-completed data elements R1, R2 and R3. Examples below:

DE_R1: Agency's ID [12]	DE_R2: Operator's ID [13]	DE_R3: Date of Record YYYY-MM-DD [HH:MM] [14]
GR-A1-SWS-001	GR-A1-SWS-001-3412-2-001	2021-06-11 12:14
GR-A1-SWS-001	GR-A1-SWS-001-3412-2-002	2021-06-23 11:14
GR-A1-SWS-001	GR-A1-SWS-001-3412-2-002	2021-07-06 09:11
GR-54-SWS-004	GR-54-SWS-004-3412-3-001	2021-07-29 11:08

DE_R4: SOURCE OF REFERRAL

Source of information for each of the recorded incidents in the system, as it is presented in the graph below, in most of the cases it was one of the parents (the non-abusive); almost half of the cases were identified through screening by the professionals-operators or reported by professionals working with or in prosecutors' offices or by anonymous reporters (often in SOS lines); ~1/10 incidents the information was provided by the children-(alleged) victims themselves. In some cases the information was provided to the CAN-MDS Operator by health professionals, by friends or neighbors of the child (alleged) victim or by other source.



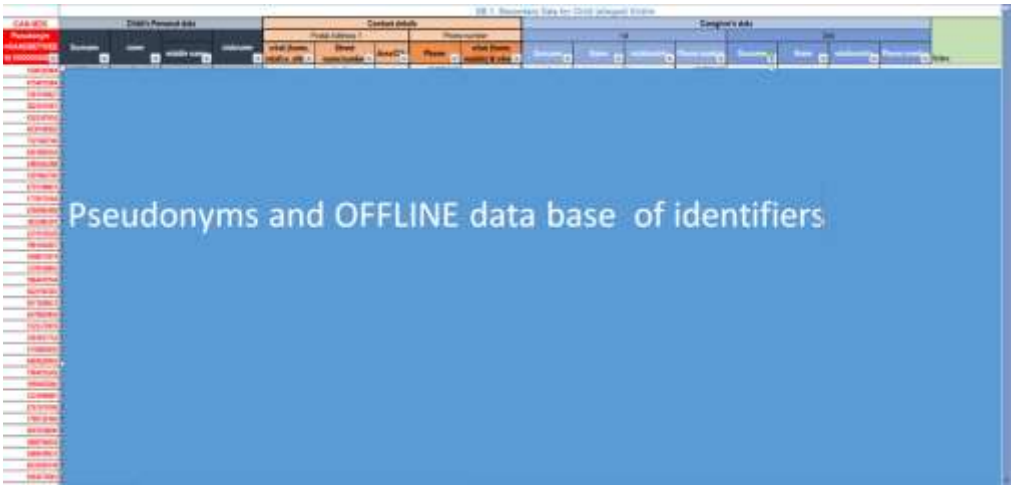
In the following pages a brief presentation of the data collected via the CAN-MDS for a number of CAN-incidents will be presented; as it will become obvious completeness of data is satisfactory (missing data in live cases are observed only in a few cases) and details are also available. The data that are presented below are the basic descriptive data, without further analysis as it would be in a full periodic report based on data collected via the system.

AXIS: CHILD

DE_C1 "CHIILD's ID"

In all 38 cases professionals-operators communicated with the CAN-MDS Administrators and applied the process to acquire a pseudonym for the child suffered CAN (namely the incident that recorded in the system).

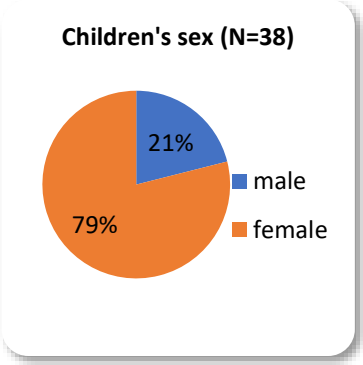
The offline database is available in the premises of ICH-MHSW (National Administrative Authority of the System) and it can be used for the production of further children's pseudonyms. Documentation for the 38 procedures is available.

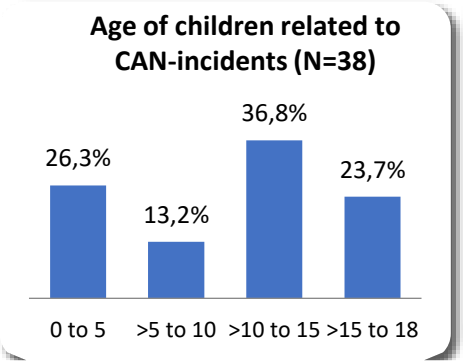


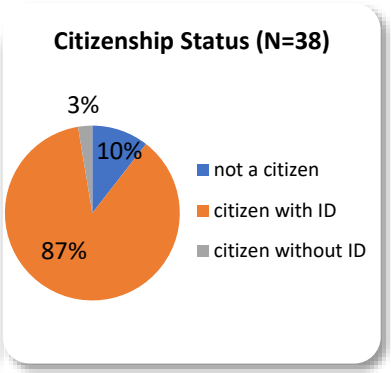
Use of pseudonymization and maintenance of offline database with personal data ensures that CAN-MDS operates in alignment with GDPR provisions and according to what provisioned by the law about protection of personal data

DE_C2 "CHILD's Sex", DE_C3 "Child's DoB" and DC_4 "Citizenship Status"

Concerning children characteristics, 30 out of the 38 (78.9%) are girls and 8 (21.1%) are boys. As for their citizenship status, 34 (89.5%) are Greek citizens and all but 1 with ID (the remaining 4 children are not Greek citizens). Age of children range from a few months up to 17 years and 9 months. The distribution is presented below:



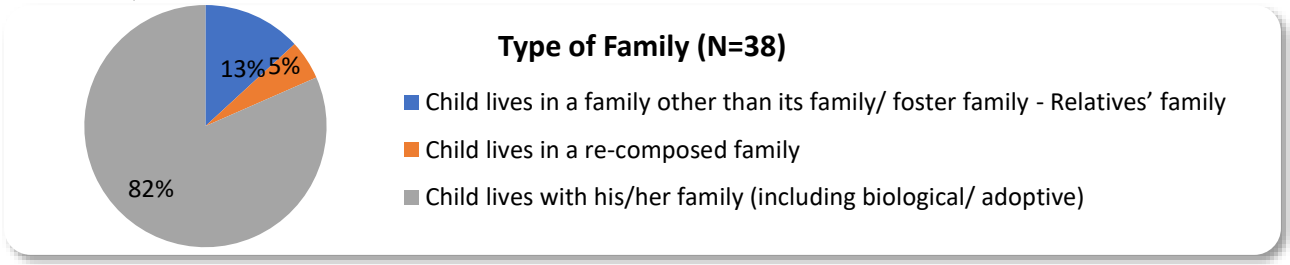




AXIS: FAMILY

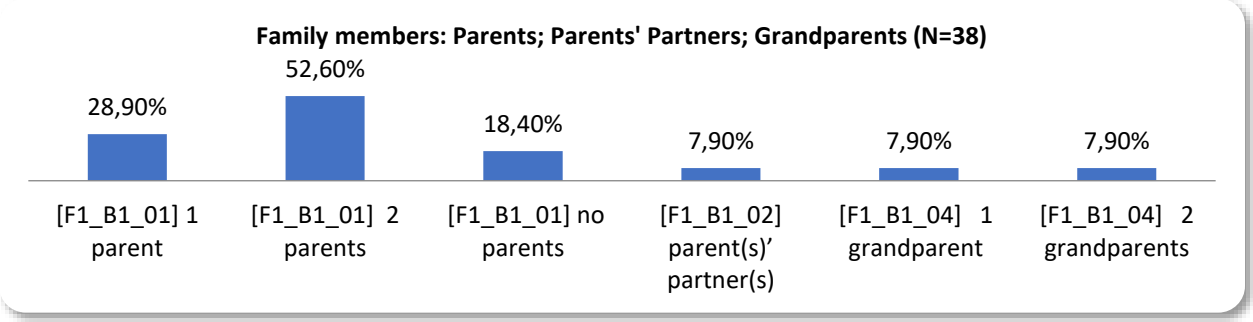
DE_F1.A "FAMILY COMPOSITION"

In most of the cases children live with their families while in 2/10 cases children live with foster or relative families or in re-composed families.



[F1_B1] MEMBER(s) OF FAMILY – IDENTITIES/RELATIONSHIP TO CHILD & NUMBER PER IDENTITY

In 7 out of the 38 cases children live without their parents; in 11 cases children live with one of their parent while in more than half of the cases 20) children live with both of their parents. In some cases apart from parents children live in the same house with the partner of their parent (3 cases) or with one (3 cases) or two (3 cases) grandparents.



Twenty three out of the 38 children have one to four siblings while 40% (15 children) have no siblings. In most of the cases children have 1 or 2 siblings and in two cases there are 3 and 4 siblings. The total number of siblings is 38; 16 of them are younger than the children (alleged) victims, 16 are older than the children (alleged) victims but also under 18 years old while 6 of the siblings are adults (>18). This information, especially for the minor siblings, is important for services and professionals depending on the nature of the CAN incident.

[F1_B1_03] sibling(s) number	N (38)	(%)	[F1_B1_03.1] sibling(s) younger than the (alleged) victim	[F1_B1_03.2] sibling(s) older than the (alleged) victim (<18)	[F1_B1_03.3] sibling(s) older than the (alleged) victim (>18)
0	15	39.5%	NA	NA	NA
1	11	28.9%	5	5	1
2	10	26.3%	10	5	5
3	1	2.6%	1	2	0
4	1	2.6%	0	4	0

In 3 cases children live in families with relatives other than their parents, siblings and grandparents. In 1 case with 1 adult blood relative; in 1 case with 2 adult blood relatives; in 1 case with 2 blood relatives, one adult and one child and in 1 case with 5 relatives, 3 children and 1 adult blood relatives and 1 adult relative by law.

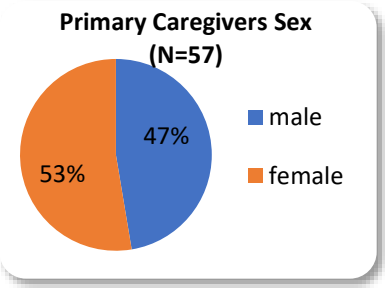
[F1_B1_05] other relative(s)	N	%	[F1_B1_05.1] blood relative (s)	[F1_B1_05.1.1] blood relative(s) [child(ren)]	[F1_B1_05.1.2] blood relative(s) [adult(s)]	[F1_B1_05.2] relative(s) by law	[F1_B1_05.2.1] relative(s) by law [child(ren)]	[F1_B1_05.2.2] relative(s) by law [adult(s)]
None	34	89.5%	NA	NA	NA	NA	NA	NA
1	1	2.6%	1	0	1	0	0	0
2	1	2.6%	2	0	2	0	0	0
3	1	2.6%	2	1	1	0	0	1
4	0	0.0%	0	0	0	0	0	0
5	1	2.6%	3	3	1	1	0	1

[F1_C] PRIMARY CAREGIVERs AND DE_F2 CAREGIVER(s) RELATIONSHIP TO CHILD

As for the primary Caregivers that were responsible for the children when the recorded incidents took place in half If the cases there were 2 and in the remaining half cases there was one primary caregiver responsible for the child.

Cases with two or more primary caregivers when the incident took place				Cases with one primary caregiver when the incident took place	
Cases	1st or 2nd (regardless order)		3rd or more	**Cases**	
10	Mother	father		**11**	**parent**
3	grandmother	grandfather		*7*	*father*
3	Mother	father	sibling	*4*	*mother*
2	Mother	father	grantparent	**3**	**professional caregiver**
1	Mother	mother's partner		*2*	*female*
				1	*male*
				5	**temporary caregiver**
				5	*female*

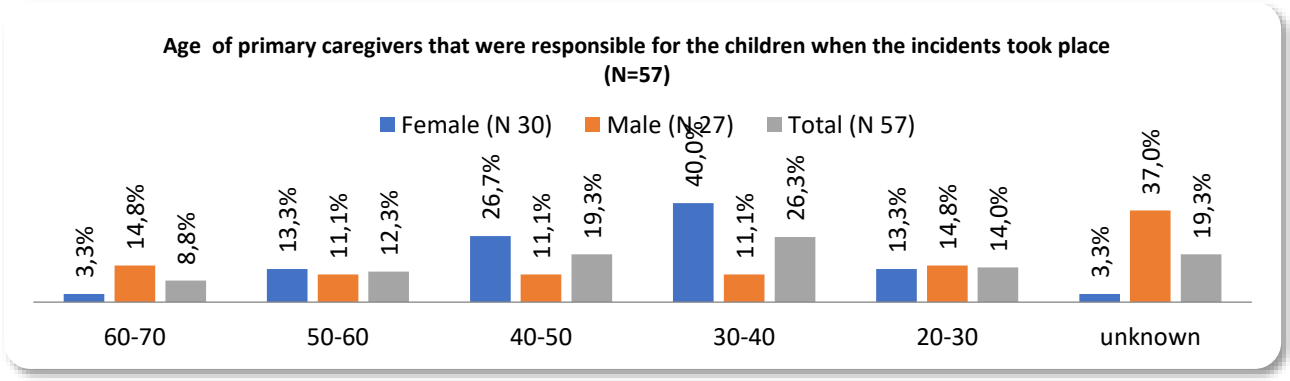
DE_F3: CAREGIVER(s) SEX



In 15 cases father and mother were both primary caregivers of the child when the incident took place; in 1 case mother and her partner were responsible for child's care while in 3 cases grandfather and grandmother were in charge for the care of the child.
From the remaining 19 cases where one primary caregiver was recorded, in 11 cases the caregiver was a parent (in 7 cases the father and in 4 cases the mother), in 3 cases were professional caregivers (2 female and 1 male) and in 5 cases were temporary caregivers (all female).

DE_F4: Primary Caregiver(s) DoB

Concerning their age of female caregivers, 65% were between 30-50 years old (while either younger than 30 or older than 60 were fewer). Concerning the age of male caregivers, the distribution was similar in the various age groups with slightly more over 60 and under 30 years old (reversed pattern than females); however, the information for almost 4/10 male caregivers was not known. In total, half of the caregivers (female and male) were between 30 to 50 years old.



AXIS: INCIDENT

DE_I1 INCIDENT ID

I1: Incident ID [24]
4322341652-20210611-121416
1591962798-20210623-111407
1690875974-20210706-91140
1708728166-20210729-110855
1776978164-20210616-120437
2374138529-20210629-164501

Auto-completed code by the system identify a single CAN-incident; the ID is composed by the CHILD ID, Date and Time of Record [DE_C1 + DE_R3]. Examples:

DE_I2 DATE (and TYPE) of INCIDENT

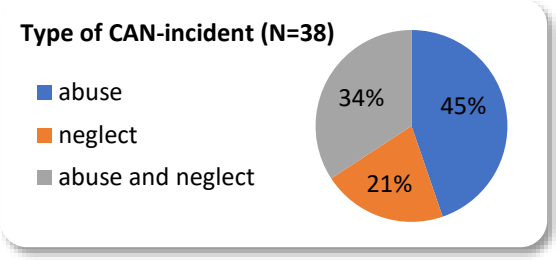
In the table below type of CAN-cases is presented, namely whether the specific incidents were distinct events or is about continuous maltreatment with or without distinct events.

Date (and Type) of incident	N	%
[I2_01] a "distinct event" took place – Not continuous maltreatment	**6**	**15.8%**
[I2_01.01] [YYYY/MM/DD] [26]	5	13.2%
[I2_01.88] Unknown	1	2.6%
[I2_02] continuous maltreatment – including "distinct event(s)"	**14**	**36.8%**
[I2_02.01] start date	0	0.0%
[I2_02.01.01] duration	0	0.0%
[I2_02.02] during the last 12 months	3	7.9%
[I2_02.03] before the last 12 months	1	2.6%
[I2_02.04] lifelong	6	15.8%
[I2_02.88] Unknown	4	10.5%
[I2_02.0A] last known CM incident date (YYYY-MM-DD)	7	18.4%
Continuous maltreatment - No "distinct event" took place	**9**	**23.7%**
[I2_03.01] start date	3	7.9%
[I2_03.01.01] duration	0	0.0%
[I2_03.02] during the last 12 months	2	5.3%
[I2_03.03] before the last 12 months	0	0.0%
[I2_03.04] lifelong	4	10.5%
[I2_03.88] Unknown	0	0.0%
Unknown	**9**	**23.7%**

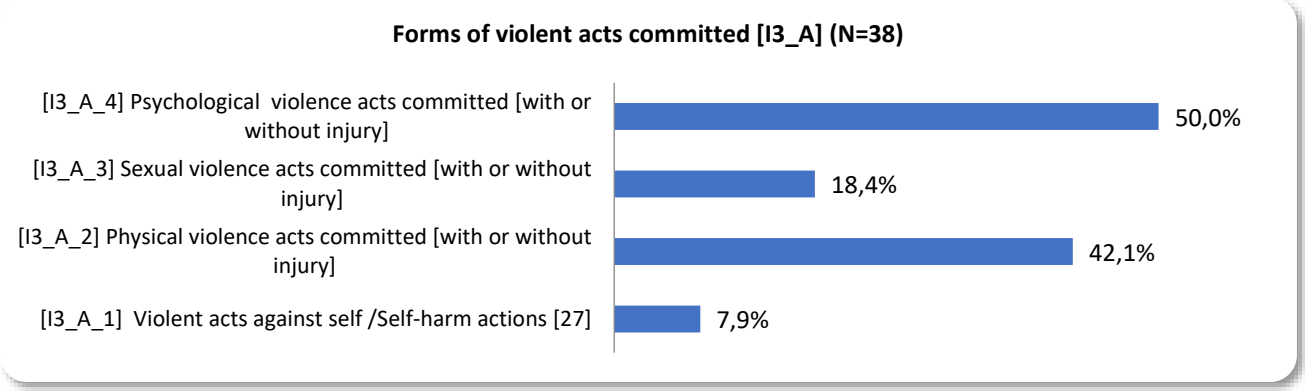
In ~37% of the cases continuous maltreatment is recorded including distinct events (and the dates of most recent events is provided in half of the cases). As for the chronicity of maltreatment, in almost half cases (6/14) is lifelong maltreatment, in 3 cases during the last year and in 1 case lasted for more than 1 year. In 4 cases is not known when the maltreatment started.

In ~24% of the cases continuous maltreatment is recorded without distinct events to be mentioned (neglectful care and psychological abuse). In 4 cases the maltreatment is lifelong, in 2 cases started during the last year and in 3 cases specific starting date is recorded.
In ~16% of the cases is recorded that one "distinct event took place" and not continuous maltreatment is recorded. In most of the cases (5/6) the specific date when the incident took place is recorded.
Lastly, for about 24% of the cases the type of maltreatment in terms of chronicity and specific date when the incident took place was recorded as "unknown".

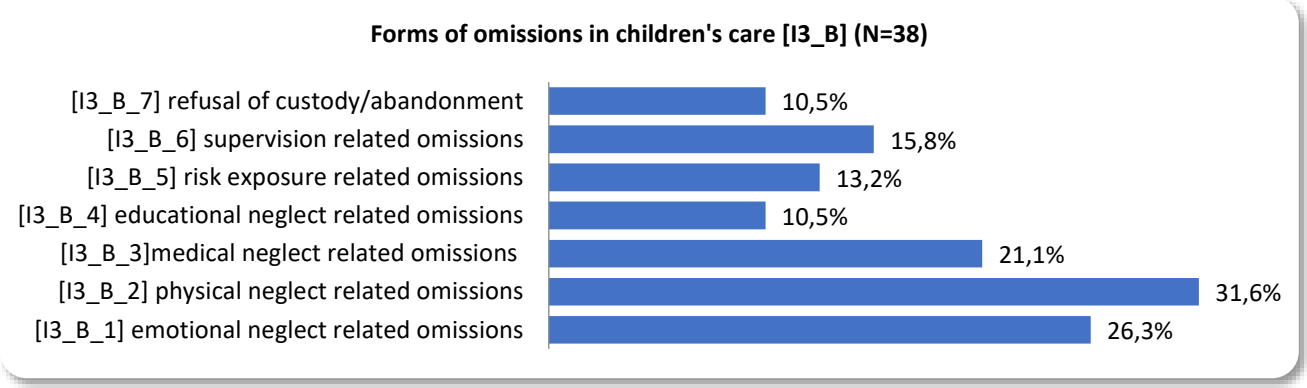
DE_I3: Forms of Maltreatment



In 45% of the cases it was recorded that children suffered abuse, in 21% of the cases children suffered neglect and in 34% suffered both, abuse and neglect.
In the 2 graphs that follow specific information on the main form of abuse (forms of violent acts committed) and neglect (forms of omissions in children's care) is presented respectively.
In half of the cased psychological violence was recorded; in more than 4/10 cases physical abuse was recorded while in 2/10 cases sexual abuse is recorded. Lastly in almost 1/10 cases violent acts against self were recorded.



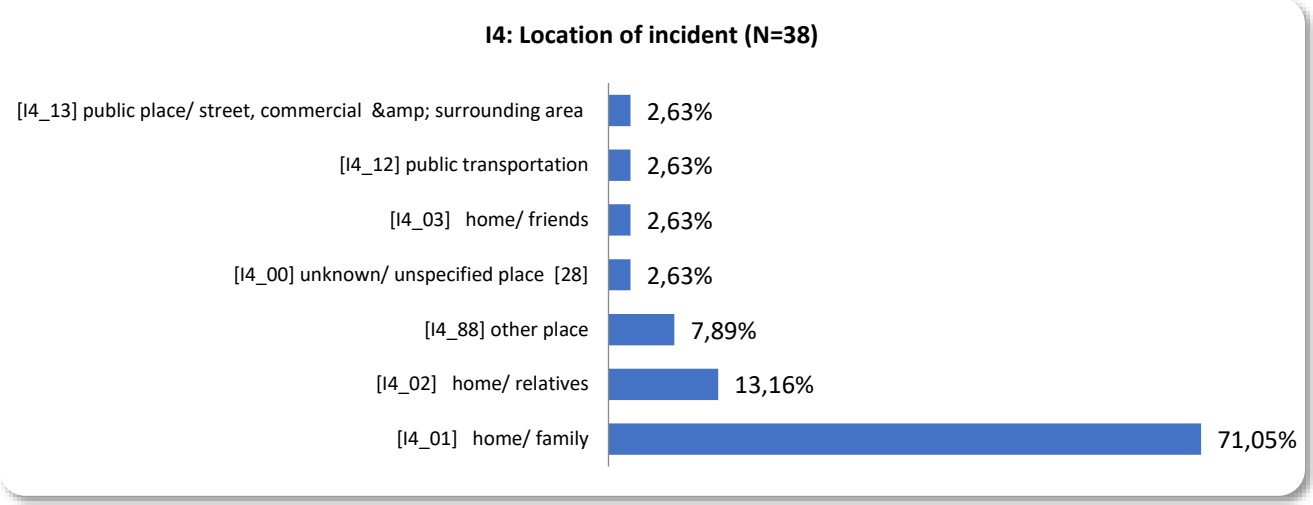
As for the cases of neglect, the most frequent type is physical neglect related omissions, followed by medical and emotional neglect. Other cases (1/10) were refusal of custody, educational neglect, risk exposure and supervision related omissions.



More details on specific types per form of maltreatment are presented in the national report (D4.4 Greece).

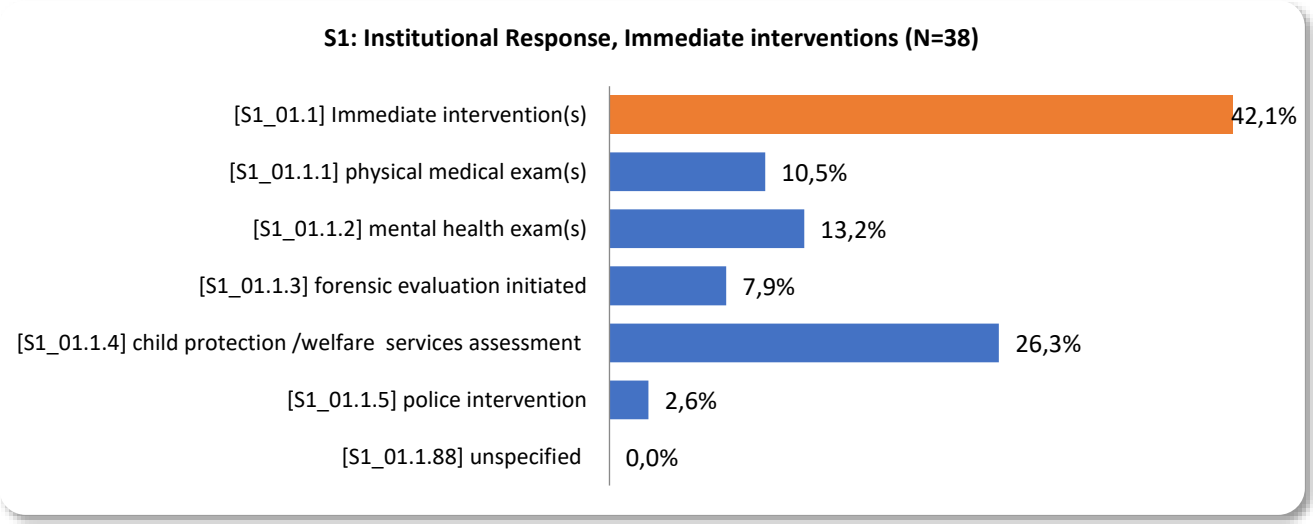
DE_I4: Place of Incident

Lastly, the location where the specific incidents took place was recorded in the system by the professionals-operators; home of children is the most common place where abuse and neglect take place followed by home of relatives (for children who lived outside home. In some cases other locations were indicated as the place where the incidents took place.

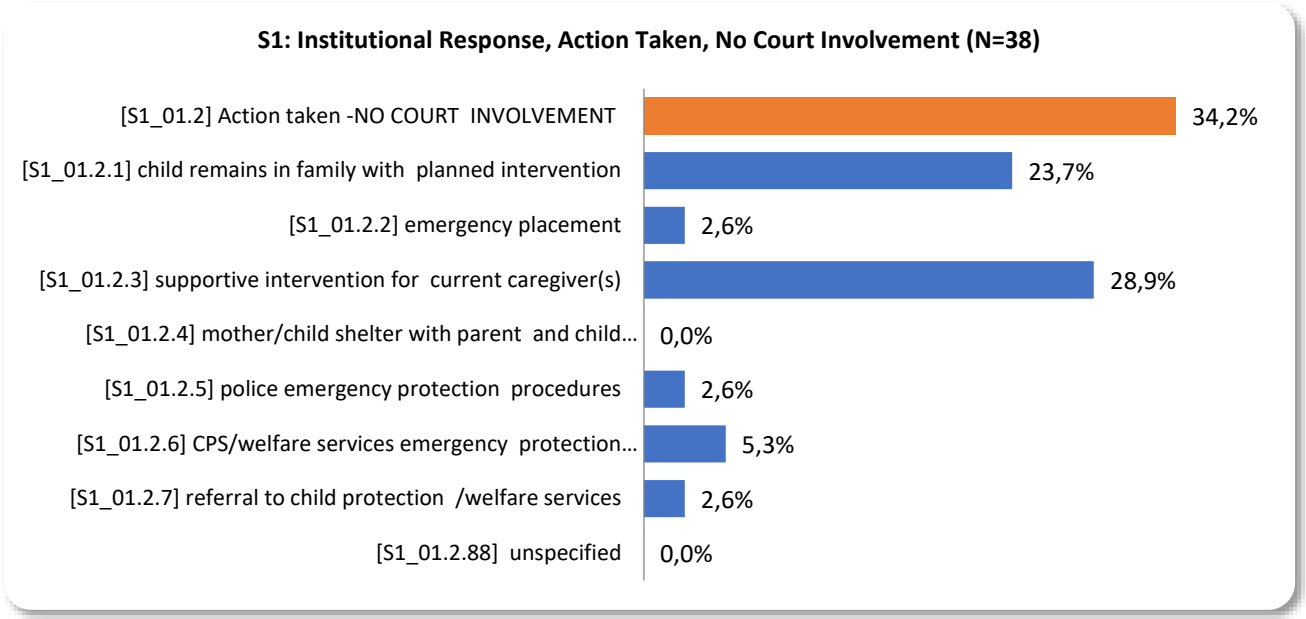


DE_S1: SERVICES PROVIDED

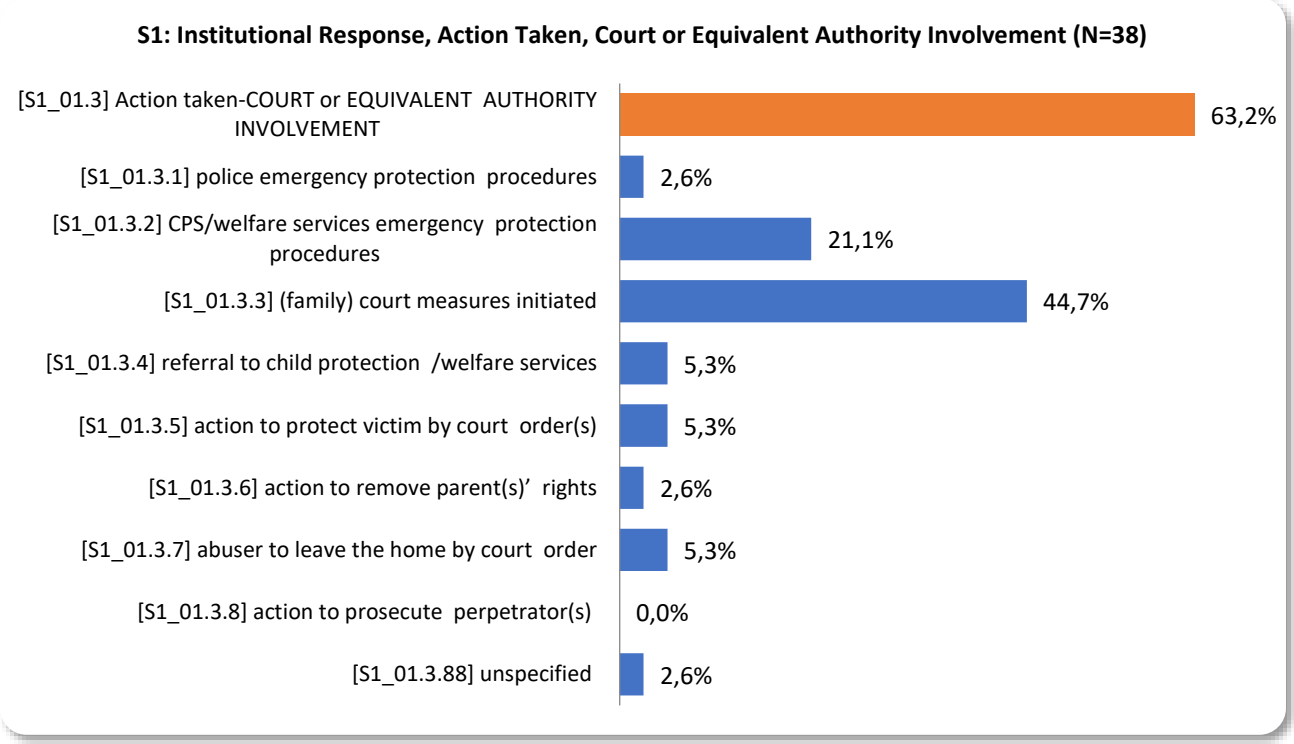
In 37 out of the 38 cases specific services were provided to the child and/or his/her family from the Agency where the professional-operator is working.
In more than 40% of the cases immediate intervention took place, as is presented below. In most of the cases immediate intervention was the assessment of the child by welfare or child protection services (often after a prosecutor's order). In other cases physical and mental health exams were conducted while in one case police intervention was also initiated by the Agency.



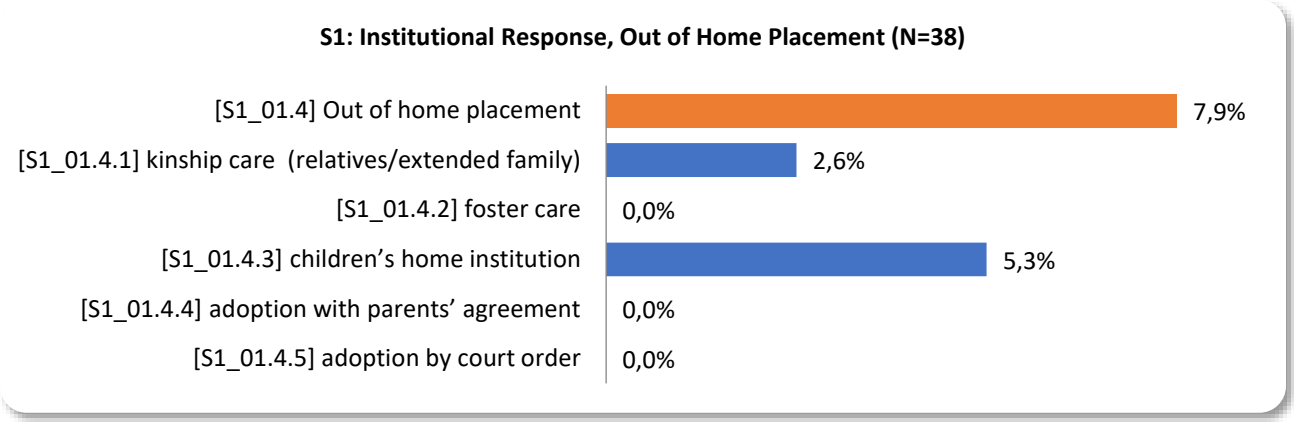
Moreover, in 34% out of the 38 cases further action was taken without, however, court or equivalent authority involvement. Action was mainly related to cases where child remained to his/her family and further intervention was planned (~24%) while the most frequent action was supportive measures for the current caregivers. In 2 cases child protection emergency protection services were involved and in 1 case an emergency placement was conducted and a referral to child protection services.



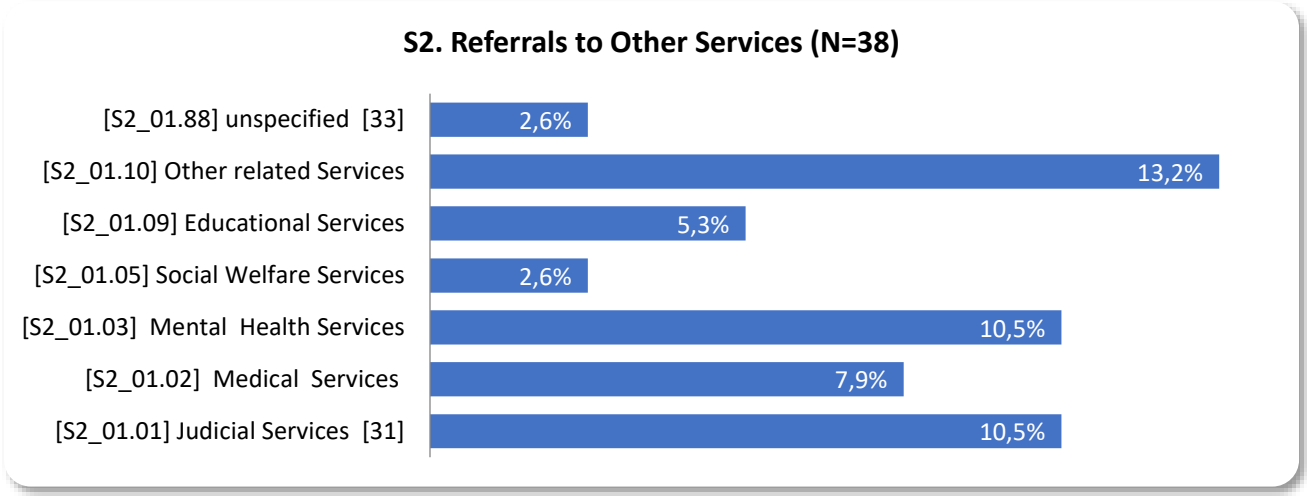
In most of the cases, however (~63%) the action taken involved justice or other authorities. Specifically, in ~45% of the cases court protection measures initiated and in 21% of the cases welfare emergency protection procedures were initiated. In 2 cases protective measures were released by the court and in another 2 cases abuser left the home by court order; in 1 case action taken to remove parental rights.



In 3 cases the child war removed from home and placed either in a children's home institution (2 cases) or the child placed in kinship care (1 case).



Apart from the action taken on the part of the Agency where the professionals-operators working in, referrals to other services took place for the further administration of 18 out of the 38 cases, as presented below.



Among the 18 cases, 5 specific referrals made via the system from one service (initially worked with the incident) to another service (in 3 cases of Mental Health Services for child and family and in 2 cases in tertiary health care, hospital, for child and family too). Up to the date of the report the services received the referrals had no reacted yet by sending a feedback to referees.

CONCLUSION

Although the duration of the piloting of the CAN-MDS System in real settings in Greece was shorter than the planned one and despite the fact that the number of participating professionals-operators was lower than the provisioned one in the customized national plan, the data collected through the system seem to provide an adequate picture of the cases. The pseudonymization process worked timely and without difficulties, cases were recorded without missing values concerning the record, the child, the incident, the family and the services provided and referrals took place among participating organizations. These preliminary results suggest that longer operation of the system with the participation of more agencies and more trained professionals nationwide will provide the data that are necessary for the epidemiological surveillance of the child abuse and neglect incidents in Greece and their specific characteristics; at the same time, continuous operation of the

system is expected to further contribute in the multidisciplinary and inter-sectoral collaboration in the administration at a case level and at the same time will support capacity building of all relevant professionals and especially improvement of their knowledge on issues related to child maltreatment.

Discussion

The necessity for data collection on child abuse and neglect is a commonly accepted priority worldwide, in the EU countries and in Greece in particular. Therefore, the necessity for child maltreatment surveillance mechanisms that provide continuous and systematic data to monitor the magnitude and impact of CAN is undeniable. However, as resulted from the BECAN Project (2013) in it is a fact that child abuse and neglect case-based data in Greece are derived from a variety of inter-sectoral sources involved in the administration of each case, and follow up of victims at local and national levels is not sufficiently coordinated among the involved services. Moreover, available data are collected by various agencies and professionals on the basis of different definitions, methods and tools usually in distinct databases and even though all this information unified in single databases, data are not comparable and it is not feasible to draw valid and reliable results from their analyses and therefore not so useful for planning preventive polices and measures. In the General Comment 13 (2011) of the UN CRC it is noted that "[…] The impact of measures taken is limited by lack of knowledge, data and understanding of violence against children and its root causes, by reactive efforts focusing on symptoms and consequences rather than causes, and by strategies which are fragmented rather than integrated."

Main barriers for effective administration of CAN include: difficulties in recognition of CAN by professionals working with and for children; underreporting -even from mandated professionals; lack of common operational definitions; weak follow-up at a case level; lack of common registering practices and the use of a variety of methods and tools for collection and sharing information among stakeholders. Due to insufficient registration of CAN reports follow up of cases at local and national levels is not sufficiently coordinated among the involved sectors. At an international level, where currently monitoring systems exist, they vary considerably, so that comparisons are not feasible; reliable data, however, are crucial to end the invisibility of violence, challenge its social acceptance, understand its causes and enhance protection for children at risk; data are vital to support government policy, planning and budgeting for universal and effective child protection services, and to inform the development of evidence-based legislation, policies and implementation processes.

CAN-MDS System was developed to deal with all of the above issues. Piloting of the CAN-MDS System in Greece suggest that the system it could work, especially if all relevant sectors will be actively involved nationwide and sufficient number of professionals with multiple cognitive backgrounds will be trained to become operators of the system.

Sustainability of the system; National Inter-Sectoral Board decided to continue the supporting of the system after the end of the project and to strengthen professionals' commitment to systems' use and operation. Concerning the support of relevant stakeholders, current synthesis of the National CAN-MDS Inter-Sectoral Board suggests that the effort will be enforced during the piloting phase (until Dec

2021) but also –and this is the most important commitment- afterwards. A discussion was started for the institutionalization of the system involving all relevant ministries.

CAN-MDS Training results suggest that Operators' seminars are effective while the asynchronous online training is a convenient method for the participants, especially in the new pandemic-related conditions where in person training is often not feasible or taking into account that many professionals work from home.

CAN data (both, mock and real cases) collected for a short period of time via a fully controlled surveillance mechanism could be used for the assessment of system's operability and as a baseline for evaluation of existing or new CAN prevention practices and policies. Simulation (working with mock cases) after the training indicate that training is adequate in order for the professionals to record sufficiently a CAN-incident into the system, regardless of their professional specialty and the agency where they are working. Data collection on living cases suggest that they system is able to provide the results that it was developed to collect and at the same time facilitate CAN incidents administration at a case level.

Romania

[from D4.4 Romanian Report on CAN-MDS Piloting]

Context

As explained in the national report on training, we recruited and trained operators in three counties and Bucharest. UBB was responsible all along the project for Satu Mare and Covasna counties, FONPC for Bucharest, the capital, and DASM worked in the city of Cluj. All three Romanian MDS teams developed trainings for the operators of these regional four sites.

To demonstrate the need of the project, the trainings and workshops named some of the discrepancies in reporting, as presented in the table bellow, where for the year 2019 Satu Mare county, has 5 times more sexual abuse cases than the larger Cluj county, or the Bihor county. Maramures county has 27 times more emotional abuse cases than Salaj county. Bistrita Nasaud county has 27 times more neglect than Salaj county, which shows the different definitions and procedures used case work.

Region/ county 2019 , before MDS	Disparities in CAN CASES REGISTRATION BY THE NATIONAL AUTHORITY OF CHILD PROTECTION						
	Emotional abuse	Physical abuse	Sexual abuse	Exploatation for criminal activity	Child labor	Sexual Exploit.	Neglect
National TOTAL	978	686	426	37	156	25	5381
Nord-Vest	150	74	45	0	2	1	479
Bihor	5	12	4	0	1	0	19
Bistrita Nasaud	7	16	10	0	0	0	188
Cluj	42	15	4	0	0	0	16
Maramures	81	17	7	0	1	0	135
Salaj	3	2	0	0	0	0	4
Satu-Mare	12	12	20	0	0	1	117

The context of the COVID, which increased the difficulties to respond to the needs of children and their families, worsened the reporting of CAN, separated the helping professionals and deepened the discretionary aspects of coordinated action. For the entire year 2019 there had been 15996 situations of child abuse and neglect reported[2], while for 2020 there had been 14170 cases[3] as reported by the National Authority for the end of the years 2019 and 2020.

[2] http://andpdca.gov.ro/w/date-statistice-copii-si-adoptii/
[3] http://www.copii.ro/statistici-2019/

This was the case both at mayoralty level, in the services destined to do the initial evaluation of children at risk of CAN, and also at the level of the specialized services, with the role of detailed CAN assessment and the implementation of services fir children exposed to CAN. Referring children towards publican CAN services was has been mainly performed by completing paper forms. Though the Law 272/2004 mentions definitions of the different forms of maltreatment against children, data collection by the National Authority does not cover the newer forms of violence, like cyberbullying (in spite the fact that in 2020 domestic violence law 2017 has been completed with the definition of cyber-violence). On the other hand, the definitions were not completed with clear and commonly accepted criteria for CAN risk assessment. This resulted in different definitions of maltreatment depending on local and institutional policies, thus large differences in reporting data on CAN in different counties.

The need of collaboration between agencies for a coordinated response in case of violence is also recognised in the Romanian law 49/2011, while on the field there is very little collaboration at local level between child protection-health and education, or between public and non-profit agencies. These statements have been discussed in details in the trainings and in the workshops held before and during the period of operating the platform. Thus, on the field, the collaboration and the coordinated interventions are rare, which needed to be addressed in the local networks.

Preparation for Piloting the Platform

The Romanian consortium prepared the application of the digital platform by targeting the following objectives, as indicated in the project:

- recruiting partners for local consortiums, to work together for improving the response to the needs of children victims of CAN: create local, regional and a national a framework to the collaboration processes between agencies and between specialists in CAN
- offering continuous support to the local consortiums all along the preparation, but also along the period of the actual functioning of the platform
- continuously analysing the advantages of digitalization of child abuse referrals and data collection on the platform
- To improve the rate of referrals on CAN.

Working for the introduction of the CAN MDS platform, the consortium partners created a new context and structure for networking which gave opportunity for the participating agencies to work on the common understanding of CAN between sectors (through discussions around clarification of modalities of introducing a specific case in the system).

In Sfantu Gheorghe (Covasna county) and in Satu Mare (Satu Mare county) were organized to on site meetings, one before the training and one after the training in each of the two locations, where participating representatives of the child protection, educational, medical, judicial sectors and police could clarify their sectoral, institutional, and professional roles related to reporting child abuse and neglect cases. This contributed to the enhancement of coordinated intersectoral interventions in CAN

cases. Later, from December 2020, the monthly online meetings of the local networks of operators gave the opportunity to present difficult cases and plan case conference.

To prepare the application of the platform to the local authorities in Bucharest, FONPC sent letters to the 6 offices of the mayor's Office of the 6 sectors of Bucharest and the General City Hall in order to involve local councilors in promoting the CAN-MDS system.

To obtain the support of the central authorities in Romania – the consortium worked also closely with the Ministry of Justice. FONPC is a member of the working group on the protection of victims of crime organized by Ministry of Justice. At the meeting on 24 March 2021 of the permanent working group we presented the CAN MDS system. *http://www.just.ro/protectia-victimelor-infractiunilor-o-prioritate-a-ministerului-justitiei/*

Promoting the CAN-MDS system towards the central authorities in Romania – on 31 March we had a meeting with the new President of National Authorities for Persons with disabilities, Children Rights and Adoption. FONPC also organized a meeting with the new President of National Authorities for Persons with disabilities, Children Rights and Adoption in order to present the program and to ask for the support related the promotion of the CAN – MDS system among the local public authorities - General Directorates of social assistance and child protection. ANPDPCA offered support letter, recommending the agencies and institutions to join the consortium and cooperate for piloting the platform. The objective was to involve institutions and operators to use the CAN MDS system for each of the cases of suspicion or abuse / neglect. (10) Autoritatea Națională - Persoane cu Dizabilități, Copii și Adopții - Postări | Facebook

The trainings took place starting July 2020 and continuing with August, September, and October 2020. The actual start of the data collection was 4th December 2021 on the platform, with the regional network in Satu Mare. Toward the end of December, other regions also started the data collection. Between the training and the start of working on the platform the collaboration agreements were signed with different agencies and the national administration of the platform. 149 professionals opened accounts on the platform, they became the operators. Bucuresti: 54, Cluj: 27, Covasna: 32, Satu Mare: 31, plus 1 from Iasi, 3 from Galati, and another one from Bacau.

48 Agencies with whom the Consortium established cooperation contracts, as follows: The national Authory for Child Protectio (ANDPDCA) , The Child Ombudsman Office, 8 Directorates of Child Protection (5 DGASPC in Bucharest, 1. Covasna, 1 Cluj, and 1 Satu Mare), I University (Bucharest University), 3 School inspectorates (Bucharest, Cluj, Covasna), 1 School, 4 Counselling Centers for school children (Bucharest, Covasna, Cluj, Satu Mare), 6 Mayoralty Social Services, 8 Medical Institutions (including 4 Emergency Hospitals, 2 Police inspectorate Agencies (one in Bucharest and one in Satu Mare), 8 NGOs (Charities), 1 Daycare Center, 1The Questors Office in Satu Mare (Procuratura)

In July and August UBB organized online trainings for Satu Mare and then for Covasna counties. Training was supplemented later, in January. In September, October, DASM organized trainings for Cluj County (continued in January and March). Also in September 2020, FONPC organized online

operators training for Bucharest. In October and in November, the national administrator kept in touch with the operators and supported them, so that in December, we started the piloting phase. Later in the spring, on 24 – 25 June 2021, FONPC organized a training for Judicial and law enforcement personnel (30 participants – 9 prosecutor and 17 policemen. At the training there were representatives of the National Institute for magistrate, the Police of the capital).

Operators were recruited from the following areas: social field – child protection (local and departmental authorities), schools (teachers and psychological counsellors), hospitals (medicines and social workers), ombudsman office (central and departmental office), NGOs. Not all training participant became operators. Mostly those from social fields – child protection DGASPC and DASM became active operators.

On 3.02.2021 (14:00-16:00) and 5.02.2021 (10:00-12:00) the National administrator of the Consortium organized, with the participation of FONPC, DASM and UBB working sessions with the operators in order to support them to use the CAN-MDS platform. The purpose of the working sessions was to answer all the questions regarding the introduction of data process, since the piloting started on 4th of December 2020.

The National administrator and the Consortium have also organized 2 workshops with operator: on 08.04.2020 (10:00-14:00) with the operators from Bucharest, and on 14.04.2020 (10:00-14:00) with the operators from Cluj, Covasna and Satu Mare. The workshops had the main goal to analyse how the inter-sectoral communications between operators was functioning, and how the sectors cooperate.

The College of Social workers granted professional certificates to those social workers who participated in training and workshops.

The National administrator and the consortium organized a last meeting with the Council of the MDSCAN platform on the 24th, June 2021. There were 16 participants. On the agenda we had the presentation of the National Report generated by the platform and the discussion of the quantitative and qualitative results. The data presented are the same as those in this report. All representatives of the consortium and of the four sites piloting the platform were represented in the meeting. Representatives of the National Agency of the Rights of Persons with Disabilities, Children and Adoptions, The Children's Advocate (People's Advocate Institution), The National College of Social Workers in Romania, Ministry of Justice, Bucharest University, The International Foundation for the Child and the Family (FICF) participated to the meeting of the Council. Participants much appreciated the results.

During the period of piloting the system (4th Dec 2020-30 June 2021), 287 cases of abuse and neglect were registered in total, coming from Satu Mare (134), Bucharest (62), Covasna (28) and Cluj (63).

Cases introduced: 287 (100%)	Satu Mare	Covasna	București	Cluj
DGASPC	131 (45,64%)	18 (6.27%)	61 (21.20%)	24 (8.36%)
Mayoralty Welfare Services	3 (1%)	5 (1.8%)	-	39 (13.6%)
Medical sector	-	5 (1.8%)	-	
ONG			1 (0.33%)	
	134	28	62	63

For Covasna county the number of referred children represent a significant increase, as in the similar period in 2020 only 5 children have been registered. For Satu Mare the number is almost similar, 134 in 2021, compared to 146 in 2020. For Cluj there is an increase in the data referred by the municipality social services to the Cluj County Directorate of Child Protection.

There is an increase in the number of referrals also to the social services of the mayoralty of CLUJ (DASM). If in 2020 there were 51 referrals, in the six months of running the MDS project in 2021, there were 39 cases.

For Bucharest the number of referred children was 62, the operators for the child protection system (social services) was more involved that than other professional categories (57 of the cases were reported by social workers). In Bucharest are active 6 local services named General Directorate of Social Assistance and Child Protection. Only the DGASPC sector 4 was not active at all, DGASPC sector registered 2 cases, DGASPC 2 – 11 cases, DGASPC 3- 14 cases, DGASPC 5 – 20 cases and DGASPC S 6 – 14 cases.

Only 2 cases were registered in data bases in 2020, 60 have been registered in 2021, because the piloting phase started in December 2020.

According to the child's gender, 122 male and 165 female cases have been introduces.

As in fig. 1, 270 (94.07%) of the children had a birth certificate (blue); 5 lacked this document (green); for 10 children the existence of the documents was uncertain (dark blue), and two children had not yet the birth certificate (yellow).

Counting the number of continuous incidents, versus distinct events, 140 new incidents have been introduced in the database during the 6 months of piloting (nearly half the total data), other 75 new incidents for continuous maltreatment cases (more than a quarter of the total number of cases); for

30 cases(10.45%) there were no distinct events signalled, but continuous maltreatment, and for 42 (14.63%) cases the issue of continuous versus single incident remained unknown.

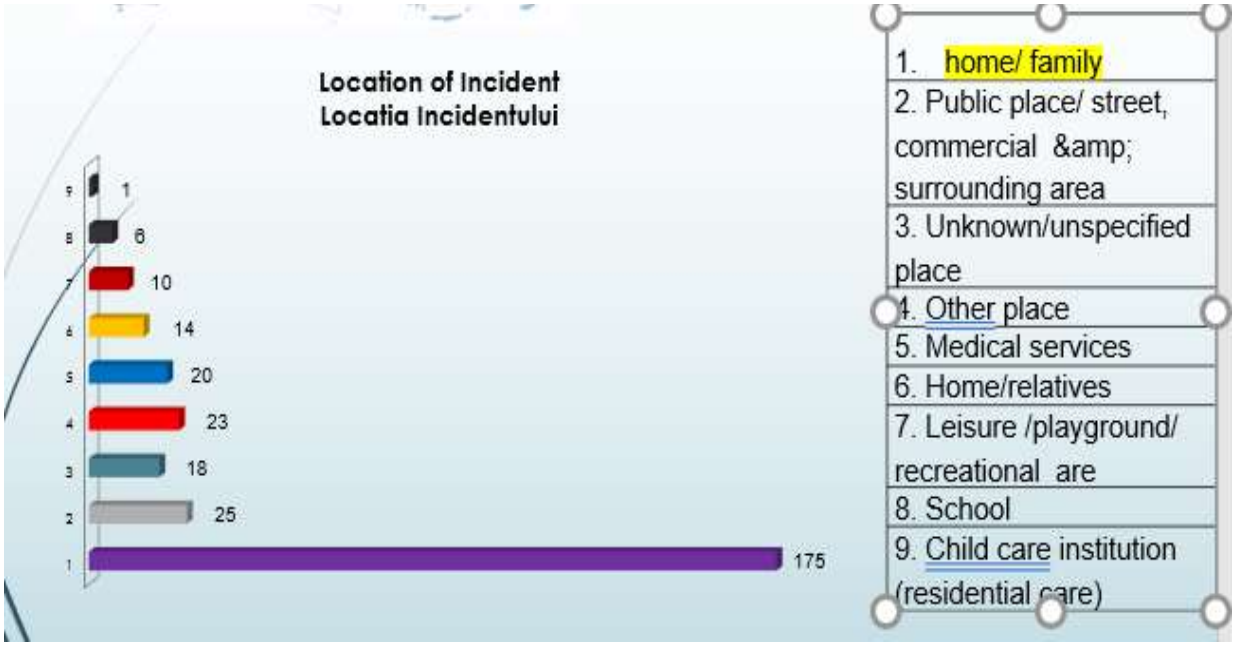
There were operators who reported cases were:

1. Personnel working in Social Services/ Public/Central/Local (77 cases, 26.82%)
2. Parents/foster parents/partners/care provider (55 cases, 19.16%)
3. Personnel working in Police/law enforcement (42 cases, 14.63%)
4. Personnel working in Health services (49 cases, 17.07%)
5. School /preschool /kindergarten personnel (20 cases, 6.97%)
6. Relative (siblings, grandparents, etc.) not living with the child (19 cases, 6,62%)
7. Others (25 cases, 8.71%)

The forms of maltreatment introduced on the platform were as follows:

1. Violent acts against self/self harm,16 cases (5.57%)
2. Physical violence committed against the child, 52 cases (18.11%)
3. Sexual violence against the child, 41 cases (14.29%)
4. Psychological violence, 40 cases (13.94%)
5. Neglect, omission 158 cases (55.05%)
6. (some cases were introduced as multiple forms of violence)

Most of the incidents took place in the homes of the children (175 cases, 60.98%), and other 14 in the homes of relatives (4.9%), 25 took place in public places like the streets and shops (8.71%), 20 in medical services (6.97%), 10 (3.48%) in leisure places (parcs, playgrounds, recreational areas), 6 (2.09%) took place in schools and 1 in a childcare residential home (0.33%). For 41 cases (14.28%) there was no such information. In 5 cases violence has been observed in more than one place.



The majority of cases introduced on the platform the children lived with their own families (247 cases, 86%), while 6 children live in a recomposed family (2%), 6 children live with their relatives (2%), 6 children (2%)live with friends' families, 3 children (1%) live with a foster family, 14 (5%), children live in residential care and for the others the care situation is uncertain (6 children, 2%).

As for the institutional response, in 87% of the referred situations there has been a specific institutional response, for 9% the response was not specified, and for 4% there has been no response till the end of the piloting period. In 13% of cases court action has been taken or an equivalent authority has taken a decision. Social welfare services intervened in 122 cases (42.50%), educational services intervened in 6 cases (2%) and also NGOs were involved in 6 cases (2%).

The discussions in the workshops with the operators revolved around the necessity to continue developing this platform in order to allow feed back to those who referred the cases, and for a better follow up of the longitudinal evolution of cases, and their trajectory along different services. The common definitions and the existence of a set of standardised investigation evidence based would also improve the assessment of CAN, and the consecutive response.

For the moment, after the first six months of piloting we cannot demonstrate an overall increase in referrals, as the counties started on different dates and with different staffing, and backgrounds. We can only compare the percentage of different forms of violence (only those mentioned in both datasets), where we can see an increase in referring physical and sexual abuse.

Distribution of the share of different forms of violence reported the first semester of 2020 and 2021

Forms of violence* reported	Emotional abuse	Physical abuse	Sexual abuse	Neglect
% forms of violence 2020 June	13.60%	9.60%	7.3%	66.93%
% forms of violence MDS2 platform 2021 June	13.94%	18.11%	14.29%	55.05%

*Some cases were introduced as multiple forms of violence. In this table we did not give place to self-harm, and to labour exploitation, as they did not appear in both data sets.

Data on the platform compared to data at county/Bucharest sector (Satu Mare, Covasna, and Sector 3 in Bucharest). One can see that in the county which previously had a large number of reported cases have continued in 2021 to have a similar number of reported cases, in spite the fact that at national level the services faced difficulties and CAN referrals have been reduced compared to 2019, see table below. The county with the fewest reporting nationally (Covasna) now has increased its number of referrals from 5 to 28, which is 5,6 times. The 3rd sector in Bucharest, with only 8 cases reported in the first semester 2019, now has 14 cases, 1.7 more compared to the same period in 2019.

Counties/Forms of CAN in 2020/ 2021	emotional abuse	physical abuse	sexual abuse	neglect	Total
Satu Mare 2020	10	9	32	92	143
Satu Mare 2021	6	17	25	88	136
Covasna 2020	0	0	2	3	5
Covasna 2021	6	3	1	18	28
Bucharest sect 3, 2020	1	5	1	1	8
Bucharest sect 3, 2021	6	5	2	1	14

Conclusion

In conclusion, the platform is useful because

- the list of descriptors and the clear definitions discussed in the training enables the operators working with the platform to improve the identification of the cases, as well as to respond to the needs of children and their families. Not only the definitions per se, but the clarifications while discussing them in the workshops contributed to more cases being reported.
- the platform being a well organized instrument, it helped the operators organize the modalities to identify and describe the situations of CAN.
- making data visible on a platform encourages collaboration between agencies and professionals, bringing forward the efforts of the child protection system and other related sectors in responding to accountability issues and justifying budgets.
- The feedback in the workshops demonstrated an increase in the motivation of the majority of participants to respond to the needs of maltreated children.
- Using the platform and communicated online during the workshops contributed to the development in the agency's digital competencies, initially sceptical in using the platform. They learned that cooperation is possible on a common platform, without threats to security, and in an ethical way, is another strength of the program.
- Data show an increase in the county which previously had one of the lowest reporting CAN rates.
- The platform fist very well in the actual social context in Romania, as there is a tendency, but also a pressure to digitalize the administrative work in social services, including child protection.

Spain

[from D4.4 Spanish (Catalan) Report on CAN-MDS Piloting]

Pre-pilot Evaluation

Pilotage territory: As planned the pilot test was conducted at a provincial level in the region of Catalonia (Spain) covering a minors' population of 543,796. Specifically, the pilotage territory has been the province of Barcelona including three regions of which the city of Barcelona stands out, were most of the agencies have a higher scope (Municipal Institute of Social Services of the Barcelona City Council, EDUVIC and ABD), or have the regional headquarters as it is the case of the Directorate General for Child and Adolescent Care (DGAIA).

Format of pilot test: The pilot test had an initial duration of 6 months but, as described in the project monitoring reports and in the communications with the Greek lead entity and the rest of the consortium member countries and as communicated to the European Commission, the period of the pilot test has been finally reduced to 2 weeks, from June 15 to June 30, 2021.

By way of summary, the reasons that motivated and explain the short duration of the pilot test -which were already reported and included in the referred reports- are the following:

Impact of COVID-19 pandemic:

- In the linkage of the different sectors and agencies: the crisis generated by the pandemic since the beginning of March 2020, has had a considerable impact on the linkage of the agencies to the project since, in many cases, they had to prioritize the attention to the emergency situation generated (significantly affecting children and adolescents) and left in the background their involvement in the project, which was in the process of concretion when the crisis began. Thus, sectors such as education, health and justice, among others, decided to abandon their participation in the project in order to respond to the crisis situation that had arisen. Specifically, more than 60 bilateral meetings were held to try to involve the different sectors and relevant agencies, as well as numerous e-mail communications and telephone calls with the representatives of each department.
- In the training seminars: the health circumstances derived from the pandemic forced to cancel the continuity of the face-to-face training initiated at the beginning of March 2020, in view of which it was necessary to 3 consider alternatives due to the impossibility of carrying out face-to-face training and guaranteeing compliance with the indications of the health authorities. In this sense, a debate was held with the members of the Consortium and the proposal to carry out training in online format was defined, as well as the request for a temporary extension of the project to the

European Commission to be able to comply with the planned actions that had been affected by the impact of the pandemic. Once the possibility of online training was approved, all the materials were adapted to this format and the new proposal was communicated to the members of the Intersectorial Board and to the professional operators eligible to receive the training.

Two electoral processes in Catalonia:

During the period of execution of the project, 2 electoral processes took place in Catalonia, which affected the project in terms of mobilities and the change of political leaders and referents of the institutions and departments invited to participate in the project. Thus, these changes implied in some cases the disappearance of the links established with some referents or made the establishment of communications very difficult due to the temporary lack of definition of referents that characterizes the transition periods between terms of office of the legislatures.

In this sense, and in view of the project being affected by the danger of the lack of involvement of key sectors, numerous communications were made with political leaders to call on them to intercede and facilitate the participation of these sectors, but the efforts made did not achieve the desired result and it was not possible to involve all the sectors and agencies that were called upon to participate and that sought to bring together all the sectors that could carry out actions for prevention, detection, care and recovery, as well as the design of concrete plans and policies in relation to child maltreatment.

Complexity of public administration processes:

In Catalonia, it is the Directorate General for Child and Adolescent Care (DGAIA) of the Department of Social Rights that has the responsibility and competences to host systems of data collection, reporting, coordination and response for child protection. In this regard, communications with that agency began in early 2019 and, after numerous bilateral meetings, communications and documentation submissions with its legal services, cybersecurity department and technical team, it 4 was finally in January 2021 when the authorization for the installation of the application on its server was received, starting then a period of intense and coordinated work with the IBM ICT team of the Generalitat de Catalunya, the Greek ICT team and the Aroa Foundation. However, during the installation of the application on the server of the national agency in Catalonia (DGAIA), several technical incidents occurred in the final stages of checking the correct functioning of the application, which were dealt with in coordination between the ICT team (IMB) of the DGAIA, the ICT team of the leading Greek entity, and the supervision and support of the Aroa Foundation team. These incidents led to a further delay in the start of the pilot test, which were finally resolved, and the solutions could be validated on 14th June and the pilot test officially started on 15th June.

It is relevant to note that long before this process, on month 7 from the project' kick off, the management of the ToR with the agency signature procedure was ongoing, which was also a requirement to start the pilot test but, therefore once the technical part was advanced, the signature of the agreement was still pending at this point (M30) even multiple communications were exchanged with agency' legal services during all this period. Even this challenge it was possible to obtain the authorization and start the pilot test, thanks to several meetings and joint work with the representative of the DGAIA at the Intersectorial Board.

CAN-MDS National Agency in Catalonia

In Catalonia, the National Agency Administrator of the CAN-MDS system has been the Directorate General for Child and Adolescent Care (DGAIA), since it is the agency that has the legal mandate and resources to host the installation of highly sensitive data recording systems, such as those related to children and adolescents, and as stated in Law 14/2010, of May 27, on the rights and opportunities for children and adolescents in Catalonia. Thus, some of the general functions of this agency, which are the basis of its role as national administrator, are:

- the planning of policies for children and adolescents, the programming of services and resources for protection and the elaboration of guidelines in the field of abandonment.
- the promotion and elaboration of collaboration plans and protocols that guarantee the organization of actions for the detection, prevention, assistance, recovery and reintegration of children and adolescents who have been victims of maltreatment and that ensure comprehensive action in accordance with Law 14/2010.
- the promotion and provision of specialized public services to deal with child and adolescent abuse, in accordance with Law 14/2010.

In this way, the DGAIA has assumed the National Administration of the CAN-MDS system in Catalonia and, therefore, also the administration of the installation of the system on its server and the pilot test.
In its role as national administrator, the DGAIA has assigned to the professionals their individual access data to the application (user and password) as established by the CAN-MDS system and as indicated in the National Administrator's package, as well as ensuring compliance with the ethical indications of the treatment of children's data through their anonymization as established by the RGPD and also included in the Catalan legislation.
The role assumed by the Aroa Foundation, as the National Coordinating Agency of the CAN-MDS project in Catalonia, has been the continuous and proactive information, advice and support to those responsible designated by this agency, as well as the position of expectation in relation to the project, and the constant offer of help. Also, the Aroa Foundation has carried out the evaluation of the data resulting from the pilot test, extracted once the test was completed and provided by the agency administering the system.

Sectors and agencies involved

The sectors and agencies that were invited to participate in the project and with which more than 60 bilateral meetings and separate communications were held, in addition to an informative meeting with the entities (NGOs) and numerous telephone and e-mail Child Promotion Barcelona .

- ✓ Director of the General Directorate of Children and Adolescence Support (Government of Catalonia)
- ✓ (Head of Victim Support Office), Justice Department (Government of Catalonia)
- ✓ Education Department (Government of Catalonia)
- ✓ Mossos d'Esquadra (Government of Catalonia)
- ✓ Official of the Barcelona Urban Police and president of European Network of Policewomen
- ✓ Catalan Institute of Health Department (Government of Catalonia)
- ✓ Social Services Department (Government of Catalonia)
- ✓ Social Services Barcelona CityHall
- ✓ Institute of Forensic Medicine (Government of Catalonia)
- ✓ Ombudsman of Children
- ✓ Child Promotion Barcelona
- ✓ Barcelona Diocesan Charity
- ✓ Vicky Bernadet Foundation
- ✓ Association for Family and Community Health Ventijol
- ✓ Health and community Foundation
- ✓ Intress - Institute of Social Work and Social Services
- ✓ ABD - Welfare and Development Association
- ✓ EDUVIC social initiative cooperative

Finally, the agencies participating in the project, as well as in the pilot test, were the following:

- General Directorate of Children and Adolescence Support
- Social Services Barcelona CityHall
- EDUVIC social initiative cooperative
- ABD Foundation
- Aroa Foundation

Profiles professionals who received pre-pilot training: The profiles of the professionals who participated in the training have a high level of specialization in relation to addressing child maltreatment. In some cases, they are profiles linked to public child protection agencies, such as Social Services or the General Directorate for Child and Adolescent Care. In other cases, they are profiles belonging to entities also specialized in some of the areas related to child abuse, such as those that manage publicly owned centers for minors, entities that work with children in situations of diverse vulnerability, or those that carry out preventive actions and psychotherapeutic care for the comprehensive recovery of children and adolescents who live or have lived through situations of violence in different environments, such as the family, school (bullying), etc

Below the profiles of the 59 trained professionals is presented: 17 Social Workers, 14 Psychologists, 9 Family therapists, 6 Pedagogues, 4 Child Protection Services Coordinators, 3 directors, 2 Social Services Coordinators, 2 Teachers, 1 Helpline coordinator and 1 Deputy Director

Package of materials delivered: During the training phase prior to the pilot test, professionals were provided with the CAN-MDS package materials to train them on the system and support their participation in the pilot test: Guide for operators; Data collection protocol; Access to the "demo" version of the case registration application and Examples of mock cases to practice

Pre-pilot training: As described in the training seminars report, a total of 59 professionals received the CAN-MDS resource package training, from March to November 2020, in classroom and online format. After the face-to-face and online seminars (from November 2020 to May 2021), 4 group spaces (to a total of 36 participants) and 15 individual tutorials were offered to the participating professionals to reinforce the learning acquired and to deepen the practice with the case registration application.

The training offered to the professionals was aimed at transmitting knowledge and strengthening the competencies of the participants in relation to the contents of the CAN-MDS training package, as well as numerous practices were carried out to help the professionals become familiar with the system of variables, the values allowed, and the recording of variables in the online application.

As explained in the Training Seminars report, the profile of the participating professionals is highly specialized in this topic and the approach to child maltreatment, since most of them belong to specialized agencies in the sectors of care and protection to children at risk. Due to this, most of the participants already had a fairly solid theoretical basis in relation to the contents and were also very aware of the need and obligation to report, and they were also very aware of the importance of interdepartmental coordination and had a sufficiently broad accumulated experience to provide assessments in relation to the functioning and effectiveness of such coordination and the need to improve it, identified from their extensive professional practice and background.

It should also be noted that in most cases these are professionals who use or have used one or more case registration systems, either for notifications, data recording or coordination between departments among which this work system is integrated. For this reason, it was easy to incorporate the use of the application and make the records quite easily for them.

Thus, the specialization of the participating professionals facilitated, on the one hand, the realization of the seminars and allowed a use based on their experience and contributions and, at the same time, highlighted the relevance of the absence of other sectors that did not manage to link up, which we value as a sample of the situation of the inter-sectoral approach to cases of child abuse in Catalonia and the challenges that are still pending to be faced to achieve a more coordinated and effective work.

In addition, during the phase prior to the pilot test, the professionals were able, in addition to familiarizing themselves with the concepts and use of the application, to make contributions based on

their work experience and specialization in the field. The following section presents some of the contributions collected specifically on the application and the collection of CAN-MDS variables.

Contributions from professionals regarding the application

- It would be advisable to make it possible to record data such as the situation of cohabitation of the child with the main caregivers. In situations of suspected child abuse or maltreatment there may be circumstances of shared custody but not constant cohabitation, different visitation regimes or custody conditions, which are considered important for case management and to facilitate coordination between the different sectors and agencies involved.
- Institutional responses are often not specific to the maltreatment suffered by the child, but secondary to the institutional response to a situation of, for example, gender-based violence against the mother. It would be important to be able to reflect this and shows the pending work in relation to addressing vicarious violence, which is only recently being given the attention it deserves as a specific form of male violence against women's children.
- It would also be advisable to expand and improve the inclusion of situations of possible perinatal maltreatment (pregnant women), since the application considers them superficially.
- It would also be positive to deepen and improve the possibility of recording in a deeper and more specific way all situations of mistreatment derived from institutional negligence or from the families' own socioeconomic circumstances derived from issues such as, for example, social crises (such as the current one derived from the COVID-19 pandemic).
- Regarding the registration process, it would be advisable to be able to have a draft of each registration at times when it is not possible or not all the information is available to be entered at a given time.

Evaluation during the Pilot

Agencies and Professionals participating in the pilot: The professionals who have participated in the pilot test are those who have undergone training in the CAN-MDS system and belong to the agencies involved in the project. Of the total of 59 trained professionals, 45 have completed the pilot test. This reduction in the number of participants in the pilot is due, in some cases, to the fact that in the training participated professional profiles in positions of management or coordination of teams of the entities or services, whose direct functions do not include contact with children and adolescents that makes possible the detection and registration of cases of child abuse; instead, these profiles perform tasks more linked to the management, direction and coordination of teams, so that the participation of these professionals was justified by their willingness to learn about the project to be able to adequately 11 accompany their team during the process. Thus, with respect to the professionals who

finally did not participate in the pilot, the reasons were related to issues such as: development of managerial or team coordination roles, not susceptible to perform case identification and registration; change in the assigned professional role; geographic mobility for the performance of their functions; or coincidence with vacation periods.

Challenges and difficulties during the pilot

The assessment of the challenges and difficulties of the pilot test is determined by the factors that have been pointed out in relation to its final format, specifically with respect to its short duration, factors that are related to and have interacted with those mentioned above and those described below, exerting significant pressure on the participation of professionals and, therefore, on the development of the pilot test:

Overload of the participating entities and services (mostly specialized): the majority presence of agencies and entities specialized in care and protection for vulnerable children and adolescents defined a highly qualified professional group participating in the pilot test, but with a great overload of work. This overload informs us of weak and strong points of the child protection system in Catalonia that have already been referred to in the training report, such as the favorable aspect of the existence of a consolidated system of care for child abuse, as well as the aspect to be improved of the existence of a great saturation in the professional teams. This overload, in relation to the pilot test, has hindered the involvement of the professionals in such a short period of time, as both the professionals and the heads of the departments of the different agencies reported when confirming the final period available to carry out the records. On the other hand, the health emergency situation and the socioeconomic crisis derived from it has also had a very important impact due to the added overload on the services, both due to the increase in cases of child abuse and to the increase in situations of risk and vulnerability of families and children.

Coincidence of the pilot with the vacation period of the professionals: another factor that has exerted great pressure on the pilot has been the lack of availability of the professionals during all or a good part of the pilot period. Thus, of the 45 professionals who were originally scheduled to carry out the pilot, more than 12 were finally unable to participate because they were on vacation or on sick leave for personal reasons of various kinds.

Coincidence of the pilot with the end of the course and the reporting period at the level of the participating services and entities: this factor is part of the one related to work overload, but is presented separately due to its specificity, since it would not have had the same impact if a longer pilot could have been carried out. Thus, the timing of the preparation of reports and reports of the different participating teams has conditioned and hindered to a large extent the participation of professionals, as has also been mentioned by both the base teams and the management and coordination bodies of the teams themselves.

Coincidence of the pilot test with a national bank holiday in Catalonia: it should be noted that, of the 15 calendar days of the pilot test, only 11 were working days, of which one of them was non-working

for some professionals as they requested the day off after the bank holiday to link it with the weekend.

Change of position and/or professional dedication of some operators: because 8 months to 1.5 years elapsed between the training and the start of the pilot in some cases, the professionals have changed their position within the same agency or have joined another agency, resulting in drastic changes in their work role in terms of the possibilities of detecting cases of child maltreatment. These changes have also occurred, occasionally in the moments immediately prior to the pilot, which is why the participation of these professionals was initially foreseen.

Poor compliance with the commitment to participate in the project: exceptionally, a lack of compliance with the commitment established by some of the participating agencies has been identified in relation to their collaboration and active participation in the project, specifically with respect to the participation of trained professionals and candidates to carry out the pilot test. In this regard, it should be noted that in some of the agencies, as in the case of DGAIA, there has been no involvement of the figure of the referent and responsible for the department and the professionals have not responded on their own to the requests for collaboration made in various communications. This has resulted in professionals included in the pilot test not participating in it and not justifying their absence according to one or more of the different reasons referred to above. In other cases, such as that of the social entities involved (NGOs ABD and EDUVIC), at the beginning of the pilot test they expressed their difficulty to participate for the reasons described above (short duration of the pilot), and could not assume the realization of a minimum registration of cases, so that only one professional (EDUVIC), contributed to the test by reporting an incident. It should be noted that in none of the cases in which the agencies, and specifically those responsible for them and the professionals themselves, argued the impossibility of making records in the pilot test, did they refer to the lack of incidents to be recorded, so we can conclude that, during the pilot period and the period close to it, there were cases of suspected or confirmed child abuse that were not incorporated into the records of the CAN-MDS application by these agencies. This information is relevant in terms of the analysis that can be made of the data finally obtained with respect to its representativeness and significant value. We consider it important to highlight this point because, beyond the lack of individual collaboration of the operators or those responsible for each service/entity, this reality confronts us, once again, with the challenge that the involvement of the different agencies has represented and continues to represent when undertaking a project such as CAN-MDS.

Difficulties in assigning the correct nomenclature of the different participating professional profiles according to the International Standard Classification of Occupations (ISCO-08): during the process of entering the professionals through the system administration console, there were difficulties in correctly registering the different profiles following the available ISCO-08 classification. The main difficulties were related to the lack of availability of occupations related to specialized roles in the areas of child and adolescent care, which made it difficult to adequately record the participants who perform specific occupations, especially in the social and health sectors, so an adaptation was made

to the available categories and, in many cases, specialized roles were grouped to the available profiles (e.g. social workers and social educators as "social work associate professionals" or psychologists and family therapists as "psychologist"). It is important to emphasize this point in order to avoid making invisible the variety of professional profiles available in Catalonia, since their existence is an indicator of the reality and the progress made in relation to specialized care 15 for the general population on the one hand, and specifically for children and adolescents in situations of vulnerability due to maltreatment.

Actions to deal with difficulties

Request for support to the heads of the departments of the participating agencies: in this sense, the help of the referents was requested, as in the case of the Municipal Institute of Social Services of the Barcelona City Council, which was actively involved by forwarding emails and personally contacting the professionals to encourage their participation. Regarding the requests to other agencies, the expected response was not obtained as indicated in the previous section.

Offer permanent support and assistance spaces for the professional operators: with the aim of facilitating participation during the short period of the pilot, permanent communication channels were set up and operated every day, by e-mail and telephone. This allowed several of the professionals who participated, such as those from the Municipal Institute of Social Services of the Barcelona City Council, to obtain support at any time during the conduct of the registries, such as on weekends.

Delivery to professionals of a small, practical guide specifically designed to facilitate the recording of cases as indicated in the CAN-MDS resource pack: a brief document was prepared and delivered to professionals to support their participation in the pilot and indicating the ways and means of contact to resolve possible difficulties or incidents.

Adaptation of the specialized profiles to the available ISCO-08 classification given the lack of availability of specific profiles in said classification, all options were analyzed and reviewed in order to make a record as relevant as possible and adjusted to the role and functions performed by the professionals. Another of the actions taken to address this difficulty is the reference to it in this report, which will be sent to the European Commission, which will allow this factor to be considered in future projects or similar initiatives.

Development of the pilot:

In relation to the use of the registration application by the professional operators, during the pilot test, as planned, several requests for support were answered to resolve any doubts during the registration process or during the 16 first accesses to their personal accounts to consult difficulties related basically to errors that occurred during the entry of their personal data.

Occasionally, queries were also received regarding the most appropriate choice of values for the variables to be recorded, which were answered by gathering doubts and concerns and providing suggestions in accordance with the criteria and descriptions described in the CAN-MDS Operator's Guide and the Data Collection Protocol.

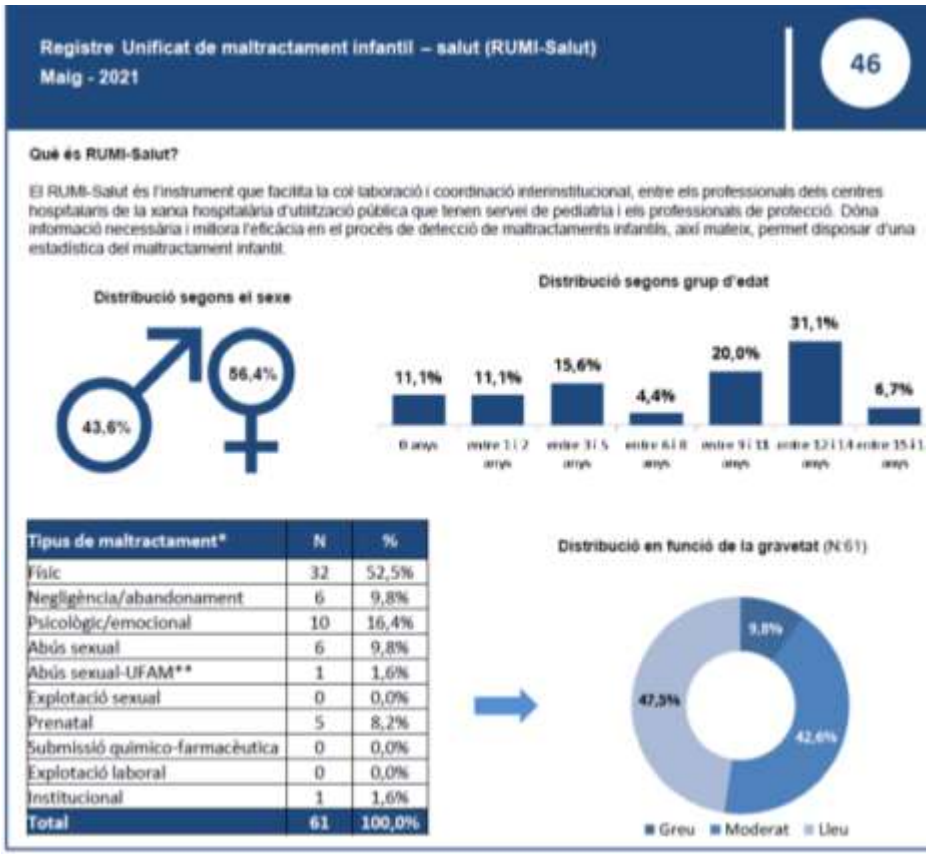
Post-Pilot Evaluation

Results of case registration

Of the 5 agencies initially involved in the training and committed to carrying out the pilot test, only 3 have carried out case records. The reasons related to this low participation have also been extensively described in this report in the previous sections. In total, 12 operators registered 30 cases.

Agencies (3 out of 5) & operators (12 out of 45) that registered CAN incidents during a 15 day period			
5 operators	from Social Services of Barcelona	registered	20 CAN incidents
6 operators	from Aroa Foundation	registered	8 CAN incidents
1 operator	from EDUVIC	registered	2 CAN incidents

With regard to the record of incidents obtained, and taking into account the complex circumstances in which the project and specifically the pilot test were carried out, we can affirm that it is a very satisfactory result with respect to the objectives and numerous challenges faced by CAN-MDS. It should be noted and recalled, as previously mentioned, that the lack of records from other agencies is not an indicator of the absence of detections of suspected or confirmed cases of child maltreatment, and proof of this are the data published by different agencies, some of them participating in the project, such as those shown below, extracted from the DGAIA website:



Registre Unificat de maltractament infantil – salut (RUMI-Salut)
Maig - 2021

46

Què és RUMI-Salut?

El RUMI-Salut és l'instrument que facilita la col·laboració i coordinació interinstitucional, entre els professionals dels centres hospitalaris de la xarxa hospitalària d'utilització pública que tenen servei de pediatria i els professionals de protecció. Dóna informació necessària i millora l'eficàcia en el procés de detecció de maltractaments infantils, així mateix, permet disposar d'una estadística del maltractament infantil.

Distribució segons el sexe

Distribució segons grup d'edat

Tipus de maltractament*	N	%
Físic	32	52,5%
Negligència/abandonament	6	9,8%
Psicològic/emocional	10	16,4%
Abús sexual	6	9,8%
Abús sexual-UFAM**	1	1,6%
Explotació sexual	0	0,0%
Prenatal	5	8,2%
Submissió químico-farmacèutica	0	0,0%
Explotació laboral	0	0,0%
Institucional	1	1,6%
Total	**61**	**100,0%**

Distribució en funció de la gravetat (N:61)

In the previous image, the data refer to cases detected by the health sector (finally disassociated from the project after attempts to get its involvement), specifically by the network of hospitals in Catalonia with pediatric services, from where the cases are registered in the RUMI tool reported in the contextualization study of the existing registration systems in Catalonia and which is only implemented in this sector (Primary Care Health Centers have recently been added). Link to data source

Another of the agencies participating in the pilot test, and which has not introduced cases, is the telephone line "Infància Respon", which depends directly on the DGAIA. There is available information about the monthly evolution of the calls received on this line and a description of the typology of these calls. We can affirm, also with respect to this agency, that the lack of records is not due to the absence of case identification.

Another example in relation to the incidence of cases, this time in sectors that have not been linked to the project, can be found in the following news of April, which reports the detection of 70 cases by a recently created resource (March 2021) in the Department of Education (Unitat de Suport a l'Alumnat en situació de Violència - USAV, oriented to the management of cases of child abuse, mistreatment, bullying and other violence and discrimination) (available at: https://www.ara.cat/societat/educacio-rep-70-denuncies-violencia-menorsmes_1_3961716.html)

Analysis of the case register

As for the analysis of the 30 incidents recorded, it is necessary to begin by explaining that they all refer to different children, which means that only one incident has been recorded for each child. It is also necessary to specify that the representativeness of the data presented below is limited and refers exclusively to the context of the registry, i.e. the participating agencies and the majority percentage of registrations by a specific agency, such as the 20 Municipal Institute of Social Services and, within that agency, 2 specialized services, which are:

EDEIAR (demand team for the childhood and adolescence at risk study): this is a team that is centralised at city level and has specialised professionals. Its role is to complement the work carried out at the public social centres (Centres de serveis socials), with the aim to centralise the demand register for children and adolescents at risk in the city, preparing the risk study and issuing the response to the requesting and competent bodies (Public Prosecutor's Office, courts and DGAIA) within the established deadlines.

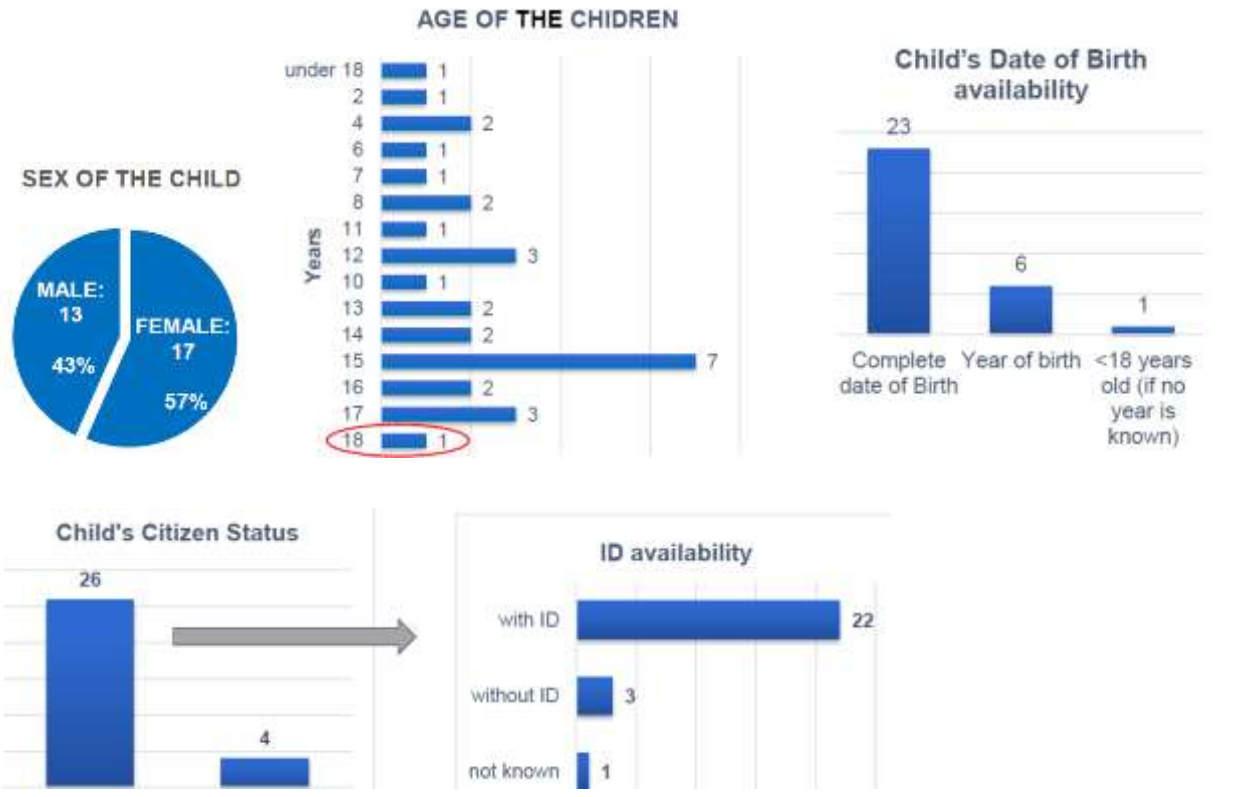
ECEIA (Central Team Specialised in Childhood and Adolescence) - EAIA (Childhood and Adolescence Care Team): receive cases that indicate a situation of neglect, or a risk of neglect detected by the primary social services, judicial or police bodies or the General Directorate for Childhood and Adolescence Care (DGAIA). They provide the diagnosis based on an assessment of the children and their social and family environment and propose the most appropriate measures for each case.

From this point on, the data are presented without the possibility of making a conclusive analysis of the trend or prevalence of child abuse in Catalonia, but with the understanding that they refer to a limited sample, conditioned by the reduced temporality of the test and the volume of records obtained, reiterating the existence of unrecorded cases, as previously stated.

The data, extracted from the registry of the server of the National Agency of Catalonia where the application is hosted (DGAIA) and provided by said agency, are presented in graphs to facilitate their understanding and, in some cases, an explanation or commentary is added to facilitate the reading of the data or to share some reflection that may be relevant with respect to the set of data.

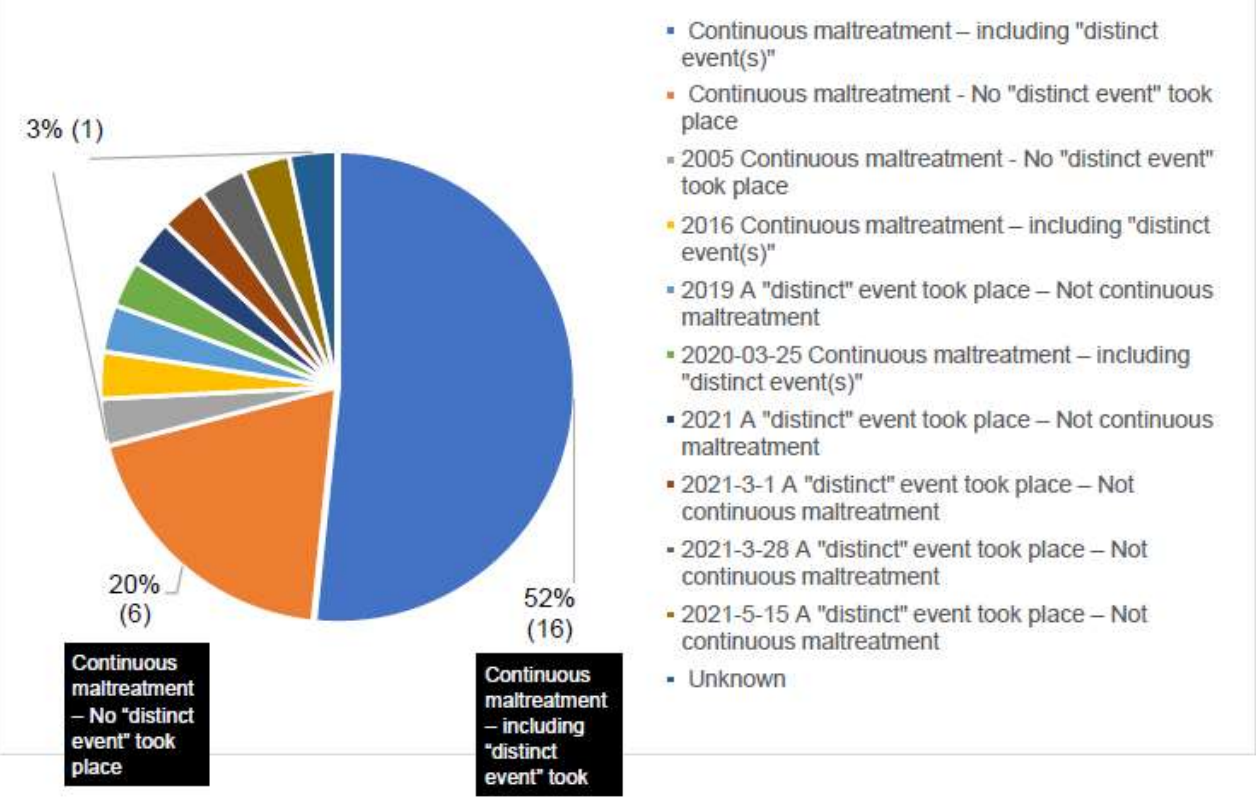
Thus, even with the limitations of the data collected and the impossibility of carrying out meaningful analyses with the sample obtained, it is possible to draw the conclusion that confirms and reinforces the hypothesis of the potential of systems such as CAN-MDS in terms of their capacity and possibilities for gaining insight into the real incidence and scope of child maltreatment from a multi-sectoral approach.

Data Elements related to "CHILD"

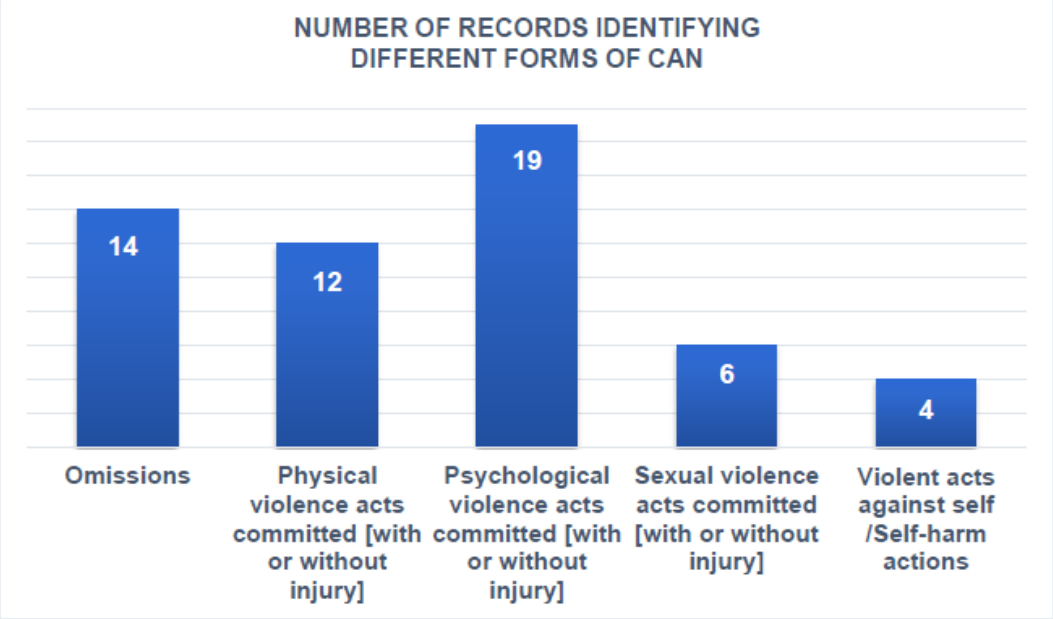


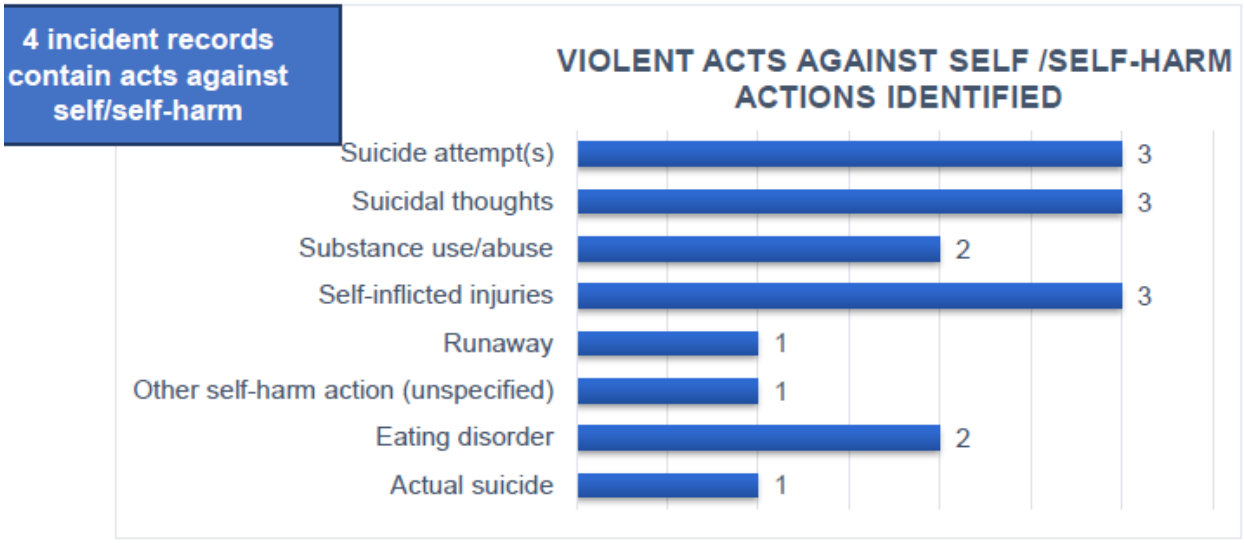
Data Elements related to "INCIDENT"

Date and Type of Incident



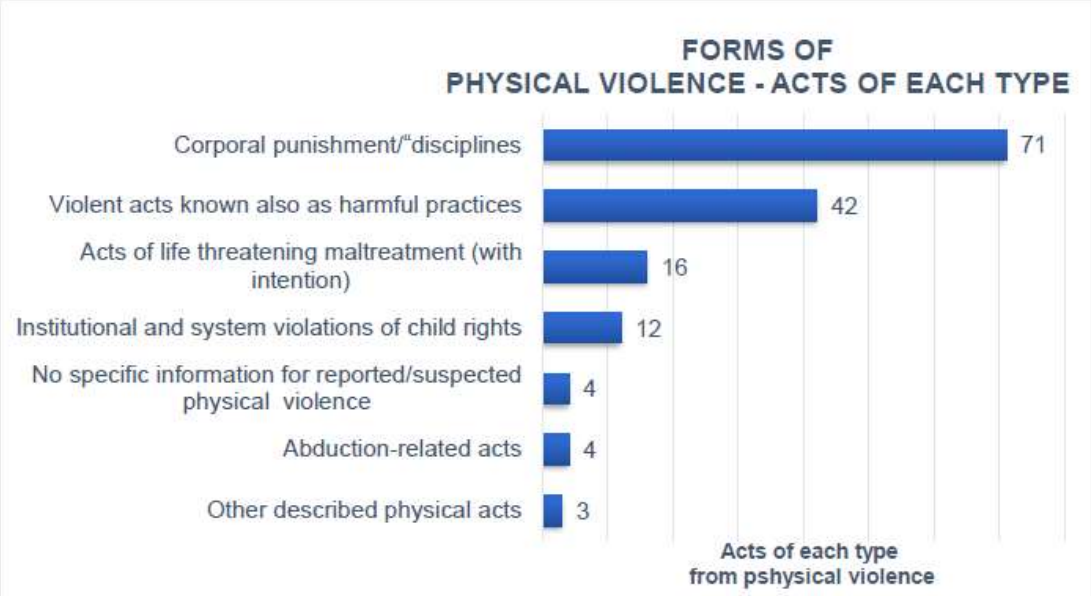
Forms of Maltreatment



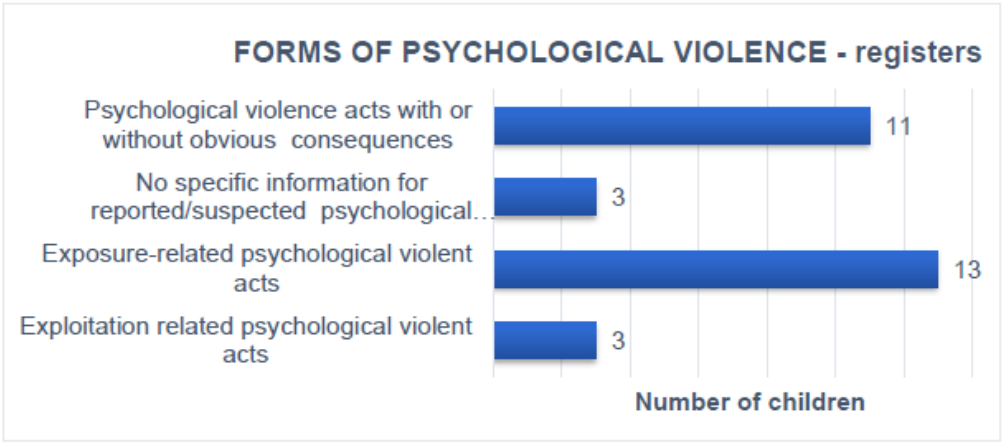


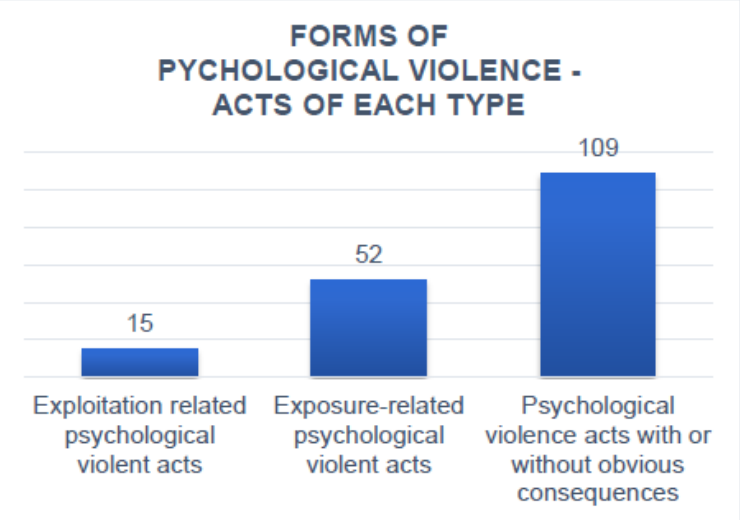
With respect to the recording of incidents of acts against self/self-harm, there are only 4 records in which this type of maltreatment is identified in a very high volume and with a great variety of acts in only 4 children. These striking records should be observed with caution, considering the possibility of their lack of reality and also taking into account the possibility that some error may have occurred during the recording, which would be expected in the case of a pilot test of a system that is not yet permanently integrated into the management circuit of child maltreatment cases. Moreover, in this protected context of piloting, in which the intersectoral comparison of information was limited in order to guarantee the protection of the minors' data, this type of incident would be foreseeable and is part of the testing process, therefore its indication is included as part of the feedback report on its development.

Physical Violence

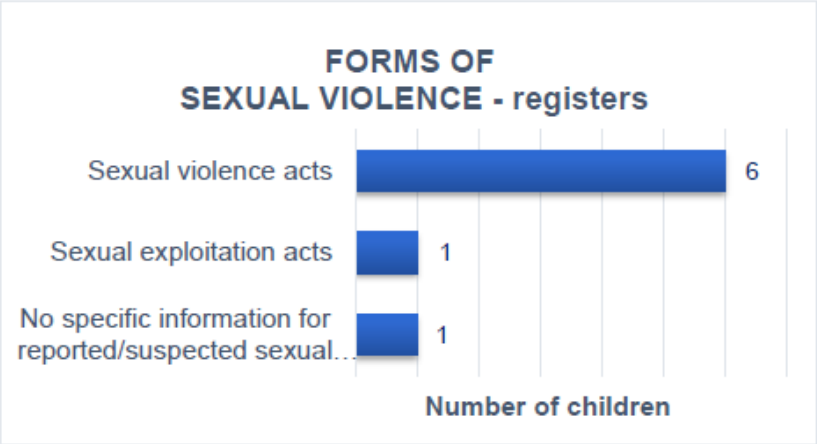


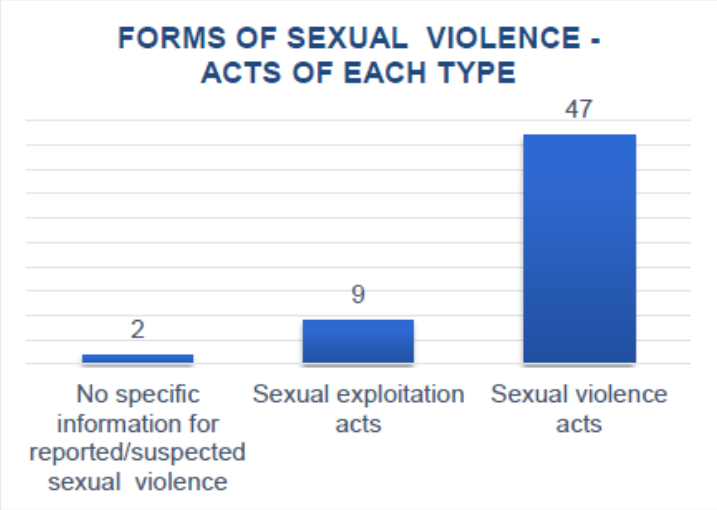
Psychological violence



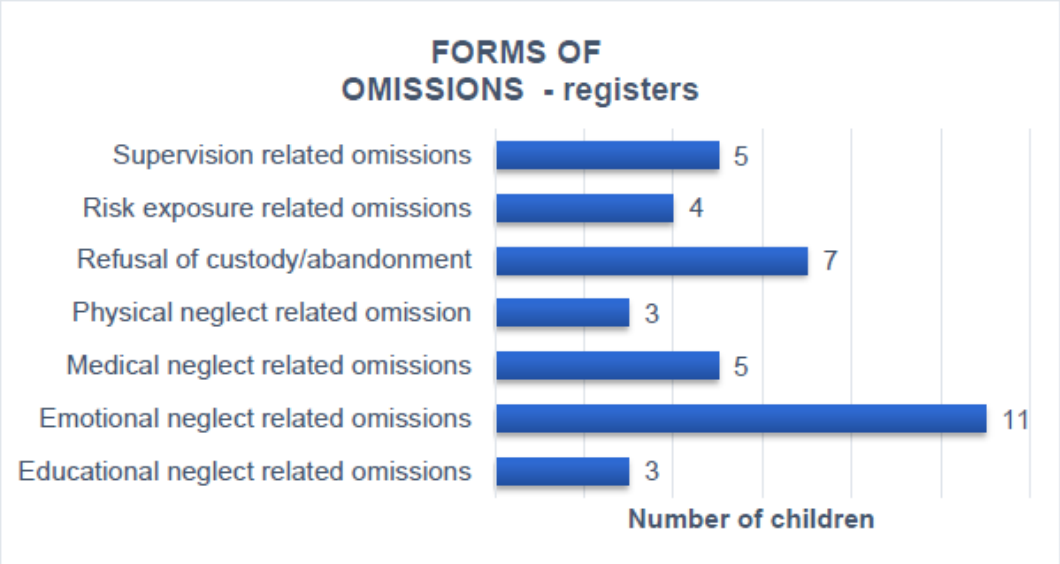


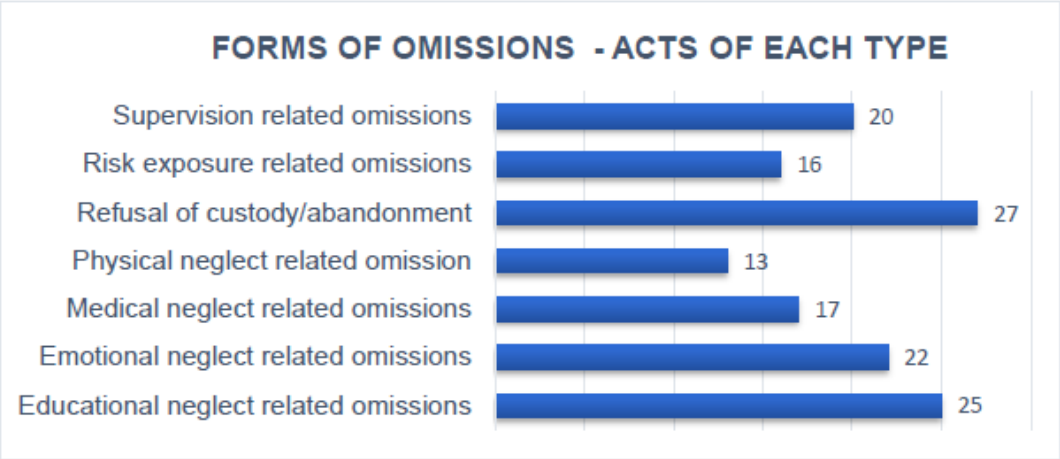
Sexual Violence



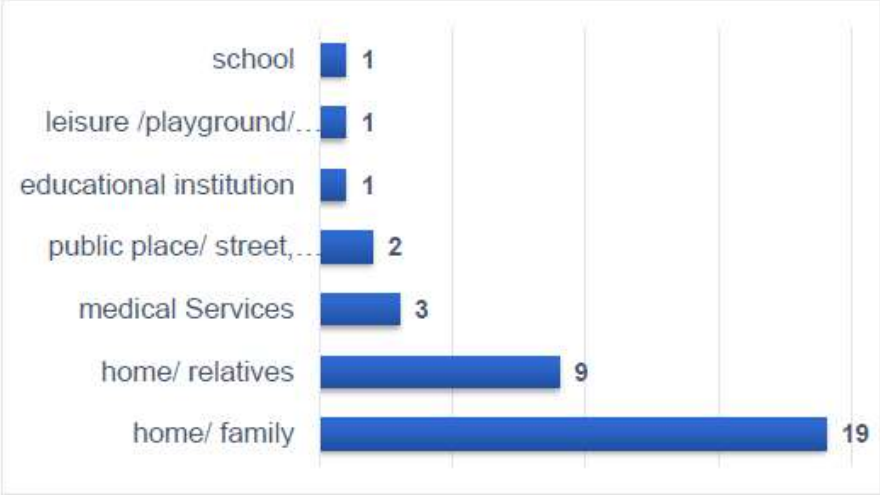


Omissions



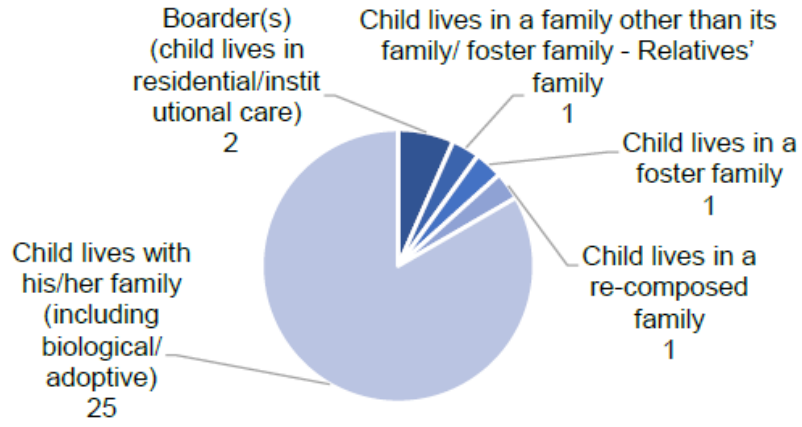


Location of Incident

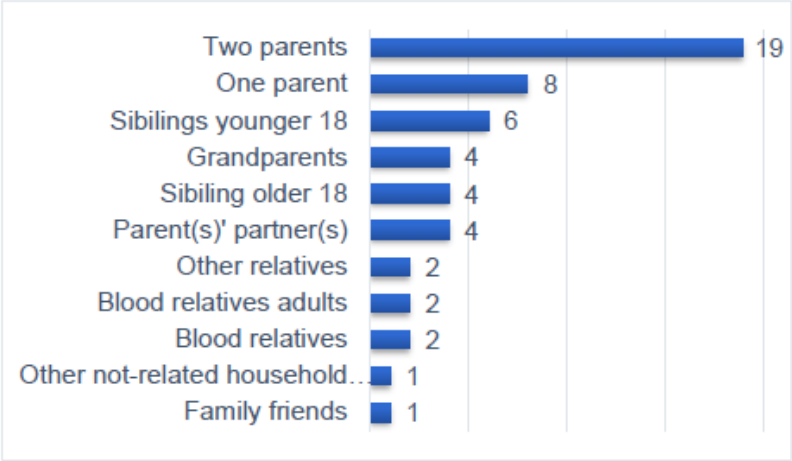


Data Elements related to "FAMILY"

Type of Family



Members of Family



Primary Caregivers (N=45 for 30 children)

Number of Primary caregivers when the incident took place

15 cases 2 primary caregivers

15 cases 1 primary caregiver

Primary caregiver(s)' relationship to child

28 cases were family members

27 cases were parents

3 cases were parent's partner

2 cases were grandparent(s)

2 cases were professional caregivers in institutional care

Primary caregiver(s) of each child

12 cases one parent

11 cases two parents

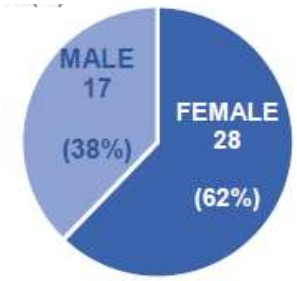
3 cases parent and parent's partner

2 cases parent and grandparent

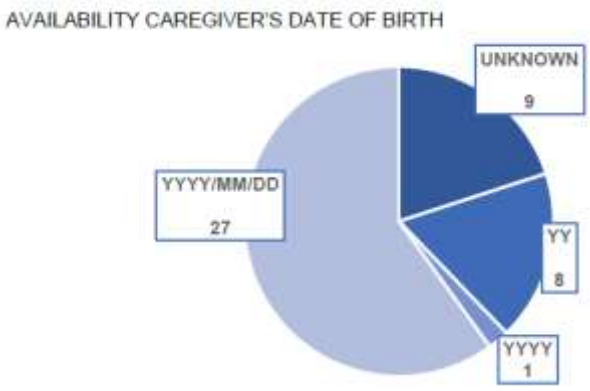
1 case professional caregiver in residential/institutional care

1 case one grandparent

Primary Caregiver(s) SEX



Primary caregiver(s)' Date of Birth (and age)



Data Elements related to "SERVICES"

Institutional Response

Response

27 cases YES
3 cases UNKNOWN

Type of Institutional Response

17 cases - immediate intervention(s)
12 cases - action taken – no Court involvement
9 cases - action taken – Court or Equivalent Authority involvement
5 cases - out of home placement

All the institutional responses to the incidents recorded are presented below, classified according to their specific type. In addition, those with the highest number of records are highlighted.

34

IMMEDIATE INTERVENTION(S)	
child protection /welfare services assessment	15
mental health exam(s)	6
police intervention	7
physical medical exam(s)	4
forensic evaluation initiated	1
unspecified	1

20

Action taken -NO COURT INVOLVEMENT	
referral to child protection /welfare service	8
emergency placement	3
child remains in family with planned intervention	3
mother/child shelter with parent and child together	2
police emergency protection procedures	1
CPS/welfare services emergency protection procedures	1
supportive intervention for current caregiver(s)	1
unspecified	1

21

Action taken-COURT or EQUIVALENT AUTHORITY INVOLVEMENT	
referral to child protection /welfare services	6
abuser to leave the home by court order	5
action to prosecute perpetrator(s)	3
police emergency protection procedures	2
action to protect victim by court order(s)	1
action to remove parent(s)' rights	1
CPS/welfare services emergency protection procedures	1
(family) court measures initiated	1
unspecified	1

12

OUT OF HOME PLACEMENT	
children's home institution	5
foster care	2
kinship care (relatives/extended family)	2
adoption with parents' agreement	1
adoption by court order	1
unspecified	1

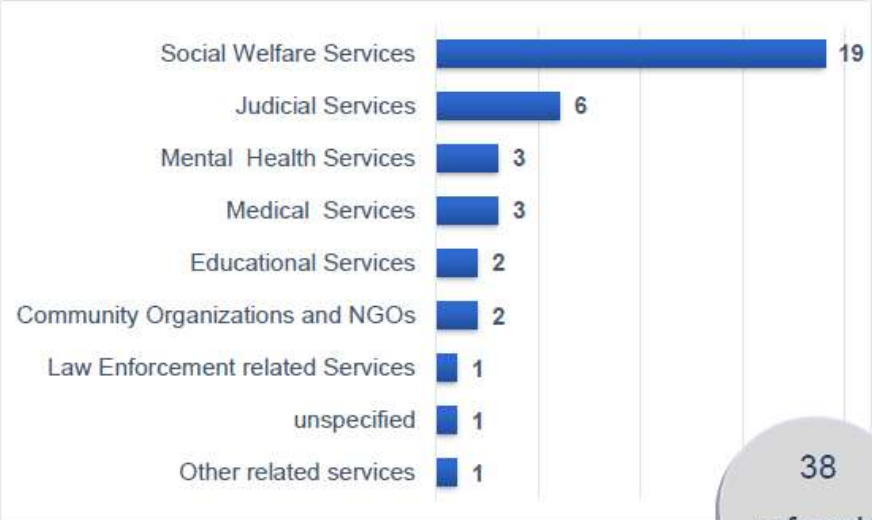
Referrals to Services

Referrals to other services

26 cases YES

4 cases NO

As shown for institutional responses, all the referrals to the different services made for the incidents recorded are presented below, classified according to their specific type. In addition, those with the highest number of records are highlighted.

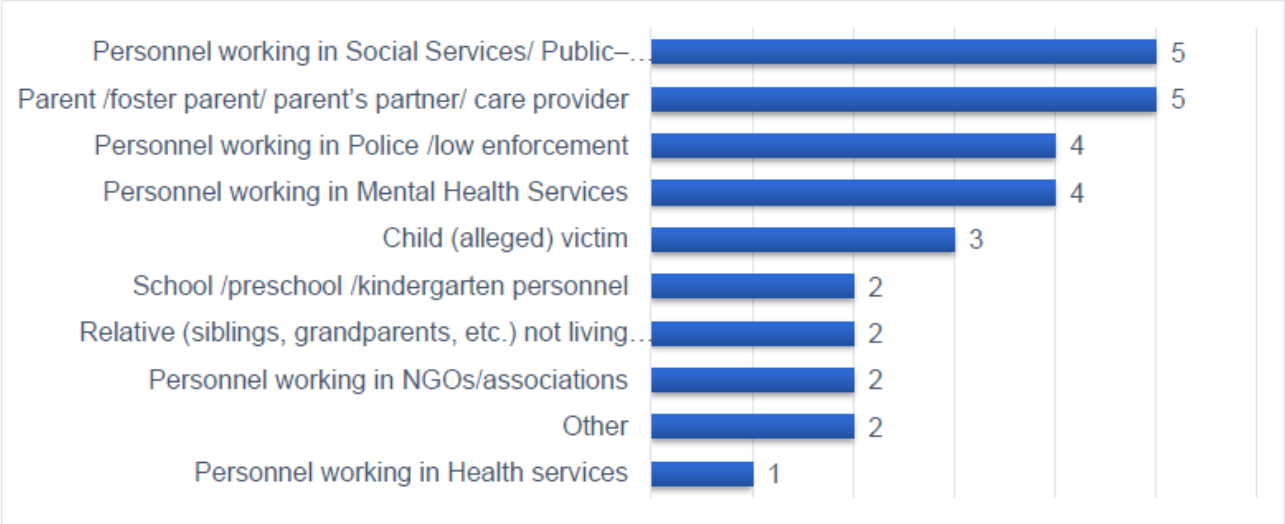


Social Welfare Services	Serveis Socials Ajuntament de Barcelona for child AND family	10
	DGAIA - Direcció General d'Atenció a la Infància i l'Adolescència for child ONLY	1
	DGAIA - Direcció General d'Atenció a la Infància i l'Adolescència for child AND family	2
Medical Services	CATSALUT for child ONLY	1

Educational services	EDUCACIÓ - EAP (Equips d'Atenció Psicopedagògica) for child AND family	1
	EDUCACIÓ - Inspecció educació (BCN ciutat) for caregiver(s) ONLY EDUCACIÓ - EAP (Equips d'Atenció Psicopedagògica) for child AND family,	1
Law Enforcement related services	Mossos d'Esquadra - GAV (Grup Atenció Victima) Violencia Doméstica for caregiver(s) ONLY,	1

Data Elements related to "RECORD"

Source of Information



Exhaustiveness of the records (data elements entered)

In general, the exhaustiveness of the records obtained was positively assessed. Thus, the variables have been completed in a fairly specific manner by the professional operators and those in which more general or unspecific information is identified are those relating to, for example, the dates of birth of the main caregivers; on the other hand, this variable has been completed with approximations to the decade of birth of these persons and we can deduce that the conditions in which the pilot study was carried out have facilitated this loss of completeness in some cases (little time to make the records, for example).

It should also be noted that the high level of completeness achieved is probably directly related to the degree of specialization of the participating agencies that have registered most of the cases entered, as is the case of the Municipal Institute of Social Services. In this sense, a lower exhaustiveness of the records (but an increase in their volume) could be expected if more sectors had been involved, such as those that do not have among their direct functions the management of cases of abused children, as well as a higher volume of cases and a greater concreteness in the records could have been expected if those sectors that already have specific protocols and specific tools for the notification of cases of suspected or confirmed child abuse (such as health services: hospitals and recently primary care centers) had been involved.

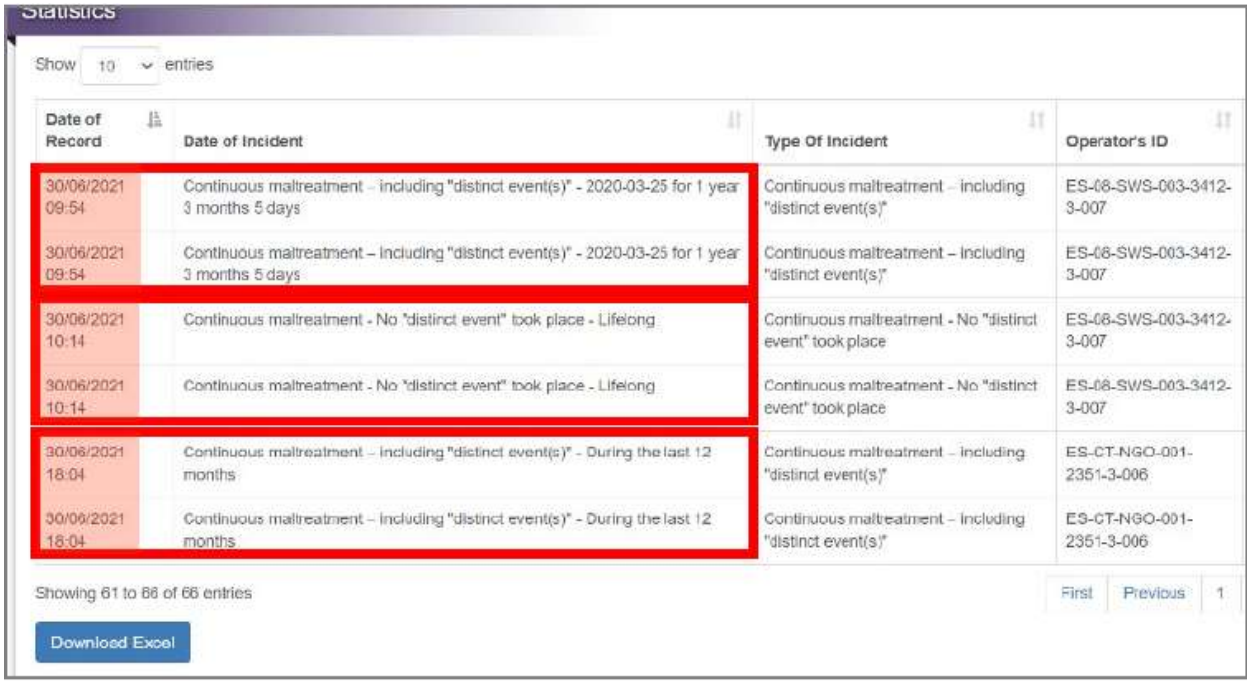
This may be due to the fact that the pilot test was carried out under protected conditions in which this functionality was limited by the level of access and operability of the operators (the agencies did not make referrals or exchange information among themselves) and, therefore, the professionals may have economized on the time dedicated to recording this information by limiting this variable due to a supposed "lack of interest", Therefore, the professionals may have economized the time dedicated to the recording of this information by limiting the specification of this variable due to a supposed "lack of interest", although the complete recording was requested at all times, as was done during the training and subsequent practical reinforcement sessions.

We can say, then, that the completeness of the data recorded is sufficient and satisfactory in view of the objectives and conditions of the pilot, and allows us to consider the sample collected as relevant for drawing limited but relevant conclusions, always taking into account the limited number of records and the reduced variety of agencies participating in their collection.

Based on the results obtained, it is worth pointing out the future potential of the system in terms of achieving the greatest possible completeness of the records by involving and operating jointly and sharing the entire range of sectors and agencies likely to manage cases of child abuse, from the initial stages of detection, to care, recovery, and the initiative and development of preventive policies and actions.

Detected incidences

At the end of the piloting phase on June 30, a technical incident attributable to the case registration application or the server receiving the cases (cause not identified at the time of writing this report) was identified, because the data extraction carried out showed a duplicity in the registration of practically all the incidents entered. This duplicity led to a total of 48 cases recorded as of Monday, June 29 (a figure that was shared at the presentation of the European Conference) and 66 on June 30. Once the records were reviewed one by one, this error was identified and resolved by discarding the duplicate records and generating a new list to which the data in this report refers. The incident is shown below:



Statistics

Show 10 entries

Date of Record	Date of Incident	Type Of Incident	Operator's ID
30/06/2021 09:54	Continuous maltreatment - including "distinct event(s)" - 2020-03-25 for 1 year 3 months 5 days	Continuous maltreatment - including "distinct event(s)"	ES-08-SWS-003-3412-3-007
30/06/2021 09:54	Continuous maltreatment – including "distinct event(s)" - 2020-03-25 for 1 year 3 months 5 days	Continuous maltreatment – including "distinct event(s)"	ES-08-SWS-003-3412-3-007
30/06/2021 10:14	Continuous maltreatment - No "distinct event" took place - Lifelong	Continuous maltreatment - No "distinct event" took place	ES-08-SWS-003-3412-3-007
30/06/2021 10:14	Continuous maltreatment - No "distinct event" took place - Lifelong	Continuous maltreatment - No "distinct event" took place	ES-08-SWS-003-3412-3-007
30/06/2021 18:04	Continuous maltreatment - including "distinct event(s)" - During the last 12 months	Continuous maltreatment - including "distinct event(s)"	ES-CT-NGO-001-2351-3-006
30/06/2021 18:04	Continuous maltreatment – including "distinct event(s)" - During the last 12 months	Continuous maltreatment – including "distinct event(s)"	ES-CT-NGO-001-2351-3-006

Showing 61 to 66 of 66 entries

First Previous 1

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Conclusions: Lessons Learned and Challenges

The overall conclusion is that the assessment of the pilot test is positive. Thus, despite the difficult conditions in which it has been developed, the pilot test has had satisfactory results, both in terms of confirming the potential of systems such as CAN-MDS, and in terms of identifying the challenges that need to be faced to achieve its objectives towards the unification of registration systems for better coordination and management of child abuse cases, with minimal data collection and overcoming the challenges involved in the protection of children's data.

The data collected, together with those noted in this report on the evidence of cases in different sectors, reinforces the well-founded suspicion that there is a lack of coordination and underreporting of cases of child abuse even in areas such as Catalonia, where there is specific legislation, protocols, systems and consolidated mechanisms of care for child abuse.

The pilot test also confirmed the existence of a high level of saturation of services and reaffirmed the superior commitment of certain specialized agencies (IMSS). Thus, the contrast between the contributions of the professionals during the training seminars and their limited real involvement in the pilot test confirms what they themselves pointed out in the spaces for reflection: the overload of the services, the lack of resources and the need to improve the protocols for a coordinated approach to child maltreatment. On the other hand, the lack of involvement of specialized sectors with a key role in the attention to child abuse, confronts us with the need to work intensely to promote the changes promoted by CAN-MDS in terms of intersectoral coordination and the unification of the registry.

The majority involvement of agencies specialized in child maltreatment highlights the challenge of overcoming the unidimensional perspective of child maltreatment towards an integral and structural approach with all the agents involved.

Also, the difficulties in complying with the agreements by some of the agencies participating in the pilot test determine the need to reinforce the work at a deeper level and with appropriate approaches to the processes in projects of the CAN-MDS magnitude.

On the other hand, it is known that the territorial circumstances of each country configure very different scenarios when considering the implementation of systems such as CAN-MDS: in the case of Catalonia, the existence of registration systems has possibly limited its assessment by several of the invited agencies, which finally did not join the pilot test due to, in addition to the factors referred to in this report, a possible "erroneous belief in the existence of control and effectiveness" in the approach to child abuse in Catalonia.

As for the sustainability of the system in Catalonia, it is currently not possible to maintain the continuity of the application as a system for recording cases, mainly due to the existence of proprietary systems in some sectors and protocols which, although it has been confirmed that they present challenges and needs for improvement, also require intense analysis work by those responsible at the political and administrative levels and by all the agencies involved to establish a clear priority for their review and improvement along the lines of systems such as CAN-MDS.

Thus, Catalonia, with its advanced position in terms of legislation, protocols, and registration mechanisms, has the potential to have traveled a necessary path that it can provide and contribute to the rest of European countries and, also, has the possibility of identifying the pending challenges and face them jointly with them.

Finally, it should be noted that it is essential to incorporate the information gathered in this and the other reports on the challenges faced in the project for the development of future proposals aimed at the implementation of systems such as CAN-MDS. And, last but not least, it is worth remembering that the apparent advanced position of territories such as Catalonia should be taken into account in the collaboration and networking initiatives at European level, as well as in the call for the involvement of policy makers, because, otherwise, there is a risk of moving towards improvement in territories with less presence and coverage of child protection systems, and leaving aside those that are in more advanced positions but still have challenges to face and improvements to achieve in addressing child maltreatment

Overall results

Capacity building activities, formulation of national Inter-Sectoral Boards, involvement of multiple agencies and professionals and continuous monitoring were among the necessary steps in order for each country to proceed with the piloting of the system in real settings, namely during the routine work of a large number of front line professionals with multiple specialties working with children in various sectors. For the implementation of all of the above activities in person meetings and communication, travelling and, mainly, focus on the issue of child maltreatment (identification and prevention) was required, according to the initial plan.

A number of unexpected conditions hindered the implementation of the project in general and the piloting of the system in particular. By March 2020, COVID-19 and the consequent preventive measures that adopted in all countries, including the partners' countries, didn't allow project's partners to implement the necessary activities as they were planned. Conduction of in person training seminars was not possible; bilateral in person meetings with Authorities in each country as well as meetings of the national CAN-MDS Inter-Sectoral Boards were not possible to be organized; provisioned monitoring visits during the pilot phase were also not possible. At the same time, focus of the Governmental and other relevant authorities shifted to pandemic and approaching them made even more difficult; in many cases front line staff had to change also their routine work and almost all targeted professionals had to work from home and to use IT for communication. As a result, Project's consortium had to re-design many of the initially planned activities, which caused delays in implementation of the project. An amendment was submitted in the Grant Agreement in order trainings, for example, to take place online and the training module along with the accompanied material had to be modified respectively. Approaching and meetings with members of the Inter-Sectoral Boards were organized also online, while monitoring visits were replaced by a series of online consortium meetings. In this context CAN-MDS II partners proceeded with the piloting of the system with more or less difficulties depending also from aspects such as the level of piloting (regional piloting, for example, proved easier than the piloting at a national level, where the central governmental authorities had to be involved).

Despite these difficulties, partners (with the exception of France) completed the project and succeeded to a greater or lesser extent. In the following table piloting of CAN-MDS system is briefly summarized per country:

Country	Piloting related tasks achieved	Piloting related tasks that weren't achieved
Bulgaria *Regional level* *3 areas*	– Preparation of necessary resources (toolkit; training material) – Approaching of Governmental and relevant Authorities – Discussion and Resolving of GDPR related issues – Formulation of Inter-Sectoral Board (1 board meeting) – Cooperation with national agencies and recruitment of professionals (13 agencies, 21 professionals-not to the planned extent) – Conduction of Operators' training (21 operators instead of 122) – Active participation in all consortium meetings	– Set-up of the CAN-MDS System (online platform) – Piloting of the system in real settings and data collection – Difficulties in cooperation with a main national organization

Cyprus *National level*	– Preparation of necessary resources (toolkit; training material) – Approaching of Governmental and relevant Authorities – Discussion and Resolving of GDPR related issues – Formulation of Inter-Sectoral Board (1 board meeting) – Cooperation with national agencies and recruitment of professionals (6 agencies; not to the planned extent and 89 professionals) – Conduction of Operators' training (89 operators more than planned 86) – Active participation in all consortium meetings – Set-up of the CAN-MDS System (online platform) – Piloting of the system in real settings (6 agencies; 34 operators)	– Piloting phase was shorter than the provisioned – No real cases were introduced by operators (only the mock cases)
France *National level - Sample areas*	– Preparation of some of the necessary resources (e-tool; toolkit-not fully completed) – Approaching of Governmental and relevant Authorities-some meetings took place – Started cooperation with national agencies and recruitment of professionals (not completed)	– Training module – Formulation of Inter-Sectoral Board – Operators' training – Participation in consortium online meetings – Set-up of the CAN-MDS System (online platform) – Piloting of the system in real settings and data collection
Greece *National level*	– Preparation of necessary resources (toolkit; training material) – Approaching of Governmental and relevant Authorities-a discussion is currently open at a ministerial level for the institutionalization of the CAN-MDS System – Formulation of Inter-Sectoral Board (3 board meetings-ongoing) – Cooperation with national agencies and recruitment of professionals (59 agencies and 127 professionals) – Conduction of Operators' training (112 operators, planned 400-the process is ongoing) – Organization and active participation in all consortium meetings – Set-up of the CAN-MDS System (online platform) (discussion is ongoing with the Ministry of Digital Governance for hosting the system in the governmental cloud) – Piloting of the system in real settings and data collection (59 agencies; 112 operators; 38 CAN cases)	– Piloting phase was shorter than the provisioned – Not all sectors are currently represented in the system
Romania *Regional level* *4 areas*	– Preparation of necessary resources (toolkit; training material) – Approaching of Governmental and relevant Authorities – Formulation of Inter-Sectoral Board (2 board meetings-ongoing) – Cooperation with national agencies and recruitment of professionals (61 agencies and 171 professionals) – Conduction of Operators' training (171 operators, more than planned 95) – Active participation in all consortium meetings – Set-up of the CAN-MDS System (online platform) – Piloting of the system in real settings and data collection – as planned (42 agencies; 146 operators; 287 cases) (currently system is operating in 3 counties of Romania)	-
Spain *Regional level* *3 areas*	– Preparation of necessary resources (toolkit; training material) – Approaching of Governmental and relevant Authorities – Formulation of Inter-Sectoral Board (4 board meetings-ongoing) – Cooperation with national agencies and recruitment of professionals (27	– Piloting phase was shorter than the provisioned – Not all sectors are currently represented in

	agencies and 59 professionals) – Conduction of Operators' training (59 professionals, planned 150) – Active participation in all consortium meetings – Set-up of the CAN-MDS System (online platform) at DGAIA (Governmental) cloud; validation of the platform by the IBM – Piloting of the system in real settings and data collection (27 agencies; 45 operators) (started)	the system

Overall, apart from partners' organizations more than 220 organizations, governmental, independent and non-governmental, were involved in the pilot phase of the CAN-MDS system as National Administrative authorities (5 organizations), as members of the national inter-sectoral boards (65 organizations), as data sources for the CAN-MDS System (~150 organizations). In addition, apart from the staff of the project ~530 professionals were involved in the pilot phase (85 as members of the national inter-sectoral boards participating in a series of meetings and supporting the recruitment of agencies-data sources and operators and 450 front-line professionals participating in trainings and most of them in the piloting of the system).

Specifically:

~220 organizations were involved in the piloting of the CAN-MDS System in partners' countries		
5 organizations undertook the role of the National CAN-MDS Administrative Authority (signing relevant ToRs)	**~ 65 organizations** were participated through representatives in the 5 **national inter-sectoral boards** (signing relevant ToRs)	**~ 150 organizations** were involved in the **piloting** as **data-sources** (signing relevant bilateral agreements)
1 per country (Bulgaria, Cyprus, Greece, Romania, Spain)	**6** in Bulgaria, **10** in Cyprus, **14** in Greece, **27** in Romania, **6** in Spain **Identities:** **6** independent authorities, **12** Ministries, **18** national level public authorities/Services, **16** Regional Level Authorities/Services, **4** universities and **13** NGOs in the field of child protection	**13 agencies in Bulgaria** (Health, Mental Health, Education, Education/Health, Social Welfare/Social Services) **6 agencies in Cyprus** (Social Welfare Services; Ministry of Justice and Public Order; Police; NGO (Children`s House operated by Hope for Children CRC Policy Center) **59 agencies in Greece** (Independent Authorities; Welfare (Municipal Social Welfare Services); Health; Mental Health; Education; Socio-Medical Services; Research and other Relevant Organizations; NGOs) **42 agencies in Romania** (social services/child protection services/ social assistance; justice; law enforcement; education; health/mental health; NGOs) **27 agencies in Spain, Catalonia** (education; health; mental health; social welfare; NGOs)

~570 professionals were involved in the piloting of the CAN-MDS System in partners' countries		
~ 40 project's staff members (academics, researchers, consultants, national child protection experts, IT experts, data analysts, Research Ethics experts, administrative staff)	~85 as members of the inter-sectoral boards (13 in Bulgaria, 27 in Greece, 9 in Cyprus, 30 in Romania, 7 in Spain)	~450 front line professionals 21 trained professionals (psychologists; social workers; nurses; preschool teachers; nursery teachers) in Bulgaria 89 trained professionals / 34 operators (Psychologists; social workers; administration professionals; police officers; child care workers) in Cyprus 112 Operators (medical doctors; nurses; health associate professionals; teaching professionals; special needs teachers; lawyers; sociologists; psychologists; social workers; health visitors) in Greece 171 trained professionals/ 146 operators (teaching professionals; legal professionals; IT technicians; managing directors; medical doctors; social and religious professionals; researchers; social welfare managers; education managers; psychologists; sociologists; social workers; medical assistants; police officers) in Romania 59 trained professionals/ 45 operators (psychologists; social workers-social work associate professionals; health professionals; education method specialists) in Spain
4 National CAN-MDS Systems were installed (+the EU demo version) 355 child abuse and neglect incidents were recorded in the system by trained professionals in 3 countries >450 mock child abuse and neglect incidents were recorded (in the context of professionals' training)		
Romania: Greece: Spain: Cyprus: Bulgaria:	6 months piloting – Regional level (4 regions) 3 months piloting – National level 0,5 month piloting – Local level (3 areas) less than 1 month piloting - National Level No piloting (recording took place only during training)	278 CAN incidents >270 mock CAN incidents 38 CAN incidents >110 mock CAN incidents 30 CAN incidents >60 mock CAN incidents >80 mock CAN incidents >20 mock CAN incidents

Discussion

Apart from COVID-19 pandemics, various barriers were faced in partners' countries during the preparation of the piloting and of the piloting phase. In Spain, for example, were mentioned issues such as the overload of the participating entities and services (mostly specialized), related at an extent to pandemics, the coincidence of the pilot with the vacation period of the professionals, the coincidence with the end of the course and the reporting period at the level of the participating services and entities and with national bank holidays; other difficulties reported were related to change of position and/or professional dedication of some operators but also poor compliance with the commitment to participate in the project in some cases.

Similar difficulties were faced in other countries too. In Bulgaria, a major issue that arise was related to personal data protection regulations. One of the main stakeholders (national organization) opened a discussion on the specific and legitimate purposes for providing data for children, the legal grounds for disclosing personal data of children and in connection with Regulation (EU) 2016/679 on data protection: *who will process the data of children after their disclosure/provision; which subjects will have access to data, in what period of time they will be processed, as well as for the respective guarantees for the exercise of the rights.* This discussion led the Bulgarian partners to ask the opinion of the National Commission for Personal Data Protection. The Commission, after receiving all necessary information, replied that "*a. the implementation of the CAN-MDS II Project does not require the consent of persons under the Art. 11a from the Child Protection Act. The reason for data processing under the project should be found in Art.9, par.2 from the GDPR in accordance with the special legislation regulating the functions and rights of the project participants.*" and

"b. When there are one or more reasons according to Art.9, par.2 from the GDPR in connection with Art. 6a from the Child Protection Act, the Agency for Social Assistance can provide data to the State Agency for Child Protection for the project purposes". Afterwards, new concerns were expressed from main national stakeholder leading to further delays in the preparation for the piloting. Eventually, despite the efforts of the project's team, the piloting of the system CAN-MDS did not take place in Bulgaria. South West University and National Agency for Child Protection, CAN-MDS Action Bulgarian partners concluded that "*To introduce and maintain CAN-MDS as a permanent operation/service needs time and more awareness and joint efforts by the respective authorities. We hope that even though we didn't succeed with piloting the system CAN-MDS, strong basis for its future implementation in Bulgaria was made in the frame of CAN-MDS-II project. We are continuing our efforts for encouraging professionals, and lobbing for implementation of CAN-MDS, in order to create effective system for registration and monitoring cases of child abuse and neglect and build fruitful inter-sectoral collaboration in the field of child protection*".

In France there were also difficulties that were mainly related to pandemics but also to internal organizational issues and, at some extent, to misunderstandings on the project's activities and specific delays during the preparatory phase. In March 2021 ONPE decided that the implementation of the project was not feasible anymore, informing ICH that "*in spite of our will, we were not able to carry out*

this project as planned due to various cumulative elements: longer than expected time for the availability of the CAN-MDS 2 software; instability and departure of staff within the ONPE team; occurrence of the Covid-19 health crisis making it impossible to access les "unite s d'accueil pe diatriques" and work with hospital professionals; commitment of the ONPE team, at the request of the French State, in a reform of child protection requiring strong and priority mobilization of ONPE teams."
In the final report of ONPE was noted that "*the ONPE professionals involved in this project continue to believe that this project was well constructed, very useful and that its potential results are expected by professionals in the field. The very particular circumstances of 2020-2021 have had a major impact on the world of child and adolescent protection, shifting the priorities to be implemented*."
Encouraging were the piloting results from Catalonia, Spain in regards to the exhaustiveness of the records obtained, that was positively assessed. The variables have been completed in a fairly specific manner by the professional operators; the completeness of the data recorded is sufficient and satisfactory in view of the objectives and conditions of the pilot, and allows to consider the sample collected as relevant for drawing limited but relevant conclusions, always taking into account the limited number of records and the reduced variety of agencies participating in their collection. Based on the results obtained, it is worth pointing out the future potential of the system in terms of achieving the greatest possible completeness of the records by involving and operating jointly and sharing the entire range of sectors and agencies likely to manage cases of child abuse, from the initial stages of detection, to care, recovery, and the initiative and development of preventive policies and actions.
The overall conclusion is that the assessment of the pilot test is positive. Thus, despite the difficult conditions in which it has been developed, the pilot test has had satisfactory results, both in terms of confirming the potential of systems such as CAN-MDS, and in terms of identifying the challenges that need to be faced to achieve its objectives towards the unification of registration systems for better coordination and management of child abuse cases, with minimal data collection and overcoming the challenges involved in the protection of children's data.

However, the data collected, together with those noted in the national report on the evidence of cases in different sectors, reinforce the well-founded suspicion that there is a lack of coordination and underreporting of cases of child abuse even in areas such as Catalonia, where there is specific legislation, protocols, systems and consolidated mechanisms of care for child abuse. The pilot test also confirmed the existence of a high level of saturation of services and reaffirmed the superior commitment of certain specialized agencies. Thus, the contrast between the contributions of the professionals during the training seminars and their limited real involvement in the pilot test confirms what they themselves pointed out in the spaces for reflection: the overload of the services, the lack of resources and the need to improve the protocols for a coordinated approach to child maltreatment. On the other hand, the lack of involvement of specialized sectors with a key role in the attention to

child abuse, confronts us with the need to work intensely to promote the changes promoted by CAN-MDS in terms of inter-sectoral coordination and the unification of the registry.

As for the sustainability of the system in Catalonia, it is currently not possible to maintain the continuity of the application as a system for recording cases, mainly due to the existence of proprietary systems in some sectors and protocols which, although it has been confirmed that they present challenges and needs for improvement, also require intense analysis work by those responsible at the political and administrative levels and by all the agencies involved to establish a clear priority for their review and improvement along the lines of systems such as CAN-MDS.

Thus, Catalonia, with its advanced position in terms of legislation, protocols, and registration mechanisms, has the potential to have traveled a necessary path that it can provide and contribute to the rest of European countries and, also, has the possibility of identifying the pending challenges and face them jointly with them.

Finally, it should be noted that it is essential to incorporate the information gathered in this and the other reports on the challenges faced in the project for the development of future proposals aimed at the implementation of systems such as CAN-MDS. And, last but not least, it is worth remembering that the apparent advanced position of territories such as Catalonia should be taken into account in the collaboration and networking initiatives at European level, as well as in the call for the involvement of policy makers, because, otherwise, there is a risk of moving towards improvement in territories with less presence and coverage of child protection systems, and leaving aside those that are in more advanced positions but still have challenges to face and improvements to achieve in addressing child maltreatment

In Cyprus, the delay in the completion of necessary capacity building activities led also the national partners to start the pilot phase of the system late enough. Thus, even though the piloting phase started in a national level, the cases added by the end of the project (June 30) were from Nicosia regional offices only. Social Welfare Services, Ministry of Labour and Social Insurance and the "Hope for Children" reported that the sectors that involved in the piloting phase in Cyprus were the Children's House, which handles the investigation of cases of children sexual abuse and the Foster department which deals with the home replacement of children. In regards to the system and its understanding, professionals from Cyprus said that in conclusion the platform is easy to navigate as it's step by step and it's not confusing, while they also noticed the importance of the Operator's Manual as this helped them to understand the terms were written solving any confusions. Overall, the professionals involved in the piloting phase of the CAN-MDS II platform were particularly satisfied of this initiative and interested to see the results of this new reporting mechanism built within the framework of the project. In conclusion, the pilot implementation of the CAN-MDS II project in Cyprus proved to be both challenging and stimulating. The feedback provided by the professionals that participated in the different stages of the project will serve as a guide to improve the current mechanism. Yet, as the piloting phase did not finish due to the delay of the situation with the

pandemic, Cypriot partners engaged with the professionals to continue the piloting phase in a total of six months; after the piloting phase, the project team in Cyprus plans to continue with the comparison of the data and to collect the feedback of the professionals through focus groups in order to fix any issue.

Similar was the situation in Greece; because of the delays in the training and the preparatory phase, the piloting phase of the system started late enough. As for the evaluation of the operational aspects of the system, correctness and completeness of records was assessed based on a simulation of the registration procedure using a mock case (64 records) as well as on the registration of living cases in the system by the trained operators (in total 38 cases); also the feasibility of the procedure for the pseudonymization was tested. From the results it seems that CAN data (both, mock and real cases) collected for a 2 month period via a fully controlled manner could be used for the assessment of system's operability and as a baseline for evaluation of existing or new CAN prevention practices and policies. Simulation (working with mock cases) after the training indicate that training is adequate in order for the professionals to record sufficiently a CAN-incident into the system, regardless of their professional specialty and the agency where they are working. Data collection on living cases showed that they system is able to provide the results that it was developed to collect and at the same time facilitate CAN incidents administration at a case level. The pseudonymization process worked timely and without difficulties. These preliminary results suggest that continuous operation of the system with the participation of more agencies and more trained professionals nationwide would be able to provide the data that are necessary for the epidemiological surveillance of the child abuse and neglect incidents in Greece and their specific characteristics. At the same time, continuous operation of the system is expected to further contribute in the multidisciplinary and inter-sectoral collaboration in the administration at a case level and at the same time will support capacity building of all relevant professionals and especially improvement of their knowledge on issues related to child maltreatment.

Piloting of the CAN-MDS System in Greece suggest that the system it could work, especially if all relevant sectors will be actively involved nationwide and sufficient number of professionals with multiple cognitive backgrounds will be trained to become operators of the system. In this context and in terms of sustainability of the CAN-MDS, it is of note that the National Inter-Sectoral Board made the decision to support the training and the piloting of the CAN-MDS system for at least the next 6 months (until December 2021), over and beyond the Action. In this context, Board Member Authorities/Organizations will continue the recruitment of Agencies and Professionals from ALL sectors to participate in the piloting and, afterwards, in the normal operation of the system while ICH undertook the responsibility to coordinate both, training and piloting for this period. In addition, a number of members of the Board suggested that during the same period shall take action towards the preparation of the appropriate legal framework for the operation of the system (probably in the context of an Inter-Ministerial Decision). Currently there open discussions for the institutionalization of the CAN-MDS System at an inter-sectoral level with the Ministry of Labour and Social Affairs, the

Ministry of Health and the Ministry of Digital Governance (where other members of the Board also participate).

A 6-month piloting of the system took place in 4 regions in Romania. According to the reporting of the results by Babes-Bolyai University, DASM and FONPC, the Romanian project's partners, in conclusion it seems that the platform is useful for a variety of reasons, as listed below:

- the list of descriptors and the clear definitions discussed in the training enables the operators working with the platform to improve the identification of the cases, as well as to respond to the needs of children and their families. Not only the definitions per se, but the clarifications while discussing them in the workshops contributed to more cases being reported.
- the platform being a well-organized instrument, it helped the operators organize the modalities to identify and describe the situations of CAN.
- making data visible on a platform encourages collaboration between agencies and professionals, bringing forward the efforts of the child protection system and other related sectors in responding to accountability issues and justifying budgets.
- The feedback in the workshops demonstrated an increase in the motivation of the majority of participants to respond to the needs of maltreated children.
- Using the platform and communicated online during the workshops contributed to the development in the agency's digital competencies, initially sceptical in using the platform. They learned that cooperation is possible on a common platform, without threats to security, and in an ethical way, is another strength of the program.
- Data show an increase in the county which previously had one of the lowest reporting CAN rates.
- The platform fist very well in the actual social context in Romania, as there is a tendency, but also a pressure to digitalize the administrative work in social services, including child protection.

The National administrator and the consortium organized a last meeting with the Council of the CAN-MDS platform on the 24th, June 2021, were the National Report generated by the platform was presented and a discussion took place on the quantitative and qualitative results. All representatives of the consortium and of the four sites piloting the platform were represented in the meeting. Representatives of the National Agency of the Rights of Persons with Disabilities, Children and Adoptions, The Children's Advocate (People's Advocate Institution), The National College of Social Workers in Romania, Ministry of Justice, Bucharest University, The International Foundation for the Child and the Family (FICF) participated to the meeting of the Council. Participants much appreciated the results. Discussions are open in counties for maintaining the system after the pilot phase. Lastly, it is of note that the College of Social workers granted professional certificates to those social workers who participated in training and workshops.

In conclusion

The necessity for data collection on child abuse and neglect is a commonly accepted priority worldwide, in the EU countries. Therefore, existence of child maltreatment surveillance mechanisms that provide continuous and systematic data to monitor the magnitude and impact of CAN is undeniable. Available data, where exist, are collected by various agencies and professionals on the basis of different definitions, methods and tools usually in distinct databases and even though all this information unified in single databases, data are not comparable and it is not feasible to draw valid and reliable results from their analyses and therefore not so useful for planning preventive polices and measures. In the General Comment 13 (2011) of the UN CRC it is noted that "*[…] The impact of measures taken is limited by lack of knowledge, data and understanding of violence against children and its root causes, by reactive efforts focusing on symptoms and consequences rather than causes, and by strategies which are fragmented rather than integrated.*" Main barriers for effective administration of CAN include difficulties in recognition of CAN by professionals working with and for children; underreporting -even from mandated professionals; lack of common operational definitions; weak follow-up at a case level; lack of common registering practices and the use of a variety of methods and tools for collection and sharing information among stakeholders. Due to insufficient registration of CAN reports follow up of cases at local and national levels is not sufficiently coordinated among the involved sectors. At an international level, where currently monitoring systems exist, they vary considerably, so that comparisons are not feasible; reliable data, however, are crucial to end the invisibility of violence, challenge its social acceptance, understand its causes and enhance protection for children at risk; data are vital to support government policy, planning and budgeting for universal and effective child protection services, and to inform the development of evidence-based legislation, policies and implementation processes.

CAN-MDS System was developed to deal with all of the above issues. Piloting of the CAN-MDS System suggest that the system it could work in at least to some countries having no similar systems in place under the condition that all relevant stakeholders will be committed and actively involved in such a system.