Common protocol for a healthcare response to gender violence

HEALTHCARE 2007
MINISTRY OF HEALTH AND CONSUMERS AFFAIRS. SPAIN

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Common Protocol for a Healthcare Response to Gender Violence

Commission Against Gender Violence of the National Health System's Interterritorial Council. Spain

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Plan de Calidad para el Sistema Nacional de Salud

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Foreword

Assembled for plenary session in September, 2004, the National Health System Interterritorial Council agreed to create a Commission Against Gender Violence, presided by the Healthcare Secretary General and formed by the NHS's Quality Agency Directorate General, representatives of each Autonomous Community, the Equality Policies General Secretariat, and the Women's Institute, The Observatory on Women's Health assuming its secretaryship. This Commission held their first meeting in November, 2004.

Organic Act 1/2004 for the Comprehensive Protection Against Gender Violence, enacted in December, 2004, establishes in Chapter III that this Commission shall provide technical support and direct the planning of healthcare measures. It shall also assess and propose the actions necessary for the full implementation of the healthcare protocol and of any other measure that might be deemed advisable for contributing to eradication of this form of violence. It also states that: *"The Commission shall issue an annual Report which shall be forwarded to the State Observatory on Women's Violence and to the Plenary of the Interterritorial Council"* (Art. 16).

Likewise this Act establishes in its Article 15, that the Healthcare Authorities, within the NHS's Interterritorial Council, shall promote those healthcare providers' actions aimed at the early detection of gender violence.

And shall put forward the necessary measures to improve efficacy in the struggle against this kind of violence through the developing of awareness and continuing training programmes for healthcare personnel that may enable the promotion of early diagnosis, care and rehabilitation of women suffering maltreatment. In addition, Article 32.3 promotes the enforcement, updating and dissemination of protocols containing homogeneous action guidelines to confront this problem.

Finally, diagnosing, and addressing gender violence, both in the primary as well as in the specialized care areas, are included in Royal Decree 1030/2006, of 15 September, by which the NHS's common services portfolio is established, as well as the procedure for its updating.

The Protocol we now present is the first on this issue proposed for its being implemented in the NHS as a whole. Its main target is to provide healthcare professionals with homogeneous action guidelines when faced with cases of violence specifically directed against women, covering both care and follow-up as well as prevention and early detection. We do hope it will be especially useful for Primary Care professionals, as it is at this level

where the contact with gender violence victims is more immediate and direct.

This initiative gives an impulse to the NHS's effort to address this issue, and abides by the legal mandate. The protocol, approved by the Plenary of the Interterritorial Council in its meeting of December, 2006, has been drafted by the Council's Gender Violence Commission. For its drafting, the criteria of numerous experts and the work already developed in some Autonomous Communities have been taken into account. The task has been thorough and very participative for which I wish to give my special thanks for their efforts, to all who have taken part in it.

Elena SALGADO
Minister of Health and Consumers' Affairs

Objectives and methodology

The **main objective** of this protocol is establishing a standardized and homogeneous action guideline for the National Health System (NHS), for both early detection as well as for assessment and action in detected cases and their follow-up. The eventual purpose is providing the NHS's healthcare personnel with guidelines for achieving comprehensive physical, psychological, emotional and social care to women enduring gender violence who resort to a healthcare centre.

This protocol targets any form of violence or ill-treatment inflicted on women over 14 years of age, regardless of whom the aggressor may be, although the actions it entails, focus primarily on violence inflicted by the intimate partner or ex-partner, as they stand as the most common forms of violence in our country.

When sexual assault is the case, healthcare attention and action are specific, bearing in mind the medical-forensic and legal measures and implications this kind of assault entails, for which a chapter devoted to it has been included.

This protocol equally intends to attain other **secondary objectives:**

1. To make NHS's healthcare personnel aware of the seriousness of violence against women as a health concern;
2. To promote the empowerment of women enduring maltreatment, enabling them to gain awareness of their situation and to seek solutions;
3. To contribute from the National Health System (NHS) to the general population's awareness of this issue.

For the final drafting of this Protocol, the existing Autonomous Communities' healthcare action protocols have been revised. The document produced is the outcome of discussions and general assent within the *Taskforce in charge of Protocols and Healthcare Action Guides for Addressing Gender Violence,* issued from the NHSIC's Commission. The group integrates representatives of the Autonomous Communities and Official Institutions such as the Government Special Delegation Against Violence on Women, The Women Institute (MTAS) and the Ministry of Health and Consumers' Affairs' (MHCs'A) Public Health General Directorate. Technical support has been provided by the Andalusian School of Public Health and the Spanish Society of Family and Community Medicine (SSFCM: translation of the Spanish acronym "SEMFYS"). The Group coordination has been taken on

by the Observatory on Women's Health, of the Ministry of Health and Consumers' Affairs' Quality Agency General Directorate.

This Taskforce will continue developing the aspects relating to implementation and protocol assessment in the near future.

General concepts

1. Definition

> "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life".
>
> *(Resolution of 1993 United Nations General Assembly)*

At present, different forms of violence against women are defined:

Physical violence

It encompasses any non-accidental act involving deliberate use of force, such as slapping, beating, thrashing, shoving, causing injuries, fractures or burning that provoke or may provoke bodily lesion, harm or pain in women.

Sexual violence

Resulting from a sexual conduct being imposed on a woman against her free will, whether by her partner or other people.

Sexual assault encompasses all attempts against another person's sexual liberty, through violence or intimidation. Rape is included among these: when sexual assault involves penetration with the male organ through the vagina, anus or mouth, or insertion of any kind of object or body limbs (fingers for instance) through the vaginal or anal ducts. There also exists sexual assault when a woman's sexual liberty is threatened even if such an assault does not involve physical contact between her and her assailant (when forced to masturbate or engage in sexual intercourse with third parties).

Sexual abuse also includes any attempt against a person's sexual freedom, although not involving violence or intimidation, but conducted without the person's free consent. Those acts in which the perpetrator obtains consent, benefiting from a situation of proven superiority imposed on the victim through coercion of her free will, are (apart from those imposed on minors under 13 years of age) considered to be non-consented sexual abuse.

In the work sphere, *sexual harassment* is also a form of violence against women. It occurs when favours of a sexual nature are requested from a woman (for themselves or for third parties) hence provoking in the victim a situation objectively and seriously intimidating, hostile or humiliating.

Offences against sexual liberty or indemnity are categorized under Title VIII, Book II of the Spanish Criminal Code.

There also exist other less studied forms of sexual violence in our country that cannot be overlooked such as for instance sexual mutilations, trafficking with girls and women or sexual tourism, amongst others. These forms of violence also constitute gender violence.

Psychological violence

Deliberate and longstanding conduct, that puts in jeopardy the woman's psychical and emotional integrity and her personal dignity, with the purpose of imposing those behavioural rules the man considers his partner should abide by. It materialises in threats, verbal abuse, humiliations or debasing treatment, exigency of obedience, social isolation, attribution of blame, freedom deprivation, economic control, emotional blackmail, reject or abandonment. This kind of violence is not as visible as the physical or sexual one; it is more difficult to prove and often it is not identified as such, by the victim herself, but just as particular traits of the aggressor's character.

In addition, in the case of violence inflicted on women by their intimate partner or ex-partner, two important elements should be considered: **reiteration of violent acts**[1] and the aggressor's dominant position who uses violence to **subjugate and control his victim.**

Finally, we must not forget that there are women groups that due to their personal profile or to their particular social or legal situation, are in need of specific care that may give response to their actual needs, for a correct follow-up. Such is the case of **physically, psychically or sensorially disabled women, inmigrants, from rural environments or in a situation of social exclusion (as the case may be of prostituded or drug addicted women).** The vulnerability to maltreatment these groups present, forces healthcare personnel to provide them with special assistance.

[1] Under current criminal statutes on gender violence, reiteration of violent acts is not a requirement for such an offence to be deemed perpetrated, notwithstanding the fact that the existence of such reiteration might be significant in terms of aggravation of derived criminal responsilility.

2. Causes

Gender violence's main determining factors are an unequal relation between men and women and the existence of a "culture of violence" as a means of resolving conflicts.

Violence against women is **structural.** Violence does not arise from particular and pathological features of a series of individuals, but presents structural traits of a cultural form of defining identities and relations among men and women. Violence against women occurs in a society that maintains a system of gender relations which perpetuates men's superiority over women, and ascribes different attributes, roles and locations, according to sex. Up until recently, restriction of the personal and social development of women, the exigency of their exclusive devotion to the family, their duty of abiding by the male authority, were considered to be something normal and natural, endorsed by customs and the law. In that context, men's resorting to violence to reinforce their authority, was socially tolerated. Today, social tolerance towards violence is lower. Nevertheless, too many women still endure a high degree of violence, both within and outside their couple relations. This happens in all social classes, religions and education levels.

In conclusion, the main risk factor for violence against women is, precisely, the fact of being women.

Violence against women is, in addition, **instrumental.** Men's power and women's subordination, a basic trait of patriarchy, requires some kind of subjugating mechanism. In this sense, violence against women is the way to consolidate that dominance. Gender violence more than an end in itself, is an instrument of dominance and social control. And in this case, is used as a mechanism for maintaining male power and reproducing female submission. Maltreating men have **learned** through the socializing process –different for men and for women– that violence is the best way to get control and dominate women.

It has been argued that use of alcohol and other drugs is the cause for violent conducts. Although consumption of alcohol and other substances is often associated to violence situations, there are also men who abuse alcohol without incurring in violent behaviour, with many assaults against women being perpetrated in the absence of alcohol.

It has also been claimed that certain personal character traits of women sustaining gender violence might be the cause of maltreatment. For instance, some currents of opinion have resorted to masochist traits or pathologies such as hysteria or dependant personality disorder to explain why some women remain in or return to a situation of maltreatment. There exists today enough documented knowledge demonstrating that there are, before the on-

set of maltreatment, no different psychic character traits, between women who endure it and women who do not, but that disorders and psychological disturbances of maltreated women are a consequence of maltreatment and not its cause.

3. The process of violence

In the case of violence within the couple, the most frequent occurrence is the starting of maltreatment through conducts of psychological abuse at the beginning of the relationship, which are usually attributed to the man's jealousy or his eagerness to protect the woman. They usually are restrictive and controlling conducts that progressively undermine the woman's capacity for decision and autonomy, provoking dependency, isolation and fear, as happens for instance with the controlling of clothing, friendships or activities.

Progressive increase of violence may extend over a long period of time, being usually difficult for the victim to realise what kind of process she is immersed in. The **Theory of the Violence Cycle** by Leonor Walker, establishes three stages for this phenomenon to develop:

- **Building up of tension:** It is characterised by a gradual rise in tension, where the man's hostility to the woman increases for no understandable or apparent reason. Verbal abuse intensifies and the first signs of physical violence may surface. They come up as isolated episodes the woman believes she is able to control and that will clear up. Tension rises and builds up.
- **Outburst or assault:** Violence blows up and physical, psychological or sexual assault occur. It is at this stage when the woman usually reports or seeks help.
- **Calm or reconciliation or honeymoon:** At this stage, the aggressor claims to be repentant and asks the woman for forgiveness. He uses strategies of affective manipulation (presents, caresses, apologies, promises) to avoid the breakup of the relationship. The woman often thinks it will all change. As violent behaviour consolidates and gains ground, the reconciliation stage tends to disappear and the violent episodes get closer and closer in time.

Nonetheless, although the cycle of violence is very frequent in couple relationships where maltreatment is present, it does not always occur. Another kind of violent relationship has recently been described where the situ-

ation of frustration and threats is continual but where only occasionally does physical assault occur.

This so-called "moderate way of violence" would be more difficult to detect than other more severe forms of abuse.

Throughout the process of violence

The woman goes through a progressive loss of self-esteem, also giving up all hope of a change in the situation, the submission to the aggressor and the fear for him growing greater.

For the assaulting man this will come as a proof of the success of his strategy. All this makes it difficult for the woman to break up.

Hence, when a woman seeks help, she must get actual support to change her situation, at all times, respecting her and not putting the blame on her for her decisions. It is important for her to understand that violence will continue and will grow worse, and that she will not be able to curb her attacker's conduct, in order for her to become aware of the danger she is facing.

4. Consequences for health

FATAL CONSEQUENCES

- Death (by homicide, suicide, etc.)

CONSEQUENCES FOR PHYSICAL HEALTH

- Lesions of diverse nature: bruising,, traumatism, injuries, burns,... that might entail disability.
- Functional decline
- Unspecific physical symptoms (headaches for instance)
- Poorer health

CONSEQUENCES FOR CHRONIC HEALTH CONDITIONS

- Chronic pain
- Irritable bowel syndrome
- Other intestinal tract disorders
- Somatic complaints

CONSEQUENCES FOR SEXUAL AND REPRODUCTIVE HEALTH

- Through imposed sexual intercourse: loss of sexual appetite, menstrual disorders, sexually transmitted diseases including HIV/AIDS, vaginal bleeding and fibrosis, dyspareunia, chronic pelvic pain, urinary infection, unwanted pregnancy.
- Arising from maltreatment during pregnancy: vaginal hemorrhage, miscarriage threat, foetal death, premature delivery, low weight at birth.

CONSEQUENCES FOR PSYCHIC HEALTH

- Depression
- Anxiety
- Sleeping disorders
- Post-traumatic stress
- Feeding Conduct Disorders
- Suicide Attempts
- Alcohol, drugs and psychopharmaceuticals abuse

CONSEQUENCES FOR SOCIAL HEALTH

- Social isolation
- Job loss
- Work absenteeism
- Decrease of healthy days span

CONSEQUENCES FOR THE HEALTH OF SONS AND DAUGHTERS

- Risk of disrupting their full development
- Feelings of being threatened
- Difficulties for learning and socialising
- Adoption of submissive or violent behaviours towards their schoolmates
- Higher frequency of psychosomatic disorders
- Frequently victims of maltreatment by their father
- Trans-generational violence with high tolerance to violence situations
- Violence can also affect other persons dependant on the woman and living with her

5. Importance of healthcare services personnel

A crucial role may be played by healthcare services to help women enduring violence, as most women get in touch with them at some moment of their lives (pregnancy, delivery, medical care to children, care of the elderly, etc.). Also, maltreatment affects women's health, which causes them to resort to health services more often, in particular to Primary Care, Emergency Services, Obstetrics and Gynaecology and Mental Health.

This type of violence profile demands active implication of all the personnel of healthcare services who will have to bear in mind that the addressing and resolution of the consequences of violence must start with detecting the problem, but also that the victims seldom talk about their situation spontaneously. They are often scared, ashamed, minimise the seriousness and dangerousness of their situation, are unwilling to admit it and may even get to blame themselves for it.

Very often interdisciplinary interventions are required from professionals that are not always available at primary care centres, what makes coordination among all institutions involved necessary, with the aim of giving a comprehensive and integrated response to this kind of situations.

It is hard to identify situations of maltreatment when there are no physical lesions. A correct diagnosis could be given if healthcare services personnel were able to go in some depth, through a therapeutic relationship, into the psychosocial and gender aspects related to the way and style of life of the person experiencing it, to her problems and family situation. Detection of a situation of violence by healthcare personnel will encourage the breaking of the silence which will mean a first step towards the understanding and visualisation of the problem. Not recognising a maltreatment situation as a health problem conditioning factor, especially by figures vested with "authority", as healthcare personnel are, might entail a new victimisation for the woman which might lead to chronicity of the maltreatment and medicalisation of the problem.

As stated by the World Health Organization (WHO) in its report "Violence Against Women. A Priority Health Issue" addressing healthcare personnel: *"Do not be afraid of asking. Contrarily to the popular belief, most women are willing to reveal maltreatment when asked in a direct and non judgmental manner. In fact most of them are silently waiting for someone to ask"*

The WHO claims that the minimal functions to be performed about this subject from within the healthcare system are as follows:

- Ask all women, regularly, whenever feasible, about the existence of domestic violence as an habitual task within preventive activities.
- Be alert for possible signs or symptoms of maltreatment and do their follow-up.
- Provide healthcare assistance and register it on the health or medical history.
- Help them understand that their discomfort and health problems are a consequence of violence and fear.
- Inform and orient the patients towards resources available in the community.
- Maintain the privacy and confidentiality of the information obtained.
- Encourage and support the woman throughout the whole process, respecting her own evolution.
- Avoid unsympathetic or blaming attitudes as they might strengthen their isolation, undermine their self-confidence and detract the possibility of their seeking help.
- Effect coordination with other professionals and institutions.
- Cooperate in dimensioning and investigating the problem through case registering.

"Not doing" is letting violence go on and women's health get worse. Acting, apart from being able to solve the case, contributes to making all the myths and beliefs surrounding gender violence disappear. Frequently action is not taken for fear of not knowing what to do, to cause more harm..., but it is important to point out that the mere fact of listening with respect is a therapeutic act. Very often the doctor's is the only place a woman has to speak her mind. By talking to the woman it can be gradually discovered what she can be helped out with and how.

6. Difficulties for identifying gender violence

ON THE WOMAN'S SIDE

- Fears (to her partner's reaction, to not being understood and being blamed, confidentiality not being respected, to not being able to initiate a new life, to economic, legal, social difficulties, to what may happen to her children...)
- Low self-esteem, feeling of guilt
- Suffering from a disability, being an immigrant, living in the rural world or in a situation of social exclusion
- Being economically dependant. Being outside the work market.
- Shame and humiliation
- Wishing to protect her partner
- Reluctance to accept what is happening to her
- Distrust in the healthcare system
- Minimising what is happening to her (sometimes they are not aware of their situation and have trouble identifying danger or how the situation is deteriorating)
- Isolation and lack of social and family support
- Values and cultural beliefs (if society tolerates this, so will I)
- They are used to hiding it
- Physical and psychic trauma keeps them paralysed, confused, alienated

ON THE HEALTHCARE'PERSONNEL'S SIDE

- Be immersed in the same socialising process as the rest of society
- Not to consider violence a health problem
- Personal experiences as regards violence
- Believing that violence is not that frequent
- Trying to rationalise the aggressor's conduct
- Double victimisation of the woman (maltreated woman blamed for her situation of maltreatment)
- Being afraid of offending her, of making the situation worse, of her own safety or my own physical integrity
- Lack of knowledge about the right strategies to deal with this kind of situation
- Biologistically oriented training (lacking an approach to psychosocial problems)
- Frequent paternalistic attitudes

AT THE DOCTOR'S SURGERY

- Lack of privacy and intimacy
- Difficulty at communicating (language for instance in the case of immigrant women...)
- The woman comes escorted by her partner
- Attendance overload
- Poor training in communication skills at the medical interview

IN THE HEALTHCARE SPHERE

- Lack of knowledge and coordination among different resources
- No team work whatsoever
- Poor training in violence issues

7. Recommendations for the prevention of violence in the healthcare system

Violence prevention activities may be grouped in three areas:

PROFESSIONAL:

- Inclusion of aspects to prevention, early detection and comprehensive care in healthcare personnel's ongoing training.
- Conducting multidisciplinary clinical sessions on real cases having already been dealt with at the centre or service itself.
- Conducting joint sessions with other professionals and institutions.

IN WOMEN'S COMPREHENSIVE HEALTHCARE:

- Inform by posting billboards and leaflets at visible places telling women that violence is the object of healthcare aid and that help can be provided in there.
- Encourage, through the relation of healthcare personnel with the patient, attitudes, values and activities stressing on the woman's personal autonomy and the exercising of her personal, sexual and social relations rights.
- Include gender violence awareness and prevention contents in the activities of Education for Health and in Maternal Education groups.

IN THE COMMUNITARIAN SPHERE:

- Cooperate with communitarian associations through workshops, conferences and talks on this kind of violence explaining the role of healthcare personnel.
- Propose and participate in actions, campaigns or symposiums related to the subject, that institutions and social organizations may be conducting.

Response procedure in primary and specialised care

Primary care teams are in a position to take action in early detection and comprehensive care to women in situation of gender violence. Features such as accessibility, direct and continued contact with patients and the possibility of their relying on extra interdisciplinary teams may render it easier.

As regards early detection, this protocol requests from healthcare personnel an alert attitude in the presence of conducts, symptoms or suspicion signs. It is also recommended, at each woman's first visit, during the opening of the medical history, that exploratory questions using a psychosocial approach should be made.

When providing care to women experiencing maltreatment, apart from the assistance to, and follow-up of the patient herself, should sons or daughters or other dependant persons on the woman's charge, exist, coordination with pediatrics or relevant services would be necessary.

Something to bear in mind is that pregnant women, those physically, psychically or sensorially disabled, immigrants, those in situation of social exclusion or those living in rural environments, are more vulnerable to maltreatment, for which it is necessary to provide them with special aid. The action protocol is thus structured in phases, as follows:

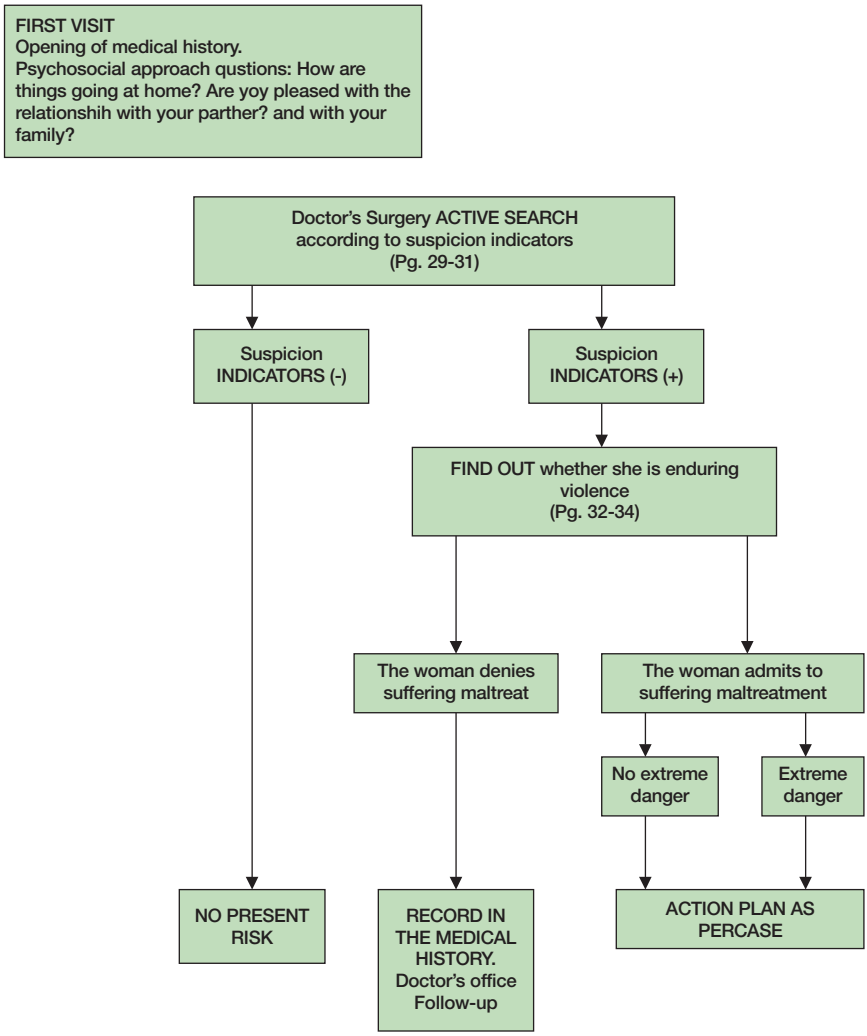
1. DETECTION AND ASSESSMENT

- Suspicion indicators
- Identification
- Assessment:
  - – Biopsychosocial
  - – Of the violence situation
  - – Of risk

2. INTERVENTION

- Information about the problem
- Work at the doctor's surgery - follow-up
- Redirecting
- Recording in the medical history
- Action targeting sons and daughters (when appropriate) or other dependant persons if there were any
- Issue in due course grievous bodily harm and relevant medical reports

1. Detection and assesment Response Action Algorithm



2. Suspicion Indicators

There is a series of signs and symptoms that may lead to think that a woman is sustaining gender violence. It is important for the healthcare personnel to know them and to maintain an alert attitude during the medical interview, in order to identify cases.

Table 1a. SUSPICION INDICATORS IN THE WOMAN'S BACKGROUND AND PERSONAL PROFILE

1. **A Record of Having suffered or witnessed maltreatment during childhood**

2. **Personal background and life habits record**
   - Frequent lesions
   - Alcohol or other drugs abuse
   - Prescription drugs abuse, mainly psychopharmaceuticals

3. **Gynaecologic-obstetric problems**
   - Absence of fertility control (many pregnancies, unwanted or unaccepted pregnancies)
   - Presence of injuries in genitalia, abdomen or breasts during pregnancies
   - Dyspareunia, pelvic pain, recurrent gynaecological infections, anorgasmy, dysmenorrhea
   - Repeated miscarriages history
   - Low-weight newborns
   - Delay in requesting prenatal care

4. **Frequent psychological symptoms**
   - Insomnia
   - Depression
   - Anxiety
   - Post-traumatic stress disorder
   - Suicide attempts
   - Low self-esteem
   - Psychic exhaustion
   - Irritability
   - Feeding conduct disorders
   - Emotional lability

Table 1a. SUSPICION INDICATORS IN THE WOMAN'S BACKGROUND AND PERSONAL PROFILE (continuation)

5. Frequent physical symptoms

- Headache
- Cervical pain
- General chronic pain
- Dizziness
- Gastrointestinal upsets (diarrhea, constipation, dyspepsia, vomiting, abdominal pain)
- Pelvic upsets
- Breathing difficulties

6. Use of health services

- Existence of periods of overfrequentation and others of absence (long)
- Failure to keep appointments or treatments
- Repeated use of emergency services
- Frequent hospital admissions
- Coming with her partner when she did not use to

7. Situations of a greater vulnerability and dependence for the woman

- Situations of life changes:
  - Pregnancy and puerperium
  - Courtship
  - Separation
  - Her own or her partner's retirement
- Situations that increase dependence:
  - Isolation from both family and social environment
  - Migration, domestic or international
  - Disabling illness
  - Physical of economic dependence
  - Difficulties at work and unemployment
  - Difficulties for training and promotion at work
  - Absence of social skills
- Situations of social exclusion (prison inmates, prostitution, poverty)

8. Information from family, friends or workmates, or institutions about the woman being victim of maltreatment.

Table 1b. SUSPICION INDICATORS DURING MEDICAL INTERVIEW

1. **Lesions and health problems profile**
   - Delay in requesting assistance for her physical injuries
   - Inconsistency between lesion type and explanation about its causes
   - Haematomas or bruising in suspect areas: face/head, inner face of arms or thighs
   - Injury from self-defence (arm inner face)
   - Different healing-stage lesions which indicate long standing violence
   - Lesions in genitalia
   - Lesions during pregnancy in genitalia, abdomen and breasts
   - Typical lesion: tympanum bursting

2. **Woman's attitude:**
   - Fearful, evasive, uneasy, nervous, she stirs when door opens for instance...
   - Depression signs: sad, demotivated, disillusioned, in dispair
   - Low self-esteem
   - Feelings of guilt
   - State of anxiety, anguish, irritability
   - Feelings of shame: bashfulness, hard to communicate with, avoiding direct look in the eyes
   - Clothing suggestive of an attempt to hide lesions
   - Untidiness
   - Justifies her lesions or tries to play down their importance
   - If her partner is present:
     – Fearful in her answers
     – Constantly seeking his approval

3. **Partner's attitude**
   - He requests being present during the whole visit
   - Very controlling, he, himself, giving all the answers or, on the contrary, detached, disparaging or trying to banalize facts
   - Excessively concerned or solicitous with her
   - Sometimes choleric or hostile with her or with the professional

3. Identification

When healthcare personnel suspects a woman of being victim of maltreatment, they will have to either confirm or rule out a situation of violence. To do this, a **specific medical interview** will have to be conducted. In the table below, some tips are given to create an atmosphere of ease and confidence that may help make it possible.

Table 2a. TIPS FOR THE MEDICAL INTERVIEW TO THE WOMAN UNDER SUSPICION OF BEING MALTREATED

- See the woman alone, assuring confidentiality
- Observe her attitudes and emotional state (through verbal and non verbal language).
- Ease the expression of feelings.
- Keep an empathic attitude, making communication easy, through active listening.
- Follow a logical sequence of more general and indirect questions to more concrete and direct ones.
- Broach the subject of violence in a direct way.
- Express clearly that violence is never justified in human relations.

In the case of her admitting to it:

- Make the woman feel that she is not guilty of the violence she is sustaining.
- Believe the woman, without questioning the facts interpretation, without giving opinions, trying to take fear off the disclosure of the abuse..
- Help her think, organise her ideas, and make decisions.
- Alert the woman about the risks and accept her choice.
- DO NOT give the impression that everything will be easily solved.
- DO NOT give false hopes.
- DO NOT criticise the women's attitude or her lack of response, with remarks like: “Why do you stay with him?; If you wanted to break up he would leave...”.
- DO NOT underestimate the sensation of danger expressed by the woman.
- DO NOT recommend couple therapy or family mediation.
- DO NOT prescribe medication that may decrease the woman's capacity of reaction.
- DO NOT adopt a paternalistic attitude.
- DO NOT impose criteria or decisions.

Some examples are presented in this table of general questions that might be used in medical interviews for an active search of cases of maltreatment in case of suspicion.

Table 2b. EXAMPLES OF QUESTIONS WHEN IN SUSPICION

In case of suspicion because of information obtained from the patient's background and characteristics:

- I have gone through your medical history and have found some things I would like to talk to you about. I can see that... (mention the findings), "what do you think may be the cause of your discomfort or health problem? You look a little uneasy; what is bothering you? Are you going through any kind of trouble that makes you feel like that? What can you tell me about it? Do you think it might all be related?
- In many cases women with problems like yours, such as... (mention some of the identified problems, the most relevant) may be suffering some kind of maltreatment from someone, like for instance their partner. Is that your case?
- In the case of suspicion due to a medical record of dyspareunia, pelvic pain...., ask whether their affective and sexual relations are satisfactory.

In case of suspicion due to her apparent physical injury:

- This kind of lesion usually turns up when you get a shove, a blow, a cut, a punch... Is that what's happened to you?
- Does your partner or any other person use force against you? How? Since when?
- Have you ever been more seriously aggressed? (thrashing, with some kind of weapon, sexual assault)

In case of suspicion due to symptoms or psychic problems found:

- I would like to have your opinion on the symptoms you have told me about (anxiety, nervousness, sadness, apathy)..): How long have you been feeling that way?, What do you think the reason for that is? Can you relate them to something?
- Has anything happened in your life that makes you sad or concerned? Maybe you have some kind of problem with your partner? Or with your sons or daughters? With anyone in your family? At work?
- You look somehow alert, frightened. What are you afraid of?
- Have you got some kind of difficulty to see your friends or family? What is stopping you?

Table 2c. QUESTIONS FOR ASSESSING THE SITUATION AND TYPE OF VIOLENCE

Physical violence

- Does your partner shove or grab you?
- Does your partner beat you, slap you or assault you in some other way?

Sexual violence

- Does your partner force you to have sex against your will?
- Does he force you to do something you would rather not do sexwise?

Psychological violence

- Does he often yell at you or speak to you in an authoritarian manner?
- Does he threaten you with hurting you, your children, or other people, or your pets?
- Does he abuse you, makes fun of you, scorns you, when you are alone or in front of other people?
- Does he get jealous for no reason at all?
- Does he prevent you from seeing your family or friends?
- Does he blame you for all that happens?
- Does he control the money you spend, or forces you to account for all the expenses?
- Does he stop you from working out or study?
- Does he threaten you with taking your children away from you if you leave him?
- Does he ignore your feelings, your presence, etc.?

4. Appraisals

Once a woman admits to being in a situation of maltreatment, a thorough probing of the injuries and examination of her emotional state must be undertaken, informing her of all the exploratory actions being taken and their purpose.

Table 3. APPRAISALS

BIOPSYCHOSOCIAL

- Lesions and physical symptoms
- Family situation
- Economic, work and occupational situation
- Woman's social support network
- Emotional situation

OF THE VIOLENCE SITUATION

- Type of violence, since when she has been sustaining it, its frequency and intensity.
- Aggressor's behaviour with respect to the family or socially wise; whether there have been aggressions to other people or family members.
- Adapting mechanisms developed by the woman.
- Stage of the process, she is in.

OF HER SAFETY AND RISK APPRAISAL

- Determine whether or not the woman is in extreme danger, understanding by extreme danger a current situation likely to result imminently in an event entailing a veritable death risk for the woman's life or her children's Extreme danger indicators. This appraisal will be made jointly with the woman.
  - Threats with weapons or use of the latter
  - Homicide threats or attempts on her or her children
  - Threats of or attempted suicide by the patient
  - Maltreatment to children or other members of the family
  - Serious injury, even requiring hospital admission
  - Threats or harassment despite their being separated
  - Increase of intensity and frequency of violence
  - Assault during pregnancy
  - Repeated sexual abuse
  - Violent behaviour outside the home
  - Extreme jealousy, obsessive control of her daily activities: where she goes, who she is with or how much money she has.
  - Increasing isolation
  - Alcohol or drugs consumption by partner
  - Decreasing or absence of remorse shown by the aggressor.
- Considerate the perception of danger by the woman herself, both for her and for other members of the family environment. If this indicator is present, the situation gets automatically labelled as one of extreme danger
- Professional opinion after joint assessment (mainly during interview and with the biopsychosocial appraisal in hand).
- If a situation of danger is detected, ask:
  - Do you feel safe at home? Can you go home now?
  - Are your children safe? Where is the aggressor now?
  - Do your friends and family know? Would they help you?

5. Courses of action

Confirmation of suspicion of maltreatment to a woman does not end healthcare personnel's action. On the contrary, and from that very moment a concerted effort must be made, to inform and provide assistance to the woman, working in the doctor's surgery, or redirecting the patient when the case characteristics make it advisable.

Healthcare personnel's course of action will be different depending on whether or not the woman admits to maltreatment, and the kind of danger situation she may be in.

So, the 3 possible situations are described, according to which different action guidelines will be followed:

- Woman suspected of suffering maltreatment.
- Woman admitting to suffering maltreatment but in no extreme danger.
- Woman admitting to suffering maltreatment in extreme danger.

Plan for taking care of a woman presenting suspicion indicators but not admitting to suffering maltreatment

- **Record in the medical history both suspicion and actions taken accordingly**
- **Inform the woman about the situation she is in**
- **Work at the centre-follow-up:**
  - Comprehensive/interdisciplinary care
  - Care for physical/psychical/social problems detected
  - Offer follow-up visits: empathize with the woman in her acknowledging of the situation of violence and in her decision making
  - Offer, whenever possible, participation in group meetings (groups of women at the centre or other area facilities)

Plan for taking care of a woman admitting to suffering maltreatment but in no extreme danger

- **Register in medical history**
- **Inform the woman on the situation she is in**
- **Work at the centre-follow-up:**
  - – Comprehensive/interdisciplinary care
  - – Care for physical/psychical/social problems detected
  - – Discuss the devising of a safety strategy when faced with an extreme situation.
  - – Establish a follow-up meeting plan to:
    - ◦ Discuss and smooth the path for decision making in order for changes in the situation to be undertaken
    - ◦ Be with her when confronting her situation
    - ◦ Prevent new situations of violence
    - ◦ Offer, whenever possible, participation in group therapy meetings (groups of women at the centre or other area facilities)
- **Redirect** (if deemed necessary and with the woman's previous consent)
  - – To social workers
  - – To those resources most in keeping with the woman's actual situation
- **Issue grievous bodily harm report in due course***
- **Action taking on children and other dependant persons if there were any**

* In those cases in which the woman refuses to report and should the healthcare personnel have well founded suspicions of the existence of physical or psychic maltreatment (when there is no clear verification of the injuries' origin that would enable the issuing of the relevant grievous bodily harm report), it is recommended to communicate the situation to the public prosecutor's office as it is legally mandatory. The public prosecutor's office will decide, in view of the circumstantial or additional evidence that might be contributed, which the procedure shall have to be.

Plan for taking care of a woman admitting to suffering maltreatment and in extreme danger

- **Inform her on the situation of danger she is in, and present her with the possible strategies to be followed. Let her know she is not alone.**
- **Urgently Redirect to Social Work or to Social Emergencies Round-the-Clock Support Services for women suffering maltreatment.**
- **Record the episode and courses of action taken in the medical history. This record may be used as evidence in a legal procedure.**
- **Issue the grievous bodily harm and medical reports, handing the woman a copy and informing her on the implications.**
- **Get to know the situation of her family, dependant persons and resources she can count on.**
- **Call 112 (Emergencies) or your autonomous community's specific services**

Addressing emergencies

Women suffering gender violence can also resort to emergency services, both in primary and specialised care. Most of the courses of action established in the previous chapter may equally be recommended for emergency services, exception made of those referring to doctor's surgery follow-ups. In emergency services, patients' injuries and symptoms are likely to be more serious. Women coming to emergency services because of this kind of problem may or not, admit to having suffered maltreatment.

1. Steps for detecting violence

- Keep on full alert and pay attention to those signs and symptoms that may lead to think that the patient is suffering maltreatment. (Suspicion indicators. Table 1b. Page 31)
- In suspected cases, conduct a specific medical interview in other to detect maltreatment. (Identification. Table 2b. Page 33)
- Take care of the woman in the right closeness atmosphere. (Identification. Table 2a. Page 32)

2. Steps for providing care

First of all, the woman's state of health, both in physical and psychological terms, will be addressed, and a diagnosis and the right treatment will be established.

The care provided to the patient will be in keeping with the type of injuries and symptoms displayed and in case she does not require hospital admission, the urgent intervention of psychology/psychiatry and social work professionals shall have to be assessed.

Equally, inquiries shall be made about the existence of minors or dependants who might be enduring the same violence, in case immediate measures should have to be taken.

The discharge report, the woman will be provided with, will have to clearly state the injuries she presents and her psychological state. It must be handed to the woman as long as it does not put her safety in jeopardy (the alleged aggressor may be with her or he might discover the discharge copy's

existence when she gets home). If that is the case she may be informed that if she is afraid of taking the copy with her, it may be handed to some relative or person she trusts. Another copy will be for primary care, in order to enable follow-up and conducting whatever actions deemed necessary.

3. Safety assessment

Whenever a gender violence case is dealt with at an emergency service, an appraisal of the woman's safety and risk, will have to be made. (Appraisals. Table 3. Page 32)

4. Information and redirecting

Once due care and aid have been provided, the relevant information actions will be taken and redirecting, when deemed advisable in accordance with the case being treated, will be effected.

5. Legal action

In Spain, it is mandatory that legal authorities be apprised of the existence of injury when there exists verification of maltreatment. This legal imperative is complied with by notifying the court through a grievous bodily harm and accompanying medical report, previously informing the affected woman about this dispatch and recording the latter on the medical history.

Addressing sexual assault

Action guidelines to be followed when addressing cases of sexual assault present particularities that justify their being dealt with in a separate section. Definitions for these cases appear on pages 17-18.

Sexual violence against women may be inflicted on them by their own intimate partner or by other men. Women tend to report, in general, when the aggressor is not their partner. When sexual assault occurs within the couple, reporting is quite unusual. These are the cases where sexual violence remains hidden and it is hard to be detected.

Healthcare personnel from Primary Care or from other extra-hospital healthcare operation groups, confronting a sexual assault, and with the exception of severity of injuries or risk for the patient's life that would require immediate medical treatment, will expedite the victim as urgently as possible and in an ambulance to the nearest hospital, without allowing washing or clothes changing. In the case of fellatio, it is important, as far as possible, to avoid liquids or food taking before the victim is examined in hospital.

It is imperative to provide the woman with understanding care, creating an atmosphere that enables communication, confidentiality and as much privacy as may be possible. If the victim so wishes, someone of her entire trust may be present. No awkward questions should be made, collecting just those data the woman is willing to provide.

The woman must be informed of all the explorations she is going to go through and their purpose, describing, at all times, what is being done and asking for consent whenever necessary.

It obviously stands to reason, that after an assault, the number of psychical impacts the woman should go through, would have to be limited to the very least possible. That is why not only is it justified but it is certainly advised to conduct both gynaecological and medical-forensic assessments at once, while keeping healthcare and legal tests independent but always trying not make new examinations necessary. For all of the above, and not existing legal or ethical impediment –quite the opposite– for examinations in case of sexual assault to be performed in a simultaneous and coordinated manner, immediate telephone communication with the police court is imperative, who will arrange for the forensic doctor attendance, or will entrust the doctor on call with the taking of samples and specimens of legal interest*.

* In order to legally proceed against sexual assault criminal offences, a complaint filed by the offended person, their legal representative, or criminal charges filed by the State Prosecutor's

Below, the different general actions to be undertaken by each one of the experts in this type of cases, are listed:

Actions to be undertaken by medical doctors:

- Anamnesis and medical examining
- Request the intervention of forensic doctors through the Police Court and cooperate with their work
- Take samples from genitalia for detection of sexually transmitted diseases
- Request complete blood tests
- Immediate treatment of possible physical injuries
- Treatment of sexually transmitted diseases
- Pregnancy prophylaxis
- Issue grievous bodily harm report

Action to be undertaken by forensic doctors:

- Samples taking for legal purposes **
- Signalling the location and importance of injuries (take photographs)
- Issuing of Medical Forensic Report for the Police Court

office (when the victim is a minor, disabled or destitute person, a complaint filed by the Public Prosecutor's Office will suffice) are indispensable requirements. Even when the woman might, at that moment, express her intention of not lodging charges, the facts will have to be communicated to the Police Court, in order for them to file the relevant legal suit where legal investigation and securing measures will be made available in case the rest of the legitimately involved or the woman herself in the future might want to exercise her right to initiate a criminal complaint.

** The National Institute of Toxicology and Forensic Sciences and the Women's Institute, in cooperation with the Centre for Legal Studies of the Ministry of Justice, have presented in various provinces and Autonomous Communities, a kit for the taking of samples in cases of sexual assault. It contains all the necessary equipment for a correct taking of specimens (cotton swabs, nail clippers, comb, sample bags, labels...) Apart from this equipment, the kit also contains a series of elements intended to improve the environment in which medical examining will have to be conducted, providing the privacy and dignity which in this kind of cases is highly necessary to try and reduce the risk of secondary victimization.

In the tables that follow, actions to be taken by **emergency services** in cases of sexual assault are described in detail:

RECORDING IN MEDICAL HISTORY

- It may be used as an important piece of evidence during legal proceedings
- Transcribe events recounted by the patient in connection with the assault (date, place, time, type of sexual assault) and everything having taken place after the assault and before medical exploration (personal hygiene, food or medication intake, etc.)
- Diseases, surgical, medication records, associated consumption of alcohol and other drugs, etc.
- Violence record if any.
- Gynaecological history: menarche, menstrual cycle, latest period date, contraceptive method, latest sexual intercourse.

EXPLORATION *(GENERAL AND GYNECOLOGICAL)*

- **Examination of the body surface:**
  - Detail location and importance of lesions (injuries, bruising, erosions, lacerations), registering their absence when appropriate. In case these exist, it is advisable to take photographs *with the woman's previous consent*
- **Samples of legal interest:**
  - Take samples of semen, urine, blood or other fluids on the body surface, using sterile swabs, slightly dampen with distilled water, placing the samples in test tubes to be sealed and labelled, and keep refrigerated (4-8 °C).
- **Gynaecological exploration:**
  - Vulvo-vaginal inspection: detail injuries, haematomas, bruising, contusions, registering their absence when appropriate. In cases of sexual assault on women having never before had sexual relations, it is of interest to record the possible existence and location of hymenal tearing that evidence the existence of penetration.
  - Bimanual tactile exploration: to determine uterine size, shape, consistency and mobility, as well as possible existence of masses or adnexa pain. An eventual ultrasound scan might be necessary.

EXPLORATION *(GENERAL AND GYNECOLOGICAL)* (continuation)

- **Samples of legal interest:**
  - Vaginal (or anal, or buccal) smears with dry and sterile cotton swabs for sperm investigation. They will be kept in their caps, not dipping them in any conservatives, and refrigerated (4-8 °C) and labelled. It is advisable to do the smear with at least two swabs.
  - Vaginal (or anal or buccal) wash with 10cc of sterile saline solution for collection of possible sperm remains. Collect the wash liquid in an appropriate sterile tube to be hermetically sealed and labelled. It will be kept refrigerated (4-8 °C). Vaginal wash will be done after sample taking, to enable screening of sexually transmitted infections.
  - Clothes the patient was wearing during the alleged assault: place each item of clothing in a separate and labelled bag.
  - Swabs dampened in saline solution, in cases of anal or oral aggression, taken from both cavities, afterwards placing the swabs in a tube to be sealed and labelled.
  - Nail clipping fragments (possible skin from the aggressor).
  - Combing of the assaulted woman's pubic hair (possible pubic hair from the aggressor).

Sample labelling will include the name of the patient, date and signature of the professional. The different samples will be introduced in an envelope with the woman's name, addressed to the Forensic Medicine Department at the Police Court..

When samples are not taken by a Forensic Doctor, secure the **custody channel** in order for the samples obtained to have legal value: That is to say that the person responsible for the sample taking and the one responsible for the transport of the samples to the medico-forensic service of the Police Court will record their identity documentarily, as well as an accurate listing of the samples obtained and dispatched. Written record of the person taking delivery of the samples, will be kept at the medico-forensic quarters.

BLOOD TESTS

- **Determine the patient's blood type and Rh factor**
- **Test for toxics**
- **Pregnancy test**
- **Infections and sexual transmission:**
  - Culture for detection of gonorrhea and chlamydia, 1st and 7the day
  - Syphilis, 1st and 7th day.
  - HIV 1st day, 6 weeks and after 3 and 6 months
  - Hepatitis B: 1st day and 6 weeks
- **Smear test also useful for monilias and trichomonads**

ATTENTION AND FOLLOW-UP

- **Treatment of physical injury and psychological after effects:**
  - Physical traumatism: treat the wounds and dress them to prevent infection and if advisable effect tetanus prophylaxis.
  - Psychological Trauma: In general, urgently redirect the woman for her to be given preferential psychiatric or psychological care. In general, women having suffered sexual assault develop anxiety, feelings of guilt, humiliation and shame, that require help.

- **Sexually transmitted diseases prevention:**
  - Preventive care must be given to prevent gonococcemia, chlamydia or possible incubating syphilis.
  - The need for prophylaxis against HIV: The risk of transmission of HIV may be high if the aggressor is HIV+, suffers from other sexually transmitted diseases and there was ejaculation. Consider prophylaxis by following the guidelines on non occupational post-exposure prophylaxis.
  - The need for prophylaxis against Hepatitis B Virus will be individually assessed.

- **Pregnancy prophylaxis:**
  - In case the woman is using contraceptives, prophylaxis will not be necessary.
  - Postcoital hormonal contraception if no more than 72 hours have elapsed since the assault.
  - If between 72h and less than 5 days have elapsed since the assault the above procedure is not considered effective and a coil will have to be placed.
  - Confirm next period or carry out pregnancy test in 2 to 3 weeks.
  - Inform the woman that in case of being pregnant and according to the law she can resort to voluntary termination of pregnancy.

INFORMATION AND REDIRECTING

- **Inform the woman on:**
  - Sexual assault is a criminal offence and the woman is entitled to file a complaint.
  - Analyse together with her physical and emotional repercussions on her health..
  - Inform her that the Law protects her rights and integrity and that if she so wishes she may request a Protection Order.
  - Inform her on the resources network and social mechanisms (preferably in writing) devised for providing care to women suffering gender violence, the way they may be organised in her Autonomous Community or province.

- **Redirecting:**
  - Importance of redirecting to/ and coordination with Primary Care and Social Work ensuring the woman psychological, social and legal attention, according to the organisation and own resources of her Autonomous Community or Province.

RECOMMENDATIONS

- Not to maintain sexual intercourse until next evaluation
- Follow-up suited to the whole process of comprehensive care to her health.

NOTIFICATION TO THE COURT

- Issue grievous bodily harm and medical reports for the Police Court*.

* Results from all medical tests performed and recommended in this protocol must be compiled in the Medical Report.

Resources guide

As it has repeatedly been pointed out throughout this protocol, coordination, and intersectorial cooperation (through social, legal, police resources, etc.) is essential to achieve protection and care for women suffering maltreatment.

It is important for each professional to be informed of specific resources available at the national, regional, provincial and local levels and their specific nature, to be able to use them rationally. In this sense, social work professionals represent an essential linking figure in the process of women redirecting. It is also important to take into account that redirecting to a different resource must not be considered the end of the process and that women's follow-up at the doctor's surgery is essential.

This section deals with nationwide resources only, as in each Autonomous Community there is an array of them, including provincial and local ones. This part of the Protocol must thus be adapted to each Autonomous Community's particularities.

NATIONWIDE LEVEL RESOURCES

- Women's Institute round -the- clock telephone information service:

  900 191 010
  900 152 152 (for deaf women)

- Casualty Care Service and Emergencies: **112**
- National Police: **091**
- Civil Guard: **062**
- Government Special Delegation to combat Violence against Women

  http://www.mtas.es/igualdad/violencia.htm

All telephone numbers listed are toll free.

We are presenting here a generic resources listing, in order for the different Autonomous Communities to provide telephone numbers and addresses for each one of them. Resources for emergency cases must be taken separately from the non emergencies.

RESOURCES IN AUTONOMOUS COMMUNITIES

- Casualty Care Service and Emergencies in Autonomous Communities.
- SAM (Spanish acronym for National Police Women Care Service) in the AC.
- EMUME (Spanish acronym for Civil Guard Women-Minor Specialists) in the AC.
- Local Police
- Reporting, Protection Orders and Mobile Telephone-Assistance Service Requests, to the National Police, Local Police, Civil Guard, Police Stations (list) Public Prosecutor's Office (address and telephones), Courts (address and telephones).
- Guidance and Legal Counselling (detail with addresses and telephone numbers):
  - AC Free toll 900 telephone (when applicable)
  - Legal Aid Services of Bar Associations
  - Autonomous Communities Equality Institutions
  - Local Councils' Social Services
  - Violent Offences Assistance and Against Sexual Liberty, Services, at the Courts
  - Women's Organizations
  - Immigrants Organizations (those who give assistance to those immigrants whose language is not Spanish deserve special attention)
- Foster Homes: information at Autonomous Communities' Equality Institutions and at Local Councils' Social Services (state just this; do not include list).
- Should there exist specific programmes related to gender violence matters, they must be mentioned
- Any other Autonomous Community's specific resource on this matter.

Ethical and legal aspects

When making decisions, faced with a situation of maltreatment at the doctor's surgery, healthcare personnel must bear in mind that one of their tasks is to listen and provide support, and respect the woman's decisions. Many of the women in spite of sustaining important lesions, do not resort to healthcare services, out of shame, threats from the aggressor or for fear of the Court being told of her lesions' origin and adopting legal measures that might affect their families.

In the process of exercising due care of the woman enduring gender violence, it is important to respect the patient's autonomy and the confidentiality commitment regarding that information received by virtue of professional duty. So is it, to safeguard life and the benefit of a patients' health (benefaction principle) and prevent them from suffering harm (non malefaction principle).

In case of a situation of maltreatment being confirmed, the Gender Violence Court will be apprised through the relevant Grievous bodily harm and Medical reports, previously informing the woman. Notification of the events to the Authorities allows the setting in motion of the legal measures targeting the protection of the woman and avoids the offence going unpunished. Issuing of a Grievous bodily harm report and the negative consequences such a move might entail, is often a source of concern for healthcare professionals especially when the woman expresses her disagreement. Part of these negative effects would relate to the woman's rejection and loss of confidence owing to her wishes not having been respected, which would possibly entail a breach of the relation healthcare professional-patient, and a potential increase of the risk for the woman's health or life, posed by an aggressor's eventual retaliation.

Bearing in mind that each case is different and that analysis and assessment must be tailored to suit each woman's personal circumstances, it is recommended to follow the actions described in the corresponding chapters.

Guidelines for dealing with the maltreater

The Ministry of the Interior and its dependant institutions and organizations have direct responsibility for intervention against and treatment of maltreaters, aiming at their possible rehabilitation and social reintegration.

As regards the maltreater himself, the only responsibilities of healthcare intervention are those related to his own health needs as a user, arising from his state of health.

In case he himself –as a patient– asked for help to modify his violent conduct, he would have to be given information on resources available in his autonomous community for cases like his.

In case the woman suffering maltreatment asked the healthcare personnel for help, for her partner or ex-partner, the same process as described in the previous case should be followed, offering them information to this respect on resources available within their autonomous community.

Grievous bodily harm and medical reports

Organic Act 1/2004, 28 December, on Comprehensive Protection against Gender Violence establishes in its Title III, about Institutional Tutelage, in its article 32 about Cooperation Plans, that:

> *"Protocols, apart from establishing the procedures to be followed, will refer explicitly to the relations with the Administration of Justice, for those cases in which there exists* ***verification or well founded suspicion of physical or psychic damage arising from assault or abuse".***

On the other hand, article 262 of the Criminal Procedure Law, establishes that:

> *"Those that by virtue of their position, profession or trade happened to learn of some public offence, shall be forced to immediately* ***report it*** *to the Public Prosecutor's Office, the competent Court, the Examining Magistrate, or failing that, to the nearest police officer or public servant, if it were a flagrant crime".*

This obligation is deemed to be fulfilled by dispatching the Grievous bodily harm report.

As established by the Criminal Procedure Law, the Public Prosecutor's Office, shall be entitled, before legal action takes place –before the report of the offence reaches the relevant Judge and the latter passes judgement– to institute preliminary investigation proceedings, in order to collect further information on the reported events.

Dispatching the Grievous bodily harm report, to the legal authority is in general tantamount to registering its entry and forwarding it to the Courts Deanery*. Once registration of the entry of the bodily harm report in the corresponding court office takes place, the legal proceedings will be the same as if the woman herself or people of her social milieu (neighbours, friends) had lodged the complaint.

The Deanery will determine which Court will try the case, firstly taking into account, the kind of competent court, according to the legislation currently in force. Secondly, and if in that administrative area there exists more than one court of the same kind, the one to try will be the one appointed in

* Deanery: Organ within the corresponding administrative area office, that among other things is in charge of the assignment of cases to the different Courts attached to it.

accordance with the application of distribution regulations previously approved by the Deanery.

Once the bodily harm report has been received, the Judge will order the initiation of criminal proceedings (or will add them, if they had had previous knowledge of the events, to the already initiated proceedings) and will rule on the practice of investigation proceedings and, if applicable, adoption of measures to protect the victim.

It is very important to identify cases of gender violence as such, for the Deanery to know that the criminal case has to be tried by a court with competence in gender violence matters, and be forwarded accordingly. Otherwise the case might be forwarded to a First Instance Court that would have to disqualify themselves from the case once they saw it was a violence gender case, delaying the procedure to the detriment of the woman.

Both the grievous bodily harm and the medical reports will have to be completed by the medical personnel responsible for the patient's examining, following the recommendations detailed below and subsequent mandatory dispatch to the Court of First Instance.

The handwriting will be clear and readable and with no corrections (these might be interpreted as manipulation). Computerising of the bodily harm and medical reports would be advisable as it would avoid the inconvenience of illegible handwriting, poor filling in, empty boxes, etc.

On occasions unreadableness of reports prevents from knowing the exact extent of the lesions, complementary explorations and other data of interest, and hence, the seriousness of the assault. It all hinders the subsequent appraisal by the forensic doctor and as a consequence, the Judge's decision.

As regards the grievous bodily harm report and the medical report that goes with it, guidelines are provided now about data that should be filled in, regardless of the format each Autonomous Community establishes in its territory.

Grievous bodily harm report and medical report forms will be available in all healthcare centres. A copy will be handed:

- To the person concerned, as long as her safety is not put in jeopardy (she may be accompanied by the alleged aggressor or the aggressor might discover the copy once she gets home). If such were the case, she can be told that if she is afraid of taking the copy with her, it may be handed to a relative or person of her trust.
- To the Court by mail. In urgent cases, notification will be sent by fax.
- It will be filed together with the woman's medical history, in the healthcare centre where she received care.

IMPORTANT:

The medical report will have to be read to the woman before its final drafting.

GRIEVOUS BODILY HARM AND MEDICAL REPORT*

DATA OF THE MEDICAL PERSONNEL RESPONSIBLE FOR THE ATTENDING:

- Hospital/Health Centre/Doctor's Surgery
- Data of the issuing professional: Name and Surname, Prof. Licence Num.

VICTIM'S PERSONAL DETAILS:

- Name and Surnames
- Identity Card N.º or Foreign Identity Card N.º
- Date of birth, Age
- Country of Origin
- Marital Status
- Address, City (P.O. Box or INE Code)
- Telephone

INJURIES PRESUMABLY CAUSED DURING ASSAULT AND TYPE:

- Type of violence inflicted
- Use of objects during assault
- Psychic and emotional state. *(Describe the woman's emotional symptoms and attitude).* Psychological maltreatment may be reflected in symptoms of depression, anxiety, suicidal tendencies, somatizations, post-traumatic stress disorder). The emotional state of any person sustaining injury is disturbed, but their attitude is different. The latter may be a great indicator or what happened, for instance: a woman having suffered maltreatment is confused, evasive, uneasy, afraid, **aggressive, overalert, apathetic, expressionless... This information is necessary to approach the patient's psychical state.**

* Although grievous bodily harm and medical reports may present different formats, be it on paper or software, they have to, at least, include this information.

- Physical lesions the patient presents: It is important that lesions (cutaneous, musculo-skeletal, ocular, auditory, genital, internal, etc.) be described thoroughly in what concerns type, shape, dimension, colour and location, which will allow to better establish dating or possible date of infliction. To this end, special attention will be paid to oldest lesions or those presenting different evolution stages, as evidence of habituality or reiteration. Taking photographs *(preferably colour ones)* of affected areas is strongly recommended, with the woman's previous consent.
- Whenever, and after medical assessment, there exists possibility of internal injury (abdominal, thoracic and/or cerebral), such information will be recorded as suspicion, as only after diagnostic tests performed in hospital, will the former be confirmed.

Other CLINICAL data

- Complementary tests conducted
- Therapeutic measures *(include prophylactic measures, pharmacological treatment, local dressings, surgical treatment, etc.)*
- Clinical prognosis

DATA RELATED TO EVENTS HAVING BROUGHT ABOUT NEED FOR CARE:

In this section, how the events happened must be reflected, quoting whenever possible the woman's same words. Also, data listed below will have to be collected:

- Address, place of the assault, date and time of events.
- Date/time of medical attention.
- Origin of lesions, expressed by the woman: Physical, pshychical, sexual.
- Suspicion of cause of lesions being different from what the woman claims it to have been.

RECORD

- Comes by herself or accompanied by (name and relationship).
- Momentary assault, first time or maltreatment reiteration.
- If assaults are longstanding, state since when they have been taking place and describe the characteristics of these assaults, type, frequency (daily, weekly, monthly...) if the violence intensity is increasing, if it has been previously reported, etc., and their evolution.
- Other persons having suffered maltreatment in the same course of events or on previous occasions *(If there are minors or other persons dependant on the woman and they are also victims of maltreatment, this has to be notified to the Centre's Pediatrics Department and Social Work services. If deemed necessary to the relevant Minor Protection Service).*
- Witnesses: Acquaintances (neighbours, friends), minors or other dependant persons in her care.

ALLEGED AGGRESSOR'S DATA:

Name and surnames
Relationship/kinship with the assaulted person
Supposed address or telephone

ACTION PLAN

Whenever applicable, include discharge or redirecting to other specialties and resources, hospital admission, if it has been necessary, and the required follow-up.

OTHER DATA

Related to situations other than those described in previous sections but need be notified to the Court, such as for instance:

- Whether or not the Court has been telephonically apprised. If so, specify when.
- Aspects of risk or safety perceived by the woman
- Women's attitude towards reporting

REMARKS

In this section, data not previously stated and considered of interest must be reflected. Even when maltreatment offences are public criminal offences that will have to be legally prosecuted, this section must be used to state if the woman expressed her not wanting to report the crime and the causes for it (being afraid of the aggressor, of losing the children custody, of family reactions, economic dependence, etc.,) with the purpose of providing the legal organ with information on the woman's personal circumstances, which might be of use for addressing the specific case).

If verification exists of previous injury pointing at the conviction or well founded suspicion of the woman's sustaining habitual maltreatment, it is important that it be reflected on the grievous bodily harm report, because of its constituting an additional offence different from grievous bodily harm.

Any threats from the aggressor (verbal, threatening to use in the future any other weapon for aggression, etc.) will be equally reflected here.

It is advisable to have a good supply of COPIES: for the person concerned / Court / Healthcare Centre (and/or medical history) and/or Healthcare Central Register.

Terms glossary

- **Action algorithm:** orderly and limited set of actions, that may be represented graphically, for solving a given problem or circumstance.
- **Screening:** epidemiological programme devised for detecting a serious health condition at an early stage in a specific and asymptomatic population, targeting a decrease in the morbidity/mortality associated rate, through an effective or health restoring intervention. There are universal screening programmes that are systematically applied to the whole population and selective screening programmes. For the first ones to be implemented some previous circumstances are required, amongst them, to rely on an effective treatment, well accepted by the population, in the case of the condition being detected at an early stage, and as long as the screening tests show a good cost/effectiveness rate (understanding by cost, not just the economic side, but also increased risks, the impact on the person's wellness, etc.). If these circumstances, among others, do not occur, then populational screenings are not recommended; selective screening programmes may at any rate be used, targeting only that population considered to be more likely to suffer from the condition or health problem.
- **Early detection:** Identification in a specific and asymptomatic population, of a serious health condition, at an early stage, targeting a decrease in the morbidity/mortality associated rate, through an effective or health restoring intervention.
- **Gender:** Gender applies to roles, rights and responsibilities, different for men and for women, that traditionally and through the socializing process have been ascribed to the ones and the others, as well as to the inequality between them, it entails.
- **Medical report:** It is the written description and assessment, medical personnel make of injuries found.
- **Maltreatment:** Any action, omission or negligent treatment that may trespass on the person's fundamental rights, jeopardizing the fulfilling of their basic needs, preventing or interfering with their physical, psychical and/or social development. This includes physic, psychic and sexual ill treatment to minors, elderly, or dependant persons (those who, due to lack or loss of physical or psychic ability are in a situation of dependence on others). In the case of infant maltreatment, notification to the Court will have to be fulfilled and processed, according to the procedure established in each Autonomous Community.
- **Grievous Bodily Harm Report:** medico-legal document, having to be compulsorily notified to the competent Court, whenever injury may constitute

misdemeanour or criminal offence. It constitutes one of the first steps of preliminary proceedings in a criminal procedure for grievous bodily harm or death.

- **Primary preventive care:** Series of healthcare procedures conducted either by communities or governments or healthcare personnel, prior to occurrence of a specific health problem. It includes health promotion, health protection and chemo-prophylaxis or vaccination.
- **Secondary prevention:** (See screening, early detection).
- **Tertiary prevention:** restoring of health once disease is present. Intervene trying to heal or alleviate a health problem or specific symptoms.
- **Secondary victimization:** it refers to those woman suffering maltreatment who apart from being victims of such a situation, are also sometimes made to feel guilty about it.
- **Gender Violence:** any act of violence inflicted on the female sex that may result in physical, sexual or psychological harm or suffering for women, as well as threats of such acts, coercion or arbitrary deprivation of freedom, arising both in public or private life. Gender violence arises as a consequence of the unequal relation between men and women and from the existence of a "culture of violence" as a means of resolving conflicts

References

- Aguar-Fernández M, Delgado-Sánchez A, Castellano-Arroyo M, Luna del Castillo JD. Prevalencia de malos tratos en mujeres que consultan al médico de familia. Aten Primaria 2006; 37:241-2.
- Alberdi I, Matas N. La violencia domestica. Informe sobre los malos tratos a mujeres en España. Fundación la Caixa. 2000.
- Alonso M, Bedoya JM, Cayuela A, Dorado M, Gómez M, Hidalgo D. Violencia contra la mujer. Resultados de una encuesta hospitalaria. Progresos en Obstetricia y Ginecología 2004; 47:511-20.
- Asamblea General de las Naciones Unidas. Declaración sobre la eliminación de la violencia contra la mujer. Diciembre 1993. A/RES/48/104. 23 de febrero de 1994. [Accessed on: 21 January 2007]. Available at: http://www.acnur.org/biblioteca/pdf/1286.pdf
- Blanco Prieto P, Ruiz-Jarabo C, editoras. La prevención y detección de la violencia contra las mujeres desde la atención primaria de salud. Madrid: Asociación para la Defensa de la Sanidad Pública, 2002.
- Boletín Oficial del Estado (BOE) de 16 de septiembre de 2006. Real Decreto 1030/2006, de 15 de septiembre, por el que se establece la cartera de servicios comunes del Sistema Nacional de Salud y el procedimiento para su actualización. Ministerio de Sanidad y Consumo. [Accessed on: 21 January 2007]. Available at: http://www.boe.es/boe/dias/2006/09/16/ pdfs/A32650-32679.pdf
- Boletín Oficial del Estado (BOE) de 28 de diciembre de 2004. Disposiciones generales. Jefatura de estado. Ley orgánica 1/2004, de 28 de diciembre, de medidas de protección integral contra la violencia de género. [Accessed on: 10 March 2006]. Available at: http://www.boe.es/boe/dias/2004/12/29/pdfs/A42166-42197.pdf
- Centro Reina Sofía para el estudio de la violencia. Estadísticas de Femicidio [Accessed on: 9 February 2006] Available FT at: http://www.gva.es/violencia/
- Claudia García-Moreno. Violencia contra la mujer: género y equidad en la salud Washington, D.C.: OPS, 2000.
- Consejo Interterritorial del Sistema Nacional de Salud. Protocolo sanitario ante los malos tratos domésticos: plan de acción contra la violencia doméstica (1998-2000). Madrid: Ministerio de Trabajo y Asuntos Sociales e Instituto de la Mujer; 2000.
- Delgado A, Aguar M, Castellano M, Luna del Castillo JD. Validación de una escala para la medición de los malos tratos a mujeres. Atención Primaria. 2006, 38(2):82-9.
- E-leusis. Índice epidémico mensual. Mortalidad por violencia del compañero íntimo en España [Accessed on: 22 January 2006]. Available at: http://www.e-leusis.net/Alerta_Violencia. htm Q5.

- Federación de Mujeres Separadas y Divorciadas. Buscador de documentos sobre Violencia contra las Mujeres [Accessed on: 21 January 2006].
  Available at: http://www.separadasydivorciadas.org/

- Fernández Alonso MC, Herrero Velázquez S, Buitrago Ramírez F, Ciurana Misol R, Chocrón Bentata L, García Campayo J, [et al.]. Violencia Doméstica. SEMFYC. Madrid; 2003.

- Fernández Alonso, M. C., Herrero Velázquez, S., Buitrago Ramírez, F., Ciurana Misol, R., Chocron Bentata, L., García Campayo, J., Monton Franco, C., Redondo Granado, M. J., Tizón García, M. J. (2003).Violencia en la pareja: papel del médico de familia. Atención Primaria, 32, 425-33.

- García-Moreno C. Dilemmas and opportunities for an appropriate health-service response to violence against women. Lancet 2002; 359:1509-1514.

- García-Moreno C. International conference on «the role of health professionals in addressing violence against women»: an overview. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics 2002; 78(Suppl. 1):S1-S4.

- Gil-González D, Vives-Cases C, Álvarez-Dardet C, Latour-Pérez J. Alcohol and intimate partner violence: do we have enough information to act? Eur J Public Health 2006; 16: 278-84.

- Golding JM. Intimate Partner Violence as a Risk Factor for Mental Disorders: A Meta- Analysis. J Fam Violence 1999; 14: 99-132.

- Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. Population Reports, Series L, n.º 11. Baltimore: Johns Hopkins University School of Public Health, Population Information Program; December 1999.

- Jiménez Casado C, Lorente Acosta M. Violencia contra las mujeres, ámbito sanitario. Sevilla; Instituto Andaluz de la Mujer; 1999.

- Krantz G, García-Moreno C. Violence against women J Epidemiol Community Health. 2005 Oct.; 59(10):818-21.

- Krantz G. Violence against women: a global public health issue! J Epidemiol Community Health 2002; 56:242-243.

- Krug E., Dahlberg L., Mercy J., Zwi A, Lozano R, eds. Informe mundial sobre la violencia y la salud. Ginebra: Organización Mundial de la Salud; 2002. [Accessed on: 21 January 2007]. Available at: http://www.paho.org/Spanish/DD/PUB/Violencia_2003.htm

- Larrión Zugasti JL, de Paúl Ochotorena J. Mujer, violencia y salud. Med Clin (Barc) 2000; 115: 620-24.

- Matud Aznar P. Impacto de la violencia doméstica en la salud de la mujer maltratadas. Psicothema. 2004;16:397-401.

- Ministerio de Trabajo y Asuntos Sociales e Instituto de la Mujer. Estadísticas. Mujeres en cifras. Violencia. [Accessed on: 20 January 2007].
  Available at: http://www.mtas.es/mujer/mujeres/cifras/violencia/index.htm#violencia
- Ministerio del Interior. Anuarios Estadísticos [Accessed on: 22 January 2006] Available FT at: http://www.mir.es/sites/mir/otros/publicaciones/catalogo/unidad/secgenTecnica/periodicas.html
- Nogueiras García, B. et al. (Eds.). La atención sociosanitaria ante la violencia contra las mujeres. Madrid: Instituto de la Mujer; 2004.
- Organización de las Naciones Unidas. IV Conferencia Mundial sobre la Mujer. 1995. [Accessed on: 21 January 2007]. Available at: http://www.onu.org/documentos/confmujer.htm
- Organización Mundial de la Salud. Violencia contra las mujeres. Un tema de salud prioritario. OMS/OPS; 1998. 64 SANIDAD
- Plazaola Castaño J, Ruiz Pérez I, Escribá Agüir V, Jiménez Martín JM. Adaptación española de un instrumento de diagnóstico y otro de cribado para detectar la violencia contra la mujer en la pareja desde el ámbito sanitario. OSM, 2006. Available at:
  http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/equidad/genero_vg_01.pdf
- Plazaola-Castaño J, Ruiz Pérez I. Intimate partner violence against women and physical and mental health consequences. Med Clin (Barc). 2004;122:461-7.
- Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. BMJ 2002; 325(7359):314.
- Relación víctimas de la violencia de genero año 2006.
  http://www.separadasydivorciadas.org/muertas2006.html
- Romito P, Molzan TJ, De Marchi M. The impact of current and past interpersonal violence on women's mental health. Soc Sci Me 2005;60:1717-27.
- Ruiz Pérez I, Plazaola Castaño J. Intimate Partner Violence and Mental Health Consequences in Women Attending Family Practice in Spain. Psychosom Med. 2005; 67:791-7.
- Ruiz Pérez I, Blanco-Prieto P, Vives-Cases C. Violencia contra la mujer en la pareja: determinantes y respuestas sociosanitarias. Gac Sanit. 2004;18 Supl 2:4-12.
- Ruiz Pérez I; Jiménez Rodrigo ML; Bermúdez Tamayo C, Plazaola Castaño J. Catálogo de instrumentos para cribado y frecuencia del maltrato físico, psicológico y sexual. OSM, 2006. Available at:
  http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/equidad/genero_vg_01.pdf
- Siendones Castillo R, Perea-Milla E, Arjona JL, Aguera C, Rubio A, Molina M. Violencia domestica y profesionales sanitarios: conocimientos, opiniones y barreras para la infradetección. Emergencias 2002;14:224-232.
- U.S. Preventive Services Task Force. Screening for family and intimate partner violence: Recommendation statement. Ann Fam Med 2004; 2:156-160.
- Walker L. The battered woman syndrome. Springer, Nueva York; 1984.

- Wathen CN, MacMillan HL. Interventions for Violence Against Women: Scientific Review. JAMA 2003; 289(5):589-600.
- WHO Multi-Country Study. On Women's Health And Life Events. Department of Gender and Women's Health. Family and Community Health. World Health Organization. Geneva 2003.
- World Health Organisation (WHO). Multi-country Study on Women's Health and Domestic Violence against Women. Geneva: WHO; 2003.

Appendix

Protocols and autonomous communities' Healthcare action guides

Andalusia

- Healthcare attention to women victims of maltreatment. Strategic Plan. Andalusian Health Service. Health Council. Junta of Andalusia (2001)
- Grievous Bodily Harm and Medical Reports for alleged cases of domestic violence, Maltreatment to minors and elderly persons, and Sexual Assaults. Junta of Andalusia. (pending publishing)

Aragon

- Healthcare Guide directed to the woman victim of domestic violence in the Aragon Health System. Aragon Government. Health and Consumers' Affairs Department. Planning and Securing Directorate General (2005)

Asturias

- Protocol for healthcare response when facing violence against women. Health Service of the Principality of Asturias. Principality of Asturias Government. (2003)

Balearic Islands

- Estratègies de prevenció i tractament de la violència domèstica. Conselleria de Benestat Social. Institut de la Dona. Govern Balear. (2002)

Canary Islands

- Instruction 3/03 which establishes models of official documents and steps to be taken by medical personnel in cases of healthcare attending to le-

sions that might constitute a misdemeanour or criminal offence. Health and Consumers' Affairs Council. Canarian Health Service.
- Gender Violence and Health: Handbook and Educational Units for Awareness and Prevention. Canary Islands' Government. Joint Publication of the Health and Consumers' Affairs Council. Canarian Health Service and Canarian Institute of Women (2005).
- Grievous bodily harm and Medical Reports issued in alleged cases of Domestic Violence, Maltreatment to minors and elderly persons and Sexual Assaults. Canarian Health Service (2003).
- Action Protocol for confronting gender Violence in the domestic sphere. Canary Islands' Government. Health and Consumers' Affairs Council. Canarian Health Service (2003)

Cantabria

- Protocol for healthcare action when facing maltreatment. Government of Cantabria. Healthcare and Social Services Council. Public Health General Directorate (2005)
- Protocol of Healthcare dispensed to victims of assault/sexual abuse. Government of Cantabria. Healthcare and Social Services Council. Public Health General Directorate (2006)
- Violence against women. Protocol for healthcare action when facing maltreatment. Government of Cantabria. Healthcare and Social Services Council. Public Health General Directorate (2005)

Castile and Leon

- Action Guide when Facing Maltreatment against Women. Castilian and Leonese Society of Family and Community Medicine ("SocalemFYC") (2005)
- Assistance Network to Women Suffering Maltreatment. Healthcare and Social Welfare Council Junta of Castile and Leon. (2003)

Castile La Mancha

- Action Protocol in Primary Care for Women Victims of Maltreatment. Healthcare Council. Public Health and Participation Directorate General. Castile La Mancha (2005).

Catalonia

- A Guide for Approaching Gender Maltreatment in Primary Care. Catalan Health Institute. Health and Social Security Department. Generalitat de Catalunya (2003).
- Protocol and Circuit for Approaching Gender Violence in the Health Sphere in Catalonia. Health Department. Generalitat de Catalunya (in preparation).
- Recommendations for providing health care to maltreated women. Collection: Health Plan, Book, 14. Catalan Health Institute. Health and Social Security Department. Generalitat de Catalunya (2004).

Valencian Community

- Medical Report in Alleged Domestic Violence (adults). Generalitat Valenciana. Conselleria de Sanitat (2005)

Extremadura

- Interdepartmental Protocol for the Eradication and Prevention of Violence against the Woman. Extremadura Women's Institute. Junta of Extremadura. (2001). APPENDIX 1. Action Guidelines for Professionals involved in the Emergency Route.

Galicia

- Addressing Gender Violence within the Sphere of Healthcare. A Guide for the Prevention, Detection and Care when dealing with Gender Violence in the Health Sphere. Xunta de Galicia (2002).
- Defend Your Rights. Practical Guide for Women Victims of Gender Violence. Xunta de Galicia (2007).
- Guide on Gender Violence in Health Primary Care. Xunta de Galicia (2005).

Madrid

- Violence Against Women Considered as a Public Health Concern. Document of Support to Care Provided to the Health of Women Victims. Institute of Public Health. Madrid Community. (2003)

Murcia

- Protocol for the Coordination of the State Armed and Security Forces with the Judiciary, Professional College Associations, and Others Involved in the Protection of Victims of Gender Violence. Region of Murcia (2006)
- Protocol for the Detection and Dealing with Gender Violence in Primary Care in the Region of Murcia. Healthcare Council of Murcia (pending publishing)
- Healthcare Protocol for Addressing Domestic Maltreatment. Presidency Council. Sectorial Secretariat for the Woman and the Young. Region of Murcia. (2000)

Navarre

- Protocol for Coordinated Action when Providing Care to Gender Violence Victims. Guide for Professionals. Department of Social Welfare, Sports and the Young. Navarrese Institute of the Woman. Government of Navarre. (2006)

Basque Country

- Healthcare Protocol when Faced to Domestic Maltreatment. Healthcare Department. Basque Country Government (2000) included into the framework of the *"Interinstitutional Agreement for Improving Care to Women Victims of Domestic Maltreatment and Sexual Assaults" (2001).* (Healthcare Protocol currently being revised/updated).

La Rioja

- Comprehensive Programme for Detecting and Addressing Domestic Violence from the Public Healthcare System of La Rioja. Rioja Health Service. (2004)

The Protocol we now present is the first on this issue proposed for its being implemented in the NHS as a whole. Its main target is to provide healthcare professionals with homogeneous action guidelines when faced with cases of violence specifically directed against women, covering both care and follow-up as well as prevention and early detection.

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