Gender Violence 2008 Report

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Gender Violence
2008 Report

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Introduction

> Gender Violence is understood as *Any act of gender-based violence that results, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life*
> (UNO, 1993).

The now released 2008 Annual Report on the Healthcare Response to Gender Violence in the National Health System attempts to be a compendium of actions performed by Health Services in Autonomous Communities (ACs) and Ingesa[1], in their dealing with gender violence (GV), in order to make available to the Healthcare Sector itself and society in general, information on the NHS's activity in all that relates to GV.

In keeping with proceedings instituted in Organic Law 1/2004, of 28 December on Comprehensive Protection Measures against Gender Violence concerning healthcare action, this Report aims at contributing elements for reflection by highlighting ACs' similarity of objectives and diversity of possibilities and alternatives developed for the prevention, detection and all-embracing response to gender violence.

The *first chapter* of *Gender Violence 2008 Report* starts with a *situation analysis* based on GV fatalities up to 2008 including data relating to the evolution of the homicide epidemic index in Spain throughout the 2003-2008 period as well as frequencies and age-adjusted fatality rates.

A geographic study by provinces and ACs for the 1998-2008 period is also made available together with a brief descriptive analysis on some women's groups in situations of special vulnerability to GV that develops data broken down by women's age and country of origin.

Then the next section of this chapter describes the first experience of gathering information related to the *18 common indicators* of epidemiological surveillance of GV of the National Health System (NHS).

The next section of the chapter deals with qualitative and quantitative analysis of the education delivered to professionals about gender violence matters during 2008 achieved through continuing training programmes that

1 *Instituto Nacional de Gestión Sanitaria.* It manages National Health System's healthcare assistance in towns with their own Statute of Autonomy: Ceuta and Melilla.

health care services developed in Autonomous Communities. This analysis was performed on both the types of educational activities conducted (basic course, awareness activities and other educational actions) and on alumni and teaching staff characteristics, in keeping with the quality criteria approved by the Inter-Territorial Council in 2007.

In the *second chapter* of the Report a *qualitative description is offered of actions taken by Autonomous Communities towards introducing the Common Protocol for a Healthcare Response to Gender Violence* in both primary and Specialty Care. Initiatives are described in terms of involvement of gender violence in healthcare plans, inclusion of related aspects in the services portfolio, improvements to information systems for effective screening as well as designing and development of actions targeting groups and situations of special vulnerability to gender violence (pregnant women, immigrant women, disabled women and women from rural areas) and/or specific programmes targeting care to the mental health of women subjected to abuse. The chapter ends with a description of inter-institutional coordination actions or initiatives and research studies of this issue conducted at health services of Autonomous Communities.

The *third chapter* includes, as a sequel to the Annual Report previous editions, an analysis of international public policies in gender violence related matters.

In previous years, Organic Law 1/2004 on Comprehensive Protection Measures against Gender Violence was highlighted as the only one in Europe that explicitly mentioned involvement of Health Care Administrations in Public Authorities' cooperation plans to combat gender violence, as well as the only one to address gender violence in a complete and multidisciplinary way.

In this 2008 Annual Report a step forward has been taken when trying to go deeper in searches for international bibliography concerning public policies on GV and the specific role assigned to the health care sector in confronting the problem, which is internationally defined and acknowledged as a public health concern.

The purpose of searches launched was to attempt to identify existing measures, regulations or protocols relating to GV cases detection and prevention from within the health care sector. Again Spain and our National Health System's experience have turned out to be pioneering. Even though some countries encourage the drafting of protocols Spain's experience is the only existing one having achieved effective development, publishing and establishment of a Common Protocol for the whole health care system, to be used as professional training tool for early detection, assessment and action-taking in cases involving gender violence and for orienting follow-up and all-inclusive attention to physical, psychological, emotional and social health of women suffering this kind of violence.

Finally analysis is performed of treatment that special vulnerability to GV groups of women were given in these operative documents.

The general section of the Annual Report is brought to an end with an account of actions performed during 2008 by the Commission Against Gender Violence of the NHS's Inter-Territorial Council (*CISNS* for reference, NHSIC in this report), entrusted with providing technical support and orienting planning of healthcare measures instituted in Chapter III of Organic Law 1/2004 (Arts. 15 and 16), assessing and proposing actions necessary for implementing the Common Protocol and whatsoever other measures needed for the health care sector to help eradicate this form of violence.

The *last part* of the *Annual Report* is made up as previous editions were of *chapters/reports* each AC has contributed that contain all their information:

- Actions aimed at establishing the Common Protocol for a Health Care Active Response to Gender Violence in both primary and Specialty Care.
- Initiatives of interest developed at health services concerning assistance in gender violence cases (plans, services portfolio and information systems).
- Specific actions targeting special vulnerability groups (immigrant, disabled or rural areas' women) and specific programmes (for mental health and during pregnancy).
- Other actions (coordination and research).
- Training for professionals.

Once again the positive response of Health Regional Departments deserves highlighting as do their initiatives and their teams' excellent willingness to cooperate in the drafting of this Annual Report.

Hopefully the addition of so many efforts will contribute to a greater accountability and a deeper knowledge of all NHS's actions to combat gender violence and its effects on the health of women that endure it, paving the way for adopting a global perspective integrated in all those actions always aiming at improving the quality of the health care provided.

Analysis of the situation

Gender Violence Fatalities Distribution (1998-2008)

Distribution in Time of Gender Violence Fatalities in Spanish Territory (1998-2008)

Male violence inflicted on women by intimate partners or the like has caused 682 fatalities in the last 11 years in Spain as per data supplied by *Federación de Mujeres Separadas y Divorciadas* (Separated and Divorced Women's Federation).

According to data gathered on Table 1 the distribution of cases in time has remained constant. Although 2003, 2004, 2006, 2007 and 2008 account for the highest number of deaths, the highest rate of lethality deriving from violence to women by intimate partner or ex-partner amounts to 0.37 in 2008, the lowest being 0.22 in 1999.

Table 1. Frequencies and age-adjusted lethality rates for women aged 15 or over residing in Spain (1998-2008)

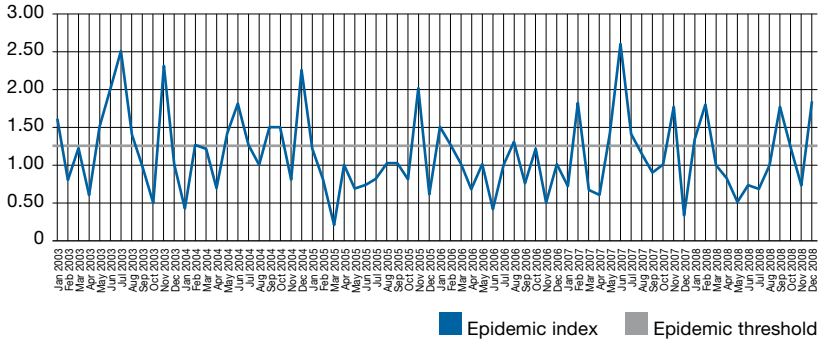
Year	Deaths	Rate × 10^5	Confidence Interval at 95 %	
			Lower limit	Upper limit
1998	46	0.26408	0.1878	0.3404
1999	40	0.22677	0.1565	0.2970
2000	57	0.32009	0.2370	0.4032
2001	52	0.32009	0.2370	0.4032
2002	47	0.25544	0.1824	0.3285
2003	66	0.35210	0.2672	0.4371
2004	61	0.35210	0.2672	0.4371
2005	54	0.28003	0.2053	0.3547
2006	61	0.31633	0.2369	0.3957
2007	71	0.36017	0.2764	0.4439
2008	76	0.37852	0.2695	0.4876

Produced In-House from data on violence against women by intimate partner or ex-partner provided by *Federación de Mujeres Separadas y Divorciadas.*
Statistics available at: www.separadasydivorciadas.org

When comparing the situation by month, gender violence lethality seems to subside from January 2005 onwards as shown in Figure 1. Broadly speaking this trend continues through 2006 charting only 3 points above the epidemic index (>1.25) in January, February and August. However 5 points above the epidemic index (>1.25) were reached in 2007, during which, June 2007 produced the epidemic index highest score since January 2003, that charted a 2.60. Between August and October 2007 the epidemic index went down back below the epidemic threshold (<1.25) to pick up again in November reaching values above the epidemic index (>1.25) to go down below this threshold in December. Compared to the previous year 2008's trend was a downward one. Only 4 values ranked above the epidemic threshold in January, February, September and December.

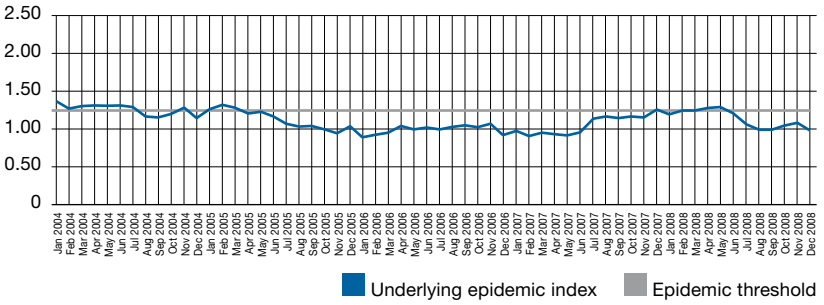
Figure 2 shows that the underlying epidemic index of deaths by GV has remained below epidemic index (<1.25). From July 2007 onwards a slight increase was recorded that reached its peak in December that same year with the first value above epidemic index since June 2006. From February to June 2008 values of the underlying epidemic index of deaths by GV

Figure 1. Evolution of epidemic index of deaths by gender violence in Spain (2003-2008)



Monthly epidemic index of deaths by gender violence in Spain: ratio between deaths by gender violence per month and death median for corresponding months in the 5-year period prior to the month in which index is being calculated. Average incidence is considered to be a resulting value between 0.76 and 1.24; in a low incidence it equals or runs below 0.75 and in a high incidence it equals or runs below 1.25. Epidemic threshold is set at 1.25.
Available at: http://www.e-mujeres.net/violenciagenero

Figure 2. Distribution of underlying epidemic index of deaths by gender violence (2004-2008)



Monthly underlying epidemic index of deaths by gender violence in Spain: average of all registered indexes in one-year period. So, for calculating September 2008 underlying epidemic index, epidemic index scores considered range from September 2007 to August 2008.

remained above the epidemic threshold. From July onwards the index was on the decrease and scored below the epidemic threshold from July to December 2008.

Homicides Geographical Distribution and Prevalence of Violence to Women by Intimate Partner or Ex-Partner by Autonomous Communities (1998-2008)

The study of geographical distribution of homicides allows spotting differences in gender violence lethality rates both at the provincial and autonomous community levels.

Data on homicides by GV retrieved up to 2008 and grouped by ACs reveal that Basque Country, Extremadura and Galicia registered the lowest gender violence lethality rates (Table 2).

With respect to the provincial distribution of GV lethality rates Lugo, Guipuzcoa and Palencia registered the lowest GV lethality rates (Table 3).

Table 2. Autonomous Community- and age-adjusted gender violence lethality rates (1998-2008)

AC	Cases	Rates × 10^6 (CI 95 %)	AC	Cases	Rates × 10^6 (CI 95 %)
Andalusia	124	3.34	Extremadura	8	1.52
Aragon	16	2.50	Galicia	29	1.60
Asturias	13	2.50	Madrid	83	2.30
Balearic Islands	23	4.63	Murcia	24	3.10
Canary Islands	47	4.50	Navarre	10	3.23
Cantabria	6	2.21	Basque Country	18	1.45
Castile and Leon	32	2.57	La Rioja	5	2.27
Castile-La Mancha	28	3.27	Ceuta	1	2.94
Catalonia	88	2.51	Melilla	2	6.42
Valencian Community	80	3.47			

Produced in-house from data on violence to women by intimate partner or ex-partner supplied by *Federación de Mujeres Separadas y Divorciadas*. CI 95 %; Confidence Interval at 95 %.
Available at: www.separadasydivorciadas.org

Groups of Women in Situation of Special Vulnerability to Gender Violence

In the study conducted on murdered women's age groups a bimodal patterning emerges in GV age-specific lethality rates. Women between 35 and 39 years (5.06×10^6) produced the highest lethality rate, followed by those aged 30 to 34 (4.85×10^6). Lethality rates of women between 80 and 84 years of age are also important (2.42×10^6) above all considering they are higher than those found in younger age groups (fig. 3).

From distribution of GV lethality rates shown in Figure 3 it may be concluded that women aged 21 to 50 years run a higher risk of dying violent deaths in all years. This trend seems to have changed only in 2004, when fatalities among 21-year-old women equalled those among women between 21 and 50 years of age.

Some studies, apart from assessing the importance of the problem as per age of women affected, identify migration as a fact of particular vulnerability when it comes to gender violence. Using country-of-origin-itemised data available on *Instituto de la Mujer* web site it can be said that gender violence lethality rates among foreign women are higher than among Spanish women although they have progressively decreased (Table 4).

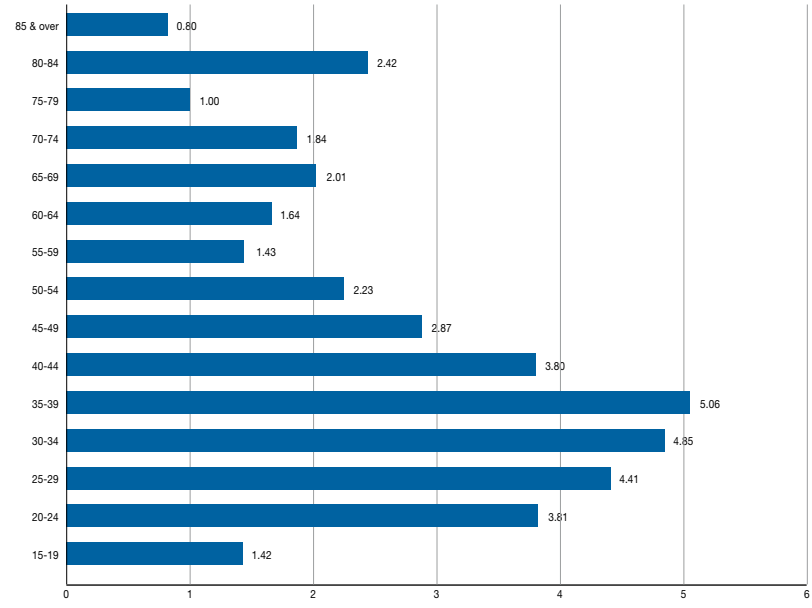
In all years under study the risk of dying victim of male violence is among foreign women residing in Spain 2 to 8 times higher than for Spanish

women. For the whole period under study (1999-2008), a foreign woman's risk of dying victim of male violence is 5.76 times higher than that of a Spanish woman (Table 5).

Table 3. Province-level age-adjusted rates of lethality by intimate partner violence (1998-2008)

Provinces	Rates × 10^6	Provinces	Rates × 10^6
Alava	1.44	Las Palmas	4.87
Albacete	3.99	Leon	2.07
Alicante	3.91	Lerida	5.73
Almeria	6.11	Lugo	0.73
Asturias	2.50	Madrid	2.74
Avila	2.32	Malaga	3.09
Badajoz	1.22	Melilla	6.42
Balearic Islands	4.63	Murcia	3.73
Barcelona	2.02	Navarre	3.62
Burgos	1.16	Orense	2.04
Caceres	1.95	Palencia	0.89
Cadiz	2.53	La Rioja	3.66
Cantabria	2.21	Pontevedra	3.27
Castellon	4.21	Salamanca	3.79
Ceuta	2.94	Segovia	3.04
Ciudad Real	3.99	Seville	1.91
Cordoba	3.84	Soria	2.58
Cuenca	1.84	Tarragona	3.32
Gerona	4.87	Tenerife	4.72
Granada	4.36	Teruel	1.99
Guadalajara	3.16	Toledo	2.58
Guipuzcoa	0.86	Valencia	3.16
Huelva	3.51	Valladolid	3.92
Huesca	1.75	Vizcaya	2.19
Jaen	4.70	Zamora	3.28
La Corunna	1.65	Zaragoza	3.02

Figure 3. Age-specific gender violence lethality rates (1998-2008)



	Age														
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over
Lethality rates	1.42	3.81	4.41	4.85	5.06	3.80	2.87	2.23	1.43	1.64	2.01	1.84	1.00	2.42	0.80

Cases Detected and Cared for in the Health Care Sector (2008)

The Commission against Gender Violence created within the National Health System's Inter-Territorial Council (NHSIC) in 2004, has been in charge of the NHS' s common strategy planning for achieving professionals' awareness and training with the aim of improving early detection and the way to deal with these situations. It has also promoted development of indicators that may enable appraisal of the importance of each case of gender violence at health care services in order to closely monitor affected women's health.

Table 4. Annual distribution of rates and deaths by gender violence among both Spanish and foreign women over 15 years of age (1999-2008)

Year	Spanish			Foreign		
	Fatalities	Rates × 10^6	CI 95 %	Fatalities	Rates × 10^6	CI 95 %
1999	43	2.48	1.74-3.23	7	21.69	5.62-37.75
2000	50	2.87	2.08-3.67	9	22.91	7.94-37.88
2001	36	2.05	1.38-2.72	9	15.78	5.47-26.09
2002	37	2.10	1.43-2.78	13	16.17	7.38-24.96
2003	61	3.45	2.59-4.32	10	9.32	3.55-15.10
2004	53	2.99	2.19-3.80	17	14.00	7.34-20.65
2005	37	2.08	1.41-2.75	18	12.15	6.53-17.76
2006	48	2.69	1.93-3.45	20	12.13	6.81-17.45
2007	43	2.40	1.68-3.12	28	15.42	9.70-21.14
2008	40	2.23	1.54-2.92	36	17.10	11.51-22.68
1999-2008	448	2.53	2.32-2.85	167	14.61	11.64-16.46

CI 95 %, Confidence Interval at 95 %.

Table 5. Annual relative risk of death by GV when comparing foreign to Spanish women over 15 years of age (1999-2008)

Yaer	RR	CI 95 %
1999	8.73*	3.93-19.41
2000	7.98*	3.92-16.23
2001	7.68*	3.70-15.95
2002	7.69*	4.09-14.47
2003	2.70**	1.38-5.27
2004	8.67*	5.02-14.97
2005	5.84*	3.33-10.26
2006	4.51*	2.68-7.61
2007	6.42*	3.99-10.33
2008	7.68*	3.71-15.93
1999-2008	5.76*	4.49-6.66

*$p < 0.001$; **$p = 0.0036$. CI 95 %, Confidence Interval at 95 %; RR, Relative Risk.

Epidemiologic surveillance is defined as the systematic, continuing, timely and reliable collection of relevant and necessary information on certain conditions affecting the population. It stands as a useful tool for analysis and interpretation of data and, above all, provides a basis for decision-making when actions have to be programmed around problems being dealt with[2]. Information generated by epidemiologic surveillance systems helps determinate the need for changes, for expanding the scope of laws or for a larger amount of resources to combat epidemics, and improve their organisation.

In compliance with the provisions of Organic Law 1/2004 on Comprehensive Protection Measures against Gender Violence and from the State Observatory on Violence Against Women (inter-ministerial collegial organ attached to the Ministry of Equality through the Government Office for Gender Violence) a system of indicators and variables relating to gender violence was devised, upon which a data base would be built up with information coming from the different sectors (justice, education, health and its related services, etc.).

In accordance with these criteria the NHSIC Commission Against Gender Violence have put in continued work to establish the 18 NHS Common Indicators in an attempt to get to know the magnitude and repercussions of gender violence on women's health and for the health care system (Table 6).

We must point out that in 2007 the National Health System's Inter-Territorial Council approved a set of 18 common indicators for the epidemiologic surveillance of gender violence. During 2008 the Commission Against Gender Violence conducted the relevant technical work for completing each of the 18 descriptive files thus making compilation easier from ACs' health care services in a standardised and uniform way.

Therefore this first experience of gathering of indicators for attention to gender violence in the NHS in this section of the report is purely descriptive of the process, its challenges and difficulties. The variety of existing sources of information for identification of cases at health care services has emerged as well as the heterogeneous nature of possible codifications in today's array of computerised systems (Primary Care and Specialty Care).

Hence, inclusion of the first quantitative and aggregated data on cases detected and attended to, will have to wait until the Gender Violence 2009 Report is due for publishing.

2 Teutsch SM, Thacker SB. Planning a public health surveillance system. Epidemiol Bull 1995; 16 (1): 1-6.

Table 6. Informative Common Indicators for Gender Violence Occurrences. Health Care for Confronting Gender Violence in The National Health System

General goals	
Awareness on magnitude and consequences of GV on health and the healthcare system	
Specific goals	
• Facilitating planning of the healthcare response to gender violence once its extent and the profile of women affected are known • Promoting improvement of quality and equity of the health care response to gender violence through assessment of the impact of actions implemented by health authorities especially those listed in the Common Protocol • Fostering collaboration and exchange of experiences and good practice among authorities	
Common Indicators	
Extent	1. Cases detected per 100,000 women over 14 years of age 2. Number of bodily harm reports issued
By care level and source	3. Cases detected at primary care level 4. Cases detected at specialty care level
By maltreatment features	5. Cases detected per maltreatment pattern 6. Cases detected per maltreatment duration 7. Cases detected per type of cohabitation relation with perpetrator
By profile of abused woman	8. Cases detected per age group 9. Cases detected per nationality 10. Cases detected per work situation 11. Pregnant women cases detected 12. Disabled women cases detected
By type of attention affected women received	13. Women seen and given information and support by socio-health care resources 14. Women seen and risk-evaluated 15. Women seen for whom a tailored security plan was put together 16. Cases detected and redirected to primary care 17. Cases detected and redirected to specialty care 18. Cases detected and redirected to social services

To help draw up 2008 Report on health care response to gender violence in the scope of the NHS not only did Autonomous Communities health departments supply information on the diverse preventive and training actions around male violence taken in their territory, but also the first 11 indicators' data gathering outcome, in keeping with specifications included in epidemiologic surveillance data sheets for planning and assessment of health care interventions in gender abuse occurrences.

It is only fair that the effort put in by ACs for collecting 2008 data relating to first 11 indicators (Table 7) be highlighted.

Table 7. Information chart on common indicators of gender violence supplied by Autonomous Communities

	Annex I	1	2	3	4	5	6	7	8a	8b	9a	9b	10	11
Andalusia	•		•	•	•									
Aragon	•	•		•	•				•	•				
Asturias	•	•	•	•	•	•		•	•	•	•	•		•
Balearic Islands	•	•	•	•		•			•	•	•	•		•
Canary Islands	•	•	•	•		•	•		•	•	•	•	•	•
Cantabria	•	•	•	•		•								
Castile and Leon	•	•	•	•	•									
Castile-La Mancha	•	•	•	•		•		•	•	•	•	•	•	•
Catalonia*	•													
Valencian Community	•	•	•	•	•	•		•	•	•	•	•	•	•
Extremadura	•	•												
Galicia	•	•			•				•	•				
Madrid	•	•		•	•				•	•	•			
Murcia	•	•	•	•	•	•		•	•		•			•
Navarre	•	•		•		•								
Basque Country**	•													
La Rioja	•	•	•	•	•	•		•	•	•	•	•		•
Ceuta	•	•	•	•	•	•		•	•	•	•	•		•
Melilla	•	•	•	•	•			•			•			

*Catalonia did present Annex I but data supplied had not been gathered together for the whole autonomous community but were segmented by health regions.
**The Basque Country only supplies number of cases without specifying whether or not they correspond to women admitting for the first time having suffered maltreatment.

Most ACs forwarded information on extent indicators (cases detected per 100,000 women over 14 years of age and number of bodily harm forms issued) as well as those relating to care level (cases detected at Primary Care and cases detected at Specialty Care).

Catalonia and Basque Country do not appear on the table, as Catalonia only supplies disaggregated information per health region failing to provide aggregated data for the community as a whole; contrarily, the Basque Country's contributed information gathers the number of maltreatment cases received at Primary Care from 2005 to 2008 and in the hospital network from 2006 to 2008, failing to specify if cases registered were or not of women who, for the first time, admitted being subjected to maltreatment.

In the case of the Valencian Community, their *Protocolo de atención sanitaria de la violencia de género* (Protocol for health care watch on gender violence) was published in 2008. At present the computer application is under way and will be installed in Primary Care and Specialty Care (Abucasis and Orión). This application will allow gathering information on detection, follow up and assessment of cases of male violence as well as putting into action the ensuing intervention plan adopted after detection. The system is expected to be partly established by 2010. That is why this autonomous community failed to provide data on common indicators deriving from this first collection. However, most epidemiologic indicators may be obtained from the relevant bodily harm report (exception made of indicator 6).

Once the information from all ACs had been compiled, suitability of data gathered was then revised as was their compliance with corresponding data sheet specifications for each indicator (numerator, denominator, rate or percentage) to determine their suitability as required by the methodology signed and approved by the Inter-Territorial Council for GV epidemiological surveillance in the NHS, and the improvement of planning and assessment of health care interventions called for.

Some common aspects were identified that limit the need for analysis of the whole of the NHS's to the resulting outcome.

Heterogeneity of information sources is one of the main factors limiting the analysis of data submitted by the ACs on common indicators. A quotable example refers to indicator 3 on "cases detected at Primary Care" According to the data sheet, it requires, as numerator, the number of cases of women 14 years or older identified by the health system who in Primary Care and for the first time, admitted that they were suffering ill treatment at the time of the declaration. Population of women 14 years or older will be used as denominator. This data sheet also specifies the sources of information as medical records and Primary Care records this information should derive from. However, some ACs extracted numerator data from other sources of information such as bodily harm forms or emergency call numbers (e.g. 112).

Another aspect that hinders a joint analysis concerns *the differences in the age range of the female population under consideration,* i.e., inclusion or exclusion of women aged 14 years. Whether or not 14 year-old women are included in the collection of data is largely dependent on the lower-age limit each community sets for adults health care or, in other words, the upper-age limit they set for pediatric care.

This second aspect may be considered of minor importance, given the correlation observed between the lower-age limit included in the numerator and that included in the denominator of statistical values calculated for each indicator; that is to say, ACs which did not include cases of 14 year-old women in the information collected, did not include them either in the baseline population for calculating the indicators.

The *different itemisation levels* each indicator data sheet requires has also been one of the limiting factors for analysing resulting data jointly.

Indicators concerning types of maltreatment (indicator 5), type of cohabitation relation (indicator 7), age (indicator 8a) and nationality (indicator 9a) often failed to comply with the methodology described on the data sheet. For instance, indicator 5 "cases detected as per maltreatment type" data sheet established that itemising levels be psychological, sexual and physical. However, some ACs failed to provide data on sexual abuse, only submitting data on psychological and physical violence. The opposite case, arose when some ACs came up with information on other forms of violence, like economic, currently not covered by the relevant data sheet consensus for that indicator.

Once we identified these issues in the information provided by the ACs, we proceeded to draw a graph representing the number of ACs whose information was in full compliance with the proposed methodology in these indicators data sheets. As shown in Figure 4, 13 ACs comply with agreed methodology for indicator 1. As far as indicators 2 and 3 are concerned, a total of 12 and 13 ACs respectively submitted datasheet-normalised information. As per indicators 6, 8b, 9b and 10 only the 1 or 2 ACs that followed data sheet specs, to the letter, got charted.

Tables 8-10 describe the various sources of information used by health services of the ACs for the collection of variables that make up the 18 common indicators of the health system.

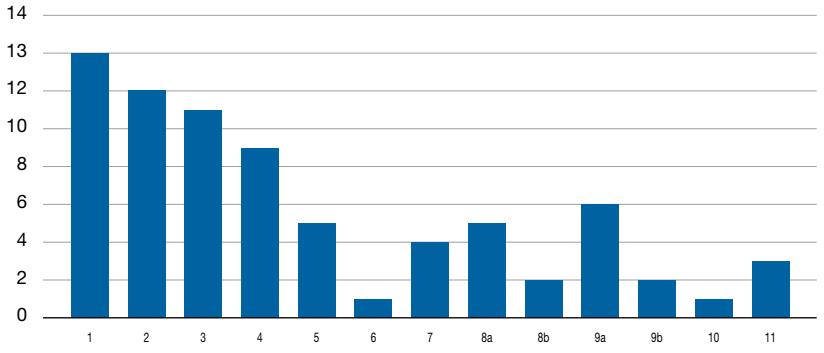
Table 8 lists the different types of sources used in each regional health service. The following two tables (Tables 9 and 10) provide separate sources of information on cases detected in Primary Care and Specialty Care.

Given the variety of information sources, it is necessary to standardise the collection criteria for a single source, to guide equally and according to common criteria all health services of ACs in data collection.

During 2009, the Commission's technical team in charge of this task will work on the standardisation of codes and standards for collection from each source of information, which will allow to assess comparability of data collected for each indicator by all health services that make up the National Health System.

Therefore, we will have to wait for the Gender Violence 2009 Annual Report to include the first quantitative, comparative and aggregated data for the whole National Health System (NHS).

Figure 4. **Autonomous Communities that present the gender violence indicator required by methodology**



	Indicators												
	1	2	3	4	5	6	7	8a	8b	9a	9b	10	11
Autonomous Communities	13	12	11	9	5	1	4	5	2	6	2	1	3

Professionals' Training in the National Health System

The Ministry of Health and Social Policy has identified health personnel's awareness and training in gender violence as one of the key elements in addressing this problem, so, within the Inter-Territorial Council's Commission against Gender Violence of the National Health System (NHSIC) a working group for training health professionals in dealing with gender violence was specifically created.

This section of the report analyses the training initiatives on gender violence conducted by the various autonomous communities and autonomous cities of Ceuta and Melilla in 2008. It then presents an analysis of training activities conducted by the Autonomous Communities and the autonomous cities of Ceuta and Melilla from the information requested periodically to put together this Annual Report.

Table 8. List of sources used for the analysis of data common indicators of gender violence

Sources	1	2	3	4	5	6	7	8	9	10	11
ICD-9[a]	•		•		•			•	•		•
Drago-PC[b]	•		•		•	•		•	•	•	•
CMO-PC[c]	•		•		•			•	•		
Summa 112[d]	•							•	•		
Bodily Harm Report[e]		•	•	•	•		•	•	•		•
Primary Care Service Extremaduran Health Servicef[f]	•										
List of Diagnostic Codes[g]				•				•			
Ingesa[h]	•	•	•	•	•		•	•	•		•
Atiende Programme[i]				•							
Z12-Z25[j]			•	•	•						
Continuous and cumulative Record of Mental Health: codes Y05,Y07, Y09[k]				•							
Hospital (PCH)[l]	•	•		•				•			

[a] Clinical coding system used by AC of Aragon, Balearic Islands and Basque Country.

[b] In the absence of a unique clinical history for all levels of care, the Canary Islands uses the information system Drago-PC that collects information from Primary Care and hospital emergency services of Tenerife, Fuerteventura, El Hierro, La Gomera and La Palma.

[c] Computer Programme implemented in all Primary Care network of the Cantabrian Health Service and in Aragon, Asturias and Madrid.

[d] Emergency medical service of the Autonomous Community of Madrid.

[e] In Asturias Vimpa record (Health Care Record of Violence against Women in the Principality of Asturias) is used. In the Valencian Community data are currently being collected from the specific bodily harm form but the software application to be implemented in primary and Specialty Care is being designed (Abucasis and Orión). This application will collect information on the detection, monitoring and evaluation of gender violence cases and the intervention plan that is established after detection.

[f] Source of data used by the Autonomous Community of Extremadura.

[g] Source of data used by the Autonomous Community of Galicia.

[h] Health Management System Ceuta.

[i] Intervention Unit for Emotional Harm developed by the Autonomous Community of Madrid.

[j] Diagnostic codes used by the regions of Navarre, Aragon and Asturias

(Z12: Problems of relationship between spouses. Psychological abuse/emotional and Z25: problems arising from violence/aggression. Includes physical abuse, child, spouse, rape and sexual assault).

[k] Source of health information used by the Autonomous Community of Asturias.

[l] Collects information from the Emergency Services in the Basque Country.

CMO, Computerized Medical Office; ICD-9, International Classification of Diseases 9; PC, Primary Care.

Table 9. Sources used by ACs for indicator 3 (cases detected at Primary Care)

AC	Bodily Harm Report	Health care sources	Other
Andalusia	•		
Aragon		•	
Asturias		•	
Balearic Islands		•	
Canary Islands		•	
Cantabria		•	
Castile and Leon		•	•
Castile-La Mancha		•	
Catalonia			
Valencian Community			
Extremadura			
Galicia			
Madrid		•	
Murcia			•
Navarre		•	
Basque Country		•	
La Rioja		•	
Ceuta		•	
Melilla	•		

The NHSIC worked throughout 2006 on the Common Protocol for a Health Care Response to Gender Violence that was approved by the NHSIC in December 2006 and was officially presented and distributed to the different autonomous communities in April 2007.

In order to improve implementation of the Common Protocol, the NHSIC Committee Against Gender Violence also developed quality standards for the basic training of professionals, approved by the NHSIC in December 2007.

Health care staff basic training in addressing gender violence aims to provide all professionals with the appropriate tools that may enable them to:

- Provide all-encompassing, continuing and quality attention from a gender perspective, by applying the established action protocol.
- Acknowledge gender violence as a public health problem.

- Help improve quality and equity of health care delivery to women who suffer gender violence.
- Support health authorities in the organisation of the training through sharing processes, materials and best practices.

Table 10. Sources of information used by ACs in indicator 4 (cases detected at Specialized Care)

AC	Bodily Harm Report	Health care sources	Other
Andalusia	•		
Aragon		•	
Asturias		•	
Balearic Islands			
Canary Islands			
Cantabria			
Castile and Leon		•	
Castile-La Mancha			
Catalonia			
Valencian Community			
Extremadura			
Galicia			
Madrid		•	
Murcia			•
Navarre			
Basque Country		•	
La Rioja		•	
Ceuta		•	
Melilla	•		

Training Initiatives on Gender Violence Conducted in Autonomous Communities and Cities with Autonomy Status

Information on the training initiatives on gender violence developed in 2008 by Autonomous Communities and cities with autonomy status, was also extracted in some cases from technical reports of agreements reached between ACs and the Ministry of Health and Social Policy, and in others from reports issued by ACs themselves. In both cases, training activities' technical descriptions were directly obtained from ACs.

Female and male health care professionals are uniquely placed to prevent and early detect gender violence bearing in mind that most women enter the health system at some point in their lives; it is thus essential for them to acquire the knowledge, skills and attitudes suited to care for women who see themselves in situation of abuse. In this regard, training professionals contributes to the implementation of the Common Protocol as it provides tools to improve early detection and care for women.

Such training chiefly targets professionals in Primary Care services (family medicine, pediatrics, nursing, midwifery, physiotherapy and social work) but also professionals from the emergency services (medical and nursing), mental health units (psychiatry, psychology, nursing and social work in some autonomous community) planning, obstetrics and gynaecology centres, sexually transmitted infection units, trauma services, etc.

Creation of Commissions and Groups of Support to Training in Gender Violence

Galicia has a Commission for Health and Gender. Its functions include policy advice on training for professionals working in the health setting in which special emphasis is placed on the gender perspective and on identifying training needs of health workers from this perspective. In the Balearic Islands and the Basque Country, in addition to this function, the Commission on Health and Gender has the following functions: promote studies to analyse the indicators related to health and gender violence, to advise on the development of equality policies to be carried out in the fields of health, education and support to women's empowerment, and report on the incorporation of new services aimed at improving health care for health problems arising from gender violence.

In Castile and Leon, teams were created for supporting and supervising training in gender violence, made up of persons with expertise on helping women in situations of abuse; they act as references in Primary Care management offices performing training and advisory functions in complex cases.

Training in Implementing the Common Protocol for a Health Care Response to Gender Violence

Since implementing the Common Protocol was decided most Autonomous Communities have provided training and conducted awareness activities. In fact, the contents of the Protocol have been used by many ACs as basis and tool for professionals' training, which, in turn, meets the quality criteria approved by NHSIC. To this respect, Andalusia, Aragon, Asturias, Canary Islands, Cantabria, Castile and Leon, Catalonia, Madrid and Murcia mention the existence of plans for continuing education on gender violence. By way of

example, in the Autonomous Community of Madrid, a Training Programme in Gender Violence has been included in the Continuing Training Plan 2008. All training courses are accredited by the Commission of Continuing Education.

Measures adopted to facilitate Health Professionals' Training

In Aragon, Cantabria, Castile and Leon, and Galicia, training was provided during business hours and while professionals were replaced in their jobs, in order to make attendance to the training easier for them. With the same objective, in other ACs, professionals were trained in their normal working environment and in Castile-La Mancha, for instance, courses programmed for 2009 were held in the form of video conferencing and on-line.

In the Autonomous Community of Madrid all documentation of the basic courses of Primary Care is inserted into Lain Entralgo Agency's web page (the agency responsible for training), being available at any time to all professionals who may wish to access it. It contains PowerPoint presentations, technical papers of the Autonomous Community of Madrid and bibliography. In addition, teachers have a "teaching kit" that, together with all the above, contains videos made ad hoc with training purposes.

Likewise, actions carried out in training courses include delivery of basic documentation that can be of support or be kept for further consultation.

Training in Gender Violence Educational Formats

In Catalonia, Canary Islands, Andalusia and the Valencian Community, participation in "basic courses" is believed to be the first step in the right direction; they also strongly recommend to consolidate what has been learned in other courses or in fields more closely related to the experience such as clinical sessions. One of the most widely accepted methodologies by the majority of ACs is "to train the trainers". Catalonia and Ceuta implemented this method in 2008 and continued through 2009. Other ACs like Andalusia, the Valencian Community and Madrid planned its implementation for 2009.

Castile and Leon carried out a second course in 2008 and launched an advanced modular training programme that has given continuity to the ongoing Training for Trainers Group, begun in 2007.

Publishing of Educational and Teaching Material

In Asturias, Galicia, Canary Islands and the Valencian Community publishing of educational and interactive teaching materials is the basis for both the running of training sessions and for the training programme contained in the protocol implementation. These ACs consider that the use of audiovisual materials makes understanding concepts much easier.

The Autonomous Community of Madrid published, exclusively for professionals' training purposes the DVD *Fragmentos: mujeres, salud y violencia* (Fragments: women, health and violence), visual document on testimonies of women having been subjected to abuse who openly and without hiding their identity, talk about how they have lived and currently live their situation and their relation with the health system.

Inclusion of Gender Violence in Undergraduate Curricula

Cantabria, in coordination with the School of Medicine and the School of Nursery, intends to include the teaching on gender violence in undergraduate curricula as a public health issue. Likewise, training in gender violence is both addressed to all new recruits among Primary Care professionals and to those who in previous years could not complete their basic training. Also, in the Canary Islands and the Basque Country measures have been introduced to raise awareness among intern physicians *(MIR)* through the teaching units of Family and Community Medicine with the aim of providing some fresh insight into gender violence and its repercussions on health through growing closer to the Protocol. Castile and Leon have included awareness-raising actions in the *MIR* Family and Community Medicine Programme and also among intern midwives (*EIR*, Intern Nurse).

Inter-Institutional and Interdisciplinary Coordination and Collaboration in Gender Violence Training

Castile and Leon, Galicia, Murcia, Basque Country, Canary Islands, Aragon and Andalusia promote socio-health professionals' attendance to diverse congresses, seminars, courses and workshops that other institutions organise. They are intended to get acquainted with the way other working environments function such as the police or the judiciary and to get to know which means and resources they can rely on at local and at national levels.

Murcia encourages professionals' stays in other communities and institutions for their being trained in services and actions of prevention, detection and addressing gender violence.

For developing some of the training activities carried out in the different ACs, collaboration was relied upon from various public and private institutions, as the Women's Institute (*Instituto de la Mujer*, for reference), some autonomic institutes of women, the National Health School *(Escuela Nacional de Sanidad),* community health departments and offices, Andalusia School of Public Health *(Escuela Andaluza de Salud Pública [EASP]),* the Spanish Red Cross *(Cruz Roja),* State law enforcement and security bodies, penitentiary institutions, some NPOs (non profit organisations), etc. In Catalonia, the emphasis has been placed on shared activities with other professionals from different institutions and bodies *(Mossos d'Esquadra),*

other professionals from *Conselleria de Bienestar Social* (Social Welfare Office), local councils' personnel, etc.

Training for a Multidisciplinary Intervention in Cases of Gender Violence

In Asturias, Balearic Islands, Cantabria, Castile and Leon, Galicia and Basque Country, reference is made to the need for reinforcing gender violence training among mental health units' professionals in an effort to meet the demand and to reduce waiting time. They also highlight the need for training at users' care services in Primary Care *(AP),* at hospital emergency services, points of call *(PAC)* and family counselling centres *(COF).*

In the Autonomous Community of Madrid they were expecting to train, between 2008 and 2009, at least one professional from the psychiatry, clinical psychology, nursing and social work specialties, at each one of the 37 mental health centres of the community.

Training in Screening in the Health Setting and for Addressing the Medical Interview at the Doctor's Office

Cantabria's view in relation with training in gender violence is that both relational aspects, as well as ethical, legal and management of emotions matters should be included when handling the screening in suspicion cases, and their recording as health problem on the clinical history and relevant ethical and legal reflections.

Empathy interviews also called motive interviews are part of the Syllabus contents of the training Cantabria, Castile and Leon, Balearic Islands, Catalonia, Canary Islands, Galicia and Madrid provide. Cantabria for instance, encourages professionals having received basic training, to enrol on communication skills courses with a view to conducting the medical interview to women suffering abuse. Castile and Leon address the emotional impact on professionals who care for them and the handling of their own emotions to avoid potential negative effects both on the care provided to women and on themselves. Likewise, all courses and workshops include the addressing of ethical and legal issues.

Training for Professionals in their Pondering the Different Contexts of Vulnerability, Abused Women Present

Concerning the contents of the training conducted in all autonomous communities special emphasis is placed on women in situations of the greatest vulnerability as pregnancy, disability, immigration, social exclusion, etc., for professionals to pay special regard to women's multiculturality when dealing with this issue.

Along these lines, Canary Islands have updated their teaching material on these situations of greater vulnerability and dependence of women and

Aragon has established a training project for a comprehensive response to gender violence in rural areas that has been granted accreditation by the *Comisión de Formación Continuada* (Continuing Training Commission). Also the *Comisión de Seguimiento de Actuaciones para prevenir la Mutilación Genital* (Projects Monitoring Commission for the Prevention of Female Genital Mutilation) have revised and published during 2008 a new version of the existing document and, in turn, continued its implementation through information and training activities for health professionals. Also Castile and Leon provide for the protection, care and safety of women victims of abuse in rural areas and so do they in the courses and workshops they host in which situations of special vulnerability are dealt with such as pregnancy, disability and immigration.

Inclusion in Training, of Other Forms of Abuse

In Cantabria, the highlight is the II Action Plan: Women's Health (2008 -2011); *(II Plan de actuación: salud de las mujeres [2008-2011])* that includes the update of other kinds of abuse such as sexual harassment, in their training. In Galicia, sexual harassment has also been included in the contents of the training in confronting gender violence.

Assessment of Educational Activities Developed in Autonomous Communities

Qualitative research studies and evaluations on the impact/transfer of the training have been initiated in different autonomous communities such as Aragon, Castile and Leon, Catalonia, Cantabria, Madrid, Galicia and Murcia with the aim of knowing if the training and awareness activities and availability of the guide/protocol are responding to the professionals' expectations concerning education and training needs (level of satisfaction, coverage, relevance and effectiveness). The purpose is to use the findings from the evaluation as a reference for developing new training programmes, knowing their strengths and weaknesses.

Personal interviews and surveys have also been conducted among professionals working at call points *(puntos de atención continuada [PAC]*) to identify the difficulties with both material resources, lack of information and training in gender issues as well as with lack of awareness on gender violence and its impact on women. Professionals were interviewed, pre- and post- intervention tests were given and training workshops held.

All trough 2008 the Community of Madrid conducted an evaluation of the impact of training on area 11 of Primary Care, entitled *Impacto de las acciones formativas sobre la detección de la violencia de pareja hacia las mujeres en atención primaria* (Impact of training actions on the detection of intimate partner abuse of women, at Primary Care). Detection of cases,

achieved after the training received in 2007 was assessed; that year the performance of Primary Care teams (PCT *[EAP]*) that had received training was compared to that of teams that had not. The resulting conclusion was that trained professionals had detected 25 % of cases more that non-trained ones.

In Galicia it was concluded that training raises awareness in all professionals giving them self-confidence which results in an improvement of the care provided to women in situations of gender abuse. Likewise, Castile and Leon conducted a qualitative study on differences found in socio-health professionals' performance on abused women, in the urban and rural settings. The outcome of this study has been highly useful for the planning of training activities both concerning prioritisation as well as orienting of some of the contents.

Also the study Effectiveness of an educational intervention for awareness among Primary Care professionals for improving domestic violence diagnosing *(Estudio de efectividad de una intervención sensibilizadora formativa en profesionales de atención primaria para la mejora del diagnóstico de la violencia doméstica),* whose results were presented at the European Congress of the WONCA (Istanbul, 2008).

Recommendations for the future

Table 11 shows some aspects that should be taken into account when collecting information in coming years.

Table 11. Aspects to be taken into account when collecting information regarding NHS professionals' training

- Include percentage of trained personnel in relation to the total of staff to be trained by each Autonomous Community
- Include educational content and objectives intended to be conveyed to practitioners attending training
- Provide information regarding accreditation of teaching
- Take into account the number of hours taught for each type of training activity (basic courses awareness activities, etc.)
- Take into account the professional profile of participants attending the training
- Consider mechanisms or tools used in autonomous communities for facilitating attendance to the training (substitutions, programme contract, etc.)
- Include the education format "train the trainer" (in the indicators of the different training activities)

Analysis of educational actions

Nationwide Data

Data follow, that were obtained from the analysis of all training actions developed throughout the country. They show on the one hand, the number of the various activities conducted, that is: basic courses, awareness activities and other Non-specific educational actions, and on the other hand, the number of teaching hours imparted, always differencing all three settings they were given at (Primary Care, Specialty Care and Casualty) and sex-itemised attendance to them. As regards sex-related attendance it has to be said that not all Autonomous Communities were able to provide the said breakdown for all categories[3] in this first collection of information. Data relating to teachers' professional profile and their attachment to different institutions are also provided.

Teaching provided at Primary Care, Specialty Care and Casualty

Most of the teaching was provided at Primary Care as it is in this area where the most training activities were put into action (332) with a total of 3,908 teaching hours. In Casualty, less activities were conducted (34) and more teaching hours afforded (fig. 5).

Training Activities conducted in Primary Care, Specialty Care and Casualty

With respect to percentages of training activities conducted, the most frequent educational format has been basic courses with 86 % in Specialty Care (SC) and 77 % at Casualty.

Although basic courses have been less frequent (40 %) in Primary Care than awareness activities (54 %) it should be pointed out that this type of actions are quite balanced among them compared to what happens in other health care sectors (SC and Casualty).

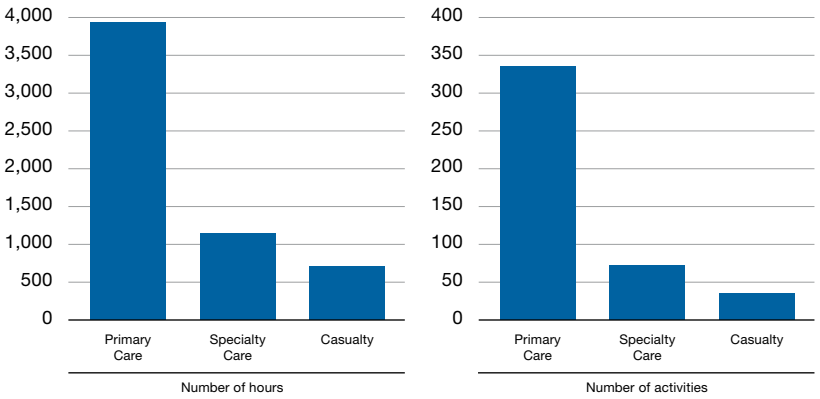
Other Non-Specific Educational Actions were less frequent in all three health care areas (figs. 6-8).

Participation in the different Training Actions

Women's participation in the different training actions (basic courses, awareness activities and other non-specific training actions) has been higher.

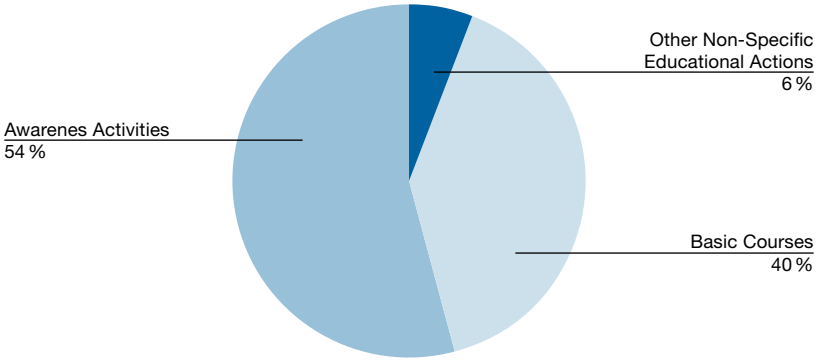
3 For instance, total persons having taken part in some kind of educational activity in 2008 in Andalusia amounts to 2,249. However, data that can be presented broken down by sex correspond to 279 personas, that is only 12.4 % of participants.

Figure 5. Number of activities and teaching hours as per health care area



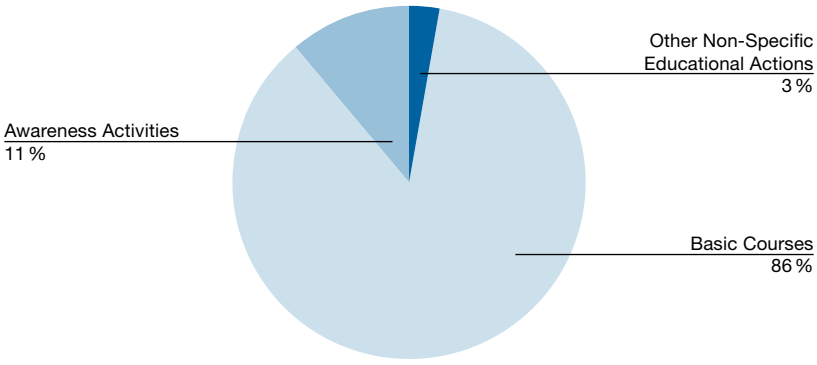
Health Care Area	Number of hours	Number of activities
Primary Care	3,908	332
Specialty Care	1,133	64
Casualty	767	34

Figure 6. Training activities conducted in Primary Care



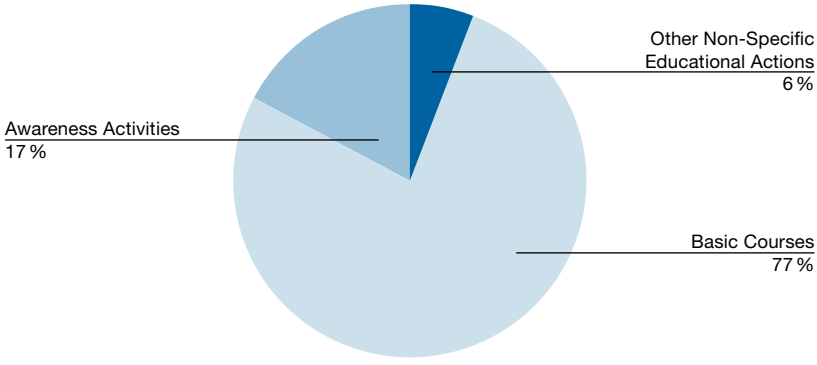
Educational Activities	Total	Percentage
Basic Courses	146	40
Awareness Activities	197	54
Other Non-Specific Educational Actions	24	6

Figure 7. Educational activities conducted in Specialty Care



Educational Activities	Total	Percentage
Basic Courses	55	86
Awareness Activities	7	11
Other Non-Specific Educational Actions	2	3

Figure 8. Educational activities conducted at Casualty



Educational Activities	Total	Percentage
Basic Courses	27	77
Awareness Activities	6	17
Other Non-Specific Educational Actions	2	6

Basic courses registered a total of 2,542 women participants against 645 men. In awareness activities 1,503 women and 570 men and in Other Non-Specific Educational Actions general participation was lower, scoring 348 women and 68 men (fig. 9).

As regards PC, women's participation was higher than men's for any of the training activities conducted. In basic courses there were 1,643 female and 377 male participants. Nevertheless, awareness activities attracted a higher number of male participants (498) although they did not outnumber female participants (1,257). Women's share in non-specific training actions was 306 participants while men's was of 42 (fig. 10).

In Specialty Care, participation in training is more frequent for women. Basic course educational format accounts for the highest participation: 767 women and 203 men.

In awareness activities there were 237 women and 73 men. Participation in other non-specific training actions was lower: 37 women and 6 men. It is worth mentioning however that this educational format is less frequently used than basic courses and awareness activities (fig. 11).

Casualty hosted less training activities although the fact that participation of men and women in this area was quite similar deserves highlighting. Basic courses were attended by 59 women and 54 men. In awareness activities, participation was of 6 women and 4 men and in Other Non-Specific Educational Actions 9 women and 5 men (fig. 12).

Conclusions of this Section are shown on Table 12.

Teaching Personnel's Professional Profile. Sex-Itemised Data

Teaching personnel's professional profile appears distributed among Medicine (the most frequent), Nursing, Social Work and Psychology.

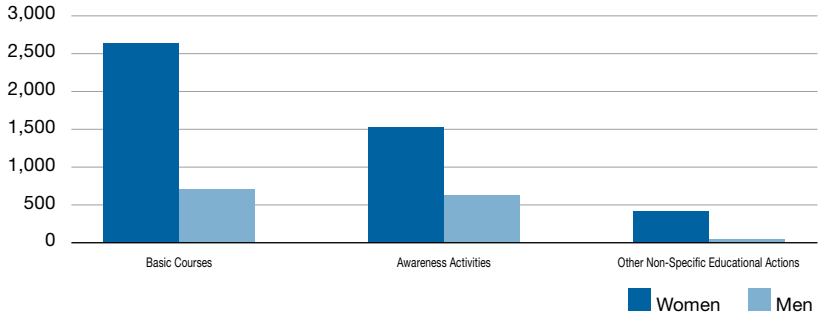
Other teaching personnel professional profiles were more in keeping with the law and legal spheres, the Judiciary, Law Enforcement Bodies and Education Sciences.

As was the case with trainees, the proportion of women having provided tuition was larger than that of men (fig. 13).

Teaching Staff's Sourcing

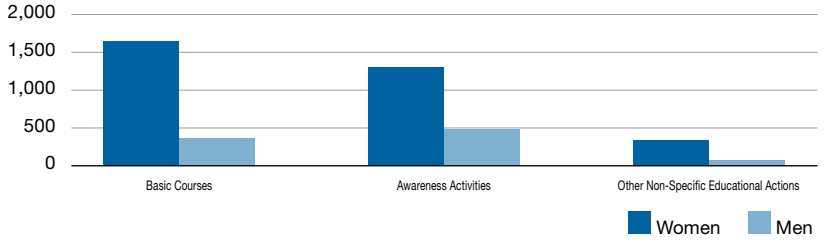
As regards teaching staff's sourcing, they for the most part belong to the Autonomic Administration (65 %) and to a lesser extent (9 %) to other public institutions and to the General Administration (8 %). The remaining 18 % pertains to a large variety of public, civil and private institutions: University, local administration, Non-Profit Organisations and telecare, amongst others (fig. 14). Table 13 lists the conclusions drawn from these last two sections.

Figure 9. Participation in the different educational activities. Sex-itemised data



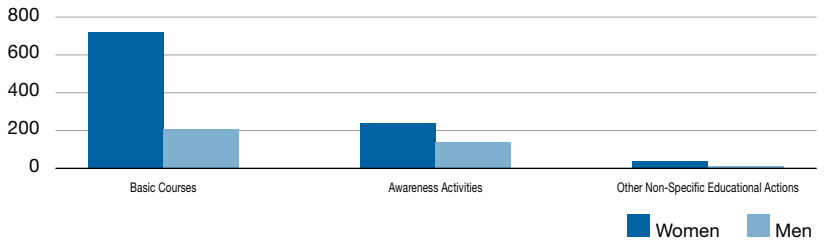
Educational Activities	Total	Percentage
Basic Courses	2,542	645
Awareness Activities	1,503	570
Other Non-Specific Educational Actions	438	68

Figure 10. Participation in Primary Care. Sex-itemised data



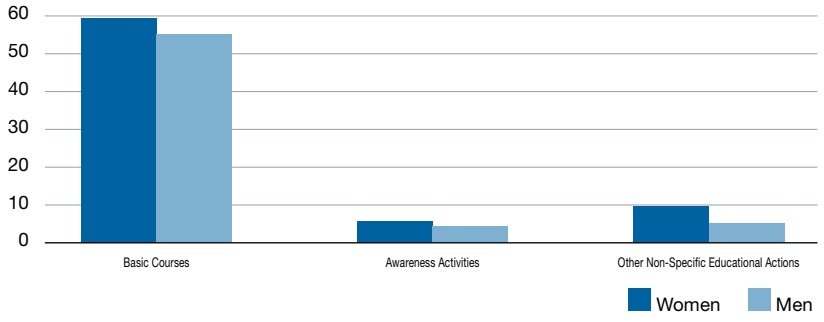
Educational Activities	Women	Men
Basic Courses	1,643	377
Awareness Activities	1,257	498
Other Non-Specific Educational Actions	306	42

Figure 11. Participation in Specialty Care. Sex-itemised data



Educational Activities	Women	Men
Basic Courses	767	203
Awareness Activities	237	73
Other Non-Specific Educational Actions	37	6

Figure 12. Participation at Casualty. Sex-itemised data



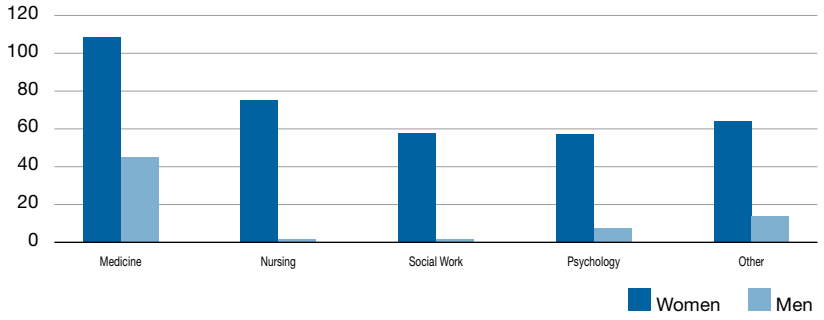
Educational Activities	Women	Men
Basic Courses	59	54
Awareness Activities	6	4
Other Non-Specific Educational Actions	9	5

Table 12. Conclusions about participation in the different educational activities	
Health Care Area	Primary Care (PC) accounts for the highest number of activities and teaching hours. Casualty scores the lowest
Educational Format	In PC the percentage of basic courses is similar to that of awareness activities. Basic courses were mostly given In Speciality Care (SC) and Casualty The format "Other Non-Specific Educational Actions" was used in all three health care areas, to a lesser extent.
Participation as per Sex	The majority of participants in the different training actions and in the different health care areas were women. Awareness in questions relating to gender and health and not simply the fact of women being the most numerous working segment are still issues to reflect upon, and participation in this type of training being the object of study

Data per Autonomous Communities

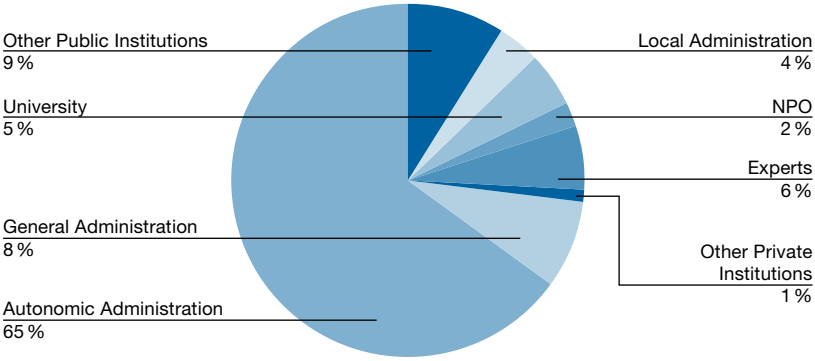
This section summarises the information provided by the different ACs and the autonomous cities of Ceuta and Melilla concerning instruction offered which is categorised as per type of educational format adopted to impart the said knowledge (basic courses, awareness activities and other non-specific educational activities) and professionals' attendance as per health care area and sex.

Figure 13. Teaching staff's professional profile. Sex-itemised data



Professional Profile	Women	Men	Total
Medicine	108	43	151
Nursing	75	2	77
Social Work	58	2	60
Psychology	57	7	64
Other	63	16	79

Figure 14. Staff's provenance



Provenance	Number	Percentage
Autonomic Administration	153	65
General Administration	20	8
Local Administration	9	4
NPO	5	2
Other Public Institutions	20	9
Experts	13	6
University	12	5
Other Private Institutions	2	1

Likewise, information is provided concerning teaching staff that refers to their professional profile, institutions they originate from and sex.

Table 13. Conclusions at a nationwide level on teaching staff's professional profile and provenance

Teaching Staff Professional Profile	The teaching staff has been mostly made up of Physicians followed by Nurses
Teaching Staff as per Sex	Men pertaining to the Medical Body participated chiefly as teachers. It is women however who are still the teaching majority in any of the professional profiles
Teaching Staff Provenance	As regards teaching staff's provenance, it mostly comes from the Autonomic Administration followed by Other Public Institutions and the General Administration

Teaching provided in each Autonomous Community as per Type of Educational Actions

Throughout 2008, it was Madrid which offered the highest number of basic courses (75) whilst Balearic Islands carried out the most awareness activities (47). The Valencian Community, Melilla and Extremadura were the only ones to use exclusively the basic courses format.

Canary Islands and Catalonia performed the most non-specific educational actions (5). They also conducted awareness activities. Catalonia offered, in addition, basic courses (fig. 15).

Types of Educational Activities conducted in each Autonomous Community as per Health Care Area

It is PC where the most teaching units in all formats were offered (basic courses, awareness activities and other educational actions). Broadly speaking, Casualty developed the least teaching activities. In fact, only 5 ACs provided teaching in this area. Of the different teaching formats the least resorted to was Other Non-Specific Educational Actions which only accounted for 5 actions performed. In the SC area, 10 ACs provided teaching.

With regard to the number of basic courses, Madrid and Andalusia were the two ACs that ran the most basic courses in Specialty Care.

The greatest frequency in running basic courses at Casualty occurred in the Valencian Community and in Galicia. The proportion of this educational format was similar for all three clinical areas in these last two communities (fig. 16).

Only Asturias, Castile-La Mancha, Murcia, Navarre and Madrid relied on Awareness Activities, Madrid having only provided this teaching format in Specialty Care.

Andalusia, Castile and Leon, and Catalonia were the only communities to provide this teaching category at Casualty.

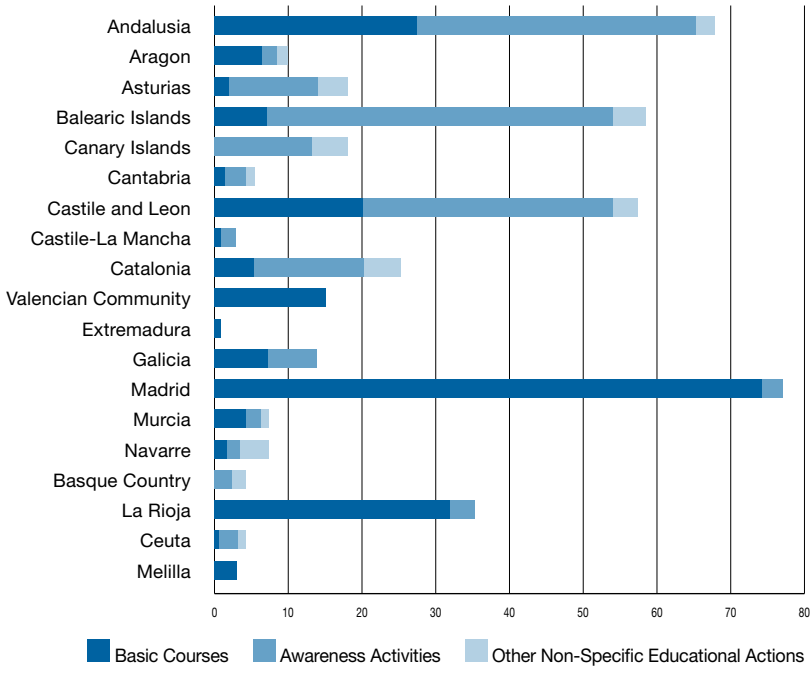
The Basque Country conducted 1 awareness activity in both PC, SC and Casualty.

The rest of Communities only provided training in PC exception made of the Valencian Community, Extremadura, La Rioja and the autonomous city of Melilla, in which this educational format was not available (fig. 17).

Concerning Other Non-Specific Educational Actions as per health care area where they were performed, it has been the least used educational format as it did not exceed 5 activities which coincides with figures released by Canary Islands and Catalonia for the Primary Care area.

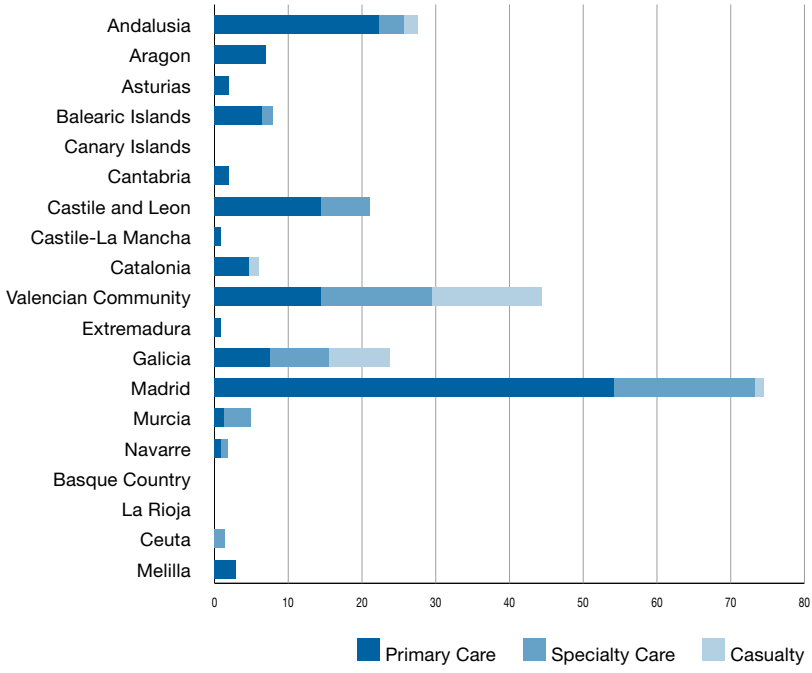
In Andalusia non-specific educational actions were exclusively performed at Casualty while in Murcia and Cantabria they took place in the Specialty Care area. The rest of autonomous communities either set them up in Specialty Care or did not rely on this training formula at all (fig. 18).

Figure 15. **Teaching load broken-down by Autonomous Community (total)**



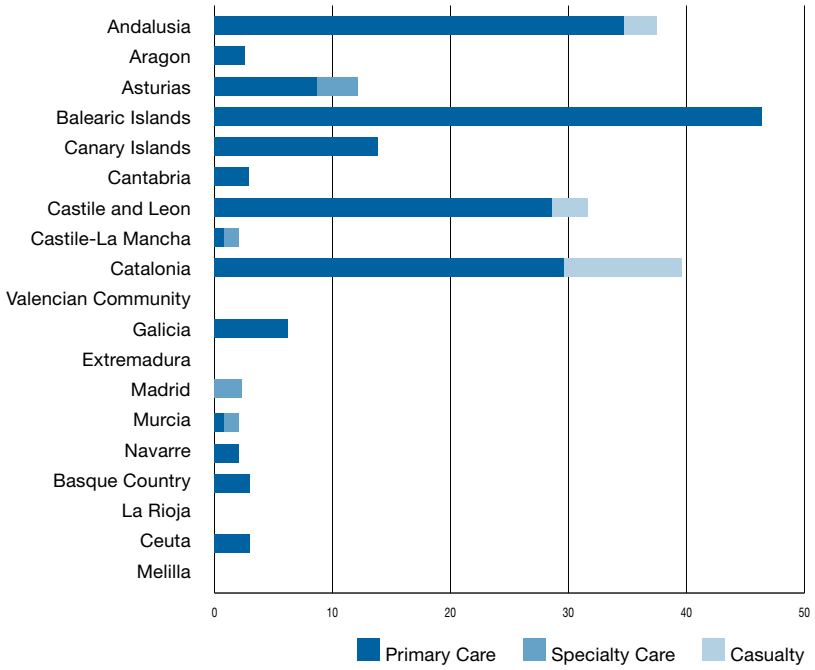
AC	Basic Courses	Awareness Activities	Other Non-Specific Educational Actions
Andalusia	28	38	2
Aragon	7	2	1
Asturias	2	12	4
Balearic Islands	8	47	4
Canary Islands	-	14	5
Cantabria	2	3	1
Castile and Leon	21	34	3
Castile-La Mancha	1	2	-
Catalonia	6	15	5
Valencian Community	15	-	-
Extremadura	1	-	-
Galicia	8	6	-
Madrid	75	2	-
Murcia	5	2	1
Navarre	1	2	4
Basque Country	-	3	2
La Rioja	33	3	-
Ceuta	1	3	1
Melilla	3	-	-

Figure 16. **Total number of basic courses conducted as per health care area**



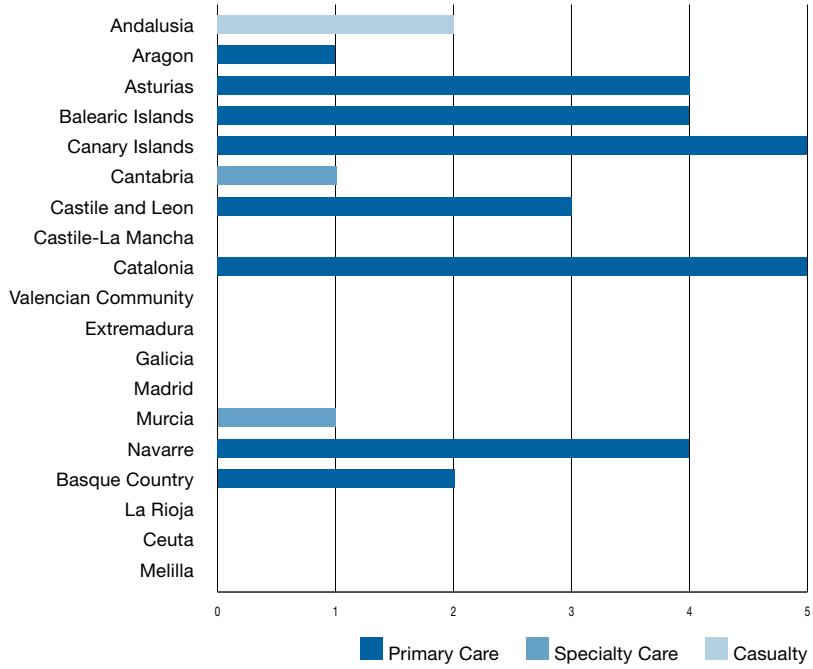
AC	Primary Care	Specialty Care	Casualty
Andalusia	23	3	2
Aragon	7	-	-
Asturias	2	-	-
Balearic Islands	7	1	-
Canary Islands	-	-	-
Cantabria	2	-	-
Castile and Leon	15	6	-
Castile-La Mancha	1	-	-
Catalonia	5	-	1
Valencian Community	15	15	15
Extremadura	1	-	-
Galicia	8	8	8
Madrid	55	19	1
Murcia	2	3	-
Navarra	1	1	-
Basque Country	-	-	-
La Rioja	-	-	-
Ceuta	-	1	-
Melilla	3	-	-

Figure 17. Total number of awareness activities per health care area



AC	Primary Care	Specialty Care	Casualty
Andalusia	35	-	3
Aragon	2	-	-
Asturias	9	3	-
Balearic Islands	47	-	-
Canary	14	-	-
Cantabria	3	-	-
Castile and Leon	29	-	3
Castile-La Mancha	1	1	-
Catalonia	30	-	10
Valencian Community	-	-	-
Galicia	6	-	-
Extremadura	-	-	-
Madrid	-	2	-
Murcia	1	1	-
Navarre	2	-	-
Basque Country	3	-	-
La Rioja	-	-	-
Ceuta	3	-	-
Melilla	-	-	-

Figure 18. Total number of non-specific educational actions as per health care area



AC	Primary Care	Specialty Care	Casualty
Andalusia	-	-	2
Aragon	1	-	-
Asturias	4	-	-
Balearic Islands	4	-	-
Canary Islands	5	-	-
Cantabria	-	1	-
Castile and Leon	3	-	-
Castile-La Mancha	-	-	-
Cataluña	5	-	-
Valencian Community	-	-	-
Extremadura	-	-	-
Galicia	-	-	-
Madrid	-	-	-
Murcia	-	1	-
Navarre	4	-	-
Basque Country	2	-	-
La Rioja	-	-	-
Ceuta	-	-	-
Melilla	-	-	-

Participation in the Training provided by Autonomous Communities. Sex-Itemised Data

With respect to participation in training as per sex, women attended training provided in all autonomous communities in a larger proportion. However in Andalusia, Balearic Islands and Murcia, men's participation was broader than in the rest of ACs. On the contrary, the lowest level of men's participation was detected at La Rioja (fig. 19).

Percentage of Participation in Basic Courses. Sex-Itemised Data. In what concerns participation in basic courses as per sex, women generally displayed a greater frequency. Andalusia and Castile-La Mancha registered greater male participation and Extremadura a lower degree (fig. 20).

Awareness Activities Participation Percentage. Sex-Itemised Data. Aragon and La Rioja did not register men's participation in awareness activities while Basque Country and Balearic Island scored the highest men percentage.

In the Canary Islands 115 people participated in this training category although no sex-itemised information was made available (fig. 21).

Participation Percentage in Other Non-Specific Educational Actions. Sex-Itemised Data. Participation of women was also greater in Other Non-Specific Educational Actions. In Cantabria there was no men participation. On the contrary Andalusia and Asturias reported men's broader participation (35.7 and 40 %, respectively; fig. 22).

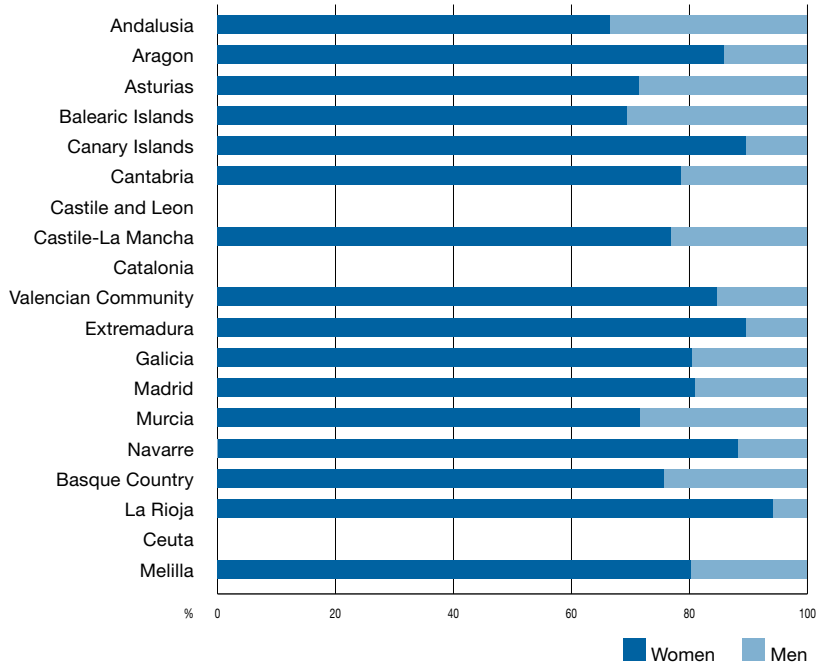
Participation in the Different Training Activities as per Area. Sex-Itemised Data

As may be observed in figures that follow, women participation percentages were higher than men's for basis courses given in any of the health care areas (Primary Care, Specialty Care and Casualty) exception made of Andalusia where participation of men was broader than women's in basic courses held at Casualty. Nevertheless, men's participation in training for addressing gender violence is increasing in frequency.

Participation Percentages in Basic Courses at Primary Care, Specialty Care and Casualty. Sex-Itemised Data. Women's participation in courses given was greater. In Primary Care of Castile-la Mancha and Murcia men outnumbered women and in Extremadura their participation was lower (10 %). In SC, in Galicia men's participation was greater while their participation was lower in Andalusia; in Casualty, male participants outnumbered women. In Melilla, only women participated in this area.

In the Primary Care area, men's participation was higher in Castile-La Mancha and Murcia while their participation in Extremadura was lower (10 %). However in any AC women's participation percentage was higher (fig. 23).

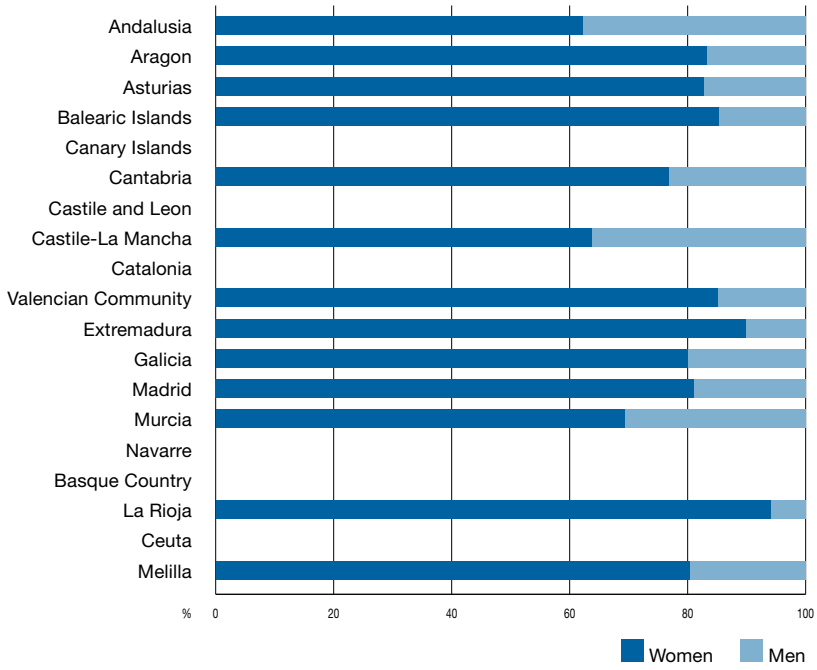
Figure 19. Participation in training given in each Autonomous Community. Sex-itemised data



AC	Women	Men
Andalusia	186	93
Aragon	176	28
Asturias	284	112
Balearic Islands	719	311
Canary Islands	150	17
Cantabria	242	64
Castile and Leon	-	-
Castile-La Mancha	192	58
Catalonia	-	-
Valencian Community	182	32
Extremadura	18	2
Galicia	257	62
Madrid	1,730	397
Murcia	126	49
Navarre	92	12
Basque Country	137	44
La Rioja	34	2
Ceuta	-	-
Melilla	50	12

No Sex-Itemisation in Autonomous Communities presenting no data.

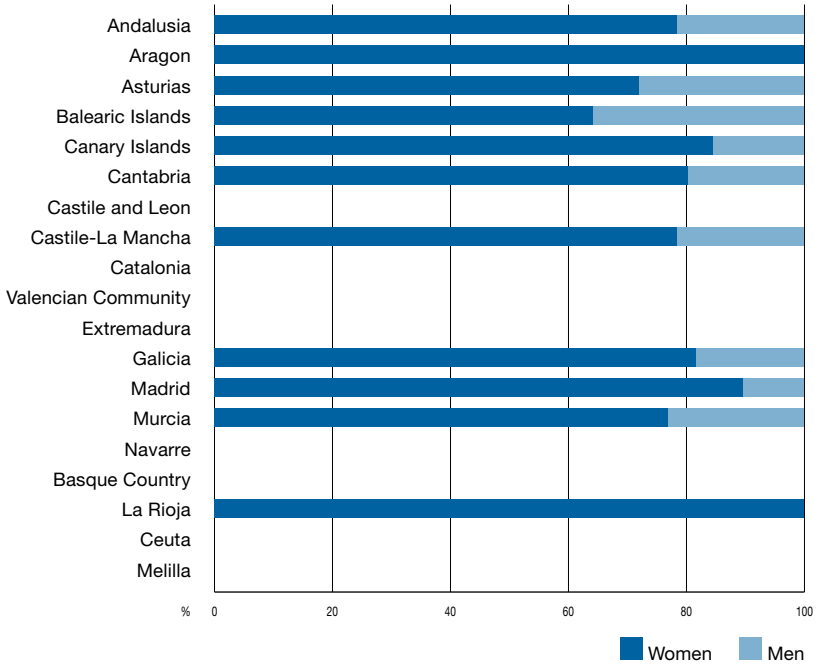
Figure 20. **Participation in basic courses. Sex-itemised data**



AC	Women	Men
Andalusia	117	71
Aragon	126	26
Asturias	19	4
Balearic Islands	23	4
Canary Islands	-	-
Cantabria	96	30
Castile and Leon	-	-
Castile-La Mancha	14	8
Catalonia	-	-
Valencian Community	182	32
Extremadura	18	2
Galicia	153	38
Madrid	1,647	387
Murcia	66	29
Navarre	-	-
Basque Country	-	-
La Rioja	31	2
Ceuta	-	-
Melilla	50	12

No Sex-Itemisation in Autonomous Communities presenting no data.

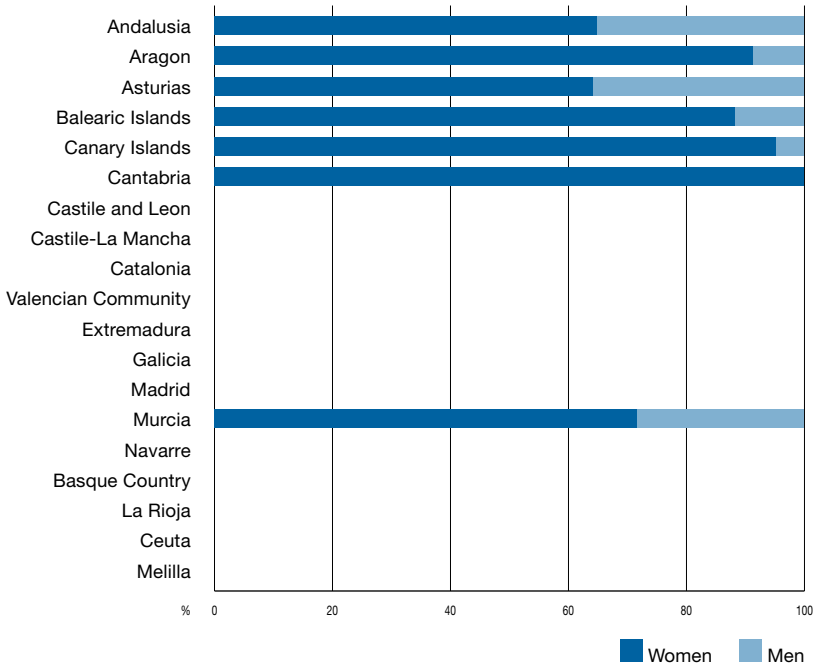
Figure 21. Participation in awareness activities. Sex-itemised data



AC	Women	Men
Andalusia	60	17
Aragon	30	-
Asturias	251	100
Balearic Islands	504	280
Canary Islands	63	12
Cantabria	136	34
Castile and Leon	-	-
Castile-La Mancha	178	50
Catalonia	-	-
Valencian Community	-	-
Extremadura	-	-
Galicia	104	24
Madrid	83	10
Murcia	45	14
Navarre	-	-
Basque Country	-	-
La Rioja	3	-
Ceuta	-	-
Melilla	-	-

No Sex-Itemisation in Autonomous Communities presenting no data.

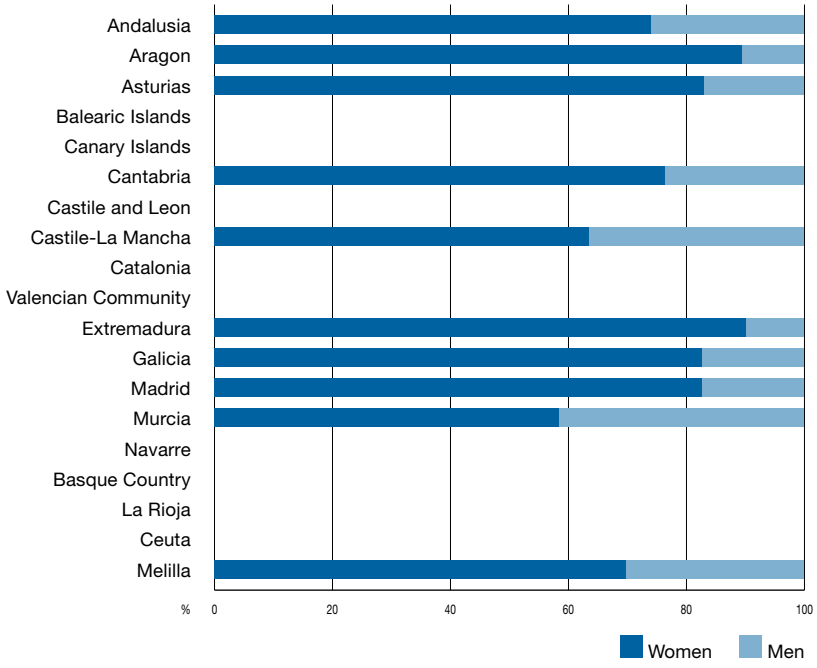
Figure 22. Participation in awareness activities. Sex-itemised data



AC	Women	Men
Andalusia	9	5
Aragon	20	2
Asturias	14	8
Balearic Islands	192	27
Canary Islands	87	5
Cantabria	10	-
Castile and Leon	-	-
Castile-La Mancha	-	-
Catalonia	-	-
Valencian Community	-	-
Extremadura	-	-
Galicia	-	-
Madrid	-	-
Murcia	15	6
Navarre	-	-
Basque Country	-	-
La Rioja	-	-
Ceuta	-	-
Melilla	-	-

No Sex-Itemisation in Autonomous Communities presenting no data.

Figure 23. Participation in basic courses in Primary Care. Sex-itemised data



AC	Women	Men
Andalusia	79	28
Aragon	106	13
Asturias	19	4
Balearic Islands	-	-
Canary Islands	-	-
Cantabria	96	30
Castile and Leon	-	-
Castile-La Mancha	14	8
Catalonia	-	-
Valencian Community	-	-
Extremadura	18	2
Galicia	135	28
Madrid	1,097	235
Murcia	27	19
Navarre	-	-
Basque Country	-	-
La Rioja	-	-
Ceuta	-	-
Melilla	7	3

No Sex-Itemisation in Autonomous Communities presenting no data.

As far as Specialty Care is concerned a greater participation of women is observed in basic courses of all Autonomous Communities. In this area more men took part in Galicia and Aragon, while in Andalusia they were outnumbered. Ten ACs, Ceuta and Melilla were unable to provide this information sex-itemised (fig. 24).

As regards basic courses run at Casualty something worth mentioning is the greater participation of men in Andalusia. No men registered for participation in basic courses run in Casualty of Melilla or Valencian Community (fig. 25).

Participation Percentages in Awareness Activities at Primary Care, Specialty Care and Casualty. Sex-Itemised Data. With regard to participation in awareness activities at any of the healthcare areas, women still participate in higher proportion than men. In Aragon no participation of men was registered either in Primary Care or in Specialty Care. In Balearic Islands and Basque Country men participated to a greater proportion in the Primary Care area. At Casualty, only Andalusia and Castile and Leon organised awareness activities.

As regards participation in awareness activities in PC, there was no participation of men in Aragon. On the contrary in the Basque Country and Balearic Islands men's participation was broader (nearly 40 %; fig. 26).

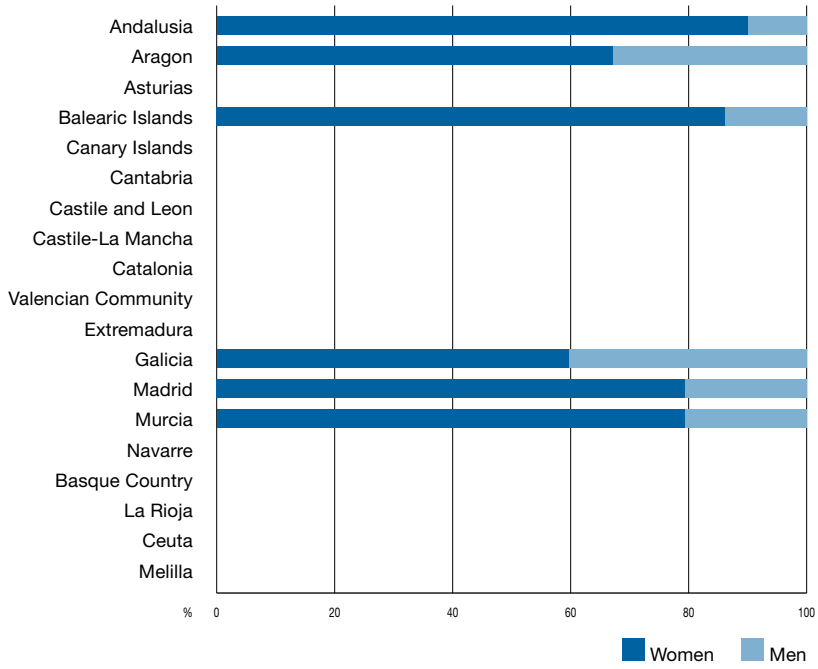
In Specialty Care, Awareness Activities were conducted in the ACs of Aragon, Asturias, Castile-La Mancha, Madrid and Murcia. Only women participated in Aragon while a greater proportion of men did in Asturias and Castile-La Mancha. Neither in the rest of Communities nor in Melilla was this type of activity developed in the Specialty Care Area (fig. 27).

At Casualty, awareness activities were only conducted in the ACs o Andalusia and Castile and Leon although the latter did not provide sex-itemised information. Again, it should be highlighted that in Andalusia male professionals' participation was unusually broader.

Participation Percentages in Non-Specific Educational Actions, at Primary Care, Specialty Care and Casualty. Sex-Itemised Data. As in the case of other types of educational formats, in non-specific training activities there was also an increased participation of women in the different health care fields. In the Communities of Aragon, Canary Islands and Cantabria participation in Specialty Care was only by women. In Asturias there was a greater percentage of participation by men in Primary Care and in Andalusia at Casualty.

In general, in the ACs that have gender-disaggregated data, it appears that the participation of men has been very low except in Asturias where it was somewhat higher (40 %). The Autonomous Community of Castile and Leon does not provide information in relation to sex and the same applies to Galicia. These ACs find it difficult to assess both the number of people

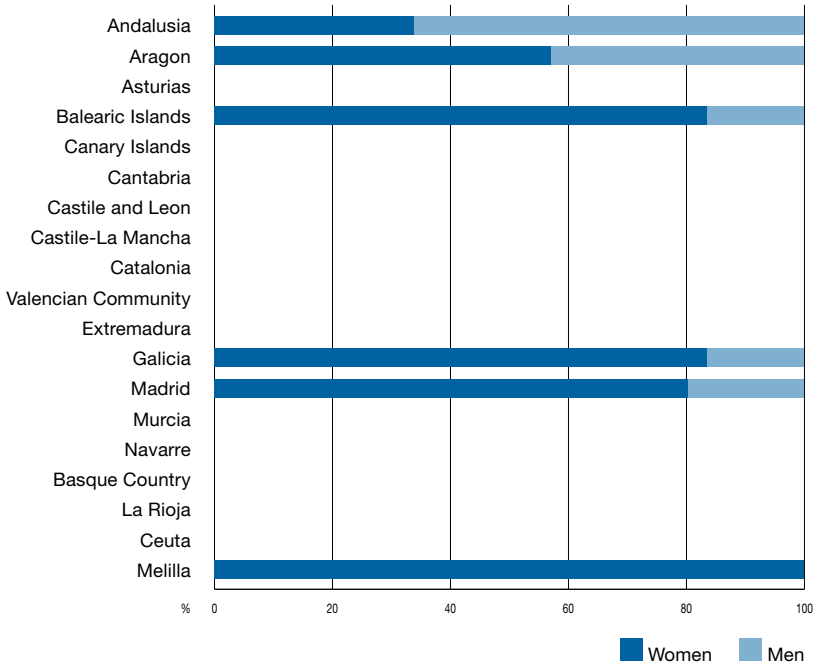
Figure 24. **Participation in basic courses in Specialty Care. Sex-itemised data**



AC	Women	Men
Andalusia	17	2
Aragon	8	4
Asturias	-	-
Balearic Islands	18	3
Canary Islands	-	-
Cantabria	-	-
Castile and Leon	-	-
Castile-La Mancha	-	-
Catalonia	-	-
Valencian Community	-	-
Extremadura	-	-
Galicia	13	9
Madrid	542	150
Murcia	39	10
Navarre	-	-
Basque Country	-	-
La Rioja	-	-
Ceuta	-	-
Melilla	-	-

No Sex-Itemisation in Autonomous Communities presenting no data.

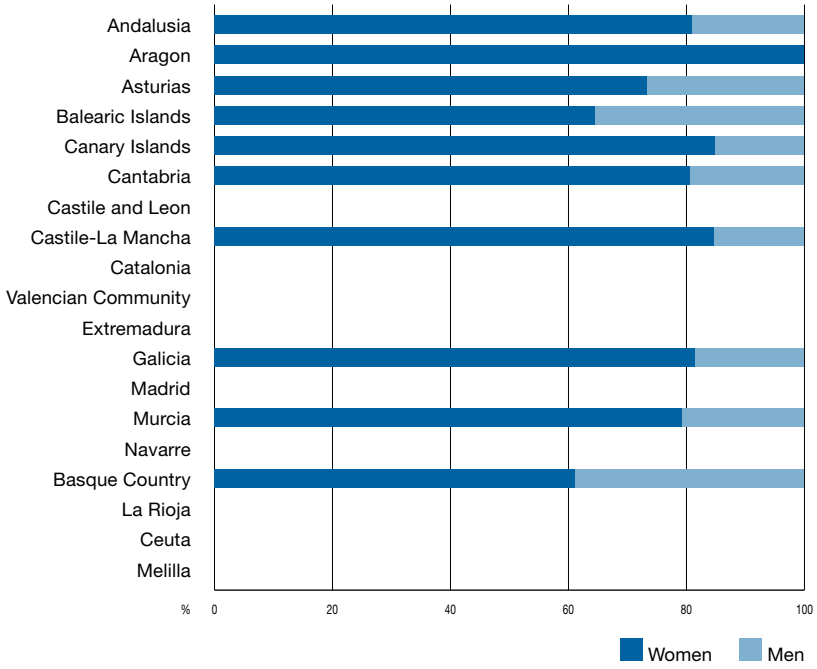
Figure 25. Participation in basic courses at Casualty. Sex-itemised data



AC	Women	Men
Andalusia	21	41
Aragon	12	9
Asturias	-	-
Balearic Islands	5	1
Canary Islands	-	-
Cantabria	-	-
Castile and Leon	-	-
Castile-La Mancha	-	-
Catalonia	-	-
Valencian Community	-	-
Extremadura	-	-
Galicia	5	1
Madrid	8	2
Murcia	-	-
Navarre	-	-
Basque Country	-	-
La Rioja	-	-
Ceuta	-	-
Melilla	1	-

No Sex-Itemisation in Autonomous Communities presenting no data.

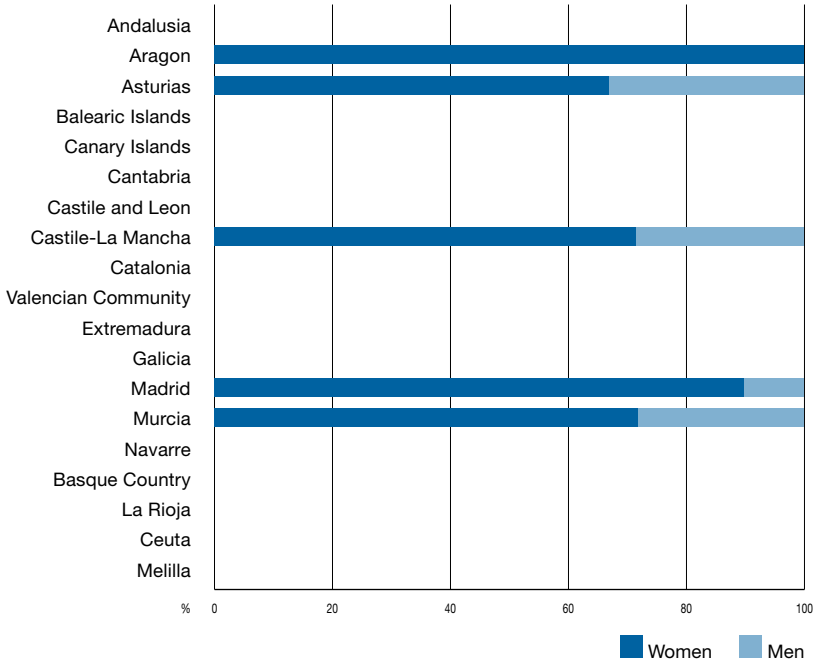
Figure 26. Participation in awareness activities in Primary Care. Sex-itemised data



AC	Women	Men
Andalusia	54	13
Aragon	21	-
Asturias	201	75
Balearic Islands	504	280
Canary Islands	63	12
Cantabria	136	34
Castile and Leon	-	-
Castile-La Mancha	98	18
Catalonia	-	-
Valencian Community	-	-
Extremadura	-	-
Galicia	104	24
Madrid	-	-
Murcia	30	8
Navarre	-	-
Basque Country	46	29
La Rioja	-	-
Ceuta	-	-
Melilla	-	-

No Sex-Itemisation in Autonomous Communities presenting no data.

Figure 27. Participation in awareness activities in Specialty Care. Sex-itemised data



AC	Women	Men
Andalusia	-	-
Aragon	9	-
Asturias	50	25
Balearic Islands	-	-
Canary Islands	-	-
Cantabria	-	-
Castile and Leon	-	-
Castile-La Mancha	80	32
Catalonia	-	-
Valencian Community	-	-
Extremadura	-	-
Galicia	-	-
Madrid	83	10
Murcia	15	6
Navarre	-	-
Basque Country	-	-
La Rioja	-	-
Ceuta	-	-
Melilla	-	-

No Sex-Itemisation in Autonomous Communities presenting no data.

attending the activities carried out in auditoriums, town halls, etc., as well as the number of men or women who have participated in them (fig. 28).

In Specialty Care, women's participation in other training actions was 100 % in Aragon, Canary Islands and Cantabria. In Murcia, men's participation in this training format reached 30 % (fig. 29).

Casualty registered the lowest proportion of other training actions. Only the Autonomous Community of Andalusia provided this type of training at Casualty.

Total Number of Tuition Hours of Training for each Autonomous Community as per Health Care Area

The highest number of tuition hours was conducted in the Primary Care field in the Autonomous Community of Castile and Leon (696.5), Andalusia (661), Madrid (555), Catalonia (512), the Valencian Community (370) and Balearic Islands (318). Galicia and the Valencian Community taught the highest number of hours at Casualty. Aragon and the Canary Islands do not provide information on the number of tuition hours totalled in the Specialty Care and Casualty fields although they provided teaching in both of them (fig. 30). Table 14 shows information from ACs on teaching activities as per field, educational format, tuition hours and participation (disaggregated by sex).

Teaching Staff Members' Profile

Professional Profile of Teaching Staff Members. The most numerous group of professionals that make up the teaching staff is Medicine (147 professionals), followed by Nursery (76), Psychology (62), Social Work (60) and others that include professionals from the Legal system, the Judiciary, Law Enforcement Bodies, etc. Also, the percentage of women versus men in the delivery of training, is higher.

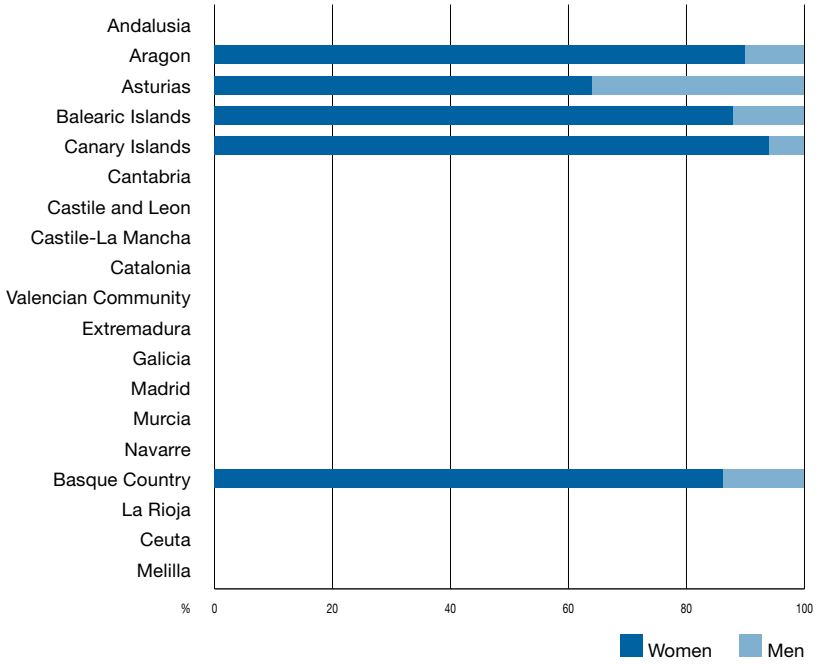
In the Autonomous Community of Cantabria, all physicians who provide training are men. In Castile-La Mancha and Melilla the percentage of male teaching staff members matching this profile is higher when compared with their female counterparts.

With respect to Nurses providing training, the majority are women.

As regards Psychologists trainers, in Asturias, Balearic Islands, Cantabria, Castile-La Mancha, Valencian Community, Madrid, Murcia, La Rioja, Basque Country, Melilla and Ceuta, they are all women. In Aragon, 50 % of trainers are men and in Castile and Leon 15 %. In Andalusia and Galicia there are also men in this area although to a lesser extent.

In relation to Social Work, male trainers can only be found in Madrid and Aragon although they are less numerous than women (figs. 31-35).

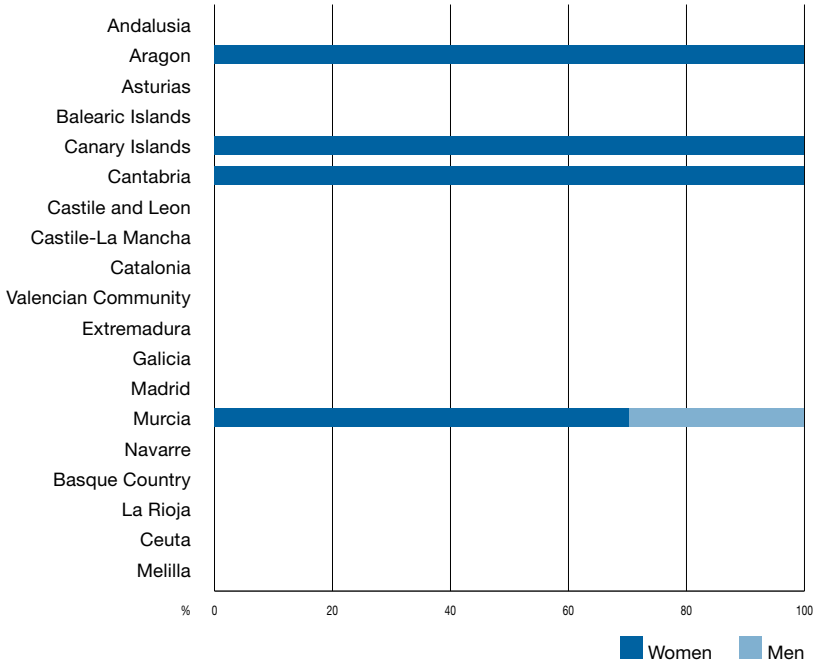
Figure 28. Participation in other non-specific educational actions in Primary Care. Sex-itemised data



AC	Women	Men
Andalusia	-	-
Aragon	18	2
Asturias	14	8
Balearic Islands	192	27
Canary Islands	77	5
Cantabria	-	-
Castile and Leon	-	-
Castile-La Mancha	-	-
Catalonia	-	-
Valencian Community	-	-
Extremadura	-	-
Galicia	-	-
Madrid	-	-
Murcia	-	-
Navarre	-	-
Basque Country	91	15
La Rioja	-	-
Ceuta	-	-
Melilla	-	-

No Sex-Itemisation in Autonomous Communities presenting no data.

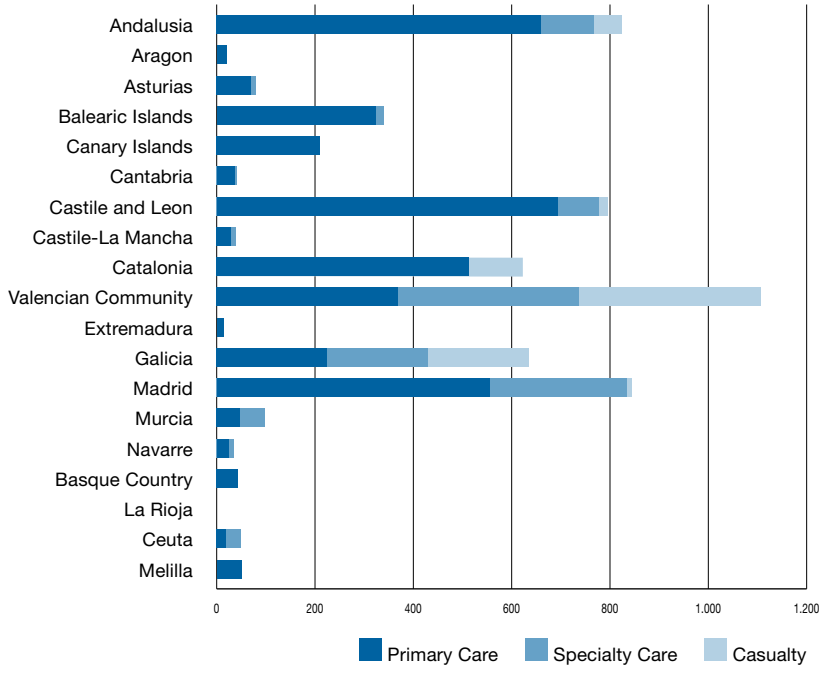
Figure 29. Participation in other non-specific educational actions in Specialty Care. Sex-itemised data



AC	Women	Men
Andalusia	-	-
Aragon	2	-
Asturias	-	-
Balearic Islands	-	-
Canary Islands	10	-
Cantabria	10	-
Castile and Leon	-	-
Castile-La Mancha	-	-
Catalonia	-	-
Valencian Community	-	-
Extremadura	-	-
Galicia	-	-
Madrid	-	-
Murcia	15	6
Navarre	-	-
Basque Country	-	-
La Rioja	-	-
Ceuta	-	-
Melilla	-	-

No Sex-Itemisation in Autonomous Communities presenting no data.

Figure 30. Tuition hours of training provided in each Autonomous Community as per health care area (total)



AC	Primary Care	Specialty Care	Casualty
Andalusia	661	106	58
Aragon	20	-	-
Asturias	68	6	-
Balearic Islands	318	15	-
Canary Islands	208	-	-
Cantabria	36	6	-
Castile and Leon	696.5	84	16
Castile-La Mancha	27	8	-
Catalonia	512	-	107
Valencian Community	370	370	370
Extremadura	15	-	-
Galicia	224	206	206
Madrid	555	282	10
Murcia	48	50	-
Navarre	24	10	-
Basque Country	45	-	-
La Rioja	-	-	-
Ceuta	20	30	-
Melilla	50.5	-	-

Table 14. Conclusions on Autonomous Communities' information on training actions as per health care area, educational format, tuition hours and participation. Data broken-down by sex

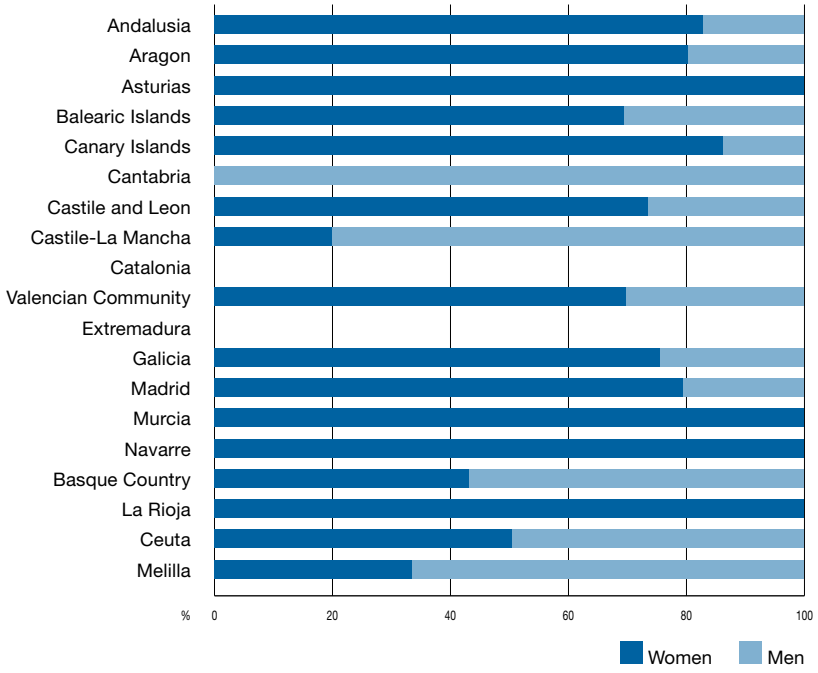
Health Care Area	Casualties developed the smallest number of activities. Only 5 ACs provided training in this field. In Specialty Care 10 ACs provided training
Educational Format	Of all ACs, 15 developed basic courses apart from Ceuta and Melilla, 15 ACs and Ceuta conducted awareness activities and 11 ACs and Ceuta performed other non-specific training actions. The Valencian Community, Extremadura and Melilla only conducted basic courses. Navarre only developed awareness activities and the Canary Islands and Catalonia performed the greatest number of non-specific training actions
Tuition Hours	The greatest number of training hours was put in the Primary Care Area in the ACs of Castile and Leon (696), Madrid (555), Valencian Community (370) and Balearic Islands (318). Galicia and the Valencian Community taught the highest number of hours at Casualty
Sex-Itemised Participation	In all ACs women participants outnumbered men participants. The ACs where men's participation was somewhat higher were Andalusia, Balearic Islands and Murcia. In La Rioja men's participation was lower. Various ACs cannot provide this information

Teaching Staff Sourcing. Broadly speaking, a high proportion of the teaching staff belongs to their autonomic administration. In Madrid and the Canary Islands the teaching staff as a whole are attached to this administrative authority while in the rest of ACs trainers belong to a large variety of institutions: *Instituto de la Mujer* (Women's Institute), General Administration, experts, University, local administration, NPOs and other private institutions (telecare; fig. 36). Table 15 compiles the conclusions on professional profiles and sex of trainers as well as on their professional origin.

Variability and Mean of Training Activities Conducted in the Different Care Setting among Autonomous Communities

Shown below, is the variability among ACs, in terms of training provided, that is, both the highest number of training activities conducted (maximum) per educational format (basic courses, awareness activities and other non-specific educational activities) as well as their lowest number (minimum) and the mean of both per health care area they take place at (PC, SC and Casualty). The said information is also provided relating to the number of tuition hours afforded.

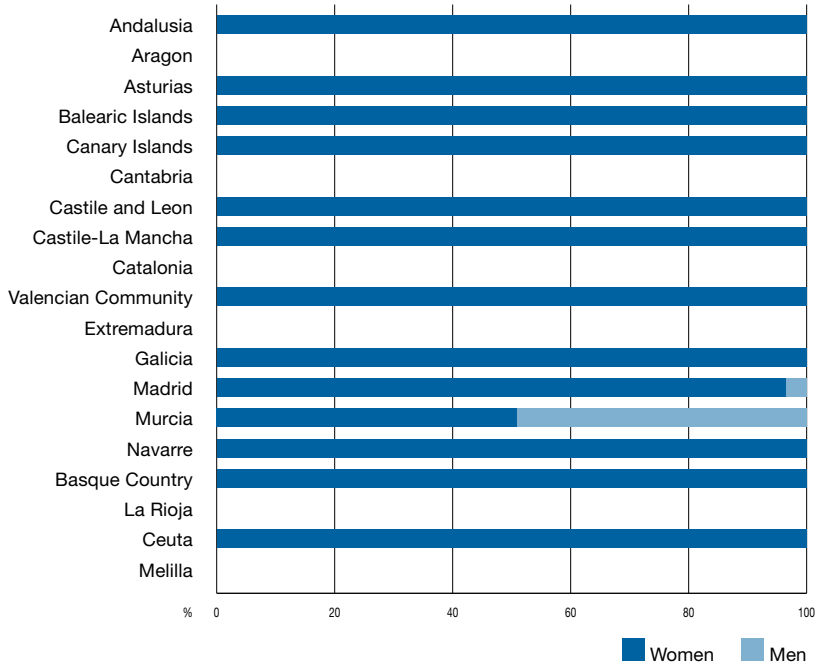
Figure 31. Medicine professionals providing training in gender violence, per Autonomous Community. Sex-itemised data



AC	Women	Men
Andalusia	14	3
Aragon	4	1
Asturias	3	-
Balearic Islands	11	5
Canary Islands	6	1
Cantabria	-	2
Castile and Leon	11	4
Castile-La Mancha	1	4
Catalonia	-	-
Valencian Community	27	12
Extremadura	-	-
Galicia	3	1
Madrid	15	4
Murcia	6	-
Navarre	2	-
Basque Country	3	4
La Rioja	2	-
Ceuta	1	1
Melilla	1	2

No Sex-Itemisation in Autonomous Communities presenting no data.

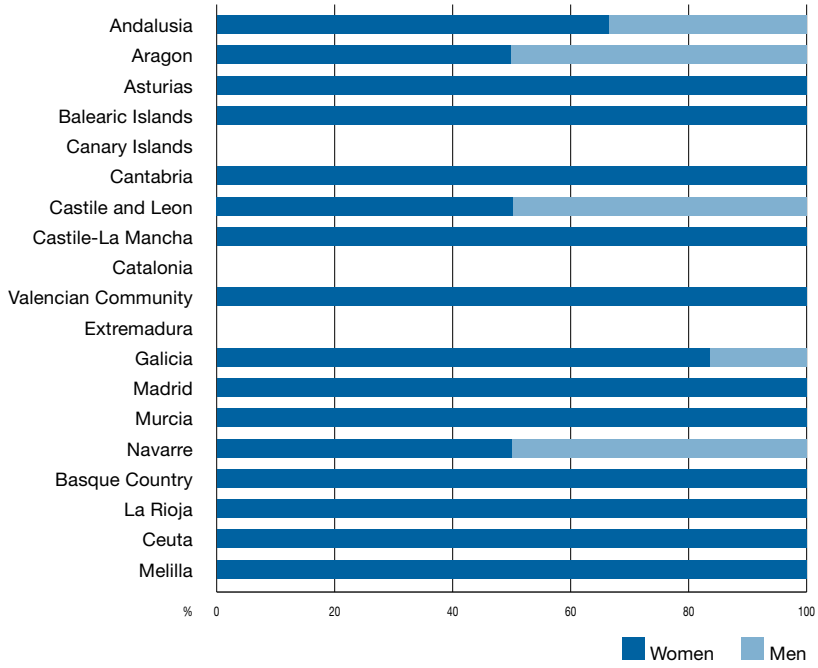
Figure 32. **Nursery professionals providing training in gender violence, per Autonomous Community. Sex-itemised data**



AC	Women	Men
Andalusia	4	-
Aragon	-	-
Asturias	4	-
Balearic Islands	8	-
Canary Islands	4	-
Cantabria	-	-
Castile and Leon	9	-
Castile-La Mancha	2	-
Catalonia	-	-
Valencian Community	15	-
Extremadura	-	-
Galicia	2	-
Madrid	24	1
Murcia	1	1
Navarre	1	-
Basque Country	1	-
La Rioja	-	-
Ceuta	3	-
Melilla	-	-

No Sex-Itemisation in Autonomous Communities presenting no data.

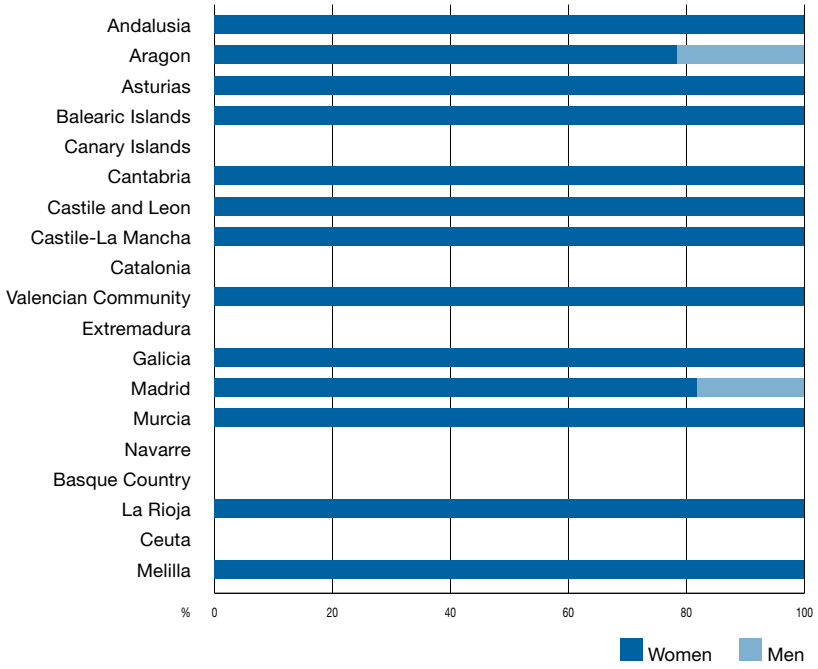
Figure 33. **Psychology professionals providing training in gender violence, per Autonomous Community. Sex-itemised data**



AC	Women	Men
Andalusia	4	2
Aragon	1	1
Asturias	3	-
Balearic Islands	5	-
Canary Islands	-	-
Cantabria	2	-
Castile and Leon	3	3
Castile-La Mancha	2	-
Catalonia	-	-
Valencian Community	15	-
Extremadura	-	-
Galicia	5	1
Madrid	4	-
Murcia	5	-
Navarre	2	2
Basque Country	3	-
La Rioja	4	-
Ceuta	1	-
Melilla	1	-

No Sex-Itemisation in Autonomous Communities presenting no data.

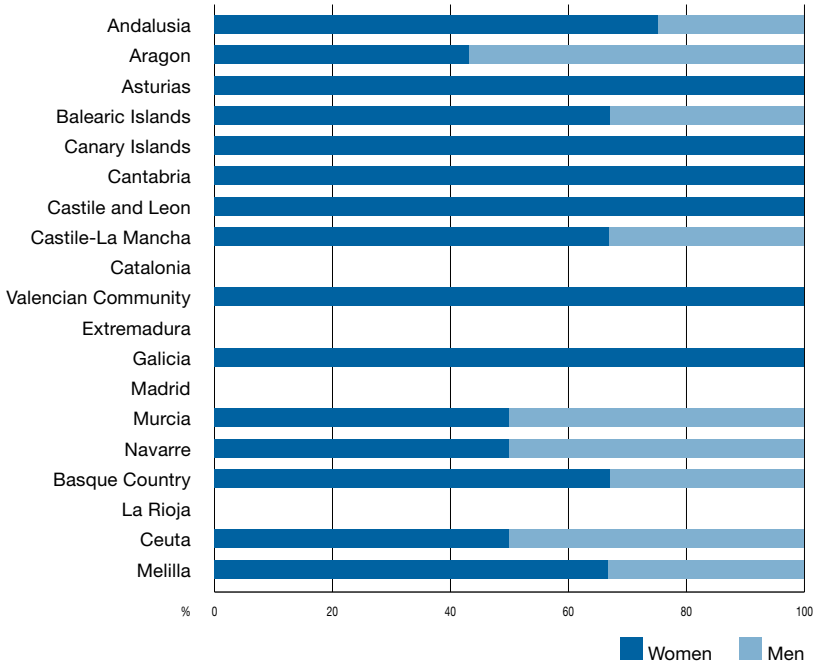
Figure 34. Social work professionals providing training in gender violence, per Autonomous Community. Sex-itemised data



AC	Women	Men
Andalusia	6	-
Aragon	4	1
Asturias	3	-
Balearic Islands	2	-
Canary Islands	-	-
Cantabria	1	-
Castile and Leon	8	-
Castile-La Mancha	3	-
Catalonia	-	-
Valencian Community	16	-
Extremadura	-	-
Galicia	4	-
Madrid	5	1
Murcia	3	-
Navarre	-	-
Basque Country	-	-
La Rioja	2	-
Ceuta	-	-
Melilla	1	-

No Sex-Itemisation in Autonomous Communities presenting no data.

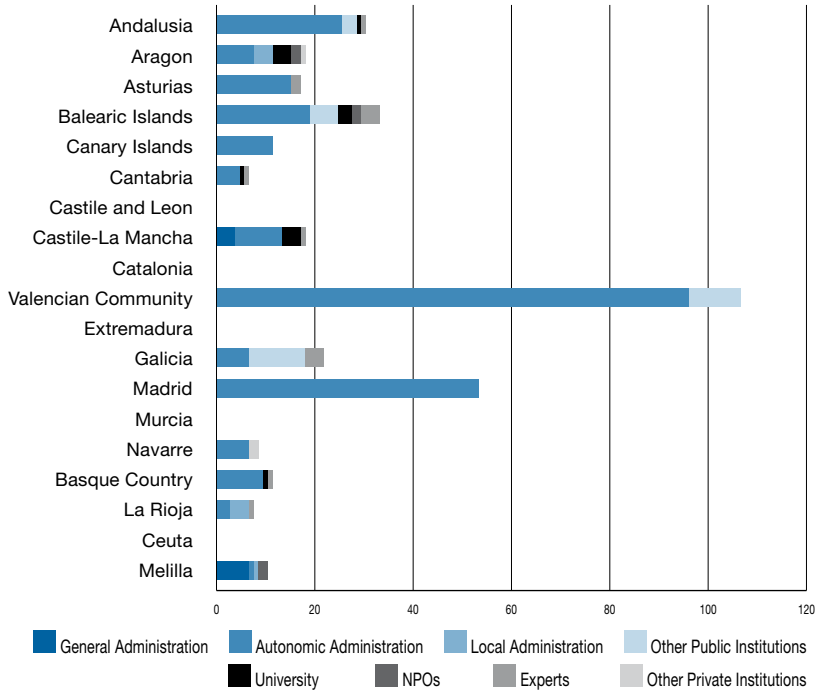
Figure 35. Professionals of other profiles providing training in gender violence, per Autonomous Community. Sex-itemised data



AC	Women	Men
Andalusia	3	1
Aragon	3	4
Asturias	4	-
Balearic Islands	2	1
Canary Islands	1	-
Cantabria	2	-
Castile and Leon	8	-
Castile-La Mancha	4	2
Catalonia	-	-
Valencian Community	22	-
Extremadura	-	-
Galicia	2	-
Madrid	-	-
Murcia	5	5
Navarre	1	1
Basque Country	2	1
La Rioja	-	-
Ceuta	3	3
Melilla	4	2

No Sex-Itemisation in Autonomous Communities presenting no data.

Figure 36. Sourcing of trainers



AC	General Administration	Autonomic Administration	Local Administration	Other Public Institutions	University	NPOs	Experts	Other Private Institutions
Andalusia	-	26	-	3	1	-	1	-
Aragon	-	8	4	-	4	1	-	1
Asturias	-	16	-	-	-	-	1	-
Balearic Islands	-	19	-	6	3	2	4	-
Canary Islands	-	12	-	-	-	-	-	-
Cantabria	-	5	-	-	1	-	1	-
Castile and Leon	-	-	-	-	-	-	-	-
Castile-La Mancha	4	10	-	-	3	-	1	-
Catalonia	-	-	-	-	-	-	-	-
Valencian Community	-	96	-	11	-	-	-	-
Extremadura	-	-	-	-	-	-	-	-
Galicia	-	7	-	11	-	-	4	-
Madrid	-	54	-	-	-	-	-	-
Murcia	-	-	-	-	-	-	-	-
Navarre	-	7	-	-	-	-	-	2
Basque Country	-	10	-	-	1	-	1	-
La Rioja	1	2	4	-	-	-	1	-
Ceuta	-	-	-	-	-	-	-	-
Melilla	7	1	1	-	-	2	-	-

Table 15. Conclusions on teaching staff members' professional profile and provenance. Sex-itemised data	
Trainers' Professional Profile	Medicine (108 professionals) is the most frequent professional profile followed by Nursing (61), Psychology (46) and Social Work (44)
Teaching Staff (Sex-Itemised)	In general, the proportion of women trainers is higher for any professional profile. However there are more Medicine male professionals than female ones in the Autonomous Communities of Castile-La Mancha, Melilla and Cantabria. In Cantabria, Medicine training staff is entirely made up of men
Teaching Staff Provenance	In general, a large proportion of the teaching staff comes from autonomic administrations. In Madrid and the Canary Islands all trainers pertain to them

The largest number of activities took place in Primary Care, in all three educational formats. Basic courses averaged 28, awareness activities 24 and non-specific educational activities amounted to 3, on mean. In the remaining health care levels, mean did not exceed 10 activities.

The highest number of tuition hours was provided in Primary Care, averaging 355.75 hours. In Specialty Care and Casualty, means were lower: 188 and 190 hours respectively.

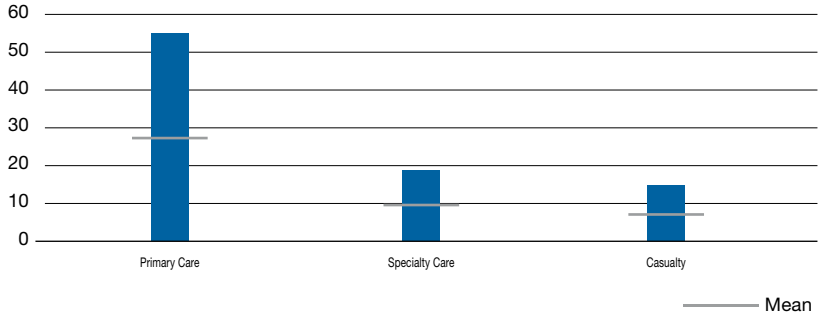
As for the different formats adopted, PC hosted all three, the most frequently. The largest number of courses conducted in PC was of 55, whereas the lowest was of 1, which amounts to an mean of 28 basic courses. In Specialty Care the largest number of basic courses conducted in an autonomous Community was 19 and the lowest, 1, which represents 10 courses on mean. Casualty accounted for the lowest number of basic courses with an mean of 8 basic courses (fig. 37).

Regarding awareness activities, a maximum of 47 were conducted in PC with a resulting mean of 24. In Specialty Care and Casualties, the number of awareness activities turned out to be very low, the mean being of 2 and 3 respectively (fig. 38).

The training format named Other Non-Specific Educational Actions was the least frequently provided in either of the three health care levels. The mean at PC was of 3, followed by SC and Casualty with 2 actions performed (fig. 39).

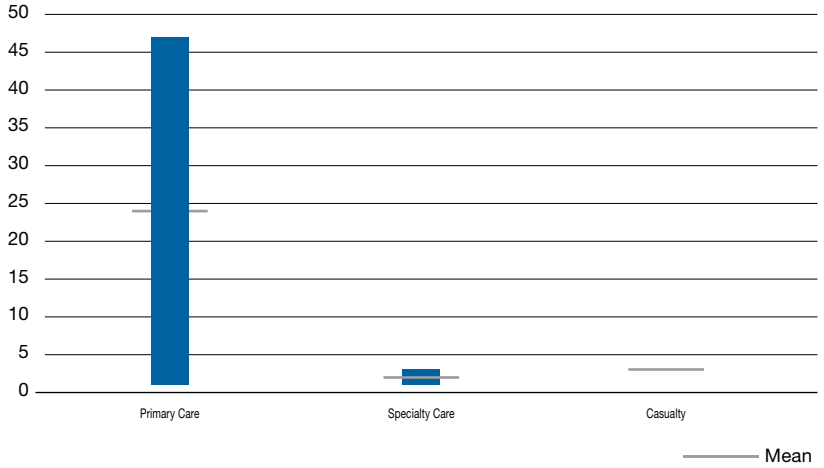
The highest number of tuition hours totalling 696.5, was provided in Primary Care, where the minimum number was of 15 tuition hours which, on mean amounts to 355.75 hours. In SC and Casualty the mean amounts to 188 and 190 hours respectively (fig. 40). Table 16 shows the conclusions on numbers of basic courses, awareness activities, other non-specific educational actions and tuition hours.

Figure 37. Number of basic courses.
Mean and variability among Autonomous Communities



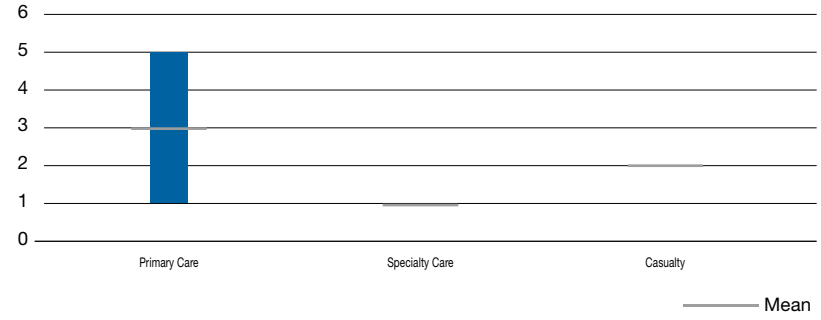
Health Care Area	Maximum	Minimum	Mean
Primary Care	55	1	28
Specialty Care	19	1	10
Casualty	15	1	8

Figure 38. Number of awareness activities.
Mean and variability among Autonomous Communities



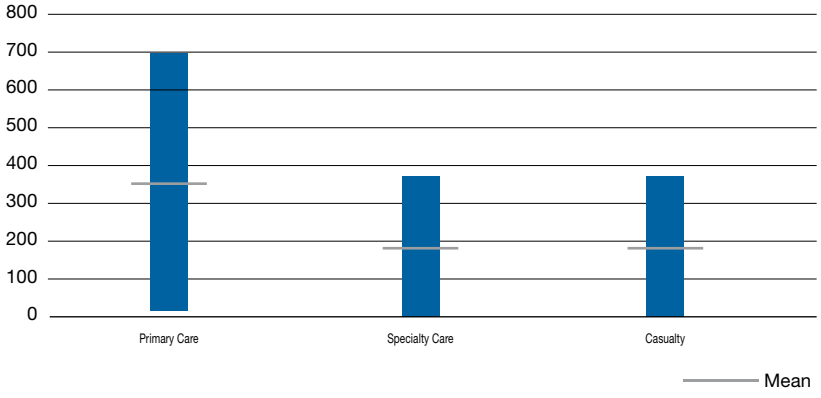
Health Care Area	Maximum	Minimum	Mean
Primary Care	47	1	24
Specialty Care	3	1	2
Casualty	3	3	3

Figure 39. Number of other non-specific educational actions.
Mean and variability among Autonomous Communities



Health Care Area	Maximum	Minimum	Mean
Primary Care	5	1	3
Specialty Care	1	1	1
Casualty	2	2	2

Figure 40. Number of tuition hours.
Mean and variability among Autonomous Communities



Health Care Area	Maximum	Minimum	Mean
Primary Care	696.5	15	355.75
Specialty Care	370	6	188
Casualties	10	370	190

Table 16. Conclusions. Training in gender violence occurrences, for professionals in Autonomous Communities. Types of training activity and tuition hours	
Basic Courses	The maximum number of courses given was 55 and the minimum 1; thus resulting mean was 28 basis courses. In SC the maximum was 19 and the minimum 1; so their mean was 10 and Casualty's 8
Awareness Activities	In PC a maximum of 47 was conducted with an mean of 24. In SC and Casualty the mean was very low: 2 and 3 activities conducted respectively
Other Non-Specific Educational Actions	This training format was the least frequent in any of the three health care areas. In PC the mean was 3 and the maximum number 5. In SC 1 and in Casualty 2 actions were performed
Tuition Hours	Primary Care provided the largest number of tuition hours reaching a maximum of 696.5 and a minimum of 15 hours, mean equalling 355.75 hours. In SC and Casualty, resulting mean was lower:188 and 190 hours respectively

Summary of Actions for Addressing Gender Violence in Autonomous Communities and Cities with Autonomy Status

Actions for Implementing the Common Protocol for a Health Care Response to Gender Violence in Primary Care and Specialty Care

The following describes the actions conducted in Autonomous Communities to implement the Common Protocol for a Health Care response to Gender Violence, approved by the National Health System's Inter-Territorial Council (NHSIC) in December 2006 and released in 2007 to be applied in Primary Care and in Specialty Care; published by the Ministry of Health and Social Policy, it aims to bring together the action guidelines for early detection, assessment and action on GV detected cases and their follow-up.

For drafting the Common Protocol for a Health Care Response to Gender Violence, all the, at the time, existing protocols for action in ACs were revised. Some ACs have subsequently worked at the publishing of their new health care protocols adapted to the Common Protocol or work directly with the Common Protocol itself. Other Autonomous Communities directly work with the Inter-Institutional Protocol or with the one that regulates action integrated with other sectors (Table 17).

The *Conselleria de Sanitat* (Health Department) of the Valencian Community drafted and released the *Protocolo para la atención sanitaria de la violencia de género (PDA),* Protocol for health care attention to gender violence, whose objective is establishing normalised guidelines that may orient the active search or the early detection of possible gender violence cases and the correspondent intervention measures in identified cases.

Implementation of the *Protocolo para el abordaje de la violencia hacia las mujeres en el ámbito de la salud en Cataluña* (Protocol for addressing violence against women, in the health sphere in Catalonia) includes conducting a pilot test of a polycentric character and its assessment, that may enable the different sectors involved to be able to respond rapid and co-ordinately to situations of abuse.

Table 17. Protocols for health care action in Autonomous Communities

AC	Health care action protocols
Andalusia	*Protocolo andaluz para la actuación sanitaria ante la violencia de género* (Andalusian Protocol for health care action when dealing with gender violence, 2009)
Aragon	*Guía de atención sanitaria a la mujer víctima de violencia doméstica* (Guide for health care attention to women victims of domestic abuse, 2005)
Asturias	*Protocolo sanitario para mejorar la atención a las mujeres víctimas de violencia de género* (Health care protocol for improving care of women victims of gender violence, 2007)
Balearic Islands	*Atención sanitaria ante la violencia de género* (Health care when confronting gender violence, 2009)
Canary Islands	*Protocolo de actuación ante la violencia de género en el ámbito doméstico* (Action protocol for confronting gender violence in the domestic setting, 2003-2004)
Cantabria	*Protocolo de actuación sanitaria ante los malos tratos* (Health care action protocol for dealing with abuse [2005; 2nd ed. 2007])
Castile and Leon	*Protocolo de actuación en atención primaria para mujeres víctimas de malos tratos* (Primary Care Action Protocol for care for women victims of maltreatment, 2003)
Castile-La Mancha	*Protocolo de actuación en atención primaria para mujeres víctimas de malos tratos* (Action Protocol for women victims of abuse seen in Primary Care [pending legal deposit])
Catalonia	*Protocolo para el abordaje de la violencia hacia las mujeres en el ámbito de la salud en Cataluña* (Protocol for addressing violence against women, in the health sphere in Catalonia [under approval])
Valencian Community	*Protocolo para la atención sanitaria de la violencia de género* (Protocol for health care attention on gender violence [PDA; 2008])
Extremadura	*Protocolo Común para la Actuación Sanitaria ante la Violencia de Género del SNS* (NHS' Common Protocol for a Health Care Response to Gender Violence, 2007)
Galicia	*Guía técnica do proceso de atención as mulleres en situación de violencia de xénero* (Technical guide of the process of caring for women in situation of gender violence [currently underway])
Madrid	*Guía de apoyo en atención primaria para abordar la violencia de pareja hacia las mujeres* (Primary care support guide for addressing intimate partner violence against women, 2007)
	Guía breve de actuación en atención primaria (A short guide for action in Primary Care, 2008)
	Guía de actuación en atención especializada para abordar la violencia de pareja hacia las mujeres (Specialty Care action guide for addressing intimate partner violence against women [currently in preparation])
Murcia	*Protocolo para la detección y atención de la violencia de género en atención primaria* (Protocol for the detection and treatment of gender violence in PrimaryCare, 2007)

Navarre	*Protocolo Común para la Actuación Sanitaria ante la Violencia de Género del SNS* (NHS' Common Protocol for a Health Care Response to Gender Violence, 2007)
	Protocolo de actuación sanitaria ante los malos tratos domésticos, físicos, psicológicos y/o agresiones sexuales (Health Action Protocol to confront domestic abuse, physical, psychological and/or sexual assault [currently in force])
Basque Country	*Protocolo sanitario ante malos tratos domésticos* (Health care protocol to confront domestic abuse, 2000)
	Protocolo sanitario ante el maltrato en el ámbito doméstico y la violencia sexual contra las mujeres (Health care protocol to confront domestic abuse and sexual assault against women, 2008)
La Rioja	*Protocolo Común para la Actuación Sanitaria ante la Violencia de Género del SNS* (NHS' Common Protocol for a Health Care Response to Gender Violence, 2007)
Ingesa (Ceuta and Melilla)	*Protocolo Común para la Actuación Sanitaria ante la Violencia de Género del SNS* (NHS' Common Protocol for a Health Care Response to Gender Violence, 2007)

The Autonomous Community of Madrid distributed and implemented in 2008 the *Guía de apoyo en atención primaria para abordar la violencia de pareja hacia las mujeres* (Primary care support guide for addressing intimate partner violence against women). Also in 2008 they released and distributed the *Guía breve de actuación en atención primaria* (A short guide for action in Primary Care) written by a multidisciplinary team of public health and Primary Care professionals, with the aim of upgrading skills and empowering professionals of this health care level in their intervention against gender violence. Both its contents, with basic information for detecting situations of intimate partner violence and guidelines for acting in possible derived situations, along with its small size, enable professionals to make use of it at all times. Also, the *Guía de actuación en atención especializada para abordar la violencia de pareja hacia las mujeres* (Specialty Care action guide for addressing intimate partner violence against women) has been completed by a multidisciplinary group and revised by an external group. This guide gathers, apart from general aspects of detection, assessment and intervention, specific guidelines for intervention in Mental Health and Social Work, elements for assessment in Nursing that allow detection of male abuse situations. In addition, it includes criteria for redirecting victims to Mental Health, Primary Care and to specific resources of a social nature, with the aim of ensuring both continued health care as well as all-inclusive assistance in all health care and social aspects.

The Basque Country released the *Protocolo sanitario ante el maltrato domés tico y la violencia sexual contra las mujeres* (Health care protocol to

confront domestic abuse and sexual assault against women) with the aim of establishing action guidelines common to the whole of the autonomous community and of ensuring a complete health care for women victims of domestic abuse, sexual assault or abuse, who resort to a health care centre.

Health Care Personnel Training

Educational or awareness and dissemination activities as a strategy aimed at establishing the protocol through conducting courses, seminars and workshops all targeting health care personnel, were conducted in: Aragon, Balearic Islands, Canary Islands, Castile and Leon, Madrid, Basque Country, Ceuta and Melilla.

Training of health care professionals has been treated at great length in the relevant section of this Annual Report on Training of Professionals.

Inter-Institutional Collaboration

Inter-Institutional collaboration is not only a strategy for facilitating the overall organisation of the assistance all sectors involved provide but a helping element for the establishment and development of the document as happened in Aragon and Melilla.

La Rioja highlights some factors that will help achieve the full implementation of the Protocol such as the Institutional Agreement for improving the care for victims of domestic abuse, gender violence and sexual assault in the community; the Observatory on Gender Violence of La Rioja Subcommittee; the inclusion of gender violence in La Rioja II Health Plan); the Government of La Rioja's III Comprehensive Plan against Gender Violence, 2006- 2009 and the inclusion of training in the syllabus of their Community Health Department.

Inclusion of the Judicial Report in Health Care Information Systems

The new model of Judicial Report was expected to be in service in Andalusia in 2009 both in paper and in digital formats through its being incorporated into the digital medical history Diraya. This is a need mentioned in the health care protocol itself.

Publishing of other Documents to Help Implement the NHS's Common Protocol for a Health Care Response to Gender Violence

A highlight among other documents published in the Madrid Community, intended to boost implementation of the Common Protocol for a Healthcare Response to Gender Violence, is the Short guide for action in Primary Care (released and distributed through 2008).

Initiatives of Interest for Addressing Gender Violence in Health Services (Plans, Services Portfolio and Systems of Information)

The decision adopted by the Commission for Health and Consumers' Affairs of the Senate, on November 4th, 2008, urges to coordinate, promote and where appropriate, to finance, among others, actions relating to "inclusion of GV in all health plans and services portfolios of the Communities, in line with the service portfolio of the National Health System, as a priority area of work, both in Primary Care and Specialty Care, including mental health services and obstetrics and gynaecology".

Plans and Programmes

Health Plans

With respect to inclusion of GV in regional health plans (Table 18), Asturias Health Plan does include activities relating to gender equality among which some highlights are: promotion and support of research in GV; training of health personnel; implementation of the Health Care Protocol to improve care for women victims of violence and assessment of the smooth running of psychosocial care services for women victims of abuse.

Extremadura's new Health Plan *(Plan de salud de Extremadura [2009-2012])* includes the objective of reducing the incidence of gender violence in their autonomous community by increasing early detection of risk situations during the term of the plan.

The Health Plan of Catalonia in 2010 Horizons *(Plan de salud de Cataluña en el horizonte 2010)* contains a specific section on differences and inequalities in health owing to gender and places addressing GV in its list of priorities. Included as strategic proposals are: territorial dissemination and implementation of protocols for gender violence prevention and early detection, and treatment and rehabilitation of victims.

Table 18. Health plans, gender violence plans or women's health plans, specific health programmes that allow for gender violence and equality plans

AC	Health Plans	Gender Violence Plans or Women's Health Plans	Specific Health Programmes that Allow for Gender Violence	Equality Plans
Andalusia		Plan for the care for Victims of Maltreatment and Male Abuse		
Asturias	Health Plan for Asturias (Inclusion of Gender Violence)			Programme of Strategies for Progressing in the Development of Equal Opportunities for Women and Men (2005-2007)
Balearic Islands			Health Care Recomendations when Addressing Gender Violence in Balearic Islands	
Cantabria		II Action Plan: Women's Health (2008-2011): "violence against women (gender violence)"		
Catalonia	Health Plan of Catalonia in 2010 Horizons			
Valencian Community	Health Plan of the Valencian Community (2005-2009)	Valencian Government Plan of Measures to Combat Violence Perpetrated against Women (2005-2008)		Plan for Equal Opportunities for Women and Men (2006-2009)
Extremadura	Health Plan for Extremadura (2009-2012)			
Galicia		Comprehensive Health Plan for Women (gender violence included)		

Madrid			They include Gender Violence: - Health Promotion Programme for women - Non-Communicable Diseases Programme - Public Health Evaluation Programme - Continued Training In Gender Violence Programme - Child and Youth Health Programme - Public Health Programme for Especially Vulnerable Groups	
Basque Country			Health and Women Programme. Target: "reducing impact of male abuse on women's health through detection and intervention at health care services"	IV Plan for Equality for Women and Men in the Basque Country Autonomous Community IV Plan for Equality for Women and Men in the Basque Country Autonomous Community Fourth Axis: Gender Violence

The health programmes in the Autonomous Community of Madrid that contain actions targeting prevention and attention to GV and that are involved in the activity of a specific technical commission, are:

- Health promotion programme for women.
- Non-communicable diseases programme
- Programme of public health assessment
- Programme for continuing education in gender violence.
- Programme for child and adolescent health
- Public Health Programme for groups in situations of special vulnerability.

Plans for Women's Health

As for specific health plans for women (Table 18), GV has been part of the Comprehensive Plan for Women's Health since 2007, and in Cantabria II Action Plan: Women's Health, "violence against women (gender violence)" has been included as one of the 8 priority areas of action, with the following objectives:

- Improve health services' performance on the response to GV and revise the health care action protocol against abuse to incorporate new initiatives in support of the treatment of women victims of abuse.
- Promote the assessment of the impact of actions carried out in the health care field when addressing GV, by including the common indicators proposed by the National Health System for epidemiologic surveillance of GV in the health care field and its assessment through quantitative and qualitative methods.

Specific Programmes

The Basque Country Programme Health and Women devised in 2008 contains a monographic section on GV "aiming to reduce the impact of gender violence on women's health through detection and intervention at health services". Actions envisaged to achieve this goal are: registration of data at health care services, training of health professionals and the study of needs of immigrant or disabled women victims of GV.

In the Balearic Islands the Health Care Recommendations when Addressing Gender Violence in the Balearic Islands is in itself a specific programme targeting GV.

Equality Plans

As for equality plans (Table 18), the Women's Institute-Presidency Department of the Asturias Community has published the Programme of Strategies for Progressing in the Development of Equal Opportunities for Women and Men (2005-2007), that incorporates all Health Sector issued programmes of attention to GV and the Health Department and the Basque Country's Osakidetza agreement to revise during 2008 all actions relating to GV, taken and compiled in the IV Plan for the Equality of Women and Men in the Basque Country Autonomous Community, GV being one of its four cornerstones.

The Valencian Community relies on the Plan for Equal Opportunities for Women and Men (2006-2009). Their Health Department is deeply involved and even though gender violence does not explicitly appear as a specific area for action, it is an issue that compels special attention as follows from the number of targets and actions where it rates special mentions (objectives 5.4, 7.3, 7.4, 7.8, 8.1 and 8.4).

Information Systems

Inclusion of the Common Protocol for a Health Care Response to Gender Violence in Information Systems

One more line of action was the inclusion of the Common Protocol and all regional protocols for health care action to confront gender violence, in the information systems of Primary Care centres (Table 19). Cantabria pioneered this inclusion of the Protocol in Primary Care centres' information systems (2006). Ceuta achieved inclusion in 2008.

La Rioja started to work to include it the medical history of the Selene computer programme (SC and two health centres of La Rioja) and Andalusia was envisaging to do the same with their regional protocol in 2009.

The Castile and Leon "Health Services Action Guide for Addressing Gender Violence" includes the expanded and adapted contents of the Common Protocol for a Health Care Response to Gender Violence.

Some Autonomous Communities conceive information systems as linked to the healthcare action guidelines set out in protocols: In the Castile-La Mancha Women's Programme, the Gender Violence Protocol is included in a computer module incorporated to the rest of the computerised medical history (Turriano application) together with sub-programmes for detection of possible abuse and follow-up care for women victims of abuse.

Table 19. Information systems

Andalusia	Programme Contract with different hospitals
Aragon	Primary Care recording system
	Computerisation of hospital emergency services
	Implementation of applications of triage (or selection)
	Implementation of the digital medical history
Asturias	Recording system in Primary Care and mental health
Canary Islands	CMO and Drago information systems
Castile-La Mancha	Gender Violence Protocol in Women's Programme
Madrid	CMO-PC Information System
Basque Country	Basque health care information system, via PCH and via Osabide (PC)

PC, Primary Care; CMO-PCH, Spanish acronyms for computerised medical office-clinical hospital post.

Registered or not, they stand as computerised systems of gathering of information: Castile and Leon Health Services ascribed specific algorithmic codes in the computer systems that feed the existing information systems in the PC area to know the number of women screened for GV and so quantify the number of them subjected to abuse.

In the Canary Islands the systems OMI and Drago currently co-exist in PC centres and it is estimated that they will be fully implemented by 2010. Work is being done to improve the computer application and introduce among the suspicion indicators, situations of special vulnerability and dependence of women, protected in the NHS Common Protocol but not in the official Protocol of the Canary Islands Health Service. Work is also being put in to adapt existing records to the common indicators approved in the National Health System.

In the Valencian Community the protocol drafted in 2008 envisages implementing an information system that may guide health care personnel through active search, early detection of cases of gender violence and into the right intervention tailored to each case. This computer application named Sivio (Spanish acronym for information system on violence) is expected to be partly implemented during 2010.

In the Basque Country the process of adapting the Basque health sector information systems is currently under way, both via CHP (clinic hospital post *[PCH]*) and via Osabide (computerised medical history programme, PC), in order to make available more exact and better quality data, in accordance with the common indicators established by the Inter-Territorial Council of the National Health System. To serve this purpose an entry form will be devised to enable a homogeneous collection of information and an objectively more precise knowledge of the situation from a health care perspective. In addition, the Community Health Department and Osakidetza intends to improve the recording system of SC cases, by systematic filling in of diagnosis and records forms through Osabide, thus completing the implementation of a computerised system that may enable a more agile and reliable collection of cases of GV especially in hospital casualty services.

The Health and Consumers' Affairs Department of Aragon started to work on the introduction in the OMI-AP Primary Care execution programme of a personal plan for addressing gender violence. Computerising of emergency services was also undertaken in general hospitals where a special medical history application adapted to the casualty setting was already available as well as a triage or selection system (actually the Spanish Triage System) that allows identification of motives for consultation possibly relating to assault.

Asturias relies on a GV early detection recording system in Primary Care and mental health since 2006.

Services Portfolio

Inclusion of Indicators in the Health Care Services Portfolio

One of the actions developed for evaluating the Protocol taking was the inclusion in the services portfolio (Table 20) of indicators for the follow-up of the health care provided in gender violence cases. Such was the case of La Rioja Health Services (Seris), Balearic Islands and Basque Country 2009 Programme-contract. In addition, this last community still continues the assessments performed via preferential offer in programme-contracts since 2006, on dissemination and systematic adoption of the Health Care Protocol in cases of abuse. Andalusia also proceeded to the inclusion of specific objectives listed in programme-contracts and services portfolio of the Andalusian Health Service.

Table 20. Services portfolio

Andalusia	Includes "health care for gender violence victims"
Asturias	Services portfolio of the programme for psychosocial care
Canary Islands	Includes "domestic violence screening and dealing with"
Cantabria	Includes "detection and attention to abuse of women"
Castile and Leon	Includes the Service for Gender Violence Watch
Catalonia	Services Portfolio of the Care for Sexual and Reproductive Health Programme
Valencian Community	Includes actions on gender violence
Extremadura	Includes a Gender Violence Service
Madrid	Includes the Family Risk Detection Service

The Primary Care Services Portfolio of Andalusia includes "Health care for gender violence victims" offered to women presenting suspicion indicators of abuse.

The services portfolio of the "Programme of Psychosocial Attention" of Asturias are aimed at enabling women suffering abuse to identify their situation and to access the necessary tools to break the noxious bond.

Since 2007, Cantabria provides "detection and attention to abuse of women" in its PC services portfolio, encoded as service 210: detection and attention to violence against women.

Castile and Leon have launched within the Primary Care portfolio, a "Service for Gender Violence Watch" and an assessment of the service coverage in Primary Care teams, which has expanded to all Primary Care teams in the autonomous community. Preventive activities of the PC services portfolio include services of anamnesis for women over 14 years of age relating to situations of abuse. Also in PC executive offices' management plans a specific coverage target was set relating to gender violence cases seen and an GV expert psychologist was hired for support to PC executive offices.

The Valencian Community Health Care Department's services portfolio incorporates: screening and care for GV cases and execution of an intervention plan adapted to each case; detection of risk situations and authorities and if necessary social services alert to situations that require their intervention, especially suspected abuse of children, the elderly and the disabled.

In 2006, the service for "screening and addressing domestic violence" was included en the Canary Islands' Services Portfolio and in the Agreed Management Programme. Annually early detection coverage data are made available.

The services portfolio of the Programme for care for sexual and reproductive health of Catalonia, revised in 2008, establishes the circuits for prevention, early detection, diagnosis, treatment and rehabilitation concerning GV.

Galicia envisages objectives and GV specific indicators to be included in the services portfolio from 2010 onwards.

Some ACs mention "specific services" within the services portfolio, such as the "Gender Violence Service" (that used to be included in the Service for Domestic Abuse), created by a work group issued from the Services Portfolio Technical Commission of Extremadura and the "Service for the Detection of Family Risk", set in motion in 2008 within the PC services portfolio of the Madrilenian Health Service.

Programme Contract

Andalusia relies, on the one hand, on a programme-contract for healthcare action in cases of GV, that targets districts and, in accordance with which, all centres in one district are expected to follow the protocols developed in the "Care for Victims of abuse and gender violence Plan", thus taking the necessary measures for their evaluation. On the other hand, a programme-contract with hospitals guarantees the victims' right to be cared for immediately, preserving the intimacy and confidentiality of actions taken (Table 21).

Table 21. Programme-contracts and commissions	
Andalusia	Programme-Contract with districts
	Programme-Contract with hospitals
Asturias	Programme-Contract with health care centres
Castile and Leon	Executive Offices
Madrid	Technical Commission for Health Action to Confront Gender Violence
	Permanent Commission for Coordination and Domestic Violence Follow-up Actions in Specialty Care
	Hospital Committees against Abuse
Basque Country	Health and Women Commission
	Programme-Contract

In Andalusia, during 2008, information systems were linked with the programme-contract; both suspicion and healthcare actions performed on women victims of abuse and/or sexual assault were recorded on the medical history (Diraya digital history). This might involve: redirecting to specialty services when required; requesting forensic presence in case of sexual assault or of whatever other serious nature, or for joint exploration, etc.. Also, judicial report and, when required, medical reports had to be completed, and the number of reports issued, recorded.

The programme-contract with Asturias' health care centres includes actions for the awareness of health care professionals and plans for dissemination of the Protocol (Table 21).

In the Basque Country and since 2005, the programme-contract for Primary Care and acute condition hospitals considers indicators directly relating to addressing GV (Table 21).

Other

Furthermore, Madrid and the Basque Country count on Commissions: Technical Commission for Health Action against Gender Violence, Permanent Commission for Coordination and Domestic Violence Follow-up Action in Specialty Care and Hospital Committees against Abuse in Madrid, and Commission Health and Women in the Basque Country. The Commission of the Basque Department of Health and Osakidetza, analyses, proposes and evaluates actions targeting women, GV being among them. It also detects health personnel training needs, keeps track of the follow-up

to the Common Protocol for a Health Care Response to Gender Violence implementation and analyses coordination and redirecting problems among health assistance levels and community resources.

This Autonomous Community also relies on groups for the improvement of the care provided to women victims of GV in health care regions: inter-institutional agreements for cooperation intended to achieve better care for women victims of GV. These improvement groups optimise prevention, detection and care of violence effects; they improve circuits of coordination and redirecting among different health care levels, resorting to community available resources; they know and address the training needs of their professionals and improve the recording of cases at health care level.

In the Autonomous Community of Madrid and within the Madrilenian Health Service, the Technical Commission for Health Action to Confront Gender Violence is in charge of planning, coordinating and assessing actions in terms of prevention, early detection and care for women exposed to abuse from their intimate partners.

This Autonomous Community also has recourse to:

- Hospital Committees Against Violence dependent on the Central Commission for Quality Assurance in Hospitals of the Madrilenian Health Service. Their mission, as that of other medical committees, is to serve as advisory body of the Technical-Health Care Board, and of the Medical or Health Care Management. The functions of these committees are in keeping with the specific objectives of the Technical Commission which namely are: to raise awareness among professionals; optimise prevention; detect and address domestic abuse; increase the recording of cases; provide professionals with updated information; adjust professional performance to specific needs and to the stage the process of abuse has reached; improve the circuits of coordination and redirecting among the different levels of health care and with the community resources; and, finally, provide professionals with guidelines for their own protection and care when confronting gender violence.
- The Permanent Commission for Coordination and Domestic Violence Follow-up Actions in Specialty Care acts as a referent for Hospital Committees and coordinates actions developed in the sphere of Specialty Care, to achieve detection, assessment and intervention in cases of abuse within the family (this including gender violence and child and the elderly abuse); it cooperates in implementing protocols and action guides, and effects follow-up on actual implementation amongst other functions.

Specific Actions Targeting Special Vulnerability Groups (Immigrant, Disabled or Rural Areas' Women) and Specific Programmes (Mental Health or Pregnancy)

The decision approved by the Health and Consumers' Affairs Commission of the Senate, on November 4, 2008, urges to co-ordinate, impulse and where applicable, finance, among others, actions relating to "systematic inclusion of early detection and effective care for gender violence cases in all specific programmes, as mental health and care to pregnancies may be" (Table 22).

Some ACs mention specific contents of the training in GV, targeting especially vulnerable groups of women, as does the Autonomous Community of Madrid whose Health Care Trainers conducted through the Laín Entralgo Agency, includes specific contents relating to these new vulnerability processes, or, the Basque Country that organises training and awareness activities in terms of GV, in cooperation with Emakunde-Basque Women Institute , in which specificities of groups facing multiple discrimination are taken into account.

Table 22. Specific actions targeting special vulnerability groups

AC	Health	Disabled	Immigrants	Pregnant Women	Environment	Women	Drug-Dependents	Over 65 years
Andalusia	•	•	•			•		
Aragon					•			
Asturias	•							
Canary Islands				•				
Cantabria	•	•	•	•				
Castile and Leon	•		•	•	•			
Catalonia	•		•	•			•	•
Valencian Community				•				
Galicia			•					
Madrid	•	•	•			•	•	
Murcia	•		•					•
Basque Country		•	•					

In the Madrid Community, the Family Risk Detection Service is backed up by the Guide for Support in Primary Care to Address Intimate Partner Abuse of Women, which warns about the need to pay special attention to most vulnerable women. Also the Action Guide in Specialty Care includes specific questions to promote early detection among women in this kind of situation. In addition, among programmes for prevention and health promotion the Health Department develops the Public Health Programme for Groups in Situation of Special Vulnerability is a highlight.

In the Basque Country IV Plan for Equality of Women and Men one of the four strategic cornerstones is GV, which, in turn, includes an objective towards improving conditions and positions of women facing multiple discrimination and find themselves in situations of risk or exclusion. Also, Emakunde-Basque Women's Institute's decrees for financial aid laid down appraisal criteria that prioritise the regard for the specific needs of women facing multiple discrimination and immersed in situations of risk or social exclusion. Their Social Services devised a unified model for collection in their area, of data on domestic violence and sexual assault against women, including indicators for women suffering multiple discrimination (disabled and immigrant women, etc.).

The Cantabria II Action Plan: Women's Health (2008-2011) set an objective of raising awareness of GV inflicted on women in situation of greater vulnerability.

Likewise, La Rioja intends to develop the concept of a number of equality agents to help gain access and ease the way to work for the most vulnerable population groups in co-operation con La Rioja Observatory on Women's Health.

To follow, ACs actions are described as per groups of women especially vulnerable to male abuse.

Mental Health

Table 23 compiles information on specific programmes aiming to provide care for gender violence victims in the mental health field, per autonomous community.

Andalusia completed the drafting of the Protocol for Detection and Intervention on Violence Against Women for Application in the Community Mental Health Units and its II Comprehensive Plan of Mental Health in Andalusia (2008-2012) has adopted a gender perspective and affords all-embracing care for GV cases (incorporating health and mental care).

In Asturias there is a recording system geared to early detect GV in Primary Care and mental health. In the setting of mental health services

there exists a Programme for Psychosocial Care (in Oviedo) in force since 2003; a specific resource committed to GV in Specialty Care with a coverage that expands to the whole autonomous community; its target population is women who experience abuse in the family setting generally from their intimate partners or ex-partners. They are offered professional help to enable them to retrieve their autonomy, to break the spiral of violence and to recover from their psychological damage. Women can access this service through redirecting from women's advisory centres, health centres (PC), centres for hospital care, mental health care and psychological support services from women's associations specialising in GV.

Table 23. Specific programmes for care to gender violence cases in the health care setting

Andalusia	Protocol for Detection and Intervention against Violence Inflicted on Women for Community Mental Health Units
	Andalusia II Comprehensive Mental Health Plan (2008-2012)
Asturias	Psychosocial Care Programme
Catalonia	Master Plan for Mental Health and Addictions
	Mental Health Comprehensive Plan for Gender Violence Victims
Madrid	*Atiende* Operational Safety Programme
Murcia	Application of the Protocol for Detection and Action against Gender Violence

In Cantabria, the II Action Plan: Women's Health (2008-2011) sets, for mental health units, the objective of improving psychological support by enlarging mental health units' teams of clinical psychology professionals trained in GV, as well as development, also at mental health units, of therapeutic groups of women victims of abuse.

In Catalonia the Master Plan for Mental Health and Addictions intends to improve Specialty Care (psychiatric and psychological care) for vulnerable populations among which range abused women –in turn incorporated in the improvement project for care for mental disorders and addictions in health Specialty Care, within the Inter-Departmental Plan coordinated with the Catalan Women's Institute and in accordance with the development of units for all-inclusive care for gender violence cases–. In addition, the Health Department subsidised the Mental Health Comprehensive Programme for Gender Violence Victims and one project for Detection and Early Psychosocial Care for Vulnerable Women Victims of Gender Abuse.

Madrid concluded the Specialty Care Action Guide that includes questions geared towards early detection in situations of greatest vulnerability and specific action guidelines in mental health. The Regional Office for Coordination in Mental Health, dependent on the Madrilenian Health Service has relied on the Operational Safety Programme *Atiende,* since 2005, with the general objective of assessing the mental health of women under protection orders and their children's and subsequently issuing the relevant medical report with due legal advance. Care and follow-up of cases in need for it and redirecting to the most suitable resource are part of this general purpose. After 3 and a half years of being run, the programme has expanded its care offer to afford protection to women with no Protective or Restraining Order or other equivalent legal measure.

Castile and Leon developed, in the Specialty Care area a training course in gender violence for mental health teams.

Murcia planned the release in 2009, of a Protocol for Detection and Action against Gender Violence, to be applied to all women, with intimate partner or ex-partner, having turned to mental health services. Also for 2009, Galicia programmed the inclusion of actions for early detection and care of GV victims in the mental health programme.

Disabled Women

Table 24 displays information itemised per autonomous community on specific programmes for care to disabled women, that feature gender violence.

Table 24. Specific programmes for care for disabled women, in which gender violence is included

Andalusia	Comprehensive Action Plan for Disabled Women in Andalusia (2008-2013)
Madrid	Action Plan for the Disabled in the Madrid Community (2005-2008)

Andalusia published the Comprehensive Action Plan for Disabled Women in Andalusia (2008-2013), incorporating as specific subject abuse against disabled women, with concrete measures.

The Autonomous Community of Madrid counts on the Action Plan for Disabled Persons in the Madrid Community (2005-2008) which incorporates the gender perspective integrated in actions whose follow-up is responsibility

of the Commission on Women and Disability which has also drafted a good practice manual for the care of disabled women.

Other ACs also include care to disabled women victims of GV in various other care programmes. For instance, the Cantabria II Action Plan: Women's Health (2008-2011) sets among its objectives that of raising awareness of women in situations of greater vulnerability among which disabled women are included. Likewise, the Action Guide to Confront Domestic Abuse and Sexual Assault against Women for Social Services' Professionals (2006) of the Basque Country, includes a section relating to aspects that should be considered when dealing with immigrant and disabled women. This autonomous community highlights thedissemination of information on assistance to deaf persons or with audition disabilities when providing Fax numbers of the Basque Emergency Service (112) on the bill posters hung on occasion of the 25 November inter-institutional campaign.

Immigrant Women

Table 25 gathers information itemised by autonomous community, on specific programmes for care for immigrant women that include gender violence.

Table 25. Specific care programmes for women immigrants, in which gender violence is included

Castile and Leon	Care Programmes for Immigrants
Catalonia	Action Protocol to Prevent Female Genital Mutilation
	Operational Paper on Female Genital Mutilation
	Practical Guide for Prevention, Detection and Care for Female Genital Mutilation
Madrid	Public Health Programme for Groups In Situation of Special Vulnerability
	Health Strategic Plan for the Immigrant Population in the Madrid Community

In Castile and Leon, in the context of Care Programmes for Immigrants Health resources have improved their coordination with existing resources to meet the specific needs of immigrant women victims of GV.

In the Madrid Autonomous Community, the Health Department through the Madrilenian Health Service, is developing the Public Health Programme for Groups in Situation of Special Vulnerability with a strategic line for addressing GV in immigrant women. Actions envisaged

are dissemination, awareness, socio-health care professional training and unification of intervention and coordination criteria. This programme is part of the Integration Plan of the Madrid Community that contains actions against GV and that intends that all actions implemented in the Comprehensive Action Plan Against Gender Violence of the Madrid Community be applied to the foreign immigrant population on an equal footing.

In Catalonia a revised new version of the already published Action Protocol for Preventing Female Genital Mutilation is being implemented and the drafting of an Operational Paper on Female Genital Mutilation is envisaged, to complement the Protocol for Addressing Male Abuse in the Health Field in Catalonia. To address this particular type of abuse a number of dissemination and training activities have been conducted both among professionals from many areas as well as within the population at risk and on suspicion; there have been experiences of coordination with the *mossos d'esquadra* in the detection and redirecting of girls at risk.

One of the objectives listed in the Cantabria II Action Plan: Women's Health (2008-2011) is raising the awareness of GV among women in situations of greater vulnerability which includes women immigrants.

Other ACs mention single specific actions targeting women immigrants that are not inserted in any plan. In Andalusia, provinces with a greater presence of immigrant population (Almeria, Jaen and Huelva) actions are being developed in healthcare districts for detecting and assisting women immigrants victims of abuse. For instance, 6 workshops on prevention of gender violence addressed to the immigrant population were held in Almeria.

The Basque Country offers a to-face and telephone simultaneous translation service at the Casualty and Gynaecology-Obstetrics services of a number of hospitals of the public health network. The service covers 50 languages but gives priority to French, Arabic, Chinese and Romanian. In the rest of hospitals and in Specialty Care the highlights are the initiatives towards collaboration with associations of immigrants, with Welfare Services of local councils or other related groups.

Murcia created in 2005 the Regional Advisory Council against Violence Inflicted on Women, in which the Department of Social Policy, Women and Immigration is actively involved.

In Galicia, actions are directed towards training health professionals in the care for women immigrants.

Pregnant Women

Table 26 contains information about specific programmes of prenatal care that include gender violence, itemised by autonomous community.

Table 26. Specific prenatal care programmes which include gender violence

Cantabria	Preparation for Parenthood Programme
	Prenatal Care Protocol
Catalonia	Sexual and Reproductive Health Programme

One of the objectives of Cantabria's II Action Plan: Women's Health (2008-2011) is to raise awareness of GV among women in situations of greater vulnerability where gestational women belong. Among their actions they highlight the inclusion in the Programme of Preparation for Parenthood literature on awareness and prevention of GV and dissemination of support resources. They also included actions geared to early detection and assistance to GV cases, in the Care Protocol for Expecting Mothers.

In the Valencian Community and with the aim of including GV early detection and health care watch in specific prenatal care programmes, a group of pregnant women attending a prenatal control programme joined a research project which allowed completing the pilot phase of the Health Care Protocol for Addressing Violence of the Valencian Community Health Department.

The Care Programme for Sexual and Reproductive Health of Catalonia includes proactive screening of potential GV in the control and follow-up of pregnancies and unwanted pregnancies. The Catalonia's Health Department completed in 2008 a Guide for Addressing Gender Abuse in Sexual and Reproductive Health; meant for professionals, this guide has been used as a base for drafting the Operational Paper on Pregnancy and Abuse that complements the Protocol for Addressing Gender Abuse in the Health Field in Catalonia –framework document that determines actions' operational procedures and the specific and proactive health care approach to abused pregnant women–.

Other ACs mention training as a specific action addressed to this population group since many training activities are conducted to this end and addressed to health care personnel participating in the care for the pregnant woman, their intimate partner or accompanying person during pregnancy, delivery and puerperium: training in gender violence workshops for midwives in PC and SC (Castile and Leon); workshops for training in the gender perspective during pregnancy, delivery and puerperium (Canary Islands); GV and its repercussions during this period are specifically emphasised here. The Canary Islands also mentions the Programme of Preparation for Parenthood where the importance of gender as a health determinant is stressed and during which GV is specifically addressed. Each woman participant has a history-file with affiliation data opened, general health state filled-in, questions asked about situation as for GV at that stage, and resources about GV given to her.

Finally, Galicia was envisaging for 2009 inclusion of GV screening and victims care actions during their pregnancy.

Rural Areas' Women

Table 27 provides information about specific programmes for attention to gender violence in rural areas.

Table 27. Specific programmes for attention to gender violence in rural areas

Castile and Leon	Autonomic Plan for Prevention and Protection against Gender Violence in Rural Areas of Castile and Leon

Only two ACs mention the existence of specific actions addressed to women in rural areas among groups of special vulnerability to GV: Aragon and Castile and Leon.

Aragon maintains training actions especially targeting rural areas. Highlights among specific objectives are to ensure pioneering and all-encompassing care in rural areas, providing care for women residents; to offer and ensure comprehensive attention to women victims of GV in terms of resources, alternatives and protection, with special attention to emergency situations and specific groups; to conduct awareness and reporting actions in order to eradicate abuse against women in the area and, finally, investigate

the problem to gain insight into real conflicts in order to prevent this type of behaviour.

Castile and Leon Health Service, in the context of activities of the Regional Plan for Prevention and Protection against Gender Violence in the Rural Areas of Castile and Leon –inter-departmental– , envisages to improve the protection, care and safety of women victims of gender violence residing in the countryside, principally in the area of Primary Care.

Young Women

Table 28 provides information about specific programmes for care of juveniles where gender violence is one of the issues.

Table 28. Specific programmes for care of adolescents which include gender violence

Andalusia	Programme for Inter-Sectoral Action *Forma Joven* (Young Fit)
Cantabria	II Action Plan: Women's Health (2008-2011)
Madrid	Child-Adolescent Health Care Programme

Only two ACs envisaged interventions addressing adolescent populations in terms of GV: Andalusia and Madrid.

Andalusia approach to prevention of GV is through coeducation, values education and awareness among students of secondary schools ([IES] Secondary Teaching Institutes), within the *Forma Joven* Programme for Inter-Sectoral Action *(Programa de acción intersectorial Forma Joven)* under the control of health care personnel and in close cooperation with teachers and youth mediators.

Madrid's Health Department developed health prevention and promotion programmes like the Programme for Child and Adolescent Health *(Programa de salud infanto-juvenil)* which among others intends to promote projects for health education in educational centres through subsidising schools and including gender violence in the criteria for projects assessment. A highlight within this programme is the activity developed by the Young Health Centre *(Centro Joven de Salud)* for area 1, whose services portfolio includes actions relating to awareness and prevention in Gender Violence related matters, more specifically, screening and redirecting.

Drug-Dependent Women

Only the Autonomous Community of Madrid, through its Anti-Drug Agency declares to rely on specific care centres for drug-dependent women and among them, victims of male abuse. In fact, one of the factors to be considered for admission in centres for comprehensive care for drug-dependents (CAID) is abuse and requests for admission under this pretence are given priority.

In Catalonia the Master Plan for Mental Health and Addictions envisaged to improve Specialty Care (Psychiatric and Psychological Care) among vulnerable populations, battered women being one of these.

Women over 65 Years of Age

The Autonomous Community of Catalonia mentions a strategy for this group of women especially vulnerable to GV, consisting of the drafting of a protocol against maltreatment for women over 65 which includes gender abuse and that is in itself a coordination experience.

Also in Murcia, jointly between the Women's Institute of the Murcia Region and the Murcia Service of Health, through the Health Care General Directorate, a Regional Protocol for Prevention and Detection of Violence against Women over 64 Years of Age was completed. This protocol intends to raise awareness among health professionals to enable them to address prevention, screening and care to women over 65 victims of abuse.

Incomeless Women

Only Galicia declares having factored in the inclusion of care and early detection of gender violence in programmes targeting women with no income.

Other Initiatives (Coordination and Research)

Coordination

ACs conducted concrete experiences of coordination among the different health levels (PC, SC, Mental Health and Casualty) and of inter-institutional

coordination (other sectors different from the health sector: forensic medicine, local and/or autonomy police, autonomy women's departments and/or local council directorates, local development and social and work integration, etc.). Below, experiences are described in terms of cooperation in decision-making and the agreement on how to act in cases of GV during 2008 in Autonomous Communities.

Coordination Among Health Care Levels

Table 29 contains information on coordination among health care levels.

Table 29. Coordination among health care levels

Andalusia	Health Committees or Technical Commissions
Asturias	Principality of Asturias Inter-Departmental Care Protocol for Women Suffering Violence
Balearic Islands	Gender and Health Commission
	Commission for Alertness to Gender Violence of the Health Area of Ibiza and Formentera
	Follow-up Commission of the Protocol for Coordination in Cases of Sexual Assault
Castile and Leon	Autonomy Plan for Prevention and Protection against Gender Violence In Castile and Leon Rural Area
Valencian Community	Health Care Protocol for Addressing Gender Violence (PDA)
Extremadura	Permanent Commission for Prevention and Eradication of Violence against Women
Galicia	Gender Violence Commission
Madrid	Health Action Technical Commission against Gender Violence
	Primary Care Support Guide for Addressing Intimate Partner Abuse against Women
	Primary Care Short Action Guide
	Specialty Care Support Guide for Addressing Intimate Partner Abuse against Women
	Hospital Committees against Violence
	Specialty Care Permanent Commission for Actions Coordination and Follow-up against Intra-Family Violence
Basque Country	Domestic Violence against Women Committee

In Catalonia and Basque Country coordination activities were carried out among different health care areas.

The Health Care Protocol for Gender Violence (PDA) of the Valencian Community encourages coordination and collaboration among the different socio-health professionals and adopting a multi-sectoral and multidisciplinary approach when confronting GV detected cases. To this end, redirecting and coordination among different health care levels have been devised in the plans for intervention in cases of GV as well as a guide containing all the available main police, judicial, social and health care resources.

Galicia encouraged the use of the protocol for dealing with bodily harm reports and their subsequent management, to respect the communication circuits in order for the medical staff of health centres to be duly informed and to ensure the correct monitoring of cases of GV identified at call points (PAC) by attaching a copy of the bodily harm report to the woman medical history.

Some ACs highlight the existence of "commissions" that work on coordination making it easier.

In Madrid, the Technical Commission for Health Action against Gender Violence, presided by the General Managing Directress of Primary Care, relies on the participation of representatives of Public Health, Primary Care, Summa 112 (Madrid Medical Emergency Service), Specialty Care, Mental Health, Information Systems, Laín Entralgo Agency and Women's General Directorate. This make-up allows the Commission to develop a coordinated work project to generate institutional commitments that may foster and promote the development of GV related action lines, aiming to progress in the integration of the gender violence issue in the performance of the Health Care System as a whole and in a coordinated matter among the different parties involved.

Along these lines initiatives to be highlighted are:

- Management Tools: Support Guide for Primary Care; the Short Guide for Action in Primary Care and Action Guide for Addressing Intimate Partner Abuse Against Women in Specialty Care. They offer specific action guidelines, redirecting criteria among health care levels and information relating to ethical and legal aspects.
- *Agencia Laín Entralgo*'s participation in the coordination and devising of educational actions and the supplies contributed for the support of the strategic line of training in gender violence at different health care levels. Along these lines, contributions that deserve highlighting are: the drafting of "criteria for training in intimate partner violence against women" and their participation in the "intermediate evaluation of the strategic line of continuing training of Primary Care professionals" in this matter.

- The building of a website in which actions and publications may be accessed, promoted and coordinated by the Sub-Directorate for Health Promotion, and where the Technical Commission participated.
- Creation of the Hospital Committees Against Violence in all hospitals of the Madrilenian Health Service: their functions, in keeping with the specific objectives of the Technical Commission, include the improvement of the coordination and redirecting circuits among the different levels of Health Care and with the community resources.
- Creation in December 2007 of the Permanent Commission for Coordination and Follow-up of Actions in Specialty Care against Intra-Family Violence, a coordination structure between health care levels and communitarian resources that acts as a referent for Hospital Committees and as an advisory body in the preparation of syllabus of specific training actions, scientific symposiums, etc.

The Andalusia Health Technical Committees work in provinces (Cordoba, Jaen and Granada) and health care districts, health centres and hospitals. They have a multidisciplinary make up and gear their actions towards implementation of protocols or each centre specific action guides to make coordination and care continuity easier when confronting GV. Also in Andalusia an Institutional Coordination Procedure has been established for prevention of gender violence and care for the victims.

In the Balearic Islands they rely on a Gender and Health Commission entrusted with the follow-up and coordination among health care levels and with the screening for processes in need of improvement.

Extremadura mentions that they were working in the coordination among care levels and in the Permanent Commission for Prevention and Eradication of Violence against Women, where many institutions are represented. Other objectives during 2008 were expanding existing call points for psychological attention to women victims of GV, dependent on the Women's Institute and locating them at health centres; also the creation of a work group for updating the Inter-Departmental Protocol for Prevention and Eradication of GV.

The Health Department of the Navarre Government coordinates PC, SC, gynaecology and obstetrics and mental health care levels with the aim of gaining a deeper insight into the extent of the GV issue, the different responses given by professionals and the existing tools available for the gathering of data for epidemiologic surveillance. A work group was also created for debating the information indicators proposed by the National Health System Inter-Territorial Council, variables to keep track of , and recording procedure.

Some ACs like Andalusia, Catalonia and Madrid, also mentioned Training as a concrete experience of coordination.

Inter-Institutional Cooperation

Some ACs refer to the existence of specific Protocols for coordination (Table 30) that list the actions each of the intervening levels commits itself to performing, the redirecting criteria among different levels and the exact location of all existing resources available in each autonomous community for caring for women victims of GV.

Table 30. Inter-Institutional cooperation

Proceedings or Protocols	
Andalusia	Proceedings for institutional coordination for prevention of gender violence and care for victims in Andalusia
Aragon	Inter-Institutional Coordination Protocol
Asturias	Inter-Departmental Protocol for Care for Women Suffering Violence
Balearic Islands	Inter-Institutional Protocol for Detection, Prevention and Watch for Male Violence and for Cases of Sexual Assault in Balearic Islands
	Coordination Protocol for Cases of Sexual Assault
Canary Islands	Inter-Institutional Coordination Protocol for Care for Victims of Gender Violence in the Autonomous Community of the Canary Islands (underway)
Castile and Leon	Professional Framework Protocol for Action in Cases of Gender Violence in Castile and Leon
	II Plan against Gender Violence in Castile and Leon (2007-2011)
Catalonia	Framework Protocol for a Coordinated Intervention against Male Violence
Extremadura	Inter-Departmental Protocol for Prevention and Eradication of Gender Violence
Madrid	Care Protocol for Victims of Gender Violence from the Coordination of Protection Orders Perspective
Basque Country	Protocol for Inter-Institutional Response to Fatalities due to Domestic Abuse
Others (Committees, Commissions and Coordination)	
Andalusia	Committees or Inter-Sectoral Technical Commissions
Cantabria	Coordination with the Cantabria Government Delegation's Unit against Violence against Women Cantabria
	Coordination with the Cantabria Government Women's General Directorate
	Commission against Gender Violence of the Cantabria Government
Castile-La Mancha	Institutional Coordination Agreement and Implementation of Protocols For Prevention of Gender Violence and Care to Women of Castile-La Mancha
Catalonia	Care Network for Women in Situations of Male Violence
	Terres de l'Ebre Coordination Network
	Barcelona Circuit against Violence on Women

Madrid	Action Plan against Gender Violence of the Madrid Community
	Regional Observatory on Gender Violence of the Madrid Community (ORVG)
	Protection Orders Coordination Post
	Atiende Programme (Answer)
Murcia	Regional Advisory Council against Violence on Women
Navarre	Follow-up Commission of the Inter-Institutional Agreement for Comprehensive Care for Women Victims of Domestic Abuse
Basque Country	II Inter-Institutional Agreement for Improvement of Care for Women Victims of Domestic Abuse and Sexual Assault
	Commission for the Follow-up of the Inter-Institutional Agreement
	Collaboration Agreement between Emakunde-Basque Women's Institute and Eudel, Basque Municipal Association: Basque Municipal Network for Equality and against Violence on Women
	Guideline Book for Adoption of Municipal Protocols and Measures for Improvement of Local Care for Women Victims of Domestic Abuse and Sexual Assault
	Vizcaya Observatory on Gender Violence

Other ACs highlight Inter-Sectoral Commissions as coordinating initiatives (Table 30).

Respectively created in Galicia and Basque Country were: a Commission Against Gender Violence of an inter-sectoral nature that devises multidisciplinary workshops for health care staff and an Inter-Institutional Agreement Follow-up Commission for ensuring effective implementation of their guidelines and criteria, and for effecting the follow-up of commitments made from institutions involved.

The Balearic Islands count on a Commission for Addressing Gender Violence in the Health Areas of Ibiza and Formentera that ensures coordination among professionals who care for women that are of have been subjected to gender abuse, and a Protocol for Coordination in Cases of Sexual Assault Criminal Offences Follow-up Commission that ensures coordination among medical staff, forensic doctors and physicians who see women victims.

In addition, during 2008 work was undertaken on the improvement of the computerising of the judicial report; the management of PC relies on a technical expert who advises health professionals on health-related legal matters, acknowledgement of receipt and processing of legal documents, medical histories, minors, assaults, etc.

The Cantabria Government's Commission Against Gender Violence, coordinates all GV related actions in different Departments and effects

follow-up, assessment and control of measures adopted in the battle against GV. This autonomous community also highlighted concrete experiences of coordination with the Unit of Violence Against Women of the Cantabria Government Delegation (basically for channelling information between health care and police agencies); the Cantabria Government General Directorate for Women (responsible for shelters for women victims of GV with which, support care to mental Health was coordinated).

In Andalusia emphasis falls on the provincial inter-sectoral technical commissions that make coordination among different bodies easier thus improving care to women. Other more specific collaboration experiences took place in Granada –with the Judiciary–, in Huelva –with institutions, associations, NPOs, etc.– and in Jaen –with the Institute of Legal and Forensic Medicine–.

In the Autonomous Community of Madrid, the Regional Observatory on Gender Violence *(ORVG)* coordinates all actions relating to gender abuse conducted in the autonomy and municipal settings and effects the follow-up of the measures contained in the Madrid Community Action Plan against Gender Violence. In it, there are representatives of the different Departments of the Regional Administration, together with the Economical and Social Council, the Women's Council and the Madrid Municipal Federation. A positive outcome of the coordinating activity of the ROGV was the approval and implementation of the Protocol for Care for Victims of Gender Violence at the Post of Coordination –Women's General Directorate unit from which care and protection to victims of GV are channelled– that gathers together the mechanisms of coordination among the different Administrations and Care Centres to promote comprehensive care for victims of violence under protection orders in accordance with agreed or any other measures it might be advisable to take, depending on the specific situation of the women suffering violence and on whether or not they have minors in their care.

In Navarre there is a general registry of gender violence files that allows access to the different Administrations and bodies that intervene at autonomy level (Inter-Institutional Agreement for Comprehensive Care for Women Victims of Domestic Abuse) and to all the information in files from various sources. The question is to store safely all informative records to apply the care protocol to all victims of gender abuse. At this first stage, the participation of the Health Department is not envisaged, but the subject of its incorporation to a second phase is already raised in the feasibility study.

Besides, coordination meetings are regularly held in Ceuta, Basque Country and the Canary Islands for joint planning of new actions and for the follow-up of GV related health care initiatives already undertaken, among which one can find the following:

- The Coordination Unit of the Government Office in Ceuta and the Ceuta dependent Women's Advisory Centre.
- The Directorate for Relations with the Administration of Justice for detecting possible mismatches in the implementation of the Basque Country Health Protocol and taking steps to correct them and for the participation in the adoption and implementation of common measures in all institutions.
- The Canarian Institute of Women, within the Programme for the Prevention and Eradication of Violence against Women.

Continuing the collaboration with the autonomy Women's Institutes, Murcia created in 2005 the Regional Advisory Council on Violence Against Women of an inter-sectoral composition whose function is to collaborate with the Institute of Women of the Region of Murcia on GV matters.

The Women's Institute of the Presidency Department of Asturias developed the Inter-Departmental Care Protocol for Women Victims of Abuse integrating protocols for action in health care, social services, police, the judiciary and legal medicine and counselling centres for women in Asturias. Also, since 2003, the Psychosocial Health Service dependent on the Mental Health Coordination Unit, redirects cases from Primary Care and Specialty Care to sectors other than Health Care.

In autonomous communities or Women's Institutes' social resources departments foster homes or other where there is a screening protocol, one might expect, as Asturias points out that most cases detected should be identified in services other than health care. In Asturias, redirecting of victims to women's counselling centres is a remarkably frequent occurrence, much of the detection coming from them.

Castile and Leon cooperates with the Directorate General of Women in the implementation and financing of training activities and provision of resources for attending to men who batter women. An experience has also been launched for coordination between the Community Health Department and the Government Sub-Delegate's Office for Gender Violence, with the Directorate General of Women and local government offices, for setting in motion the Autonomy Plan for Prevention and Protection against Gender Violence in Rural Areas of Castile and Leon. This, in turn, plans coordinated action for care, protection and follow-up of women victims of abuse residing in rural areas and women immigrants. Equally, various bodies have been created in an attempt to sit around the same table persons in charge from relevant administrations and institutions with the aim of reaching agreements and committing them to progressively better caring for women victims of male abuse. These include the Inter-Community Departments Commission chaired by the President of the Castile and Leon Junta, the Violence Against

Women Regional Commission and the Territorial Commissions Against Violence.

Also in the autonomous communities of Castile-La Mancha and Basque Country, agreements were reached and/or signed in 2008 geared to offering women victims of abuse all-inclusive and coordinated action by establishing homogeneous action guidelines that may improve the care provided to victims of domestic maltreatment and sexual assault, guaranteeing their complete protection in all healthcare, police, judicial and social sectors. Under these agreements reports were drawn up and regular meetings held.

The Vizcaya Observatory on Gender Violence deserves highlighting for their coordination actions listed below:

- A map of resources to combat gender violence in Vizcaya
- A proposal for selection of indicators in cases of domestic abuse in the social services setting.
- Drafting of the document *Cifras sobre atención a situaciones de violencia de género en Vizcaya* (Figures on gender violence addressing in Vizcaya).
- Collection of data on women victims of gender abuse and perpetrators' suicides in European Union Countries
- Creation of a news bulletin in electronic format.

Catalonia mentions experiences of coordination between the health care sector and other sectors within the Administration, intended to give a social and institutional all-inclusive response in terms of eradication of GV (Table 30). Awareness and training activities were also carried out inter-institutionally and with multidisciplinary participation (professionals of the *mossos d'esquadra* body, Community Department of Social Welfare, etc.) enlisting professionals who work in these sectors from local councils.

Specifically in the health care sector, the Autonomous Community of Madrid highlights the safety mechanism network programme *Atiende* mentioned before in this Report as concrete experience of coordination among different administrations, for its having been devised jointly by the Mental Health Coordination Regional Office of the Madrilenian Service of Health and the Women's Directorate General; its functions are to assess mental health of women under protective orders and to attend to cases and their follow-up when required. Redirecting to this mental health safety mechanism network is channelled through the coordination post of the Women's Directorate General: cases may come from both the Municipal Posts Network of the Regional Observatory of Gender Violence and from other resources of the Women's General Directorate (Care Centre for Victims of Sexual Assault, *Mira* ("Look") Programme, day centres and residing centres network).

Research

Detailed below is the research carried out on GV in the medical field (Table 31). The objects of research have been: socio-demographic characteristics of female outpatients in situation of abuse seen at the doctor's office; morbidity associated with women in situations of abuse; improvements in information systems, impact of training in the early detection of situations of maltreatment and assessment of care (coverage degree, relevance, efficacy, etc.).

Table 31. Research projects

Andalusia	Gender violence among female nurses
	Research aimed at knowing the opinion and expectations about the way abused women are treated and care they receive
	Qualitative investigation to identify other ways of male abuse against women in situations of extreme vulnerability
Asturias	Socio-demographic analysis of women who resort to the Psychosocial Care Service
	Description of the recording of gender violence cases at the health care sources of information of the Principality of Asturias
	Appraisal of costs deriving from care to gender abuse victims
Castile and Leon	Differences in performance of socio-healthcare professionals from the urban and the rural settings when treating women victims of abuse
	Study on behavioural and attitude differences when facing gender violence in women from urban and rural areas of Castile and Leon (phase II)
	Study of the effectiveness of an awareness and training intervention among Primary Care professionals for improvement of diagnosis of domestic violence *(Isfvidap)*
Catalonia	Catalonia Health Survey 2006: inclusion of one question on gender violence
Valencian Community	Family violence against women during pregnancy: social context and healthcare personnel dealing with the issue
Madrid	Training actions impact on detection of intimate partner violence on women in Primary Care

Socio-Demographic Characteristics of abused Women Who Resort to the Doctor's Office

In 2008, Andalusia developed a project of qualitative research for identifying other forms of abuse against women in situation of extreme vulnerability, collect their life stories to explore the social and economic context in which

violence starts and develops and analyse the consequences of violence in the vital project of these women and their family environment. Also, research was requested and financed on Gender Violence against Female Nurses developed at the *Reina Sofía* Hospital of Cordoba.

Asturias carried out a socio-demographic analysis of women that resort to Psychosocial Care Services whose variables were: marital status, age group, education level, children in their care and occupation.

In Castile and Leon, there is a research project in progress entitled Study of differences in attitudes and behaviours when facing male abuse, of women victims of violence from urban and rural areas of Castile and Leon *(Estudio de las diferencias de actitudes y comportamiento ante la violencia de género en las mujeres víctimas de violencia del ámbito rural y urbano de Castilla y León [fase II]).*

Morbidity associated to Women in Situation of Maltreatment

The Autonomous Community of Madrid carried out a population-based cross-sectional study to determine the prevalence of intimate partner violence against women and the health problems arising from that situation.

Asturias counts on information on co-morbidity from the *Vimpa* register (Violence against Women in the Principality of Asturias) and from the cumulative system of psychiatric cases.

In the framework of the Care Programme for Victims of Intra-Family Violence in Catalonia, a multidisciplinary study was conducted for the detection and psychological risk of victims of intra-family violence and male abuse in Cornellà de Llobregat (Barcelona).

Improvement in Information Systems

The information systems of the Autonomous Community of Madrid adjusted the exploitation of Primary Care data and built the necessary circuits for meeting the Technical Commission's information needs, adopting a work line oriented towards a depurated setting up of databases and the incorporation of new entries that may lead to obtaining new indicators. As for Specialty Care, a record sheet was being drafted specifically for intra-family violence (gender violence, children and elderly people's abuse) together with its relevant computer application developing.

The Epidemiologic Service, the Sub-Directorate of Information Systems and the Extremadura Services Portfolio's Technical Commission are working on the improvement of the information systems for adapting them to the indicators agreed by general agreement by the National Health System Commission against Gender Violence.

Other ACs such as Catalonia and the Basque Country plan or are working on developing a data collection system that may give response to

GV health care indicators since currently available data are partial, do not reflect all forms of GV and an unification of data collection systems and of criteria for the collection of information proves to be necessary.

Also, the Catalonian Health Department drafted a document on Recommendations for Introducing the Gender Perspective in the Information Systems of the Health Field *(Recomendaciones para la introducción de la perspectiva de género en los sistemas de información en el ámbito de la salud);* and still to be published was the research conducted by Mulera et al: Description of the Recording of Gender Violence Cases at Health Care Information Sources of the Principality of Asturias.

In non-computerised centres of Castile and Leon, they register anamnesis and care for victims of violence in the computer system MedoraCyL using the relevant codes. Computerised doctor's offices enter cases directly in the medical history with no need for coding. Incidence of women victims of male abuse seen will be obtained from diagnoses whose descriptions are associated internally to classifying codes ICD-9 MC: V61.11; E967.3, and 995.81 under *víctima de violencia de género* (gender violence victim).

At present, they are working on a Protocol to be included in computerised health care guides that will display, by default, the anamnesis elements still to be completed and the fields to record the pattern of performance.

Impact of Training on Early Detection of Situations of Abuse

All through 2008 the Autonomous Community of Madrid carried out an assessment of the impact of training, on Primary Care, under the title: *Impacto de acciones formativas sobre la detección de la violencia de pareja hacia las mujeres en atención primaria* (Impact of Training Actions on the Detection of Intimate Partner Violence against Women in Primary Care) –that received an accessit in the I Nationwide Congress on Gender Violence and Health, held in February 2009–. It concludes that professionals from the EAP having received training in 2007, detected 25 % more cases when compared with those that had not.

Castile and Leon also presented a communication on results of the Isfvidap, to the European Congress of the Wonca (Istanbul, September 2008) which was awarded first prize: *Estudio de la efectividad de una intervención sensibilizadora y formativa en profesionales de atención primaria para la mejora del diagnóstico de la violencia doméstica* (A study on the effectiveness of an awareness and training intervention among professionals of Primary Care for improvement of the diagnosis of domestic violence); *Isfvidap.*

Apart from this, Galicia assessed the impact of training in the continuing care call points of the Santiago de Compostela health care area, but not in

PC, SC or Casualty. In this sense the Balearic Islands stated that they had planned to assess the impact of training on early detection of situations of abuse.

Extremadura had not yet finished the training programme they had envisaged but training was however provided from the Women's Institute and from local councils and reception from health professionals was proved to have improved.

Assessment of Training Actions (Satisfaction Level, Coverage, Relevance, Efficacy and Others)

The autonomous communities that assessed training activities in what concerned satisfaction, coverage, relevance and efficacy were: Cantabria, Catalonia, Galicia, Madrid and Murcia.

Cantabria assessed Line 4 of the "Action Plan: Women's Health 2004-2007 and Galicia evaluated the training given to all health care professionals in continuing care call points *(PAC)* of the Health Care Area of Santiago de Compostela, in the context of the Programme for Improvement of Care for Women in Situation of Abuse, at continuing care call points, through questionnaires completed before and after intervention.

In the Valencian Community and in accordance with the Continuing Training Plan of the Valencian *Generalitat,* alumni complete an assessment of the course followed, rating their satisfaction, training materials received, classrooms, instructors' teams and other aspects of the course.

In addition and for courses on gender abuse, they designed a specific questionnaire (initial and final) that apart from providing the alumni assessment of the knowledge gained, permitted to know their opinion about the course, the strengths and weaknesses of each of the units discussed and their comments on the course. This specific questionnaire was prepared in 2008 and started to be used in courses imparted in 2009.

The Catalonia Health Studies Institute *(IES)* conducted a training plan that included the assessment of awareness and continuing training programmes for health staff in terms of early diagnosis, care and rehabilitation of women in situations of abuse. Courses given in 2008 included the assessment of their objectives, their contents, the satisfaction of trained personnel, the satisfaction of trainers themselves, and, as a whole, assessment turned out to be satisfactory.

The Laín Entralgo Agency of the Autonomous Community of Madrid annually assesses the Programme for Training in Gender Violence, in terms of objectives, coverage and level of satisfaction. An intermediate evaluation was also conducted in 2008 of the strategic line of continuing training of Primary Care professionals in intimate partner violence inflicted on women. This initiative, adopted within the Actions Against Gender Violence

Technical Commission, created to help improve or when applicable reorient continuing training in GV, led to draw interesting conclusions on the relevance and efficacy of training at this health care level.

In the Balearic Islands assessment of training actions was part of their intended programme.

Assessment of Care (Coverage Extent, Relevance, Efficacy and Others)

An investigation was initiated in Andalusia aiming to know abused women's opinion and expectations on the way they had been treated and cared for when being seen in health care centres and services of the Jaen province.

Castile and Leon brought to conclusion a study on Differences in performance of socio-health professionals when treating women victims of abuse from an urban area or from a rural area.

During the years 2007-2009, a research project was being conducted from the Department of Health of the Valencian Community under the title: Family Violence Against Women during Pregnancy: Social Context and its Addressing by Health Care Personnel *(Violencia familiar contra las mujeres durante el embarazo: contexto social y abordaje por el personal sanitario),* financed by the FIS (PI 061565).

Also, Castile-La Mancha regards GV as a priority content in future research studies scheduled to be conducted by the Health Service of Castile-La Mancha, with the aim of expanding the knowledge of this serious social issue through surveys and research of both quantitative and qualitative nature.

Asturias maintains an agreement between the Health Service of the Asturias Principality and the University of Oviedo for conducting the investigation project entitled: Cost Appraisal of the Health Care Provided to Victims of Abuse *(Evaluación de costes en la atención sanitaria a víctimas de violencia de género),* approved by the Science, Technology and Innovation Plan of Asturias 2006-2009 (ref. FC-07-PC0711).

Galicia, during the second semester of 2008 worked in the organisation of the I Nationwide Congress of Gender Violence and Health (that took place in February 2009) about which Castile and Leon highlights the attendance and participation of a large number of professionals from their autonomous community.

Awareness and Training

Awareness

As it is customary when the GV Annual Report is published, ACs declare to have made efforts to disseminate resources, which is part of the strategy for raising awareness of GV that targets general population and health services

professionals. Its objective is to improve information to potential patients, promote early detection and foster relevant actions.

In Galicia, for instance, talks, organised by local associations, took place in different town halls. Audiovisual material was also produced and disseminated among women's groups, general society and the medical community consisting of a documentary starring 20 women from an association and their local council, striving to disseminate the experience and the women's reflections.

Throughout 2008 the Valencian Community produced a variety of awareness and training materials relating to GV. The main production of that year was the Protocol for a Health Response to Gender Violence *(PDA),* but other materials were also produced that could be grouped in three main categories:

- Awareness materials targeting professionals made up of a three-page leaflet that summarises the Protocol and a billboard to hang in doctors' offices containing the detection algorithm developed and the different stages of the detection and intervention in violence cases.
- Awareness materials targeting women victims of abuse also consisting of a three-fold leaflet and a billboard intended to show women that they are not alone and that health care personnel can help them. The purpose is also to reinforce the idea that women are not to blame for the situation they are in, that their case is not the only one and that, on the contrary, cases are much more widespread than should be expected; this material also explains the violence cycle.
- Training material on gender violence (*PDA* Protocol). Divided in five sessions it explains the violence phenomenon (definitions, causes of violence, offender and victim's profiles, breaking up process, etc.) autonomy action protocol and main ethical and legal aspects.

In Melilla, billboards, leaflets, postcards and extra information were distributed in all health care centres, through the person in charge of the Gender Violence Coordination Unit of the Melilla Government Office.

Finally, the inter-institution technical group, after approval by the Inter-Institutional Agreement Follow-up Commission, the Basque Country Health Care Personnel, undertook distribution of informative material among the population that comes to health care centres and emergency units, in cooperation with the rest of institutions and under the leadership of Emakunde, in the context of the inter-institutional Agreement for care for women victims of domestic abuse and sexual assault. In this sense, this autonomous community healthcare sector's participation in the 2008 Campaign Day Against Gender Abuse of Women also deserves highlighting.

Training

Training activities, workshops and awareness symposiums may target both health care services' professionals as well as general population (Table 32).

Table 32. Training activities

Andalusia	Andalusia Training Network against Abuse of Women (Red Formma) 2008
	Accredited activities of continuing training of health care professions.
	Activities of Training in Gender Violence authorised for Professionals of the Andalusia Health Service.
Canary Islands	Continuing Training Plans in Centres Dependent on the Canaries Health Service since 2005
Cantabria	Inclusion of training in gender violence in under-graduate syllabuses of The Faculty of Medicine and the School of Nursing at the University ofCantabria
Castile and Leon	Gender Violence Training for Trainers Programme (started in 2007)
	Regional scope conferences on gender violence watch in Castile and Leon coordinated from the Gynaecology Service of the Santos Reyes de Aranda de Duero Hospital which were attended by 401 professionals
Castile-La Mancha	Training in gender violence is included as priority line of training in all centres of the Health Service of Castile-La Mancha
Galicia	Conference on overall health
Melilla	I Health seminars on gender violence
Madrid	Gender Violence Training Programme (Continuing Training Plan 2008 Of the Madrid Community)

All ACs' health care areas conducted training activities to enable health services personnel with the necessary tools to detect cases of GV, and to improve the care given to victims of GV[4].

Andalusia set in motion in 2008 the Andalusian Training Network against Abuse of Women *(Red Andaluza de Formación contra el Maltrato a las Mujeres [Red Formma])* with the aim of boosting from an integrated gender perspective the development of awareness and training activities in

4 They do not appear on the Table or on the description, but Asturias, Balearic Islands, Valencian Community and Murcia declare to have implemented training strategies.

violence against women, addressed to the health personnel of the public health system of Andalusia *(SSPA)*. Other aims pursued are: to facilitate the implementation of the Andalusian Protocol for a Health Care Response to Gender Violence and to improve *SSPA* professionals' skills for early detection of violence against women. Other training activities are performed in the provincial setting of health provincial offices and as internal training activities of the Andalusian Health Service in hospitals and Primary Care Centres.

Some ACs such as Andalusia mention training on-line, (training financed by the Women's Institute currently dependent on the Ministry of Equality), or Castile-la Mancha, that intends 2009 courses to be conducted by videoconferences and on-line 2009. In the Internet environment, Castile and Leon created an on-line coded access collaborative group in the health portal (www.salud.jcyl.es) to enable the training team the exchange of teaching material, bibliographic support, consultation, etc. A support and monitoring team made up by professionals expert in GV was also created to give support and work directly on training issues with the management of Primary Care, managing complex cases with professionals that might request it. In the Autonomous Community of Madrid all the documentation on Primary Care basic coursers is available in the health portal of the Autonomous Community of Madrid and in the Laín Entralgo Agency's website, all professionals may access. It contains Power-Point Presentations, technical papers of the Autonomous Community of Madrid and bibliography. In addition, educators rely on a "teaching kit" that together with the previously described contains videos made *ad hoc* for training purposes.

One of the aims of the already mentioned II Plan of Action: Women's Health (2008-2011) of Cantabria is to promote the training of health services personnel in the awareness, detection and care for GV victims. To this end, training courses were conducted (basic, for addressing, for detection, on communication skills for interviewing victims, for groups of special vulnerability and per types of violence) and GV awareness activities for healthcare staff. Also, training activities are part of the strategy of evaluation of all lines of action of the Plan, among which a highlight is reducing risks deriving from GV for women's health, and whose conclusion is the need to promote resolutely the training of professionals in hospital centres.

ACs that mention the training of educators are Andalusia, Asturias, Castile and Leon, Catalonia, the Valencian Community, Madrid and the Basque Country, where the Programme for the Training of Trainers in Gender Violence, has continued operating aimed at professionals training who in turn can train other professionals in the health care sector in prevention and care for GV. In this area there have been several training courses health care professionals have been attending.

In 2008, the actions of the Health and Consumers' Affairs Department of Aragon focused on continuing along the lines of awareness and training of professionals, promoting awareness-raising and training activities and implementing a training system pivoting on coordination and collaboration. In Ceuta there have been continuing training courses on GV in the National Institute of Health Care Management Hospital, an initiative they were planning to continue in 2009.

The Canary Islands and the Basque Country introduced awareness actions among the *MIR* (Internal Medical Residents) through the Family and Community Medicine Teaching Units with the aim to raise awareness of GV, its impact on health and the reasons for health intervention. Castile and Leon also performed this activity but including resident midwives in training *(EIR)*.

Galicia held a Seminar on Comprehensive Health to address women's specific health care problems and the construction of a health model. In addition, the training also addressed the general population with some workshops and awareness activities for 16 year-olds and over, with special emphasis on young people and in particular, battered women through a "self-help group".

The Institute of Health Studies *(IES)* of Catalonia works in order for the training of health personnel in providing care for GV victims to follow the common quality standards and educational objectives approved by the NHSIC and to respond to the recommendations of the NHS prevention strategy on GV.

In Madrid, the training of professionals revolves around the Training Programme in Gender Violence, a part of the Continuing Training Plan the Agency Laín Entralgo runs as an agency of the Ministry of Health in charge of training, research and health studies. This programme includes awareness and basic courses, the latter accredited by the Commission of Continuing Education. Personnel from the different health care levels are given training in GV and this includes Mental Health and the *Summa 112* (Madrid Service of Medical Emergencies) and also the different groups of Medical, Nursing, Social Work, Administrative staff and others. In addition, training activities meet the training standards developed within the Technical Commission, which are comparable to those approved by the NHSIC.

In the Basque Country, training activities are organised and managedfrom the Public Health Department and Osakidetza. They design training modules (courses, workshop and clinical sessions) for medical and nursing professionals on early detection of abuse and relevant healthcare actions. Other highlight initiatives are:

- A collaboration agreement between the Department of Health of the Basque Country and the University of Deusto to conduct

the practicals for attendants to the Master in Action on Violence Against Women

- The collaboration of Emakunde-Basque Women's Institute in the Master in Action on Violence Against Women organised by the University of Deusto, providing teaching and scholarships to students.
- Nahiko Programme for the prevention of abuse in schools (Department of Education, Universities and Research).

Also part of the training strategy is the attendance of health professionals to awareness activities (seminars, congresses, etc.) conducted by other institutions with the aim of providing a comprehensive, coordinated care, as is the case of the Canary Islands and the Basque Country.

One of the ACs, Castile and Leon, referred to the fact that two SC Professionals (one male doctor and one female psychologist) completed the Diploma of Specialisation in Public Health and Gender Issues organised by the National School of Public Health. This is an advanced training lasting 160 tuition hours.

The most detailed information on the number and type of specific training activities performed in each AC has been detailed in the relevant section on situation analysis of the Annual Report.

Policies on Addressing Gender Violence in the Health Care International Context

Gender Violence is currently a topic of social concern as a serious violation of fundamental human rights and a major public health concern[5-7]. This common reality for all countries explains the progressive incorporation of this issue to the agenda of political institutions.

In the international context, world conferences have been catalysts for the enactment of laws and policies relating to GV[8-10]. In this context, experts of the Council of Europe[11], the World Health Organisation[12] an the United Nations Organisation[13] have discussed the minimum standards that must be included in legislation and policies as well as public sector actors who should participate in the prevention and eradication of this concern.

5 Krug E, Dahlberg L, Mercy J, Zwi A, Lozano R (eds.). World Report on Violence and Health. Geneva: World Health Organization, 2002.

6 Heise LI, Pitanguy J, Germain A. Violence against women: the hidden health burden. Washington: World Bank, 1994.

7 Krantz G, García-Moreno C. Violence against women. J Epidemiol Community Health 2005; 59: 818-821.

8 Organización de las Naciones Unidas. *Estudio a fondo sobre todas las formas de violencia contra la mujer* [quoted on 15 February]. Available at: http://www.eclac.org/mujer/noticias/paginas/1/27401/InformeSecreGeneral.pdf

9 The Fourth World Conference on Women, Beijing, China, 4-15 June 1993. New York: United Nations, 1995 (document A/CONF.177/20).

10 *Convención Interamericana para Prevenir, Sancionar y Erradicar la Violencia contra la Mujer* (Belém do Pará. Brasil, June 1994).

11 Council of Europe. The protection of women against violence. Recommendation N.º R(2002)5 of the Committee of Ministers and Explanatory Memorandum [quoted on 6 January, 2009]. Available at: https://wcd.coe.int/ViewDoc.jsp?Ref=Rec(2002)5&Language=lanEnglish&Ver=original&Site=CM&BackColorInternet=9999CC&BackColorIntranet=FFBB55&BackColorLogged=FFAC75

12 Organización Panamericana de la Salud. *Modelo de leyes y políticas sobre violencia intrafamiliar contra las mujeres* [quoted on 12 February, 2009]. Available at: http://www.paho.org/Spanish/AD/GE/LeyModelo.pdf

13 United Nations. Good practices in legislation on violence against women [quoted on 16 January, 2009]. Available at: http://www.un.org/womenwatch/daw/egm/vaw_legislation_2008/Report %20EGMGPLVAW %20(final %2011.11.08).pdf

Since the Beijing Fourth World Conference on Women, national plans and laws against GV have been the main responses governments have given to commitments made[5]. Action plans against GV are policies explicitly materialised in public documents that contain the principles and values that govern them, the objectives they intend to attain and the strategies and interventions to be conducted to address the problem[11,14]. The protection, government institutions afford these policies about gender equity and specific legislation on GV are two important aspects to attain success[9,11].

The health care sector is one among various actors participating in thedevelopment of these policies thanks to its important role in the care for the assault traces[9,15]. Early detection of GV in the health care sector is a basic tool for implementing prevention strategies and offer women victims of abuse the opportunity to receive information on their rights and the services suited to their treatment and rehabilitation[11,16].

In some countries of Europe and Latin America the Ministry of Healthhas coordinated efforts towards implementing care protocols and surveillance systems around GV[11,12]. Health care regulations and protocols and data collection also provide the necessary insight to improve the quality of interventions and policies around this problematic[12].

Measures on GV must articulate public policies and laws to expand the Inter-Sectoral framework that may make them effective for the lives of affected persons. For this reason, the chosen study object has been the national plans and laws against GV in Latin America and Europe.

In the descriptive analysis of national plans against GV a description of the health care sector participation was issued and a revision was called for to identify the development of protocols for detecting GV and the actions towards the development of a system of epidemiologic surveillance around this problematic. Laws and Regulations and Protocols for detection of GV were subsequently revised with the purpose of exploring the involvement of the health care sphere in the needs of vulnerable groups.

To search for specific plans and legislative documents on gender violence in Latin America and Europe different databases specialised in the compilation of policies on the subject were used, as the Annual Review of

14 Peiró R et al. *Sensibilidad de género en la formulación de planes de salud en España: lo que pudo ser y no fue.* Gac Sanit 2004; 18 (Supl. 2): 36-46.

15 Ellsberg M, Clavel-Arcas C. *Hacia un modelo integral de atención para la violencia intrafamiliar en Centroamérica.* Washington: Organización Panamericana de la Salud, 2001.

16 Velzeboer M, Ellsberg M, Clavel-Arcas C, García-Moreno C. *La violencia contra las mujeres: responde el sector de la salud*. Washington: Organización Panamericana de la Salud, 2003.

Law of the Harvard University[17], the WHO- international Digest of Health Legislation[18] and the database of the General Secretariat of the United Nations on Violence Against Women in the United Nations[19]. The latter has a range of information on policies and specific programmes on GV submitted by Member States of the United Nations. Collections of Laws from the Queen Sofia Centre for the Study of Violence were also used[20].

Specific National Policies on Gender Violence

A total of 23 European countries and 14 from Latin America have been identified as relying on a specific plan, strategy or programme targeting GV. After applying exclusion criteria, 17 countries were eliminated, principally for not having the complete text of the document available. Hence, a total of 20 countries was obtained for further analysis with their respective national papers and corresponding to Latin America (n = 8) and Europe (n = 12). See Figure 41.

Once all the information selected a revision of documents collected (n = 20) began with the purpose of identifying the role of the health sector in addressing GV.

All GV specific plans incorporate different actions in the health caresector. Both Latin America (n = 8) and Europe (n = 12) focus their efforts primarily on strengthening comprehensive care of victims of abuse. In some countries, the share of the health sector is incorporated in the sector of preventive measures and actions relating to prevention campaigns and professional training around this topic.

It has been seen that plans address especially violence against women and domestic violence. Both in Europe and Latin America measures consider the care for women as victims of abuse but also for other members of the family such as children. Only Finland has a plan that specifically addresses violence against women in couples or in similar situations. So, unlike plans in

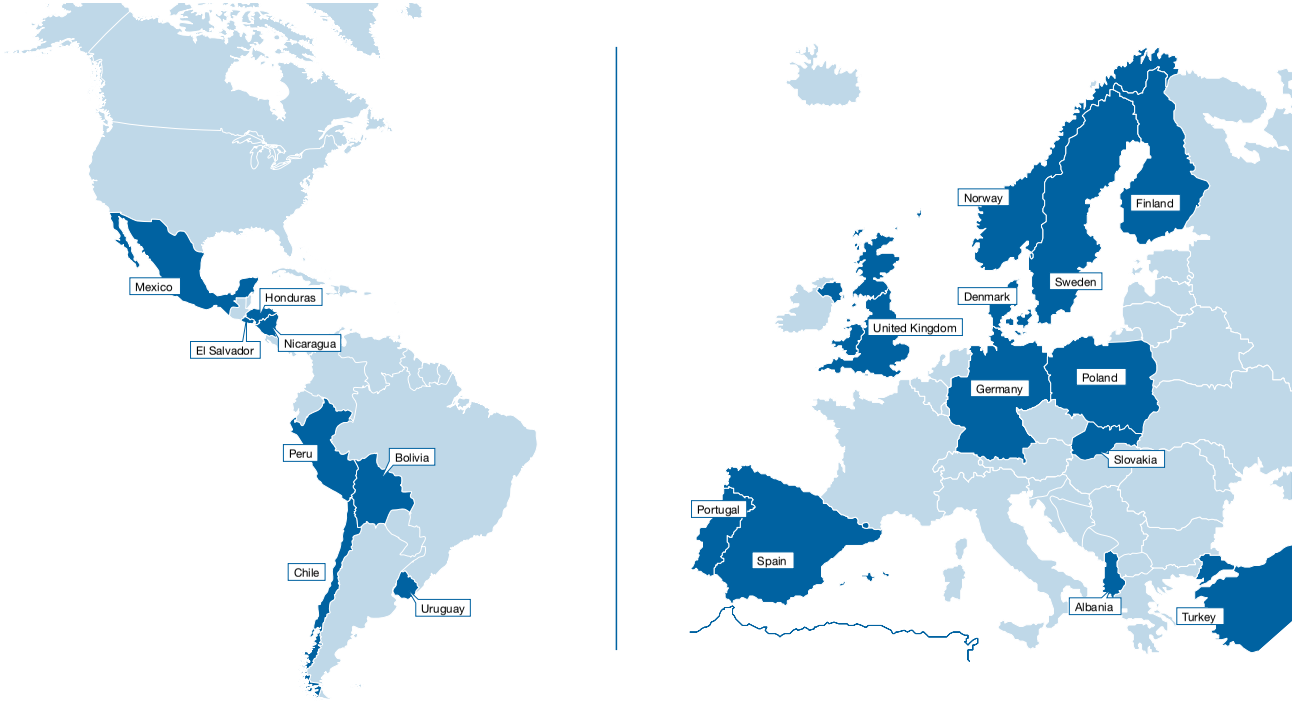
17 The Annual Review of Population Law on-line database on law and population [quoted on 17 February, 2008]. Available at: http://www.hsph.harvard.edu/population/annual_review.htm

18 International Digest of Health Legislation (IDHL) on-line database [quoted on 4 March 2008]. Available at: http://www.who.int/idhl-rils/frame.cfm?language=english

19 *Base de datos de la Secretaría General de las Naciones Unidas sobre Violencia contra la Mujer.* Available at: http://webapps01.un.org/vawdatabase/home.action; Revised in September 2008.

20 Queen Sofia Centre [quoted on 20 April, 2008]. Available at: http://www.centroreinasofia.es/english/legislacion.asp

Figure 41. Latin America and Europe selected countries with gender violence specific plans



Sources: The Annual Review of Population Law on-line database on law and population; International Digest of Health Legislation (IDHL) on-line database; Data from the Secretary General on Violence Against Women, and Queen Sofia Centre for the Study of Violence.

Latin America, their European counterparts are characterised by addressing all forms of violence against women such as female genital mutilation and forced marriages, as is the case or Norway, Sweden, Finland, Denmark and the UK.

In Europe, although the main feature of the performance of the healthsector is comprehensive care for women in situations of abuse, some measures relating to early detection of violence have also been detected as in the case of Spain, Portugal, Sweden, United Kingdom and Norway. These last two countries pay special attention to particularly vulnerable groups such as pregnant women (Table 33).

Latin America specific plans on GV point at the health sector as themain cross-sectional axis in most of the measures relating to prevention, training/qualification and access of affected women to health services, among others (Table 34).

Regulations and Protocols for Detection, Prevention and Care for Gender Violence Victims in the Health Care Sector

Once the analysis was made of the incorporation of the health sector to specific GV plans the process began of identifying in texts the measures relating to the detection of cases of male abuse such as regulations and GV detection protocols.

Of all plans analysed, eight documents in Latin America and 7 in Europe specify the development of a series of measures for identifying, from the health care sector, women suffering abuse (Table 35).

We could only access the document and full text of the "Spanish Common Protocol for a Health Care Response to Gender Violence"[21] and the Nicaraguan Regulations and Procedures for Addressing Intra-Family and Sexual Violence[22]. However, with the use of electronic resources we identified good practices regarding development of health care protocols

21 *Protocolo Común para la Actuación Sanitaria ante la Violencia de Género.* Madrid: Ministerio de Sanidad y Consumo, 2007.

22 *Normas y procedimientos para la atención de la violencia intrafamiliar y sexual de Nicaragua.* Managua: Ministerio de Salud, 2006.

in Latin American countries like Guatemala[23], Argentina[24], Ecuador[25] and Dominican Republic[26].

A subsequent revision was made of the contents of regulations and care protocols for addressing GV, trying to identify some key aspects in them. These aspects are an approximation to the key elements proposed in the model of comprehensive care to domestic violence led by the Pan American Health Organisation[11] in which importance is attached to:

- Giving greater visibility to women being abused and to professionals in the objectives of the document.
- The appropriateness of giving the Protocol an integrated approach within the framework of Human Rights and Gender.
- The need to ensure the adressing gender violence a greater scope through protocols devised to give coverage to the various forms of abuse women may be subjected to.

In the analysis performed to this end, it emerges that all protocols analysed target fundamentally awareness and training of health professionals. Women are approached in the objectives from the perspective of the psychological care, rehabilitation and follow-up of those affected as it is the case of the Nicaraguan Regulations and Procedures for Addressing Intra-family and Sexual Abuse[18]. It must be mentioned that protocols usually include among their objectives, the community as empowering agent for addressing GV. They also include as more specific aims, the education of women suffering abuse as a way of confronting the problem (Table 36).

As for the protocol approach in the context of Human Rights and regarding the gender perspective, it emerges that all documents analysed consider the care of women victims of abuse as a right, and include the gender approach in the development of the regulation itself.

23 *Protocolo de atención a víctimas de violencia intrafamiliar.* Guatemala: Ministerio de Salud Pública y Asistencia Social de Guatemala, 2008.

24 *Protocolo y guía de prevención y atención de víctimas de violencia familiar y sexual para el primer nivel de atención.* Buenos Aires.

25 *Normativa y protocolos de atención integral de la violencia de género, intrafamiliar y sexual por ciclos de vida.* Quito: Ministerio de Salud Pública, 2008.

26 *Normas nacionales para la atención integral en salud a la violencia intrafamiliar y contra la mujer.* Santo Domingo: Secretaría de Estado de Salud Pública y Asistencia Social, 2002.

Table 33. Presence of the health care sector in gender violence specific plans in the European continent (n = 12)

Country	Complete name of the Document	Action Span	Presence of the Health Care Sector
Albania	National strategy on gender equality and domestic violence	2007-2010	The development of tools for addressing this problem in the Health Care sector is not very specific
Germany	Second Action Plan of the Federal Government to combat Violence against Women		The health sector is not mentioned in a specific area of action but rather it is part of a group of several strategic areas. Actions are included for ensuring access of women victims of maltreatment
Denmark	Action plan to stop men's domestic violence against women and children	2005–2008	The health care sector is especially present in actions relating to the training of professionals whose work is connected to this issue. Special emphasis is placed on professionals of the health care sphere for strengthening information campaigns on violence against women
Slovakia	National Action Plan for Prevention and Elimination of Violence Against Women	2005-2008	The present document incorporates actions in health care pivoting around participation and training of their professionals for providing care that may meet the needs of the victims of abuse
Spain	National Plan for the awareness and prevention of gender violence conceptual framework and Intervention axes		A series of measures are adopted in the health sector that relate to three important aspects: Training of professionals in gender violence; in the formulation of common criteria for health care alertness to gender violence and in the coordination of comprehensive health care service.
Finland	Prevention of Intimate Partner Violence and Domestic Violence	2004-2007	The health care sector is present in the actions performed for ensuring comprehensive attention to victims. Special attention is paid to skills and professional training for detection and aid to victims and perpetrators
Norway	Action plan domestic violence	2004-2007	Healthcare is present in measures relating to improvement of the cooperation level and knowledge of the areas involved. Special emphasis is placed on activities connected with health care to victims, professional training and above all on the drafting of a pilot project for improving early detection methods in the health care system's maternity services.

Poland	National action plan for counteracting domestic violence	2006	This Plan establishes the adoption of measures in five strategic areas that enable dealing with this issue. The health care sector is part of these intervention areas from which implementation of actions is urged that relate to development of educational programmes for professionals who work around this issue
Portugal	III National Plan Against Domestic Violence	2007-2010	This Plan is structured in five areas of strategic intervention each of them with its own set of measures for addressing the problem. The area of strategic action targeting victims protection and preventing their becoming repeat victims proposes health care area acting towards ensuring abused victims' access to care, through a detection protocol in this field.
United Kingdom	National domestic violence delivery plan	2008-2009	This Plan against domestic violence incorporates the health sector in its objective 1 by aiming to increase early detection of victims of this kind of abuse. This document also expresses special interest in the detection of pregnant women suffering abuse
Sweden	Action plan for combating men's violence against women	2007	The Health Sector plays an important role in the development of measures relating to the improvement of the methods for the early detection of victims of abuse
Turkey	Combating Domestic Violence against Women National Action Plan	2007-2010	The health care sector is present in certain measures relating to awareness campaigns targeting GV and above all to strategies for improving the readiness of care and rehab services for victims and perpetrators

Table 34. Presence of the health care sector in specific plans against gender violence in Latin America (n = 8)

Country	Complete Name of Document	Action Span	Presence of the health care sector
Bolivia	*Programa nacional de género y violencias* (Gender and Abuse National Programme)	2004-2007	The Ministry of Health and Sports sets as main mission "to generate policies, regulations and strategies geared towards decreasing incidence of all types of gender abuse and inequities, improving the health of the general population and the community's especially vulnerable groups. The strengthening of the health sector response becomes an intervention axis in the just mentioned programme

Chile	*Política y Plan nacional de intervención en violencia intrafamiliar* (National policy and intervention plan in intra-family violence)	2000-2006	The development of this policy about gender violence involves the health sector as a cross-sectional axis of the different areas of intervention, such as the communication area, the area of promotion and prevention, the training and educational area, the public offer of services area and the area of generation of knowledge
El Salvador	*Política nacional de la mujer* (National Policy on Women)	2005-2009	This national policy on women is structured around 4 main axes; the health sector being part of the social development axis. One of the objectives set for the health sector is the creation of institutions aiming to ensure comprehensive protection for victims of violence and sexual abuse
Honduras	*Plan nacional de violencia contra la mujer* (Violence Against Women National Plan)	2006-2010	This Plan is a general guide for strategic actions to combat gender violence. It is made up of 6 strategic components, each of them with its own objectives, general and specific. The health care sector is cross-sectional to any of these components that include actions for detection, prevention, care, legislation, information, assessment and research around violence against women
Mexico	*Programa nacional por una vida sin violencia* (National Programme for a Life without Violence)	2002-2006	This Programme incorporates actions taken for reducing violence within the family. They are segmented into strategic lines: prevention, care, detection, communication and dissemination, regulation, coordination and connection and follow-up to the Inter-American Convention for Preventing, Punishing and Eradicating Violence against Women.The health care sector is part of Strategic Line III relating to detection
Nicaragua	*Plan nacional para la prevención de la violencia intrafamiliar y sexual* (National Plan for Prevention of intra-family and sexual violence)	2001-2006	This document is part of the Nicaraguan State's global strategy for responding to the demand of comprehensive action women, children and adolescents require for their development and social participation. The Health Care sector has responsibility for formulating policies and implementing programmes and projects that may ensure comprehensive health for women through a care strategy in the health care sector
Peru	*Plan nacional contra la violencia hacia la mujer* (National Plan Against Violence inflicted on Women)	2009-2015	This Plan establishes a series of actions for ensuring the adoption and implementation of public policies aiming to confront the violence against women issue at all levels of Government. The health care sector is present in Strategic Objective 2, that ensures affected women's access to the health system
Uruguay	*Plan nacional contra la violencia doméstica* (National Plan Against Gender Violence)	2004-2010	The health care sector is incorporated into the proceedings related to the approach to care, treatment and rehabilitation of victims of domestic abuse. The Health Sector is urged to organise teams trained in this issue and network-linked-in with other existing social resources on a nationwide scale

Table 35. Countries that incorporate development of regulations and protocols for health care action in their respective gender violence plans

Latin America (n = 8)	Europe (n = 7)
Bolivia	Spain
Chile	Norway
El Salvador	Poland
Honduras	Portugal
Mexico	United Kingdom
Nicaragua	Sweden
Peru	Turkey
Uruguay	

Table 36. Health care protocols targeting gender violence with explicit mention of educating and empowering women

Case 1. Spain
Promote education of women suffering abuse for their acknowledgement of their situation and for their active search of solutions
Case 2. Ecuador
Perform actions gearing towards the empowerment of the community
Case 3. Dominican Republic
Identify and appraise the perpetrator's level for their rehabilitation and social integratiion

As for the conceptual frame of regulations, the Universal Declaration of Human Rights[27] is instituted as the main establishment of legal support to determine that subjecting a person to any form of abuse constitutes a violation of human rights (Table 37).

27 Asamblea General de las Naciones Unidas. *Declaración Universal de los Derechos Humanos. Resolución 217 A (III), de 10 de diciembre de 1948* [quoted on October 30, 2009]. Available at: http://www.un.org/es/documents/udhr/

Table 37. Care protocol for victims of intra-family violence (Guatemala, 2008)

The Ministry of Health recognises the State's obligation to respond to domestic violence and based on the juridical and legal framework, identifies the responsibilities, duties and functions of the different actors in the care of the affected population. The Health sector assumes the legal rights and obligations currently in force in the Universal Declaration of Human Rights and the Convention on the Elimination of All Forms of Discrimination against Women, among others.

Regarding the scope of protocols and the type of violence they address, Healthcare protocols relate mainly to physical psychological and sexual violence perpetrated against women. Ecuador and Guatemala do not only deal with the care of women in situations of abuse, but also address that of other possible victims within the domestic sphere such as children, adolescents or the elderly.

In Europe, Spain, through the Common Protocol for a Health Care Response to Gender Violence, addresses any type of abuse inflicted on women over 14 years of age regardless of who the perpetrator may be, even though actions to which it refers are primarily geared towards violence from the intimate partner of ex-partner as it is the form of violence against women with a highest prevalence.

Epidemiological Surveillance Systems in the International Context

Epidemiologic surveillance is defined as the systematic, continuing, timely and reliable collection of relevant and necessary information on some diseases of the population. The analysis and interpretation of data should provide the basis for decision making on programmed interventions in problems[28]. The information yielded by a surveillance system is useful to determine the need for changes or for expanding the scope of the law, for improvements in the planning, organisation or management of resources in order to control an epidemic.

As experiences more closely focused on the epidemiologic surveillance of gender violence the contributions of the Centers for Disease Control and

28 Teutsch SM, Thacker SB. Planning a public health surveillance system. Epidemiol Bull 1995; 16 (1): 1-6.

Prevention (CDC) in Atlanta, Georgia, USA and the Pan American/World Health Organisation[29,30] are to be highlighted.

The proposal put forward by the CDC centres on the registry of quantitative information relating to socio-demographic profiles of victims (date of birth, sex, ethnicity, place of residence, marital status, and number of children), number of experiences gone through (physical, psychological or sexual), characteristics of the most recent one (date and place number of offenders, cohabitation status with perpetrator, whether or not the victim was pregnant, duration of the event and pattern of abusive conduct), consequences of the event (physical, psychological, need for medical attention, substances consumption or death) and perpetrators (date of birth, sex, ethnicity and place of residence).

They are useful indicators for performing prevalence follow-up and knowing the evolutional trend of the problem, being, in turn, useful too for assessing impact and results of strategies and interventions developed around the problem.

Similarly, in Latin America the Pan American Health Organisation in collaboration with the Inter American Commission of Women and other organisations convened a meeting of female experts in 2003 to establish the key components of laws and policies on gender violence[9]. As a result of that meeting a list of indicators was agreed that not only respond to evaluation objectives and monitoring of impact and results but also to the process of implementation of the said laws and policies relating to the subject.

As for the surveillance system, there are other experiences in different countries of Central America (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama). Most have focused on indicators on the extent of the problem and some use as a source of information a health care protocol that tries to pass the ICD-10 (International Classification of Diseases, 1992[31]). In all cases, the health sector assumes the ultimate responsability[32].

29 Saltzman L, Franslow J, McMahon P, Shelley G. Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0. Atlanta: Center for Disease Control and Prevention, 1999.

30 Organización Panamericana de la Salud. *Informe del III Taller centroamericano sobre el registro, vigilancia y la prevención de la violencia intrafamiliar y sexual.* Serie Género y Salud Pública, n.º 11. San José de Costa Rica, 2001 [quoted on 30 March, 2006]. Available at: http://www.paho.org/Spanish/AD/GE/gph11.pdf

31 In Spain, CIE-10.

32 *Sistemas de vigilancia de la violencia doméstica en Centroamérica.* 19.ª sesión del Subcomité sobre la Mujer, la Salud y el Desarrollo del Comité Ejecutivo. Organización Panamericana de la Salud/Organización Mundial de la Salud. Washington, 12 to 14 March, 2001. Available at: http://www.paho.org/spanish/gov/ce/msd/msd19_8-s.pdf

To identify good practices on the development of systems for epidemiological surveillance in the health sector, regulations and health care protocols of Nicaragua, Guatemala, Argentina, Ecuador, Dominican Republic and Spain underwent revision.

In the health care protocol of Ecuador, the comprehensive care for gender, intra-family and sexual abuse, from the National Health System makes visible the importance of epidemiological surveillance for addressing this problem[27]. Dominican Republic poses as part of its specific objectives to help strengthen the national information system and the mandatory notification through epidemiologic surveillance of family violence and its timely registration[27]. Spain is the only one of these countries that already relies on partial quantitative information regarding the common indicators for healthcare alertness to gender violence in the National Health System. Currently, the large variability of gathering sources among CAs and the limitations for its implementation in health information systems make aggregate obtaining difficult in the NHS as a whole.

Visibility of Vulnerable Groups in Health Care Protocols and in other Policies on Gender Violence

During the last decade, the interaction of GV with other factors that increase the vulnerability of women immersed in a situation of abuse, has become evident. The fewer opportunities of a social or economic nature and other special characteristics of women, such as disability, pregnancy, age and, especially, immigrant status or their belonging to ethnic minorities have an influence on the severity of the problem[33-38].

33 Flake DF. Individual, family, and community risk markers for domestic violence in Peru. Violence Against Women 2005; 11 (3): 353-373.

34 Kishor S, Johnson K. Reproductive health and domestic violence: are the poorest women uniquely disadvantaged? Demography 2006; 43 (2): 293-307.

35 Brownridge DA et al. Partner Violence Against Women With Disabilities: Prevalence, Risk, and Explanations. Violence Against Women .Volume 12. Number 9. September 2006; 805-822.

36 Raj A, Silverman J. Violence Against Immigrant Women. Violence Against Women 2002, 8: 367-398.

37 Field CA. Ethnic Differences in Intimate Partner Violence in the U.S. General Population. Trauma Violence Abuse 2004; 5; 303.

38 Straka S. Responding to the needs of older women experiencing domestic violence. Violence Against Women 2000; 12: 251-267.

In the international context, the political instruments developed to address prevention and eradication of GV have highlighted the need for tailoring policies and tools to the particular needs of abused women[7-9].

In this sense, we explored the existence of good practices in the visibility of vulnerable groups in regulations and care protocols as well as in legal tools such as domestic violence laws. The identification of best practices was limited, as it has been throughout this section, to countries of Latin America and Europe.

Health care protocols found were those of Spain, Nicaragua, Guatemala, Argentina, Ecuador and Dominican Republic.

The protocols of Argentina and Guatemala explicitly recognise only pregnant women as a vulnerable group that requires special attention. Their mention of disability and adulthood refers to family members who are also considered particularly vulnerable groups.

Ecuador's document is more explicit than the former ones since itrefers to situations of greatest vulnerability that endanger the lives of women. Pregnancy, disabling diseases, unemployment and internal and external migration are features that have been incorporated into the indicators of physical and psychological suspicion.

Also, the Common Protocol for a Health Care Response to Gender Violence in Spain NHS (Table 38) define as vulnerability situations those in which pregnant women, disabled women, immigrant women and those who live in rural settings find themselves as well as those who are socially excluded (prostitutes or drug addicts). This document makes an explicit recognition of these features when addressing gender violence and, above all, raises the need for providing aid resources at a nationwide and regional levels, in close intersectoral collaboration, as an essential aspect in the care of these groups.

Table 38. Common Protocol for a Health Care Response to Gender Violence (Spain, 2007)

Recognises the need to respond to the specific needs of vulnerable groups of battered women toprovide adequate monitoring
Incorporates to the *suspicion indicators* situations of greater vulnerability and dependence of women, such as: • *Pregnancy and puerperium* • Separation • Retirement, one's own or intimate partner's • Family and social isolation • *Migration both national and international* • *Disabling disease* • Occupational difficulties and unemployment • Difficulties for training and promotion at work • Lack of social skills • Social exclusion (prison inmates, prostitutes and homeless)

As regards visibility of vulnerable groups of women in situations of abuse in gender violence laws, a total of 43 laws was reviewed (25 in Latin America ad 18 in Europe). Once the documents analysed, a total of 6 gender violence laws were identified as incorporating measures targeting protection of these groups (Table 39). The areas they cover are mostly judicial, police and educational.

Table 39. Latin American and European laws that mention vulnerable groups of abused women

Latin America	
Mexico	Law for the Access of Women to a Violence-Free Life (2006)
Guatemala	Law Against Femicide and other Forms of Violence against Women (2008)
Costa Rica	Law of Criminalisation of Violence against Women (2007)
Venezuela	Organic Law on the Right of Women to a Life Free of Violence (2006)
Colombia	Law of Violence against Women (2008)
Europe	
Greece	Law on Combating Domestic Violence and other Provisions (2006)
Spain	Organic Law on Comprehensive Protection Measures against Gender Violence (2004)

As for health care measures enacted in international laws against gender violence, only the law of Spain mentions the involvement of Health Care Administrations in Public Authorities's collaboration plans for fighting GV. According to the letter of the law, the global and comprehensive attention this type of violence will be given, shall be channelled through action protocols determining the right procedures to address the issue. Furthermore, it claims that the Common Protocol for a Health Care Response to Gender Violence approved by the National Health System's Inter-Territorial Council will be of use to promote activities of prevention, early detection, and continuing intervention. Special emphasis is placed on the need to adapt to personal and social circumstances of women especially vulnerable to GV for belonging to an ethnic minority, being immigrants, being in a situation of social exclusion or having a disability.

Summary of Actions Performed by the National Health System's Commission against Gender Violence in 2008

The National Health System's Inter-Territorial Council (NHSIC) approved the creation of the Commission against Gender Violence on 22 November, 2004. This was the first step towards the coordination of programmes and the health activities that in this matter were already being performed in some autonomous communities and that can be found in more detail in previous gender violence annual reports released by the Ministry of Health and Social Policy (for the years 2005, 2006 and 2007).

Subsequently, the NHSIC, through the Commission against Gender Violence, has been taking on the specific commitments established in Organic Law 1/2004, of 28 December on Comprehensive Protection Measures against Gender Violence, for the development of common health care actions.

Under this Organic Law the National Plan for Awareness and Prevention of Gender Violence was developed whose actions are based on respect for fundamental rights and equality of men and women. It contains, in fact, a health specific axis that establishes how "violence against women is firstly an attack on their physical and psychological health; thus, actors involved in this area gain major prominence both in the detection of the phenomenon and in the care of victims".

Thus, the ultimate goal of health services regarding abuse is based on pooling efforts to improve the quality of healthcare in the prevention, diagnosis, alertness, monitoring and recovery of health in cases of violence specifically directed against women, the Commission being responsible for the planning of measures to be implemented in the National Health System for the eradication of this kind of abuse.

In 2008, this Report covers, general assent and training actions were performed that we list below:

- Firstly, the Technical Group for Training of Professionals, worked assiduously in the proposed basic educational content that will complement the educational goals that regarding gender violence were approved by the NHSIC in December, 2007, in keeping with the Common Protocol for a Health Care Response to Gender Violence (December 2006) agreed with the basic objective of

providing uniform guidelines for action in cases of violence directed specifically against women, both in the care and monitoring areas as in prevention and early diagnosis.

- The Technical Group of Information Systems and Epidemiological Surveillance of Gender Violence has geared its efforts of consensus among CAs towards the design and drafting of data collection sheets for each of the 18 indicators approved by the NHSIC in 2007. This files will enable initiating the collection of data and analysing the extent and evolution of gender violence within the NHS in order to plan and evaluate health care interventions, identifying areas that require more initiatives and resources.
- From the Observatory on Women's Health of the Ministry of Health and Social Policy and the Carlos III Health Institute's National Health School of the Ministry of Science and Innovation, training of health care professionals has continued to develop through:
  - Training of Trainers Course for prevention and alertness to gender Violence (4th ed.).
  - Prevention and Care of gender violence for mental health Teams (4th ed.).
  - II Workshops on programmes for prevention and care for gender violence.

ACs have continued developing, from their Health Care Departments and Services, actions for the training of their professionals which have been described in greater detail in the section of this Annual Report dealing with NHS's professionals training; likewise, actions targeting the improvement of information and epidemiological surveillance systems are described in the section of the first chapter about cases detected and seen in the health care sector.

The drafting of this Report as a continuation of all actions featured in its pages, is one of the systematic annual tasks the Commission Against Gender Violence's has been entrusted with.

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