Common Protocol for a Healthcare Response to Gender Violence 2012

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MINISTRY OF HEALTH, SOCIAL SERVICES AND EQUALITY

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Common Protocol for a Healthcare Response to Gender Violence 2012

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Foreword

Organic Act 1/2004 of Measures for Integral Protection against Gender Violence establishes in its Article 15 that Healthcare Authorities within the National Health System's Interterritorial Council shall promote those healthcare providers' actions that may enable early detection of gender violence. They shall also propose the actions needed to improve effectiveness in the fight against this type of violence through the development of awareness programmes and continuing education of health personnel that may allow them to promote early diagnosis, assistance and recovery of battered women. The diagnosis and attendance to gender violence victims in the fields of both Primary and Specialty Care are included in Royal Decree 1030/2006 of September 15 that establishes the Portfolio of Common Services in the NHS and the procedure for its update.

This Organic Act in its Article 16 requires that:

«Within the Interterritorial Council of the National Health System and within one year from the date of entry into force of this Act a Commission Against Gender Violence shall be created to support technically and orient the planning of the health care measures referred to in this Chapter, evaluate and propose the necessary ones for implementing the Health Care Protocol and any other measures deemed necessary for the Health Care sector to contribute to the eradication of this form of violence.

The Commission Against Gender Violence of the Interterritorial Council of the National Health System shall be composed of representatives of all Autonomous Communities with competence in the area. The Commission shall issue an annual report to be sent to the State Observatory on Violence Toward Women and the Plenary of the Interterritorial Council».

Since its inception, the Commission has been supporting technically and guiding the planning of the health care measures envisaged in Chapter III of the said Organic Act with the revision of projects and strategies developed in the Autonomous Communities' health field. Equally, it has been planning the evaluation and proposing the necessary measures for implementing the Common Protocol of the National Health System, thus contributing from the Health Sector to institute the measures of comprehensive protection and hence the eradication of this form of violence.

The Observatory of Women's Health, in their capacity as Technical Secretariat of the Commission against Gender Violence, dynamises the five technical working groups of the Commission (Epidemiological Surveillance, Health Care Protocols, Training of Professionals, Ethical and Legal Aspects

and Assessment of Interventions) and their coordination for the publishing of the Annual Report. This report contains the proceedings of the National Health System (NHS) and as the Act mandates, it is submitted to the Plenary Session of the Territorial Council of the NHS and the State Observatory on Violence toward Women.

Article 32.3 of the Act calls for promoting the implementation, update and dissemination of protocols that contain homogeneous guidelines for prevention, care and follow-up to women's state of health.

Issued in April 2007, the Common Protocol for a Health Care Response to Gender Violence was conceived as an essential tool for health care practitioners and aiming to provide homogeneous action guidelines in cases of violence specifically directed towards women both during care and follow-up as well as in prevention and early detection of such occurrence.

Its implementation throughout these years has enabled the promoting of studies and methodological proposals for a better knowledge of the real impact of this issue on public health.

The wealth of experience gained by health services of the Autonomous Communities as well as the increasing trend in scientific evidence concerning the impact of gender violence on the health of women who are subjected to it, on their children's and when in contexts of greater vulnerability, have enabled us to present today this new edition of the Common Protocol.

It has been revised and the Chapter on General Concepts updated; it goes deeper into the integral care model at health care services and also in the specific characteristics of health care intervention there where greater vulnerability is an issue (pregnancy, emigration, disability or women's living in a rural environment) which increases the difficulties women encounter when trying to put an end to a violent relationship.

The criteria for monitoring and personalised accompanying of the process, multi and interdisciplinary care on the part of the team of professionals and the coordination and collaboration with other sectors (education, public prosecutor, forensics, law enforcement and security forces, local resources, etc.) orient health care practice transversely throughout the Protocol.

Also, the need has arisen to expand the section «Ethical and Legal Aspects» in order to incorporate new information and provide health care practitioners with better decision-making tools, reflecting on ethical and legal conflicts and the due respect to women's autonomy and decision capacity.

Two Annexes complete the final section of this Protocol and include legislation, protocols and healthcare action guides to confronting gender violence developed by Autonomous Communities in compliance with the mandates of Integral Act 1/2004.

The aim of this revision and updating of the Common Protocol is to contribute to the continuous improvement of the quality of health care to women who suffer abuse and their children. For drafting it, the criteria of numerous experts in the field have been credited and also the work already done in Autonomous Communities. The task has been thorough and highly participative and I wish to express my special thanks for their effort to all who have taken part of the Protocols and Health Care Action Guides technical workgroups, and to all the experts who have cooperated from other sectors in the revision of contents (Government Delegate for Gender Violence, Law Enforcement and Security Forces, the Judiciary, Public Prosecutor's Office). I have every confidence that this new edition of the Common Protocol of the National Health System will be a basic reference instrument for both healthcare intervention as for the training and awareness raising programmes for professionals.

Ana Mato Adrover
Minister of Health, Social Services and Equality

Objectives and Methodology

The **main objective** of this protocol is establishing a standardized and homogeneous action guideline for the National Health System (NHS), for both early detection as well as for assessment and action in detected cases and their follow-up. The ultimate purpose is providing the NHS's healthcare practitioners with guidelines for achieving comprehensive physical, psychological, emotional and social care to women enduring gender violence who resort to a healthcare centre in an attempt to put an end to abusive relationships, which are the cause of increased morbility and mortality among them, and thus retrieve their health and autonomy.

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

In addition, this Protocol provides guidelines for early detection, assessment and intervention when children of women suffering abuse are involved, since they are also under the care of the NHS.

Whenever sexual assault is the case, healthcare attendance and action become specific, bearing in mind the medical-forensic and legal measures and implications this kind of assault entails, for which, just as in the previous edition, a chapter devoted to it has been included.

This protocol also intends to attain other **specific objectives**:

1. Update the vast experience-based knowledge and the scientific evidence of recent years and supply the health care personnel with more and better decision-making tools for intervening on behalf of women being abused, enhancing the collaboration and cooperation with professionals and resources, within and outside the health care system.
2. Promote the empowerment of abused women enabling them to gain awareness of their situation, to seek alternative solutions and to regain their health and their psychosocial autonomy.
3. Continue raising awareness and training of the National Health System (NHS) practitioners on the seriousness of violence inflicted on women as a health concern.
4. Educate care practitioners about the consequences of male violence on women's health and on their physical, psychological and social development and that of their children's.

5. Make visible those situations of special vulnerability that impair women's ability to identify violence and to make decisions aimed at ending the very situations that bear it.
6. Contribute from the NHS to the general population awareness of this concern.

Gender Violence is a first-rate health concern that affects women throughout all stages of their life cycle. Thus, the contents of the document that is now presented shall have to be introduced transversally in related health programmes, guides or protocols and in topics such as monitoring of pregnancy, puerperium, menopause, care for the elderly, child health, sexual and reproductive health and mental health.

The final drafting of this Protocol has involved revising the existing health care action protocols in Autonomous Communities, the international scientific evidence on gender violence and specific protocols for abused women's children, as well as references to vulnerability backgrounds.

The document we present is the outcome of the work and consensus achieved in the framework of the Workgroups: *Protocols and Healthcare Action Guides to Addressing Gender Violence* and *Ethical and Legal Aspects*, created within the Commission of the NHS Interterritorial Council (ICNHS). Both groups are formed by representatives of the Autonomous Communities and of different ministerial units (Government Delegation for Gender Violence, Women's Institute and General Directorate of Public Health). On the technical support front, we have relied on experts from the Judiciary, Law Enforcement and State Security and the Andalusia School of Public Health; also on organisations as UNICEF and Save the Children. The Observatory of Women's Health at the General Directorate of Public Health, Quality and Innovation of the Ministry of Health, Social Services and Equality has been in charge of the coordination of the groups.

The Commission on Gender Violence will continue to develop the aspects relating to implementation and assessment of the Protocol in the near future.

General Concepts

1. Definition

«Any act of gender-based violence **that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.»**

(Resolution of the United Nations General Assembly 1993)

Currently, violence inflicted on women adopts different forms defined as:

- **Physical violence**

  It comprises any non-accidental act involving deliberate use of force, such as slapping, beating, thrashing, shoving, wounding, fractures or burning that causes or is likely to cause harm or pain to women. We must not forget that any form of physical violence is at the same time a kind of psychological violence.

- **Sexual violence**

  It occurs whenever sex is imposed upon a woman against her free will through blackmail, threats or force, whether by her partner or other people.

  Sexual violence may be perpetrated in various ways:

  – **Sexual violence that does not involve body contact**:

    Exhibitionism, compelling to watch pornographic material, obscene electronic or telephone mail, obscene gestures or words, sexist insults, sexual harassment, undesired sexual solicitations, voyeurism.

  – **Sexual violence involving body contact:**

    Lewd molestation, imposition of sex intercourse or unwanted practices, force to adopt postures deemed degrading by women.

    Rape

  – **Violence against women's sexual and reproductive rights:**

    Includes any action that restricts women's right to exercise their sexual and reproductive health affecting their freedom to enjoy a

health-risk-free sexual life as well as freely exercise their right to maternity.

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

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

Sexual harassment is also a form of violence against women. It occurs through verbal, non-verbal or physical behaviour of a sexual nature, unwanted by women, which has as object or effect to strip them of their dignity or create for them an intimidating, hostile, degrading, humiliating, offensive or annoying environment.

Sexual harassment may occur in the sphere of an employment, teaching, or service providing relationship, even when advantage is taken of a higher hierarchical or superiority position or of vulnerability of the victim. It can also occur in gangs, groups of friends, in the family or in the neighbourhood.

Title VIII, Book II of the Spanish Criminal Code categorises offences against sexual liberty or integrity.

Sexual violence towards women also exists in other forms as female genital mutilation (FGM) and trafficking in women and girls for sexual exploitation, amongst others. These forms of violence also constitute gender violence, but because of their special features, they require a specific protocol.

- **Psychological violence**

  Deliberate and longstanding conduct that puts in jeopardy the woman's psychical and emotional integrity and her personal dignity, with the purpose of imposing those behavioural rules the man considers his partner should abide by. It materialises in threats, verbal abuse, humiliations or debasing treatment, exigency of obedience, social isolation, attribution of blame, freedom

deprivation, economic control (economic violence), emotional blackmail, reject or abandonment. This kind of violence is not as visible as the physical or sexual one; it is more difficult to prove and often it is not identified as such by the victim herself, but just as particular traits of the aggressor's character. Some of these forms of violence may be considered specific for certain vulnerable groups, as the case may be when women with disabilities, elderly or with severe mental illness are the object of omission of care or negligent medication.

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

It is important to bear in mind that whatever the kind of gender violence inflicted, it has consequences on all aspects of health: physical, psychological, sexual, reproductive and social.

2. Causes

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

Violence against women is **structural.** Violence does not arise from particular and pathological features of a series of individuals, but presents structural traits of a cultural form of defining identities and relations among men and women. Violence against women occurs in a society that maintains a system of gender relations, which perpetuates men's superiority over women and ascribes different attributes, roles and locations, according to

(1) The Council of Europe has been working in the field of positive parenting with the collaboration of the working group «*CS-EF Violencia*», a group specialising in parental competencies aimed in particular at the fight against the violence that affects girls and boys, and at preventing it. The Committee of Ministers through their Recommendation Rec (2006) 19, stresses the importance of working in support of positive upbringing. The group *CS-EF Violencia*, among whose experts are Mary Daly, Mona Sandbaek y Bragi Gudbrandsson, examines and analyses the main changes that affect the upbringing of children in Europe, deriving from legal situations, research and practice, addressing critical issues related to positive parenting and non-violent education.

sex. Up until recently, restriction of the personal and social development of women, the exigency of their exclusive devotion to the family, their duty of abiding by the male authority, were considered to be something «normal» and «natural», endorsed by customs and the law. In that context, men's resorting to violence to reinforce their authority was socially tolerated. Today, social tolerance towards violence is lower. Nevertheless, too many women still endure a high degree of violence, both within and outside their relations with their partners. This happens in all social classes, religions and at all education levels.

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

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

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

It has also been claimed that certain personal character traits of women that suffer gender violence might be the cause of maltreatment. For instance, some currents of opinion have resorted to masochist traits or pathologies such as hysteria or dependent personality disorder to explain why some women remain in or return to a situation of maltreatment. There exists today enough documented knowledge demonstrating that before the abuse started, there were no different psychic character traits between women that suffer or not gender-based violence . On the contrary, it turns out that disorders and psychological disturbances of abused women are a consequence of abuse itself and not its cause.

3. The Process of Violence

In the case of violence within the couple, the most frequent occurrence is the starting of maltreatment through conducts of psychological abuse at the

beginning of the relationship, which are usually attributed to the man's jealousy or his eagerness to protect the woman. They usually are restrictive and controlling conducts that progressively undermine the woman's capacity for decision and autonomy, provoking dependency, isolation and fear, as may be, for instance controlling her clothing, friendships or activities.

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

- **Building up tension:** It is characterised by a gradual rise in tension, where the man's hostility to the woman increases for no understandable or apparent reason. Verbal abuse intensifies and the first signs of physical violence may surface. They come up as isolated episodes the woman believes she is able to control and that will clear up. Tension rises and builds up.
- **Outburst or assault:** Violence erupts and physical, psychological or sexual assault occurs. It is at this stage when the woman usually reports or seeks help.
- **Calm or reconciliation or honeymoon:** At this stage, the aggressor claims to be repentant and asks the woman for forgiveness. He uses strategies of affective manipulation (presents, caresses, apologies, promises) to avoid the breakup of the relationship. Hence, this strategy adopted by the partner leads the woman to think that all will change.

As violent behaviour consolidates and gains ground, the reconciliation stage tends to disappear and only tension and assault stages remain. It is at that moment when, most frequently, women envisage separation and/or seek help, and it is also at that moment when the violent episodes get increasingly more serious, and the risk of death at the hands of the abuser gets greater.

Nonetheless, although the cycle of violence is very frequent in partner relationships where maltreatment is present it does not always occur. Another kind of violent relationship has recently been described where the situation of frustration and threats is continual, or dynamics in the relationship that adopt the structure of domination, but where only occasionally does physical assault occur, this being more difficult to detect than the most severe expressions of abuse.

In the case of women with children, it is important to be aware that the latter also experience the process of violence in all its phases, those in which violence is active as well as stages of «honeymoon». This means that just like

women themselves, their children feel strong insecurity and emotional instability for not being able to foresee what will happen next, which destroys whatever their expectations may be of what to expect from an affective relationship. This lack of certainty in their parental bonds directly affects the mental health of those children.

Throughout the process of violence:

The woman suffers a progressive loss of self-esteem also giving up all hope of a change in the situation, which increases her submission and fear toward the aggressor.

As for the abuser, this will ratify that his strategy works while it makes it increasingly difficult for the woman to break up.

That is why, when a woman seeks help she should rely on specific support to change her situation at all times, respecting her without making her feel guilty for her decisions. To be aware of the danger she faces, it is critical for her to understand that violence will continue and intensify, and she will not be able to correct the abuser's behaviour.

4. Children of Women in Abusive Relationships

The children of women suffering physical, sexual or emotional violence inflicted on them by their partners or ex-partners **are always direct victims of gender violence.** Continued exposure to an abusive atmosphere towards their mother, is a serious form of psychological abuse of the children in her care, thus vulnerable to a large range of hazards that include:

- Watch their mother while she is being battered, threatened or even murdered**.**
- See bruises, cuts or other lesions on their mother, or witness the emotional consequences of violence such as fear or intimidation, stress, anxiety and depression without having been direct witnesses to violent acts.
- Witness violent, aggressive or even cruel behaviour knowing that it comes from their father or from another male in the capacity of paternal figure.
- Hear, from another part of the home, blows, yelling, threats, breaking of objects and any other form of violence.

- Experience the different stages of the process being unable to predict whether or not violence is going to break out, thus living in a climate of emotional instability.
- Witness the disavowal, devaluation and disqualification of their mother as maternal figure.
- Experience the feelings of fear, anxiety, insecurity, powerlessness, vulnerability and helplessness that living in an environment of enormous tension and hostility where violence is in the air, generates.
- Be under threats of harm or death, blackmail and manipulation.
- Be at risk for direct violence, physical, emotional or sexual.
- Face violence for self-protection or defend their mother, stand between the aggressor and their mother at the risk of suffering harm, wounding or even death.
- Witness the intervention of the police, the arrest of their father, go to trials or to confirm forensic evidence, having to leave the home or live in a shelter.
- Deal with the experience of the loss of their mother, father or both by violent death.

So, in case of detection of a situation of gender violence and if the woman has children, it is critical to know that they require special care from the health care system, the paediatrician assuming a central role, and so doing their coordination with social services within an integral health team.

It is equally important at family medicine clinics to pay attention to symptoms in adolescent and young people that may well be signs of their exposure to male violence, in order to take action in collaboration with the rest of professionals, from the primary care team and, if referred to, from specialised care.

5. Women in Situation of Special Vulnerability

Certain existential processes like migration may be especially difficult. Circumstances and social contexts as being unemployed or living in a rural environment; psychosocial situations that lead to social exclusion or to prostitution; vital stages such as pregnancy and child birth or old age; determinants of health such as disability, severe mental illness or drug addiction, all of which increase the vulnerability to violence and, in particular, the likelihood of suffering gender violence.

Pregnancy

When in the midst of an abusive relationship, pregnancy is a stage of special vulnerability and great risk. On occasions, it is at that stage when violence starts to be open and obvious. In addition, a significant percentage of ill-treatment by the partner starts in this period including physical and sexual violence. Pregnancy, in turn, adds difficulty to the possibilities of breaking up.

Ill-treatment is at the same time a gestational risk factor; a reason why every pregnancy of abused women is considered high-risk, which means an increased maternal and perinatal morbidity and mortality: stress syndromes, infections, anaemia, miscarriages, threat of preterm birth, preterm delivery, low birth weight, foetal distress and foetal and neonatal death.

Disability

Women with **physical, sensory or mental disabilities** find themselves in a situation of special vulnerability to physical, sexual and psychological violence, as they are more likely:

- To be less able to defend themselves
- To be less able to express themselves
- To be less able to offer a credible account of the facts, especially when affected by serious mental disorder.
- To be less able to access information, advise and resources, autonomously
- To be dependent on other people
- To encounter greater difficulties for finding a paid job and gain access to education
- To have a lower self-esteem and respect for their own image
- Fear the loss of the bonds that provide them care.
- To be less independent and under economic control

Immigration

Women immigrants are more likely to feature converging conditions that determine a special vulnerability:

- Economic and working precariousness
- Administratively irregular situations and the fear of being deported

- Greater difficulty for communicating and expressing themselves due to language barriers. Shortage of interpreters trained in gender violence matters
- Greater difficulty to access socio-healthcare resources
- In some cases, added possibility of having suffered other forms of violence throughout their lives and their migration processes (abuse, sexual assault and exploitation, trafficking, armed conflicts, imprisonment, torture, poverty, etc.).
- Absence or poor network of family or social support, particularly women newly arrived in the country
- Ignorance of their rights and resources
- Prejudices, discriminatory attitudes and distrust of professionals from various spheres
- In situations of a yet unresolved application for family reunification of children, fear of the file being brought to a standstill if separation took place
- The health consultation might well have to receive girls and women having also suffered one more variant of gender violence as is female genital mutilation (FGM), highly traumatic experience entailing deep emotional scars and serious consequences in all areas of health. Stigma and shame are powerful factors that often make these women shrink away from seeking help.

Trafficking in women and girls for sexual exploitation

Trafficking in women and girls has come to be well documented; yet there is still little scientific evidence with regard to signs and symptoms of suspicion and impact and health care.

Trafficked women and girls have experienced extreme violence; they may have been abducted or lured with false promises of better conditions of life in another country, a process during which they may have been drugged, beaten, raped, locked up, deprived of food or exploited for work, particularly in prostitution and forced labour.

As a result of continuing coercion and sexual exploitation, they fall prey to serious physical and psychological consequences that also affect their sexual and reproductive health: broken bones, burns, cuts and wounds, eating disorders, sleeping problems, fatigue and exhaustion.

These women suffer injuries and diseases but encounter many difficulties in gaining access to the health care system and to receiving care in a secure and confidential manner. For a woman victim of trafficking,

contacting someone in the health care sector may be the first - if not the only – opportunity to explain what happened or ask for help.

Some important risks and difficulties involved in breaking free from this situation are chiefly the control of traffickers through alleged debts women were forced to incur, the threats of harm to their relatives and to themselves and of being deported for having their identity documents withheld or being deprived of contact with the outer world and with their families or friends.

Sometimes they are also forced to marry against their will. In a forced marriage, husbands and their families may exercise control over women's lives, enslaving them sexually or for domestic service.

Even when available data are scarce the damage to women and girls subjected to trafficking is believed to be a substantial reason why trafficking in persons is now considered a health concern.

The Commission Against Gender Violence of the NHS Interterritorial Council in agreement with all health services of the Autonomous Communities has updated throughout 2010 all educational contents and common materials for the training of professionals of health care services, in accordance with the criteria listed below:

- Specific contents that NHS professional must know, concerning the trafficking in human beings with the purpose of their sexual exploitation
- Reinforcing educational materials for development of the said specific contents

At the end of 2010, the Interterritorial Council of the National Health System (NHSIC) approved these adaptations that are currently available at the website of the Ministry of Health, Social Services and Equality.[2]

Elderly women

Some factors may converge in elderly women that are likely to increase their vulnerability to male violence as they entail a greater dependence and hinder the possibilities of putting an end to a situation of ill-treatment:

- They may have been suffering abuse for many years without even being aware of it, thus developing feelings of defencelessness,

(2) Complete updated text available at: http://www.msps.es/organizacion/sns/planCalidadSNS/pdf/equidad/materialesEducativosFormacionVG.pdf

inability and helplessness that prevent them from envisaging alternatives to their situation.

- At the retirement stage, the number of hours of coexistence with the partner increases and some men try to hold greater control over women's time, activities and relations, demanding with violence their availability and presence to accompany them and tend to their needs.
- Often, the economic dependence of the couple and the low income from retirement pensions prevent women from considering the possibility of breaking up with their partner and starting an autonomous and independent life.
- At this stage in life, some women lose the daily support of their children when these become independent or even move to another city, which condemns them to unwitnessed or unmediated violence.
- Other times, elderly women who envisage ending their relationship with their partner cannot rely on the support of their children. These even blame their mothers or encourage them to change their minds, prioritising, not their mother's wellness but the situation their father will be left in, since the chances are he will not have developed skills for his self-care and autonomy in daily life, which the children would probably have to assume. Women's awareness of this situation contributes to their giving up separation as a possibility.
- There are even more and more cases, in which the children split up and return to their parents' homes overloading their mothers with domestic work and grandchildren to take care of, thus reducing their autonomy and, with more people in their charge, the possibility of their considering a change in their situation. In extreme cases, their children's violence adds to that of their partners'.
- Some women see themselves in the circumstance of having to take care of their partners who have abused them and still do, because they have become dependent or chronically ill.
- Women that reach old age in poor health or with a disability that reduces their personal autonomy are, when having to be looked after, at greater risk of being abused by their partners or of seeing the intensity or severity of the abuse they were already suffering, increased.

Rural environment

In addition to the common barriers to revealing or reporting the situation of abuse all women encounter, living in a **rural environment** adds other difficulties both for detection as for intervention:

- Difficulties to access resources due to their dispersion and remoteness
- Closer social control; anonymity is more difficult. Reporting may have repercussions on communal relations
- Greater difficulties for protection. In small towns, restraining orders are difficult to obey
- Increased risk of professional inhibition due to social control
- Lesser chance of economic independence

Women in situation of social exclusion

The feminisation of poverty leads women to experience situations of social exclusion. A significant proportion of single women with family responsibilities, women in prison or just discharged from it, prostituted women or with serious drug addictions may be undergoing these kinds of experience. They usually accumulate several factors of social disadvantage, which contribute not only to a greater vulnerability to male violence but to increase the obstacles to get out of it:

- Illiteracy or very low levels of social instruction, little or no job skills, precarious housing, serious problems in the field of personal relationships and/or family, lack or very limited economic autonomy.
- Association of further adverse circumstances: serious health problems or disabilities, low self-esteem, feelings of social rejection, shame, helplessness, hopelessness, lack of social skills, which reduce the capacity of self-determination needed to confront a separation.
- Poor access, in practice, to support services
- Lack of social support networks or too weak bonds

Women with HIV

Having HIV infection may be a risk factor for gender violence. It has been proven that women with HIV infection may be at risk of undergoing episodes of violence, from verbal abuse to physical and sexual assault, after communicating their serological status to their partners. Although various studies indicate that the rates of gender violence experienced by women infected with HIV are similar to those or women who are not, their intensity and seriousness seem to be more severe for the first ones. On the other

hand, the risk of HIV infection increases greatly for women living an abusive relationship due to the fear of the consequences to oppose unwanted sex, of rejection if trying to negotiate safer sex and of coercion and emotional manipulation to which they are subjected.

6. Consequences of gender-based Violence on Health

6.1. Consequences on women's health

Gender violence in any of its manifestations has always an impact on physical, emotional, sexual, reproductive and social health that persists even after the situation ends. The World Health Organisation (WHO) has identified gender-based vidence as a critical factor in the deterioration of health, since physical, psychical and sexual assault represent losses, sometimes irreparable, in the biological, psychological and social spheres of women and their children. That is the reason why it has declared **violence against women as a public health priority in the whole world** (49th World Health Assembly, 1996).

Table 1. Consequences of gender-based violence on women's health
FATAL CONSEQUENCES
▪ Death (by homicide, suicide, etc.)
CONSEQUENCES ON PHYSICAL HEALTH
▪ Lesions of diverse nature: bruising, traumatism, injuries, burns that might result in disability ▪ Functional decline ▪ Unspecific physical symptoms (headaches for instance) ▪ Poorer health
CONSEQUENCES ON CHRONIC CONDITIONS
▪ Chronic pain ▪ Irritable bowel syndrome ▪ Other intestinal tract disorders ▪ Sleeping disorders . ▪ Disabilities
CONSEQUENCES ON SEXUAL AND REPRODUCTIVE HEALTH
▪ Through imposed sexual intercourse: loss of sexual appetite, menstrual disorders, sexually transmitted diseases including HIV infection, vaginal bleeding and fibrosis, dyspareunia, chronic pelvic pain, urinary infection, cancer of the cervix, unwanted pregnancy. ▪ Arising from abuse during pregnancy: high-risk pregnancy, greater maternal mortality, vaginal haemorrhage, miscarriage threat, miscarriage, foetal death, premature delivery, low birth weight, increased perinatal mortality

Table 1. (Continuation)
CONSEQUENCES ON PSYCHIC HEALTH
▪ Depression ▪ Anxiety ▪ Post-traumatic stress disorders ▪ Eating disorders (anorexia, bulimia) ▪ Psychopathological disorders ▪ Suicide attempts, self-inflicted wounds ▪ Alcohol, drugs and psycho-pharmaceuticals abuse ▪ Psychological dependence on the aggressor (Stockholm syndrome or capture-bonding)
CONSEQUENCES ON SOCIAL HEALTH
▪ Social isolation ▪ Job loss ▪ Work absenteeism ▪ Decrease of healthy days span ▪ Change of address and/or city forced by the need to protect themselves

6.2. Consequences for their children's health

Factors determining the magnitude of the impact on the health of abused women's children are basically, the type, the severity and the time of exposure to violence, age, level of development, family context or the accumulation of other stress factors, as well as the presence of protective factors or the quality of other bonds. In addition, due to the constraints of gender, violence will affect differently little kids, boys or girls, or adolescents (male, female).

Table 2. Consequences of gender-based violence on children's health
FATAL CONSEQUENCES
▪ Death caused by homicide or resulting from the children acting as a buffer between the aggressor and their mother trying to curb the violence
CONSEQUENCES ON PHYSICAL HEALTH
▪ Harm and lesions ▪ Risk of disrupting their full development: growth retardation, decrease of motor skills, retarded language development skills, regressive symptoms ▪ Sleeping and eating disorders ▪ Increased frequency of psychosomatic disorders
CONSEQUENCES ON PHSYCHOSOCIAL HEALTH
▪ Anxiety, depression, low self-esteem ▪ Post-traumatic stress syndrome ▪ Deficit of attention and concentration, hyperactivity ▪ Learning and socialisation difficulties, poor social skills, low school performance ▪ Problems of social behaviour: Adoption of submissive or violent behaviours towards their school mates ▪ Risky behaviours ▪ Inhibition and isolation ▪ Addictions ▪ Parentalisation. Assumption of protective roles towards their siblings or their mother ▪ Psychopathological disorders

Table 2. (Continuatión)

LONG-TERM CONSEQUENCES OR TRANSGENERATIONAL VIOLENCE :
If there has been no elaboration on lived experiences through professional intervention or otherwise, available scientific evidence indicates that there is a stronger likelihood of: ▪ Aggressive conduct of sons towards their mothers learned from violent men in their own family environment ▪ Abuse of partner in adulthood among male children ▪ Greater tolerance to women's abuse

Detected alterations affect different areas: physical, emotional, cognitive, behavioural and social and may have effects in the short, medium and long term.

Table 3. Consequences of gender-based violence on children's health according to age

AGE	CONSEQUENCES OF EXPOSURE TO ABUSE
0 to 2 years	Delay in growth and in the development of motor and language skills, low weight, feeding and sleeping disorders, psychosomatic symptoms (asthma, eczema) inconsolable crying, irritability, increased risk of physical abuse
2 to 5 years	Altered eating and sleeping patterns, sphincters control, regressions, aggressiveness, irritability, learning and behaviour problems, hyperactivity, fears, anxiety, sadness, feelings of guilt
6 to 12 years	Aggressiveness, anxiety, fears, poor school performance, depression, low self-esteem, isolation, post-traumatic stress disorder
Over 12 years	Anorexia and bulimia, anxiety, depression, apathy, difficulty for expressing emotions, outbursts of anger, impaired social skills, establishment of troubled relations, risk behaviours and evasion, violent behaviour inside and outside the home, running away from home, truancy, drug addiction, suicide attempts, self-inflicted wounds, severe psychopathology, caring role assumption towards siblings and/or mother Among girls: pregnancies for getting to feel loved, unwanted pregnancies, establishing relations in which they suffer abuse Among boys: Greater probability of developing aggressive and violent behaviours recreating the aggressor's conduct towards their mothers or their partners.

6.3. Consequences for the woman's relational environment

Knowing the existence of an abusive relationship also affects people of the surrounding environment with which the woman keeps affective, working and /or social bonds (family, friends, and neighbours). **Repercussion is greater on the woman's dependants** and or cohabitants who are also under the influence of gender-based violence but unable to put and end to the situation, thus experiencing feelings of anger and powerlessness.

Relatives may also experience guilt at maintaining passive attitudes or having advised to keep the relationship despite the violence.

In turn, knowing that a fellow woman is living an abusive relationship also affects women who are being or have been victims of gerder violence as it may make them re-experience the situation bringing back the symptomatology.

6.4. Consequences on health care personnel

Listening to stories of violence and witness the suffering and the physical and emotional wounding on women and their children inflicted by those who are meant to provide love and protection, does not leave health care workers indifferent. It causes feelings of pain, sadness, anger, aggressiveness, impotence and affects the perception of the world and relationships they may have. All this can also have an impact on their healthcare practice. It is hence, important to rely on methodological instruments for addressing male violence, on continuing training, support and monitoring and on coordinated interdisciplinary team work, developing self-awareness and self-care in order for the emotional impact that treating victims of abuse entails not to influence negatively either the victim-related decision-making or the workers' emotional balance.

7. Importance of Healthcare Service Professionals for Confronting Gender-based Violence

The Comprehensive Health Care Model

Health services can play a crucial role in helping women who suffer gender-based since the majority of these women come in contact with them at some

point in their life (on demand and preventive consultations, pregnancies, childbirth, medical care to their children, to the elderly, etc.). Moreover, women under any kind of abuse will come more frequently to the health services, in particular to primary care, emergency care, obstetrics, gynaecology, and mental health.

These women's specific needs are multidimensional; a reason why required health care interventions should take into account biological, psychological and social aspects. This purpose requires in turn the active involvement of the health care services personnel as a whole, following a comprehensive care model.

The **comprehensive health care model** incorporates the concept of INTER-DISCIPLINE, understood as a form of articulation, which on the basis of dialogue and the sharing of diverse forms of knowledge and skills, allows building a new knowledge as well as an experience and a language that are the fruit of a shared approach to the conflicts and problematic situations each person deals with. This interdisciplinary perspective seeks to break the isolation of services and professionals and to strengthen coordination, generating interrelationship, reciprocity and recognition of the wealth that diversity brings in for promoting the quality of care.

Health care services rely on professionals from different disciplines (nursing, medicine, social work, psychology, midwives, physiotherapists, etc.) that contrive to join forces for the diagnosis and treatment of the diverse situations the health system intends to give response to, making thus possible this way of intervention from the angle of Comprehensive Health Care Model.

If the personnel of health care services is able, through active and empathic listening, to delve into those psychosocial and gender-related elements connected with the ways and conditions of life of the person affected by violence, their problems and family situation, then a correct diagnosis could be given. The health service practitioners' detecting the case of abuse will help **break the silence,** which is the first step to understanding and visualising the problem. Not recognising a situation of abuse as a conditioning factor of a health problem, especially by figures endowed with «authority» as healthcare personnel is, may entail a new victimisation for the woman that might contribute to the chronicity of the abuse and the medicalising of the problem.

Very often, interdisciplinary interventions are required by professionals who are not always available at each health centre. That is why coordination among all institutions involved is so necessary when attempting to give a comprehensive answer to this type of situations. To this respect, the role of social workers is highly relevant since some of their specific tasks are the investigation of psychosocial factors influencing the

process «health-illness», the psychosocial assessment, the designing of a project of comprehensive intervention and the referral and coordination with other institutions and professionals, inside and outside the health care system, as well as the monitoring and referral of affected women and, when applicable, of their children.

We wish to highlight especially in this protocol, the significant role of Paediatrics' professionals in detection and interventions involving the children of women who live in situations of abuse by their partners, for which purpose they rely on the support of the Comprehensive Health Care Team.

In addition, healthcare interventions during pregnancy become invaluable moments for detection and prevention of gender violence. Pregnancy follow-up makes possible a monthly contact and relation with the woman, so that midwives, nursing and obstetrics' practitioners are well positioned to observe any alarm sign the woman might show, in which case they should not hesitate to make inquiries into whatever may be found suspicious. At the same time, during Maternal Education and Preparation for Childbirth courses, topics such as «treating your partner well», equality, co-responsibility, sexuality and violence, should be addressed.

Another favourable environment for the detection and prevention of gender-based violence are services for the diagnostic and treatment of STIs, among them HIV infection. Many of these services include pre and post HIV test counselling sessions enabling exploration of potential violence.

Mental health professional teams should also be on the alert for signs of gender violence among all women they treat, with special emphasis on those who suffer severe mental illness and/or are drug users.

It is always a priority to consider very strongly the needs of women in situation of special vulnerability mentioned before such as immigrant and elderly women; women living in rural areas, HIV infected women and those who suffer from some type of physical or intellectual disability.

World Health Organisation Recommendations

WHO, in its report **Violence against Women: A priority health issue,** recommends health practitioners *«Do not be afraid to ask; contrarily to the popular belief, most women are willing to disclose abuse when questioned directly and* ***not in an evaluative manner.*** *In fact, many are silently expecting to be asked».*

It also itemises the very basic gender-related functions to perform from the healthcare system, as follows:

- Ask all women regularly, whenever possible, about the existence of domestic violence, as a habitual task within preventive activities.

- Be alert to possible signs and symptoms of abuse and do their follow-up
- Provide **comprehensive health care** and record every step on the health or medical history
- Help her understand her distress and health problems as resulting from violence and fear.
- Inform and refer patients to the resources available in the community.
- Preserve the privacy and confidentially of obtained information
- Encourage and support the woman throughout the process, respecting her own evolution
- Avoid unsympathetic and blaming attitudes that may reinforce isolation, undermine their self-confidence and subtract the possibility of their seeking help
- Ensure coordination with other professionals and institutions
- Cooperate in dimensioning and researching the problem through the recording of cases

NOT DOING is allowing the violence to continue and the health of women to worsen. ACTING, apart from enabling to solve the case, contributes to dispel the myths and beliefs that accompany gender violence. Often we fail to intervene for fear of not knowing what to do, to cause more pain …, but it is important to emphasise that the mere fact of listening with respect is a therapeutic act. Frequently, the doctor's surgery is the only place for a woman to speak her mind. Talking to the woman you can gradually work out what to help her out with and how.

8. Preventing Gender-based Violence from the Healthcare System

The healthcare system also assumes a substantial role in the prevention of gender violence that substantiates through actions in the areas of awareness and training of professionals and care to the integral health of women, which includes interventions regarding community health and health education.

Table 4. Recommendations for the prevention of gender-based violence from the health care system

IN THE AWARENESS AND TRAINING OF PROFESSIONALS ENVIRONMENT:
▪ Include in the continuing training of health care personnel, the concepts of prevention, early detection and comprehensive care to women and their children. Place special emphasis on the training in intercultural competencies and on the different situations of vulnerability to abuse.
▪ Hold multi and interdisciplinary clinical sessions on real cases dealt with in the centre or service, including cases of women being in situations of special vulnerability.
▪ Hold sessions with professionals of other institutions. In sessions dealing with abused women's children witnessing or having witnessed violence towards their mother, sessions of a special interest and significance are those relying on paediatrics', education and social services professionals.
▪ Apprise others of the importance of actions regarding detection, assessment and intervention in the cases of minors having witnessed male violence.
IN THE ENVIRONMENT OF THE COMPREHENSIVE HEALTH CARE TO WOMEN:
▪ Inform by placing posters and leaflets in visible places making women aware that male violence is an issue object of health care and that they can be helped out.
▪ Promote, through relation of health care personnel with the patient, attitudes, values and activities that encourage the woman's personal autonomy, the exercise of her personal rights and her social relations, also encouraging her to participate in group activities inside and outside the health care system that may further their psychosocial development and self-care.
▪ Include, in Health Education and in Maternal Education Groups activities, contents about awareness and prevention of male violence against women.
IN THE COMMUNITY ENVIRONMENT:
▪ Cooperate with community associations through workshops, symposia and talks explaining the consequences of this type of violence on health and the role of health care personnel
▪ Propose and participate in actions, campaigns and conferences relating to subjects being developed by institutions and social organisations, especially those concerning vulnerable women.
▪ Collaborate with the school sphere in order to favour effective coeducational models as a way of prevention of male violence towards women.

Action in Primary and Specialized Care

Gender based violence is a highly prevalent issue with serious consequences on health of a repetitive nature involving a high health care and social cost. There is great concern about insufficient detection and delay in the diagnosis of male violence as international scientific evidence and a large number of research studies reveal.

For dealing with it, early detection at health care services is an absolute priority; in other words, speed up diagnosis and make an early intervention.

According to the international literature on universal screening programmes for detecting gender violence inflicted on women by the intimate partner or ex-partner, the efficacy of these programmes depends of the convergence of various factors or processes: training of professionals, existence and availability of specific resources as well as continuity of the care provided.

In Spain, to this respect and since the release in 2007 of the National Health System's Common Protocol for a Health Care Response to Gender Violence, all Health Services of the Autonomous Communities have been developing and implementing action guides and protocols in harmony with it. They have also issued training programmes to prepare their professionals and specific tools, or adaptation of their existing information systems for the early detection and follow-up cases. In addition, they have developed collaboration programmes and inter-institutional protocols aimed at coordinating the intervention of involved areas when providing comprehensive care to victims of gender violence.

Therefore, in line with the available scientific evidence and the experience developed by the Autonomous Communities' Health Services, this new edition of the NHS Common Protocol recommends for an early detection and for improving the care provided, to ask systematically all women who come for consultation, be it their first visit (opening of medical history) or a routine check with no record on the medical history of their having been asked. To this end, they will be asked exploratory questions of psychosocial nature, and the subject of gender-based violence broached.

This protocol equally intends health care practitioners to keep an attitude of alertness and of active search of conducts, symptoms or signs of suspicion.

Accessibility features, direct and continued contact at primary care services and relying on multidisciplinary teams, may significantly enable this early detection.

Women who come for consultation to the mental health and drug addictions networks are highly likely to be suffering gender violence. They are often unaware of their situation they may minimise or silence it for various motives, perhaps never relating their health problems with the gender violence they are undergoing. That is the reason why the health teams of these services no are also meant to ask them, systematically, about their experiences of abuse.

When providing care to women experiencing maltreatment, apart from patient assistance and follow-up should sons or daughters or other dependants on their charge exist, the coordination with paediatrics or relevant social work services would be necessary.

Something to bear in mind is that pregnant women and those physically, psychically or sensorially disabled, immigrants, in situation of social exclusion or living in rural environments are more vulnerable to maltreatment, for which it is necessary to provide them with special aid.

The action protocol is thus structured in these phases:

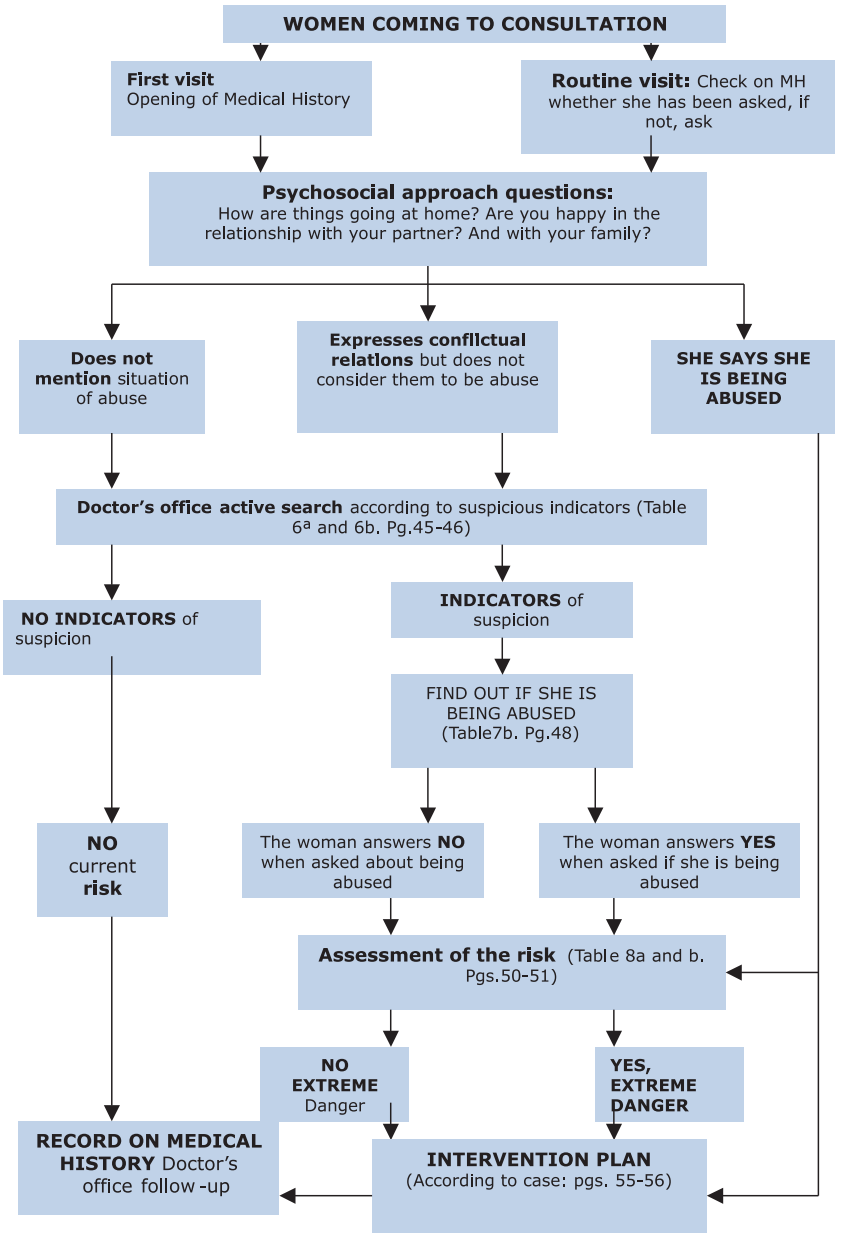
1.DETECTION AND ASSESSMENT

- Address psychosocial aspects during consultation
- Suspicious indicators
- Identification of specific question about abuse
- Assessment:
  - Biopsychosocial
  - Of the situation of violence
  - Of the risk

2. INTERVENTION

- Information about the problem
- Work at the doctor's surgery-follow-up
- Recording on the medical history
- Intervention of social workers of primary, specialised and hospital care health teams
- Referral to specialty services if applicable
- Intervention targeting patient's children or other dependants if applicable
- Issuing in due course the relevant grievous bodily harm and medical reports

Healthcare Action Algorithm in the Occurrence of Gender Violence



1. Detection

At Primary Care, any healthcare professional must investigate whatever possibility there is of male violence against any woman coming to consultation when on their medical history there is no mention of her having been asked. The query may begin with questions of the psychosocial approach type and/or informing her straightaway that given the high frequency of male violence, «*we are asking every woman who comes to consultation about that possibility*». By generalising the question we will avoid her thinking: «Why is he asking me? What does he think or know about my partner?» They must always be asked whenever safety reasons make it advisable and abiding by the proposed rules to this respect (partner no present at the consultation, conditions of confidentiality). The Activities Programme for Prevention at Primary Care offers an adequate framework for asking these questions. Consultations of Medicine and Nursing account for the highest frequentation, reason why these professionals are the ones with greater possibilities of detection. Equally, Mental Health teams play a central role when it comes to detection.

1.1. Difficulties for identifying gender violence

There are many difficulties for identifying gender-based violence, on the part of women who suffer it and by professionals of the healthcare system. They relate to social factors, as are myths and stereotypes created by culture, to psychological factors as fear to confront emotional pain and one's own fears. Among professionals, the lack of specific training is also an added factor.

Difficulties are even greater in the case of disabled women who depend on their partners even for their daily care, for migrant women in irregular administrative situation and/or hindered by language barriers or when living in rural areas where access to resources and protection may be limited. For women over 65 and especially the elderly; for those with severe mental disorders or for those who prostitute themselves, for drug users or for women in any other circumstance that may place them in situation of social exclusion.

Myths and stereotypes

Gerder-based violence is full of myths, stereotypes and prejudices about the men who commit it, the women who suffer it and about the process itself.

They are preconceived and erroneous ideas that have been a part of the social imaginary and the culture for centuries, as are beliefs and explanations about ill-treatment, internalised, often unconsciously, by all people, women and men and therefore also by health care professionals since they have also been socialised in the same culture.

Consequently, these myths and stereotypes that in general tend to absolve men from responsibility and to put the blame on women predispose negatively the professionals faced with abused women and prevent them from acting effectively, both in terms of early detection as in what concerns socio-healthcare intervention.

In recent years and largely through training programmes more and more healthcare professionals identify these stereotypes and are aware, for instance, that gender violence occurs in all socioeconomic and cultural levels and that such a profile as battered woman or violent man does not exist. Any woman who comes to consultation, regardless of their aspect, their job, education level, or socioeconomic status might be undergoing abuse. Even so, some misconceptions still linger in the collective mind such as that pregnancy is a happy stage in which violence does not occur or that even in an abusive relationship violence decreases during pregnancy. Or thinking that the children of abused women will not suffer the effects of violence as long as they are not present when it erupts or providing they are not its prime target.

Due to the influence of stereotypes in the detection and intervention stages, it is critical that health care personnel know them, become aware of them and take part of the training programmes.

Table 5 Women's difficulties to identify gender-based violence
• Fears (to her partner's reaction, to not being understood and being blamed, to confidentiality not being respected, to not being able to initiate a new life, to economic, legal, social difficulties, to what may happen to her children…) • Low self-esteem, feeling of guilt • To be living a situation of special vulnerability (see section 5, pgs 21-27) • Being economically dependent. Being outside the work market • Feelings of shame and humiliation • The wish to protect their partner • Distrust in the healthcare system • Minimising what is happening to her • Isolation and lack of social and family support • Internalised sexist beliefs and values • Being used to hiding it • Perception of gerder violence as something "normal" within the relationship • Emotional block due to physical and psychical trauma
ON THE PART OF WOMEN'S CHILDREN.
• Considering violence a normalised form of conduct • Denying violence as a defence mechanism. • Fear to be punished or suffer harm if they tell about the situation • Experiencing feelings of responsibility and guilt • The child lives a conflict of loyalty between their mother and their father • Difficulty to exteriorise emotions when seeing their mother overwhelmed by pain and anguished
ON THE PART OF THE HEALTH CARE PERSONNEL
• Be immersed in same sexist socialising process as the rest of society • Having internalised myths and stereotypes about gender abuse • Not considering violence a health problem • Live or having lived personal experiences surrounding violence • Belief that violence is not so frequent • Attempt to rationalise the aggressor's conduct • Fear to offend the woman, to worsen the situation, for safety reasons or their own integrity • Lack of knowledge about the right strategies to deal with this kind of situation • Biologistically oriented training (lacking an approach to psychosocial problems) • Poor training in communication skills for the medical interview • Unawareness of abused women's children being also victims of abuse • Believing that if not direct, it is not affecting minors' health
IN THE DOCTOR'S OFFICE CONTEXT
• Lack of privacy and intimacy, interruptions during consultation • Attendance overload • The woman comes to consultation escorted by her partner
IN THE HEALTH CARE ENVIRONMENT
• Lack of knowledge and coordination among different resources • Insufficient interdisciplinary and teamwork • Insufficient repercussion of programmes for training in gender violence throughout the whole of health care professionals • Poor development of mechanisms facilitating health care per sonnel's access to courses for training in gender violence • Shortage of translators and intercultural mediators to make communication easier

1.2. Suspicious indicators and situations of vulnerability

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

Table 6a. Suspicious indicators in the woman's background and personal characteristics

1. Violence victim record:

- Having suffered previous relationships of abuse
- Having suffered or witnessed maltreatment and/or sexual assault during childhood.

2. Personal background and habits

- Frequent lesions
- Other frequent health problems: aches, sleep and eating disorders
- Alcohol abuse, psychopharmaceuticals and other drugs

3. Obstetric-Gynaecological problems

- Absence of fertility control (many, unwanted or unaccepted pregnancies)
- Presence of lesions in genitalia, abdomen or breasts during pregnancies
- Dyspareunia, pelvic pain, recurrent gynaecological infection, anorgasmia, dysmenorrhoea
- History of repeated miscarriages
- Low birth weight children
- Delayed application for prenatal care

4. Psychological symptoms

- Insomnia
- Depression
- Anxiety
- Post-traumatic Stress Disorder
- Suicide Attempts
- Low self-esteem
- Psychic exhaustion
- Irritability
- Eating patterns disorders
- Emotional lability

5. Social aspects

- Isolation, few relations and activities outside the family, sick leaves

6. Frequent physical symptoms

- Headache
- Cervical pain
- Chronic pain in general
- Dizziness
- Gastrointestinal symptoms (diarrhoea, constipation, dyspepsia, vomiting, abdominal pain)
- Pelvic discomfort
- Breathing difficulties

7. Use of health care services

- Existence of periods of hyper-frequentation and other of absenteeism (long absences)
- Missed appointments or treatments
- Repetitive use of emergency services
- Frequent hospital admissions
- Coming with partner when did not use to

8. Situations of greater vulnerability

- Situations of vital change:
  - Pregnancy and childbirth
  - Courtship
  - Separation
  - Own retirement or partner's
- Situations that increase vulnerability:
  - Having children or dependants
  - Family and social isolation
  - Migration, both domestic and international
  - Disabling illness
  - Economic or physical dependency
  - Work problems and unemployment
  - Absence of social skills
- Situations of social exclusion (prison, prostitution, poverty)
- HIV Infection

9. Information that the woman is being abused through:

- Family
- Friends
- Healthcare system or other institutions' professionals

Table 6b. Suspicious indicators at the doctor's office
1. Lesions and wounding profile
• Delay in requesting assistance for her physical injuries • Inconsistency between lesion type and explanation of its causes • Haematomas or bruising in suspect areas: face/head, arms or thighs • Injury from self-defence (arm inner face and dorsal region) • Different healing-stage lesions which indicate long standing violence • Lesions in genitalia • Lesions during pregnancy in genitalia, abdomen and breasts • Typical lesion: tympanum bursting
2. Woman's attitude:

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

3. Partner's attitude
During pregnancy: • He requests to be present during the whole visit • Very controlling; he, himself, giving all the answers or, on the contrary, detached, disparaging or trying to banalise facts • Excessively concerned or solicitous to her • Sometimes choleric or hostile with her or with the professional
During childbirth: • Tearing or dehiscence of episiotomy • Bad or slow post-partum recovery • Urgent request of contraception under pressure of partner to resume sex • Increased incidence of hypogalactia and failure to breastfeed naturally • Unremitting post-partum depression; anxiety in the relation mother-baby • Delayed neonatal visit

When the healthcare personnel suspects a woman of being a victim of abuse, they will either confirm or rule out the situation of violence. To this purpose a **specific medical interview** will be conducted.

In the table below, we suggest some recommendations for creating a trusting atmosphere to loosen up.

Table 7a Recommendations for the medical interview to women suspected of being abused
• See the woman alone, giving her assurance of confidentiality. In case she has children, ensure they are not present during the interview • Watch closely her attitudes and emotional state (through verbal and non verbal language) • Encourage her to express her feelings • Keep an empathic attitude that may ease the communication, and listen actively • Follow a logical sequence of questions from general and indirect ones to other more specific and direct • Broach directly the subject of violence • Clearly express that violence is never justified in human relations
In the case she admits to being suffering abuse:
• Make her feel that SHE IS NOT GUILTY of the abuse she is suffering • Believe the woman's story without questioning the interpretation of the facts, without making judgments, trying to remove the fear of the abuse disclosure • Help her think, organise her thoughts and make decisions • Alert the woman of the risks and accept her decision • DO NOT give the impression that everything will be easily sorted out • DO NOT give false hope • DO NOT criticise the absence of reply with statements like "Why are you still with him? If you wanted to break up with him…" • DO NOT underestimate the sensation of danger expressed by the woman • DO NOT recommend couple therapy or family mediation • DO NOT prescribe drugs that might slow down the woman's ability to react and if necessary do it under strict medical control • DO NOT adopt a paternalistic attitude • DO NOT impose criteria or decisions

This table presents examples of general questions that may be used in consultation for the active search of suspected situations of abuse.

Table 7b. Examples of questions when suspicion exists
In case of suspicion through information obtained from the patient's background and profile:
• I have been going through your medical history and I have found things I would like to comment with you. I can see that (tell her what), what do you think your problem is due to? I can see you are a little uneasy, what is bothering you? Are you living any difficult circumstances that make you feel this way? What can you tell me? Do you think it is all related? • In many cases, women who have problems like yours… (Tell her about some of the identified ones, the most significant), this happens because they are being abused by someone, their partner for instance, is that your case? • In case of suspicion for a record of dyspareunia, pelvic pain..., ask her if her affective and sexual relations are satisfactory or not
In case of suspicion because of actual wounding she presents:
• This kind of lesion appears when you are pushed, or hit or cut or punched… is that what happened to you? • Does your partner or any other person maltreat you? How? Since when? • Has it ever been more serious? (thrashing, use of weapons, sexual assault)
In case of suspicion due to symptoms or psychic problems found:
• I would like to have your opinion on the symptoms you have just told me about (anxiety, nervousness, sadness, apathy): Since when have you been feeling that way? What do you think they owe to? do you connect them with something? Has anything happened recently in your life that is making you sad or uneasy? Maybe you have a problem with your partner? Or with your children? Perhaps someone in your family? At work? • You look tense, afraid, are you scared of something? • Can you see your friends or your family when you please? Why not? What is stopping you?
In case of suspicion in situations of special vulnerability:
• "Often during pregnancy, problems in general or at home with your partner seem to worsen; is that the case with you? How does your partner live your pregnancy? Do you feel supported by him?" • It appears that being far away from your country may increase the problems in the couple do you feel lonely?" • We know that sometimes when there is some kind of disability the relation with your partner may suffer; how are things at home?

Equally and during detection, you must especially bear in mind vulnerability situations and contexts:

- When **pregnant,** the woman may be suffering abuse too. It is important, during the health care process and from the initial stages of the pregnancy follow-up, to find a moment to talk to her alone without her partner and/or other members of the family being present, to ask her about the possibility of being suffering some kind of abuse.
- **Disabled** women are more vulnerable to male or any other kind of abuse and generally come to the surgery with their partners or it is him alone who comes instead. That is why it is imperative both at the surgery and in home visits to be allowed some space, without their partner being present, for assessing, in private, the possibility of her being subjected to abuse.

- **Elderly women** may be victims of gender violence and yet not having identified it as such. Their tolerance to this kind of situation is usually high since they, most times, have culturally assumed the woman's traditional role and even being aware of the abuse they are undergoing, it is for them much more difficult to decide on changes or even consider the possibility of breaking up with their partner.
- **Immigrant women** may be in an irregular administrative situation and thus be especially afraid to disclose their circumstances.
- In **rural areas**, where resources may be less accessible, protection less feasible and where social control is greater, women are likely to find additional barriers.
- Women **infected by HIV** may be especially afraid of letting their status go public since HIV still is a stigmatising disease that causes numerous situations of discrimination in various areas. This same stigma overlaps with the one arising from abuse, all of which may make detection even more difficult.

2. Assessment

Once the woman admits to being in a situation of abuse and/or presents suspicious indicators, the way to proceed will allow for:

1. A comprehensive assessment that includes: A thorough examination of the lesions and of her emotional state and social situation, informing her all along of what is being performed and its actual purpose.
2. An assessment on whether she is in extreme danger
3. Explore her expectations and what her position is regarding decision-making on life changes, critical aspects indeed when adapting the practitioner's intervention to the woman's actual situation

Coordination of primary care professional teams with hospitals, social services and law enforcement and justice is needed when addressing any case of gerder-based violence, particularly when dealing with especially vulnerable women. Thus, in the case of pregnant women for instance, the range of professionals from sexual and reproductive health has to maintain at all times a fluid communication with the gynaecology and obstetrics services' teams in the hospital sector and with whatever agents intervening in the care, follow-up and recovery of these women.

The support of mediation professionals or community agents may be of great help when dealing with immigrant women.

Table 8a. Assessment

BIOPSYCHOSOCIAL

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

OF THE VIOLENT SITUATION

- Type of violence, since when she has been suffering it, frequency and intensity
- Abuser's behaviour at family and social levels; whether there have been assaults to other people or family
- Mechanism for coping developed by the woman
- Stage of the process of motivation for change she is through (See Table 9, pg. 54).

OF HER SAFETY AND RISK APPRAISAL

- Determine whether the woman is in extreme danger, understanding by extreme danger the actual situation where she might suffer an imminent event, which would endanger her life or the lives of her children. Extreme danger indicators. This assessment will be conducted together with the woman herself:
  - Threats with, or use of weapons
  - Threats or homicide attempts against her or her children
  - Threats or suicide attempts of the patient
  - Abuse towards children or other members of the family
  - Serious lesions, even requiring hospital admission
  - Threats or harassment despite being separated
  - Increase of the intensity and frequency of the violence
  - Assault during pregnancy
  - Repeated sexual abuse
  - Violent behaviour outside the home
  - Paranoid disorders, extreme jealousy, obsessive control of her activities, where she goes, who is she with or how much money she has
  - Worsening isolation
  - Partner's use of alcohol or drugs
  - Decrease or absence of the remorse ever expressed by the abuser
- Consider the woman's perception of danger for her or for other members of the family. If in presence of this indicator, the situation is automatically defined as of extreme danger
- Professional opinion after joint assessment based on the interview and the performed biopsychosocial assessment)
- If a situation of danger is detected, ask
  - Do you feel safe at home? Can you go home now?
  - Are your children safe? Where is the abuser right now?
  - Do your friends or relatives know? Would they help you?

Table 8b. Questions to assess the situation and type of violence
Physical violence
• Does your partner thrust or grab you? • Does your partner hit you, slap you or any other aggression?
Sexual violence
• Does he force you to have sexual intercourse against your will? • Does he force you to have sex in ways you do not want? • Does he refuse to use prophylactic or does not allow you, or controls the contraceptive you wish to use?
Psychological violence
• Does he often yell at you or speaks to you in an authoritarian manner? • Does he threaten with harming you or your children or other people or pets? • Does he abuse you verbally, despises you in private or in front of other people? • Does he get jealous without motive? • Does he prevent you from seeing your family or friends or makes things difficult for you when you try? • Does he blame you for everything that happens? • Does he control the money and forces you to account for the expenses? • Does he prevent you from working outside the home or study? • Does he threaten you with taking away your children if you leave him[3]? • Does he ignore your feelings, your presence, etc.?
Enviromental violence
• Does he mistreat the pets? • Does he bang the walls, the doors? • Does he destroy objects you love?
On the intensity, frequency and cycle of the violence:
• Since when have you been suffering this situation? • How frequent violent episodes are? • Are there moments when he is affectionate and treats you kindly? • After an attack, does he ask you to forgive him, gives you a present and behaves as if nothing happened? • Has the intensity, the frequency or the seriousness of his violence been growing worse with time?
In case she has children:
• Do they often witness violence? • Does he direct the physical, emotional or sexual violence against them? • How do you think this violence is affecting them?

3. Intervention

The confirmation of suspicion of gerder-based violence towards a woman, far from ending the intervention of healthcare personnel must start an important effort of information to the woman, of care and work at the surgery as well as of referral when the case profile requires it.

The response a woman gives to gerder violence comes determined by its degree and features, by the harm caused and the impact it has on her

(3) In the case of women with HIV this question may be rephrased according to the specific context: for instance, ¿Does he threaten you with tellling people you are infected with HIV if you leave him?»

health, by the psychological resources she relies on and the support she can receive. Children or other dependants condition also this response. The attempt to leave the situation behind is more frequent when women have economical autonomy, family and social support and more equalitarian relations outside the domestic sphere. Women that stay in a violent relation do not because they accept or want to; they do because of motives of various sorts, psychological, cultural, social support-related or economic, that make breaking up more difficult.

The process of change in women and the healthcare intervention

It certainly is decisive to know the internal process women go through since the very moment in which they get aware of their situation and envisage initiating a process of change; equally important are the actual guidelines for action the care team adopts in each one of these stages of change. Something to highlight is that this process is not linear and both progress and setbacks can be expected.

It is also critical to understand that many women may have made their minds up, even made decisions before reaching the doctor's office, for which we must devote close attention to the moment of change in which every woman sees herself, in order not to make mistakes when intervening.

We now detail the change process providing suggestions for actual health care action taking:

Table 9. The process of change in women and the professional action

STAGES IN THE PROCESS OF CHANGE	PROFESSIONAL ACTION
No awareness of the situation of violence or denial of it	Relate her symptoms to the situation of violence. Offer criteria for enabling her to discern maltreatment from good treatment
The dawning of her awareness begins but she does not feel the situation may change or that she may act to make changes	Ease the way for her to express emotions, fears, expectations and difficulties Identify supports and strengths Analyse with her the violence cycle
She starts thinking that she cannot go on living that way but does not know how to change. She weighs up the pros and cons for a change she does not envisage to make yet	Support every initiative of change and devise with her the most advisable plan to achieve it. Analyse its difficulties Motivate her to seek other professional cornerstones and resources such as group work
She initiates changes in her life and plans for the breaking up but still amid contradictory feelings as self-confidence, guilt, fear to face the unknown	Value her progress, re-enforce her decisions, accompanying her with frequent appointments and other socio healthcare resources
The way out of violence is not linear; as any process of change it may entail moments of giving up and setbacks until one gets to consolidate and maintain one's determination	Help her understand that goings back and insecurity are part of the process Analyse with her the motives and situations that led her to take a step backwards
Once the process of change is consolidated, she envisages new life projects	Promote her participation in activities and social networks, in her establishing healthy bonds, in increasing her self-esteem and self-confidence

Group work with women as a tool for change

Gerder violence deteriorates socio-affective bonds and causes isolation, feelings of insecurity, inability and loss of self-esteem. Women thus, need to create new bonds and support networks, join social activities, learn new ways of self-care, develop personal skills, become aware of the fact that what they are undergoing is not an individual problem but a social one and thus conceive new life projects.

Work group as methodological tool, when incorporating the gender perspective, has proven to be one of the most effective and satisfactory ways to restore the physical, mental and social health of women undergoing violence. These groups of women, coordinated by specialised professionals are a space for reflection, relation, support and company in processes of change in a safe and protected environment, which in turn allow and make easier to:

- Put into words and elaborate on the lived experience
- Express feeling, wishes, difficulties and concerns
- Understand the connexion between discomfort, loss of health and gender abuse and life conditions
- Find one's own time for self-care, self-training and personal development
- Establish relationships and support networks.
- Develop skills to prevent and confront the different ways of violence
- Learn relations of kind treatment applying this kind treatment to oneself
- Develop self-confidence and personal and collective self-esteem
- Reflect on and question the traditional mandates of gender, discovering new ways of understanding life and relations
- Devise a life project of life on one's own

Health care action plans according to levels of risk for the woman

Healthcare personnel actions will adjust to whether or not the woman admits abuse, to the risk involved and the level of danger she is facing as well as to the stage of the process of change she has reached.

Thus, we present below the 3 possible situations for which different action guidelines will apply:

1. Care plan for the woman presenting suspicious indicators but who does not admit suffering abuse.
2. Care plan for the woman who admits suffering abuse but is not in a situation of extreme danger.
3. Care plan for the woman that admits suffering abuse and is in extreme danger.

3.1. Plan of care for women presenting suspicious indicators without admitting being abused

- ✓ **Record on the medical history existing suspicion and actions taken including vulnerability and risk assessments**
- ✓ **Inform the woman about the outcome of the professional's assessment on her situation**
- ✓ **Work at the doctor's office – follow-up:**
  - Establish a relation of confidence
  - Work with the woman on her becoming aware of the abusive relationship and its impact on health
  - Comprehensive/interdisciplinary care of physical/psychical/social problems found
  - Plan follow-up visits: accompany the woman in the identifying of the situation of violence and in the decision-making in an empathic manner
  - Propose, if the possibility exists and it is deemed adequate, her participation in group interventions (groups of women at the centre or at other area resource-premises).
  - If there exists a consistent suspicion of gender violence and the situation is assessed as of risk for the woman it may be communicated to the Public Prosecutor for investigation (See page 80)

3.2. Plan of care for women admitting being abused but not in extreme danger

- ✓ **Record on the medical history existing suspicion and actions taken including vulnerability and risk assessments**
- ✓ **Inform the woman about the outcome of the professional's assessment on her situation**
- ✓ **Work at the surgery – follow-up:**
  - Work with the woman on her becoming aware of the impact on health the abuse she suffers is having
  - Comprehensive/interdisciplinary care of Physical/Psychical/Social health concerns found.
  - Devise a safety strategy to be used in the event of a potential extreme situation
  - Establish a doctor's office folllow-up plan aiming to:
    - Raise and favour the decision-making needed to initiate changes in the situation
    - Accompany the woman in her addressing the situation
    - Prevent fresh situations of abuse
    - Offer her, if possible, participation in group interventions (groups of women in the centre or in other area resource premises)
- ✓ **Refer (if deemed necessary and with the woman's previous consent)**
  - To the social work personnel of the healthcare centre
  - To the resources fitting for the situation in which the woman is
- ✓ **Issue grievous bodily harm report when applicable**
- ✓ **In cases where the woman refuses to report and the healthcare personnel harbours strong suspicions of the occurrence of physical or psychical abuse**(there is no clear verification as to the origin of the injuries enabling to issue the relevant grievous bodily harm report) **it is strongly recommended to alert the Public Prosecutor's Office to the situation as required by the law.** The latter will decide in accordance with the evidence presented or likely to be furthered what the relevant procedure should be (See page 80).
- ✓ **Action towards children or other dependants if any**

3.3. Plan of care for women admitting being abused and in extreme danger

- ✓ **Record the episode on the medical history** and the actions taken in accordance with the situation of physical or psychical risk, suicide, etc. (Table 8a and 8b, pgs. 51-52). This record may be presented as evidence in a criminal lawsuit
- ✓ **Get to know her family situation**, dependants and economic means
- ✓ **Inform the woman** of the expert's assessment outcome about the situation of danger she is facing and present her with the possible strategies to develop. Let her know she is not alone
- ✓ **Issue the Grievous Bodily Harm Report (GBHR) and the Medical Report and forward them to the judge straightaway** (FAX, Email) giving the woman a copy and informing her of the implications
- ✓ **Refer urgently to social work or to 24-hours support services of social emergencies** for abused women, Tel. 112 (Emergency Care), to specific services of their Autonomous Community or if applicable, take action in accordance with the protocol for inter-institutional coordination of the Autonomous Community

3.4. Recommendations for healthcare action

Whenever healthcare action is required in a gender violence event, it is always imperative to remember to:

- Record in the medical history the suspicion and the actions taken accordingly. It might be used as substantial evidence in a criminal law suit.
- Inform the woman of the healthcare action plan and the possible repercussions of the measures which are about to be taken
- Inform her about her rights and the resources she may rely on
- Never verify the woman's testimony by talking to her abuser
- Whenever a GBHR needs to be issued, it is of the utmost importance to, previously, evaluate the woman' s safety and take the necessary protection measures to minimise whatever risk involved
- Read always to the woman the GBHR issued,
- Investigate the possibility of abuse towards other members of the family or close circle
- If there are children on her charge, get in contact with paediatrics to assess the extent of the abuse.
- Never forget the specific difficulties of women in situations of special vulnerability.
- Never recommend couple therapy of family mediation.
- Keep close coordination and collaboration with other institutions and non-healthcare services.
- Professionals need to assimilate the processes they participate in, for the training to be experiential, becoming aware of their own

attitudes, stereotypes, personal processes, ways to relate, conflicts and the impact of patriarchal mandates on their lives.

- Encourage women to participate in therapeutic groups and/or of personal development, both in healthcare centres as in specialised services.

4. Detection and Assessment of Children

Paediatrics professionals play a significant role in the detection, care and prevention of gender abuse in situations affecting children.

When a woman is living an abusive relation, and whenever she has children of paediatric care age, coordination between family medicine and paediatrics is an absolute priority for assessing the impact of violence on the children exposed to it.

Likewise, when giving healthcare to children, the suspicion that the health problems they present may be a consequence of their exposure to a violent environment at home, will make easier both detection and intervention with their mothers who are in a situation of abuse

The intervention of the health centre social workers may be of great help for conducting a psychosocial assessment; other professionals' help may be requested if necessary: Infant-juvenile mental health teams, social services teams for the psychological care to minors and psycho-pedagogical care teams of the educational system.

Table 10. Suspicious indicators in children's of women in a gender-based violence relationships

✓	Bodily harm or lesions
✓	Retarded growth, retard or difficulties in any area of development: Psychomotor functions, language, poor school performance
✓	Recurring psychosomatic disorders
✓	Sleeping and eating disorders
✓	Sphincters control disorders
✓	Frequent accidents
✓	Behavioural disorders
✓	Difficult relations (violent rapports with their peers, inhibition and isolation conducts)
✓	Depression, anxiety
✓	Suicide attempts, self-inflicted lesions.

With the purpose of identifying children exposure to a situation of abuse it is indispensable to ensure them a space where they can feel they can communicate and be listened to. We must create an environment as warm and welcoming as possible and a language and questions they can understand and thus adapted to their age and stage of development.

The aim of these exploratory interviews with the children is to ensure they feel they can share their emotions, their needs and their fears and that they can express the violence they have suffered or are suffering. We must also assess the type, severity and frequency of the exposure to violence as well as the impact on their health, the risk, the degree of protection on the part of the immediate environment, the strength and quality of the bond with the mother and the level of resilience of the children themselves.

Addressing Emergencies

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

1. Actions for Detecting Violence

- Keep on full alert and pay attention to those signs and symptoms that may lead to think that the patient is being victim of gender-based violence. (Table 6b, pg. 45)
- In suspected cases, conduct a specific medical interview in other to detect maltreatment. (Tables 7a and 7b, pgs. 47/48)
- Meet the woman in a suitable climate of confidence

2. Actions for Providing Health Care

Firstly, address the woman's state of health both in physical and psychological terms, establishing the diagnosis and the correct treatment approach.

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

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

The discharge report the woman will be given, will have to state clearly the injuries she presents and her psychological state. It must be handed to the woman as long as it does not put her safety in jeopardy (the alleged abuser may be with her at the doctor's office or he might discover the discharge copy's existence when she gets home). If that is the case, inform her that if she is afraid of taking the copy with her it may be handed to some relative or person she trusts. Another copy will be for primary care, in order

to enable follow-up and conduct whatever actions deemed necessary, always safeguarding their confidentiality. In case of her admission into the hospital, ensure the relevant report is forwarded to primary care.

3. Safety Assessment

Whenever dealing with a gender violence case at an emergency service, an appraisal of the woman's safety and risk will have to be made (Tables 8a and 8b).

4. Information and Referral

Once due health and attendance care have been provided, proceed to take the appropriate informative actions and referral when applicable, in accordance with each Autonomous Community health care and inter-institutional protocols. The emergency room will inform primary care of the situation detected by forwarding them a copy of the medical report in order for them to do the relevant follow-up.

5. Legal Action

In Spain, it is mandatory that legal authorities be apprised of the existence of wounding when gender-based violence occurrence has been verified. To comply with this legal imperative notify the court through a Grievous Bodily Harm Report (GBHR) and accompanying Medical Report, previously informing the affected woman about this dispatch and recording the latter on the medical history, always assessing the woman's safety to ensure her protection.

Addressing Sexual Assault

The action guidelines to follow when addressing cases of sexual assault present particularities that justify dealing with them in a separate section. Definitions for these cases appear on pages 13 y 14.

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

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

When the woman is given care far from a hospital (rural centre) she may demand to wash and rinse her mouth. In that case and before any rinsing is done an oral sample must be taken with a sterile and dry swab (2 samples); after, the mouthwash with physiological saline will be collected in a sterile tube for analysis. This procedure must be conducted in front of a witness and so must the sealing and labelling of the tube, ensuring the professional's custody of the samples until handed to the forensic.

It is imperative to provide the woman with understanding care, creating an atmosphere that enables communication, confidentiality and as much privacy as possible. Collect the information with the greatest tact, sensitivity and care of your language never forcing the woman to answer if she is reluctant to. If the victim so wishes someone she trusts may be present.

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

It only stands to reason that after an assault the number of psychical impacts the woman should go through would have to be limited to the very least possible. That is why not only is it justified but it is certainly advised to conduct both gynaecological and medical-forensic assessments at once, though keeping healthcare and legal tests independent but ensuring to limit examinations to the strictly necessary. For all of the above, and not existing legal or ethical impediment –quite the opposite- for examinations in case of sexual assault to be performed in a simultaneous and coordinated manner,

the immediate telephone communication with the police court is imperative. They will arrange for the forensic doctor attendance, or will entrust the doctor on call with the taking of samples and specimens of legal interest [*].

Below there is a list of the different general actions to be undertaken by each one of the experts in this type of cases:

Actions to be undertaken by medical doctors:

- Anamnesis and medical examining
- Requesting the intervention of forensic doctors through the Police Court and cooperate with their work
- Conducting general evaluation of physical and psychical state of the patient
- Physical exploration
- Taking samples from genitalia for detection of sexually transmitted infections. Taking samples from anal or oral cavities may be necessary depending on the actual type of assault suffered
- Requesting complete blood tests
- Immediate treatment of possible physical injuries
- Providing psychological assistance
- Ensuring prevention of sexually transmitted diseases including post-exposure to HIV prophylaxis
- Pregnancy prophylaxis
- Issuing of grievous bodily harm report
- Informing the woman of existing resources

Action to be undertaken by forensic doctors:

- Samples taking for legal purposes
- Signalling the location and importance of injuries (take photographs)
- Issuing of medical forensic report for the Police Court

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

[*] In order to proceed legally against sexual assault criminal offences, a complaint filed by the offended person, their legal representative, or criminal charges filed by the State Prosecutor's office (when the victim is a minor, disabled or destitute person a complaint filed by the Public Prosecutor's Office will suffice) are indispensable requirements. Even when the woman might, at that moment, refuse to lodge charges, the facts will have to be communicated to the Police Court, in order for them to file the relevant legal suit in case, in the future, the rest of the legitimately involved or the woman herself might want to exercise her right to initiate a criminal complaint, in which case all that filed information would be of legal use.

Table 11. Healthcare actions to be taken in case of sexual assault

RECORDING IN MEDICAL HISTORY

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

GENERAL EXPLORATION

✓ Examination of the body surface:

- The woman will strip naked on a white sheet, so that the clothes and debris on them (soil, hairs, etc.) may be collected
- Systematic exploration must begin from top down, in the position she will find easiest and most comfortable: standing up at first or lying on the couch
- Describe the type of lesions: aspect, shape, colour... Detail location and importance of lesions (injuries, bruising, erosions, lacerations), registering their absence when appropriate. In case they do exist, it is advisable to take photographs with the woman's previous consent.

GYNAECOLOGICAL EXPLORATION

✓ **Gynaecologic Exploration:**

- Vulvar and vaginal inspection will be conducted on the gynaecologic couch: injuries, bruising, contusions, must be detailed recording also the non-existence of wounding if that were the case. In cases of sexual assault on women with no previous coital relations, a detail of interest that must be recorded when applicable is the existence and location of hymen tearing, which would be evidence of penetration
- Do not use exploratory material that may be aggressive or harmful without having first checked the general state of the victim as there may be tearing or breakage in the vagina, rectum or rectovaginal septum. Special care will be taken with micro-traumatism that may occur during exploratory manoeuvres
- Bimanual echographic digital exploration: It is NOT advisable systematically except in painful uterine mobilisation with speculum in the vaginal examination or impossibility of vaginal examination

✓ **Sample taking**[4]:

- Sample taking is of critical importance for the clarification of the facts and must be made as soon as possible. The victim should come to the health centre without washing or changing clothes after the assault.
- Samples must be thoroughly wrapped and labelled, detailing patient's name, date and signature of the professional. Samples collected will be put in an envelope with the woman's name and addressed to the Forensic Medicine Department of the Police Court

When the forensic doctor does not take the samples, secure the **custody channel** in order for the samples obtained to have legal value. That is to say that both the person responsible for the taking and the one in charge of transporting the sample to the forensic medical service of the Police Court, will state their identity documentarily as well as an accurate listing of the samples obtained and transported. The identity of the person receiving the samples at the forensic medical quarters will be also placed on record.

Table 11. (Continued)

- **Samples of legal interest [VII]:**
  - SEMEN:
    - Vaginal, anal or mouth smears using dry sterile cotton swabs for investigation of sperm and DNA study that may enable to identifying the aggressor. They will be saved in their sheaths with no preservatives, labelled and kept refrigerated (4-8ºC). It is advisable to use two swabs per sample
    - Vaginal, anal or mouthwash with 10cc. of sterile physiological saline solution for collecting possible traces of semen. The spat fluid will be collected in an appropriate sterile sealable tube that will be labelled and kept refrigerated (4-8ºC). The vaginal washing will be done after taking the sample for screening of sexually transmitted infections
    - Clothes of the victim related to the alleged aggression, placing each garment in separate, labelled bags
    - Swabs dampened in saline solution, in cases of anal or oral aggression, taken from both cavities, afterwards placing the swabs in a tube to be sealed and labelled.
  - NAILS:
    - Nail clipping fragments (aggressor skin likely to be found); this may be done during the general exploration, sheathing each fragment separately labelling each sheath with finger and hand they belong to
  - PUBIC HAIR:
    - Combing of the assaulted woman's pubic hair (possible pubic hair from the aggressor). It can be done with a gynaecologic brush before starting the gynaecological exploration.
  - BLOOD (through draw for testing):
    - Determine the patient's blood group and Rh factor to compare results and so determine if the organic traces found (blood or other genetic material) belong to the victim or to the alleged assaulter
    - Study of sexually transmitted infections: HIV, Hepatitis B and C, Syphilis
    - Toxicity test
  - URINE:
    - Pregnancy test
  - EXUDATE:
    - Culture medium for detection of gonorrhoea, chlamydia, monillas and trichomonas
    - Cytological smear: Does nothing for the diagnosis of vaginal infections once the adequate cultures have been made

Samples will be labelled with the patient's name, date and signature of the professional. All samples collected will be put in an envelope with the woman's name and addressed to the Forensic Medicine Department of the Police Court.
When the Forensic Doctor does not take the samples, secure the **custody channel** in order for the samples obtained to have legal value. That is to say that both the person responsible for the taking and the one in charge of transporting the sample to the forensic medical service of the Police Court, will state their identity documentarily as well as an accurate listing of the samples obtained and transported. The identity of the person receiving the samples in the medico-forensic quarters will also be placed on record.

CARE AND FOLLOW-UP

- **Treatment of physical injury and psychological after-effects:**
  - Physical traumatism: treat the wounds and dress them to prevent infection and if advisable effect tetanus prophylaxis.
  - Psychological trauma: Women having suffered sexual assault develop anxiety, feelings of guilt, humiliation and shame, that require help. It is critical to refer the woman urgently to psychiatric or psychological care or to the teams of psychological care to victims of sexual assault

Table 11. (Continued)

- **Sexually transmitted infection prevention:**
  - Preventive care must be given to prevent gonococcemia, chlamydia or possible incubating syphilis.
  - Need for post-exposure prophylaxis against HIV: The risk of transmission of HIV may be high if the aggressor is HIV+ or suffers from other sexually transmitted infections. The risk is even higher it there was multiple rape and ejaculation. Consider prophylaxis by following the *Recommendations of the SPNS/GESIDA/AEP/CEEISCAT/SEMP on post-exposure prophylaxis against HIV, HBV and HCV in adults and children.*
  - The need for prophylaxis against hepatitis B Virus will be individually assessed.
- **Prophylaxis of pregnancy:**
  - In case the woman is using contraceptives, prophylaxis will not be necessary.
  - Postcoital hormonal contraception if no more than 72 hours have elapsed since the assault
  - If between 72h and less than 5 days have elapsed since the assault the above procedure is not considered effective and a coil will have to be placed
  - Confirm next period or carry out pregnancy test in 2 to 3 weeks.
  - Inform the woman that in case of being pregnant she can resort to voluntary termination of pregnancy.

INFORMATION AND REFERRAL

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

RECOMMENDATIONS

→ Not to maintain sexual intercourse until next evaluation
→ Adequate follow-up to the whole process of comprehensive health care given her

NOTIFICATION TO THE COURT

→ Issue grievous bodily harm and medical reports for the Police Court *
(*)Results from all medical tests performed and recommended in this protocol must be compiled in the Medical Report

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

VIII It is advisable to follow the protocol for collecting samples provided for in the Order jus/1291/2010, of May 13, by which the regulatons for the preparation and forwarding of samples was approved.

Healthcare Action for Dealing with Women Abusers

The Ministry of Interior, through the General Secretariat of Correctional Institutions, has complete authority and direct responsibility for intervening and dealing with men convicted on gender violence charges (exception made of the Autonomous Community of Catalonia), this not precluding the programmes developed by the Autonomous Communities in their territories.

Healthcare responsibilities from primary care are :

- Those relating to the abuser's own needs for health care as an user arising from their state of health
- In those cases where they themselves -as patients- asked for help to modify their violent conduct, they should be given information on resources available in their autonomous community. The health system's social work personnel will provide them with the latest and most detailed information there is.

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

Ethical and Legal Aspects

When dealing with a situation of male abuse towards a woman, we are facing a **public health issue with legal repercussions** for both her and her children and for the health personnel involved. Often, professionals see themselves caught in an ethical dilemma when having to make decisions.

There are women who come to the health care services and despite presenting serious wounding refuse to admit to their situation of abuse for fear of it being reported to the courts and that measures taken might affect their safety and their families'.

1. Legal Aspects

1.1. Healthcare personnel duties

In **Organic Act 1/2004 of Measures for the Comprehensive Protection of Women against Gender Violence**, physical, psychological and sexual violence inflicted on women «*by those who are or used to be their spouses or by those who may have been linked to them through similar affective relations even without cohabitation*» **is deemed to be a criminal offence** in the terms envisaged in the criminal Code.

In Spain, the health care personnel have the legal obligation to report to the judicial authorities the possible existence of a criminal act.

Article 262 of the **Criminal Procedure Law** establishes that:

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

Article 355 of this same Act mentions explicitly the obligation of medical professionals:

«If the criminal act motivating the initiation of criminal proceedings were wounding and lesions, physicians attending to the victim would be under legal obligation of informing about their state of health»

In addition, the **Royal Decree 1030/2006**, which establishes the National Health System **Common Services Portfolio**, in its Annex II, Section 6.6.3 and in its Annex IV, Section 2.8, deems, the communication to

the competent authorities of those situations that may require it, particularly cases of gender-based violence[6], to be a function of the personnel of primary, specialised and emergency care.

Suspected **abuse inflicted by the intimate partner or ex partner** shall be communicated to the Police Court through the Grievous Bodily Harm Report or Medical Report. **The reporting of the facts to the judicial authorities enables setting in motion all measures** aimed at protecting women and prevent the offence from going unpunished.

The State Organic Act articulates a set of measures to provide a comprehensive response to violence inflicted on women by their intimate partner or ex partner, covering aspects of awareness and intervention in the educational, health care, social, welfare and attendance-related spheres as well as procedural, penal and civil regulations.

In turn, most Autonomous Communities have developed their own regulations in matters of gender-based violence (See Annex I).

In our health environment, **other forms and manifestations of abuse toward women may come to the doctor's office**, as female genital mutilation, sexual assault and abuse, sexual harassment in the work place, which even though considered an offence in our legal system, are **regulated in the Penal Code and in the Law of Criminal Procedure.**

In the case of other situations of violence against the woman not perpetrated by her partner or ex-partner, the Grievous Bodily Harm Report will be also issued though not under the Section «gender violence» and will be equally forwarded to the Police Court.

1.2. Rights of abused women that the law acknowledges

Organic Law 1/2004, in its Article II, recognises the following **rights to all women victims of gender violence** inflicted on them by their spouses or ex-spouses or those who are or have been linked to them by similar affective relationships, even without cohabitation, regardless of their origin, religion or

(6) ***Primary Care Common Services Portfolio***
Section 6.6.3. Communication to the competent authorities and, if applicable to social services of those situations that require it, especially suspected gender violence or the battering of children, elderly or disabled persons»
Common Services Portfolio of Emergency Care Provision
Section 2.8., Communication to the competent authorities of situations that require it, especially suspected gender violence or the battering of children, elderly or disabled persons.

whatever other condition or personal or social circumstance. This recognition extends, when applicable, **to their children or dependants on their charge:**

- Right to specialty care adapted to their needs; to social services relating to care, emergency response, support, shelter and integral recovery. The multidisciplinary care will entail: information on their rights and available resources, psychological care, social support and follow-up to claims relating to their rights.
- Right to protection and security, to apply for a protection order, for immediate and specialised legal defence, free of charge when applicable.
- Work rights and Social Security benefits, social and economic rights, training support and job placement.
- Right, as priority group, to access protected housing and public residences for the elderly

From the health care system we must ensure that women will rely on information concerning their rights in an accessible and understandable format, translated into sign language when needed or, in the case of women from different countries, into their own language of origin.

Regarding the assistance to the children of women in situation of gender violence, health care interventions will comply with **Organic Act for the Legal Protection of Minors** (Organic Act 1/1996, of January 15, for the partial modification of the Civil Code and of the Act of Civil Procedure).

In addition, it is important to know that **Organic Act 10/2011**, of July 27, modifies articles 31 bis and 59 bis of Organic Act 4/2000 on **Rights and Freedoms of Foreign Citizens in Spain and their Social Integration.** It grants foreign women in irregular administrative situation having reported maltreatment and obtained a protection order or relevant report for the Public Prosecutor's Office (PPO) admitting evidence of male violence, automatic and no longer facultative authorisation for temporary residence and work. The Act extends this right of protection to their children until judicial resolution relating to the complaint lodged is issued. This Organic Act also extends the protection rights of women victims of trafficking, to their children and to other persons linked to them by family or whatever other bonds.

2. Ethical Principles that Should Guide Professional Action

When taking care of women in situations of gerder violence as in any other health care intervention, professionals must always keep in mind the ethical

principles of action and the rights that women as patients have and **Act 41/2002 of Autonomy of the Patient** recognises, as do all codes of professional Ethics. The specific profile of situations of abuse and the special vulnerability of women who live this kind of relations as well as their children's, require to give these aspects special attention.

2.1. Safeguard life and the benefit of health (principle of benefaction)

The ultimate purpose of health care interventions with women that live in situations of gerder violence is to restore them to health and promote conditions for their complete recovery and their developing a violence-free living.

Gerder-based violence puts women's health and life at risk and if that is the case, their children's and other persons' in their circle. That is why health care personal must be consciously aware that one of their tasks is coordination with other areas for their protection. The notification of the abuse to the legal authorities through the Grievous Bodily Harm and Medical Reports allows the setting in motion of all legal measures targeting the protection of the abused woman and in addition, avoids the offence going unpunished. On the contrary if no bodily harm reports are issued in the necessary cases as required in the action processes contemplated in this Protocol we will be failing to comply with the principle of benefaction.

2.2. Avoid harm when intervening, minimising damage (principle of non-malefaction)

Whenever deciding to issue a bodily harm report it is imperative to inform the affected woman previously, assessing her safety jointly and taking measures for protecting her while minimising risks**.**

In the event she expresses her opposition to issue harm report and we do not inquire into the reasons for her refusal or do not explore what her fears or her needs are, then we would be neglecting the principle of non-malefaction.

Whenever the issuance of the harm report entails high risk for the woman's life, her children's or other dependants, a plan should be developed on a priority basis that allows her to overcome the situation relying on appropriate security measures to safeguard their integrity.

It is equally imperative to extreme care with the actual wording of questions avoiding those that may make her feel guilty contributing to her secondary victimisation.

If the severity of the wounding so requires, the presence in the health centre of professionals from the Units of Forensic Integral Assessment may be requested in writing or by telephone, to the Police Court for the necessary explorations and tests to be performed in one single session. This very especially applies in cases of sexual assault for trying not to subject women to a double victimisation.

When the health care intervention involves children of abused women, public health system workers may be asked to act as witnesses or experts concerning the detection, consequences on health, or healthcare circumstances of the actual case. To this respect, be aware that experts' appraisals on the so-called Parental Alienation Syndrome (PAS) would not qualify since the scientific community does not accept it as a clinical entity[7].

2.3. Non-disclosure commitment regarding information known by virtue of professional exercise

While making a health care intervention it is important to bear in mind the Act that regulates rights and obligations in terms of information and clinical documentation, Act 41/2002 for the Autonomy of the Patient and the Data Protection Act (Organic Act 15/1999, of December 13, for the protection of Personal Data).

All codes of ethics reflect professional secrecy as a right of patients and a professional duty for which this commitment extends to the whole healthcare team that participates in or intervenes in care: professionals from the fields of medicine, nursing, social work, psychology, management or orderlies.

A non-disclosure commitment involves:

- **Confidential recording of information.** It is decisive for the health care personnel to be well aware of the purpose of the information they record and to assess carefully the actual content and the way in which it will be reflected in the medical history. It is equally

(7) Further information detailed in the *III Informe Anual del Observatorio Estatal de Violencia sobre la Mujer, 2010.*

important to take into account who will have professional access to it (for instance, ensure that abuse does not appear as medical background in the event an inter-consultation report were issued on paper).

- **Preserve privacy of personal data,** which might enable identification and locating of women endangering their safety. Administrative staff must also be intensely aware of the need to ensure the confidentiality of identifying data. It must be born in mind that in general and as far as family medicine and nursing are concerned, practitioners are the same for all members of one family unit this including children over 14 years of age.
- Ensure an atmosphere of intimacy during the interviews avoiding the presence of family members or other people in her environment and while giving her tests or making other health interventions
- Do not share information about the woman with members of the team in spaces that are not strictly professional
- When issuing an injury report never attach the medical history and just write on the medical report the information strictly necessary and relating to the history of abuse, bearing in mind that if a legal procedure is initiated, the defendant will have access to all the information submitted.

2.4. Respect women's autonomy

Throughout the entire process of accompanying and health intervention, the woman's autonomy must be respected and promoted. In order for women to be able to make informed decisions and play the leading role in their own process of recovery they must be informed on the different alternatives and possible courses of action, on the probable consequences of taking or not taking action, of expected benefits and risks, all of it as a measure for ensuring their safety.

On the other hand we must not lose sight of the status of subjects of law women are recognised in Organic Act 1/2004, of Measures for Comprehensive Protection against Gender Violence, in health legislation and especially in the Act for the Autonomy of the Patient.

It is equally of special importance to remember that their consent is indispensable for taking photographs and have her examined by the forensic team.

3. Ethical Dilemmas

One of the most difficult and conflictive situations health care professionals have to face arises from the collision between the legal obligations and the ethical principles that are meant to govern their proceedings.

This happens especially when **women express their desire to not report,** which faces them with the dilemma as to whether to comply with what they feel as their duty and the law requires you to abide by or to take a stand on the respect for women's autonomy and their decisions, as well as their right to confidentiality.

Issuing a bodily harm report without the woman's consent faces professionals with an ethically tough choice as they consider to be violating professional secrecy and jeopardising the patient's trust in them.

The Law establishes and specifies the cases in which safeguarding **confidentiality is not an absolute obligation** and medical secrecy must be disclosed as when suspecting an offence or in the event of being called to testify in a judicial process. There exists general duty of complaint provided for in Paragraph 1 of Article 262 of the Criminal Procedure Act exercisable in accordance with Article 544 of the said Act, (before the Police Court or the Public Prosecutor). *«Notwithstanding the general duty of complaint laid down in article 262 of this Act those health care entities or organisations, public or private, that might have learned the facts accounted for in previous section (offences against the life, physical or moral integrity, sexual freedom, liberty or safety of any of the persons mentioned in article 173.2, of the Penal Code) shall communicate them immediately to the Police Court Magistrate or the Public Prosecutor's Office in order to initiate proceedings for implementing the «Protection Order».*

Professional secrecy cannot be claimed when such possibility is expressly excluded by specific legal development as is in Articles 2 and 8 of OA 1/82 on Civil Protection of the Right to one's Honour, to Personal and Family Privacy and to one's own Image and in the relevant provisions laid down in the Data Protection Act. Likewise, for its being specifically regulated in relevant legal provision (CR.P.A).

Bearing in mind that each case is singular and that an individual analysis and assessment of each woman's particular situation must be conducted, we strongly recommend following the courses of action proposed in previous chapters.

On occasion, health care practitioners may be in doubt as to the veracity of the woman's account, and be reluctant to set in motion the judicial machinery when there are only suspicions. The Public Prosecutor's Office must be apprised of such cases.

It is important to know that the legal system guarantees the non-prosecution of professionals for issuing a grievous bodily harm report and may be called to testify only as witnesses or experts.

Some professionals may fear reprisals from the alleged abuser, accusations of slander in court or physical threats or other (cyber bullying, threats through electronic means). This is more frequent in Primary Care as in most cases the same professional attends to both the abused woman and the abuser, which makes their identification easier.

When necessary, it is possible to activate witness protection mechanisms as, for instance, testifying behind a screen avoiding being seen by the alleged offender (Organic Act 19/1994 for the Protection of Witnesses and Appraisers in Criminal Procedures).[8]

3.1. Support of the Public Prosecutor's Office

As established in the Criminal Procedure Act, the Public Prosecutor's office (PPO) may, prior to the judicial action, institute pre-trial proceedings to gather more data and information on the fact alleged.

Health care services' apprising the PPO may be a useful resource to protect professionals in cases when there is no clear evidence as to the origin of the lesions justifying a bodily harm report issuance, when the woman does not admit to maltreatment or refuses to bring charges, or when the health personnel harbours suspicion of gender abuse but rely on insufficient evidence to issue a grievous bodily harm report.

There is a standard form with basic data to notify the PPO that might contain:

(8) To this purpose it is necessary that, once established the existence of a serious danger for the person, freedom or property of anyone wishing to avail themselves of the provisions of this Law, the Examining Magistrate, of their own accord or at the request of a party, agrees to take, when they deem it necessary and according to the degree of risk or danger, the necessary measures to preserve the identity of witnesses and experts, their address, occupation and place of work.

MODEL FORM FOR NOTIFICATION TO THE PUBLIC PROSECUTOR'S OFFICE

SUBJECT: POSSIBLE CASE OF GENDER VIOLENCE

DATA OF MEDICAL PRACTITIONER
Name:
Health Centre:
Medical Licence Number:

WOMAN'S PERSONAL DATA
Name:
Address:
Contact Phone number:

DESCRIPTION OF THE FACTS CONDUCIVE TO PRESUME THE EXISTENCE OF A CASE OF GERDER-BASED : VIOLENCE

DOCUMENTATION BEING FORWARDED:

All of which I bring to your knowledge under the provisions of article 773.2 of the Criminal Procedure Act in case you deem appropriate to institute proceedings for its verification and effects

The Undersigned; In _____, the ___ of _____, _____

Grievous Bodily Harm and Medical Reports

1. Function and Purpose of the Grievous Bodily Harm Report (GBHR)

The GBHR is a **health care document**, which helps convey to the Judicial Authority whatever the professional knowledge has allowed to become known. Its purpose is to inform of the possible existence of a crime but **it is not a complaint**. The importance of issuing a GBHR lies sometimes in being the only tool the courts rely on, the evidence of an alleged offence, since there are wounds that disappear with time. It will also serve to endorse the woman's statement and primarily to activate protective measures.

2. Recommendations for Filling in the GBHR

Following the recommendations listed below, the medical personnel in charge of the attendance shall complete the GBH and Medical Reports and mandatorily dispatch them to the Police Court.

Taking the necessary time for its completion is of the utmost importance. In case the GBHR model form has not yet be computerised, it must be filled in with a clear, legible writing with no corrections (that might be interpreted as manipulation). On occasion, the unreadability of reports makes it impossible to know the nature and extent of the lesions, the complementary explorations and other data of interest and hence the seriousness of the assault. It also hinders the subsequent appraisal on the part of the forensic and the judge's evaluation. It is advisable to know well the GBHR, and as in any other health care intervention to get proficient at completing it before any case comes in. Likewise, it is strongly recommended to refrain from filling in this critical information unthinkingly or absentmindedly.

We must be very careful with the language we use in the GBHR. Do not use the terms victim or aggressor but patient and alleged aggressor. It is paramount to detail the kinship of the alleged abuser with the woman, as the judicial process will not be the same. Identifying cases of gender

violence as such, within the applicability scope of Organic Act 1/2004 makes easier for the Deanery to know that the criminal case has to be tried by a court with competence in gender violence matters. Otherwise, the case might be forwarded to a Court with no competence in these matters that would have to disqualify themselves from the case once they saw it was a violence gender case, delaying the procedure to the detriment of the woman

Reflecting the medical background data that might relate to male violence is significant as it may provide a chronological view of the violence history and the possible existence of continued maltreatment; these data must be checked against the medical history. **The medical history must not be attached to the GBHR** at the time of its first being forwarded to the Police Court. All documentation that reaches the Court including medical information, will be incorporated to the judicial file and hence become known by the defendant, the Public Prosecutor's Office and the civil service staff. It may be thus advisable to ponder over the convenience of reserving particularly sensitive medical information for the moment in which the Court request further medical history-related information they might deem relevant for the preliminary investigation into the case.

In case the court claim the medical history, there is an obligation to forward it. However, from an ethical point of view, the professional may bring to the attention of the Court that such information goes beyond what strictly needs to be known and ask them which part or aspects of the medical history they are interested in. If the medical personnel forwarded more information than needed they might have judicial responsibility in case they were sued for violating the Data Protection Act.

The GBHR and Medical Reports model forms will be readily available in all health centres. Once completed, copy will be:

- Handed to the interested party, whenever it does not jeopardise their safety (the alleged assaulter may have escorted the woman or maybe upon arriving home the assaulter might discover the copy). In such cases, let her know that if she is afraid of taking the copy with her it may be given to a relative or person of her trust instead.
- Mailed to the Police Court. In cases that urgent attention is needed it will be faxed or e-mailed in digital format (some Autonomous Communities have already computerised its sending or are at it). Likewise, in some municipalities that rely on protocols for inter-institutional coordination it is the local police who takes on the responsibility of forwarding the GBHR, as well as of accompanying the affected woman in case they bring charges.
- Filed in the woman's medical file at the health centre where she was treated, for which confidentiality of data is particularly important (pay special attention to inter-consultation forms). The

responsibility for the custody of the medical history in any of its formats falls on the institution in charge (hospital, health centre, primary care administration, etc).

Something important to remember is that legally and if necessary, any professional can draft the communication or injuries report in a sheet of paper, sign it, state their professional license number and that will suffice. However, any normalised document is always a tool that facilitates, simplifies and promotes equity.

Also regarding the GBHR and accompanying medical report, in the pages that follow we offer guidelines on of data that need to be filled in, regardless of the format established in the territory of each Autonomous Community.

MODEL FORM OF GBHR AND MEDICAL REPORT[9]

DATA OF ALLEGED AGGRESSOR:

- ✓ Kinship /bond with the abused woman (intimate partner, ex -partner - father – son – brother - unknown):
- ✓ Name and Surname:
- ✓ Address and/or telephone:

WOMAN'S PARTICULARS:

- ✓ Name and Address:
- ✓ Nationals' Identity Card Number/Foreigners' Identification Number/PASSPORT:
- ✓ Date of Birth, Age:
- ✓ Country of origin (specify also Nationality if different from Country of Origin):
- ✓ Marital Status:
- ✓ Address, Municipality (Postal Code):
- ✓ Telephone:

OTHER DATA RELATED TO THE WOMAN

- ✓ Whether she has any disability, type and degree:
- ✓ Whether she has children, how many and their ages:
- ✓ Whether she has dependants:

DATA OF ATTENDING MEDICAL PRACTITIONER:

- ✓ Health Care Centre:
- ✓ Data of undersigned practitioner : Name, Surname and PNC (Personal Numeric Code)

(9) Even when GBH and Medical Reports may have different formats and hardware they have to, a least, contain this information.

DESCRIPTION AND TYPE OF LESIONS ALLEGEDLY CAUSED DURING ASSAULT:

- ✓ Type of violence inflicted:
- ✓ Use of objects during the assault:
- ✓ Psychical and emotional state*: (Describe the woman's emotional symptoms and attitude).* Psychological abuse may cause depression and anxiety symptoms, suicidal tendencies, somatisation, post-traumatic stress syndrome). The emotional state of any person presenting lesions is somehow altered, but their attitude differs. This may be a great indicator to establish what happened, for instance: a battered woman may feel confused, elusive, worried, fearful, aggressive, hyper-alert, apathetic, inexpressive. This information is determining to approach the woman's psychical state.
- ✓ Physical injuries she presents: It is important to describe lesions (skin, muscle-skeletal, eyes, ears, genital organs, internal, etc.) in detail in terms of type, shape, size, colour and location, which will facilitate their dating or moment when they were caused. To this purpose, special attention should be paid to those that go further back in time or are in different evolutional state, as proof of frequency or reiteration. It is advisable to take photographs (*colour preferably*) of injured areas with the woman's previous consent.
- ✓ After clinical assessment, and whenever there exists possibility of internal injuries (abdominal, thoracic and or cerebral) relevant information collected will be recorded under "suspicion", as only after diagnostic tests at hospital level will this suspicion be confirmed or ruled out.

OTHER CLINICAL DATA

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

DATA RELATING TO FACTS MOTIVATING HEALTH CARE:

This section will reflect how the events happened, quoting between inverted commas, and whenever possible, the very words the woman used.
Additional data to be collected:

- ✓ Address, location of the assault, date and time of the event:
- ✓ Date/time of care delivery:
- ✓ Origin of lesions according to the woman: physical, psychical, sexual:
- ✓ Suspicion of cause of lesions differing from the woman's account:

BACKGROUND

- ✓ She comes on her own or escorted by (name and kinship/relation):
- ✓ Punctual assault, first time or repeated battering:
- ✓ If battering has been continuing for some time, state since when and describe the assaults profile: type, frequency, (daily, weekly, monthly…) if intensity has been increasing over time, if any complaint has been previously filed, and evolution of the said assaults.
- ✓ Other persons having been battered in the same incident or on other occasions *(if the woman has children or other dependants and they have been abused too, this has to be notified to the centre Paediatrics and Social Work services. If deemed advisable to the relevant Minors Protection Service)*
- ✓ Witnesses: Acquaintances (neighbours, friends) minors or dependants on her charge:

ACTION PLAN

Include, when applicable, discharge or referral to other specialties or resources, hospital admission if necessary at the time, and required follow-up.

OTHER DATA

Relating to those situations not listed in previous sections and needed to be reported to the Court as, for instance:

- ✓ Whether the assault was notified telephonically to the Court, and if so, specify when.
- ✓ Safety and risk aspects perceived by the woman
- ✓ Woman's attitude towards reporting

COMMENTS

This section will reflect information, unmentioned before but considered relevant. Although offences relating to maltreatment are public crimes that will be prosecuted mandatorily by the PPO, it should be stated here whether the woman ever expressed her intention of not filing a complaint and if so, the cause (fear of the assaulter, of losing the children's custody, of family reactions, economic dependency, etc.). The aim would be providing the Court with information on the actual circumstances the woman is in, which might help with the actual approach to the problem.

If there is evidence of previous lesions pointing at the actual grounds or the founded suspicion that the woman is being abused in a continuing manner, it is important to reflect it on the GBH report, as this is an offence different from just assault.

The existence of other threats from the abuser, if any, will also be described (verbal, announcement that in the future he will use whatever other weapon for aggressing, etc.).

It is advisable to have VARIOUS COPIES AVAILABLE: for the interested party, Judge/ Health Centre/ (and or Medical History) and/or Central Health Care Registry Office

3. Channel the GBH Report Goes Through

Once completed, the GBH Report must be dispatched as urgently as possible for its submittal to the Police Court. Its forwarding cannot be delayed. It is therefore important to systematise the different forwarding channels, making it clear which practitioner will be in charge of dispatching the Report (medical, administrative, nursing staff) and by which means it will actually be sent (via Fax, e-mail, post, police).

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

The Deanship will determine which Court will try the case, first of all discerning the kind of court competent, according to the legislation currently in force. Secondly, and if in that administrative area there exists more than one court of the same kind, the one to try will be the one appointed in accordance with the application of distribution regulations previously approved by the Deanship of each judicial district.

* Deanship of the Courts: Body within the judicial office which, among other things, is responsible for the affairs of the various courts ascribed to it.

Upon receiving the bodily harm report, the Judge will order initiation of criminal proceedings (or, if they had had previous knowledge of the events, will add them to the ones already initiated) afterwards dictating evidentiary proceedings and, if applicable, adoption of measures to protect the victim.

Had a protective order been requested, the Police Court, providing that the applicability of assumptions are met, will convene an urgent hearing for the victim, the applicant if different from the victim, the aggressor, assisted by a lawyer and the prosecutor. The hearing shall be held within a maximum period of 72 hours from submittal of application.

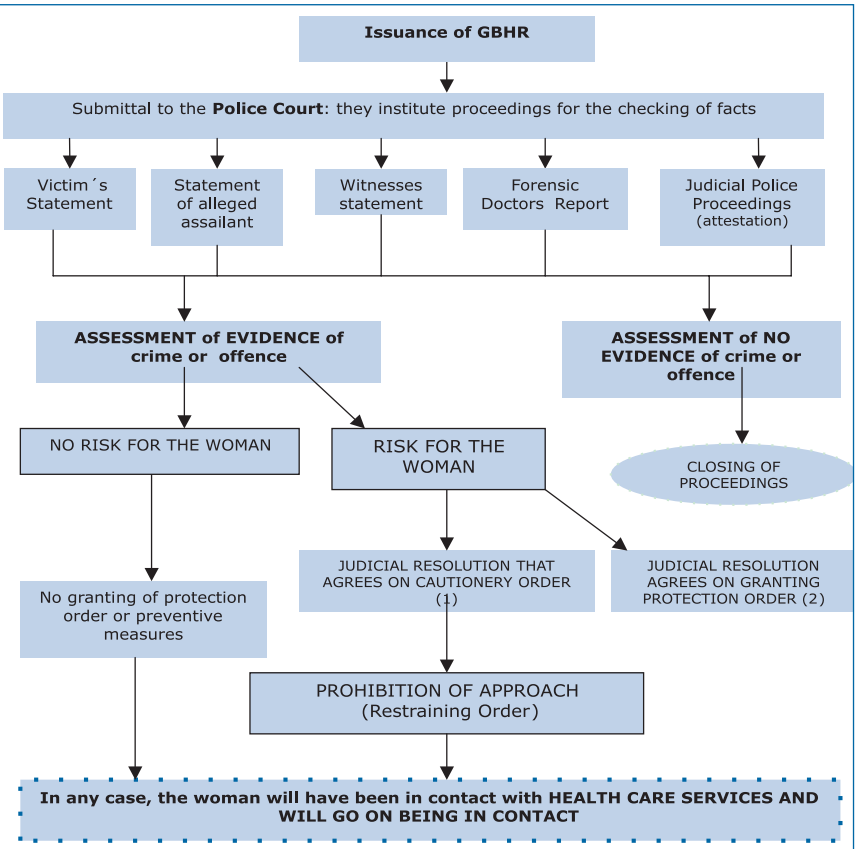
IT IS IMPORTANT TO EMPHASISE THAT:

- The GBH Report and /or when applicable, the medical report attached to the former, must be read to the woman before its final drafting

THE WOMAN MUST ALWAYS BE INFORMED ON:

- The channel the GBH Report goes trough and the consequences deriving from its submittal.
- That in case a protective order is requested, the Police Court, may call her for an urgent hearing to be held within a maximum period of 72 hours from submittal of application, after which the court will decide whether or not the Protection Order is granted..
- That the alleged assailant will also be called to declare and in case of danger he may be arrested for his being taken before the judge
- If the woman does not depose or confirm the account of events reported in the GBHR, the judge will close the case or instruct the appropriate procedure in case there are strong suspicions of male violence or concealment by the woman for fear or other causes.
- If the judge confirms them, he or she may order the continuing of the proceedings and issue when applicable a protection order with penal and civil measures, or even hold trial and pass a verdict.

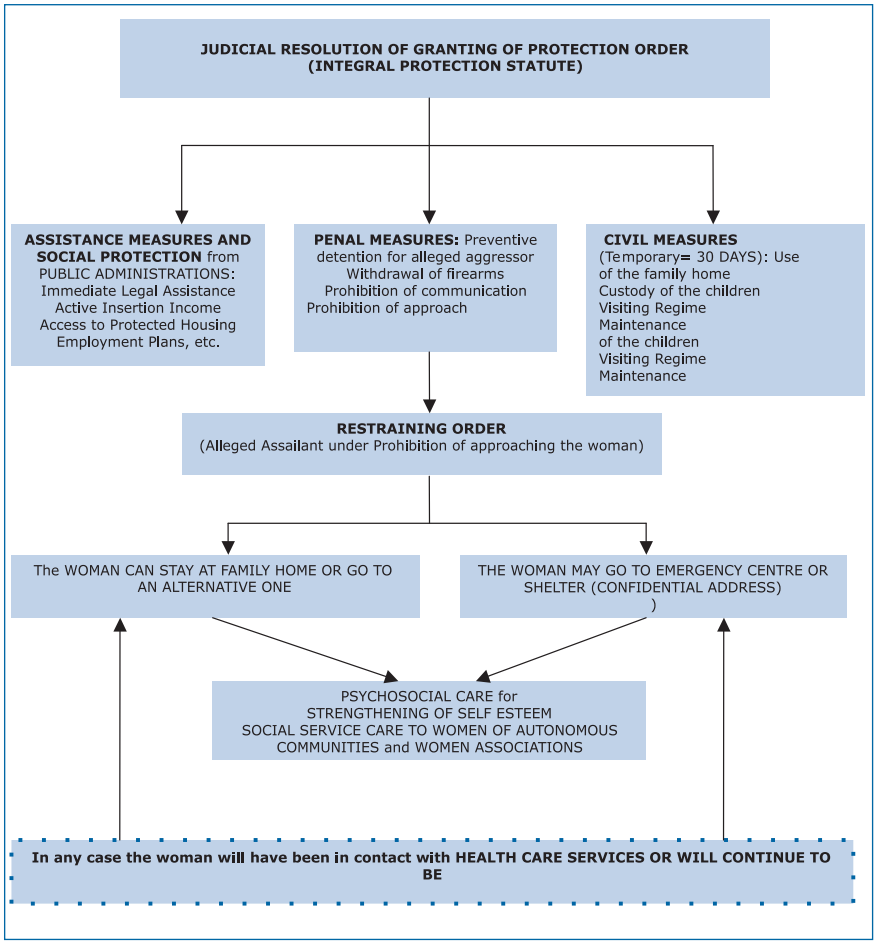
Find below two diagrams that depict the different possibilities arising from possible judicial decisions after issuance of the GBHR. These measures taken in the judicial sphere will entail repercussions of varying degrees in the daily life of women and their children. Affected women must be aware of whatever those repercussions might be as they will remain in contact with the health care environment, be it in the usual manner or in an alternative one if they were to change their whereabouts.



(1) Sometimes the judicial resolution that agrees on a cautionary measure allows access to some assistance measures and social protection established by Public Administrations.

(2) In general and apart from the Order of Protection, to qualify as a victim of GV and to access the rights recognised in Organic Law 1/2004 of December 28, the Public Prosecutor's Report stating the existence of evidence of gender violence will be admitted as certifying document.

The measures deriving from granting a **protection order** are detailed under these lines:



Resource Guide

Organic Act 1/2004 in its Title II recognises all women victims of male violence and their children, regardless of any personal condition or circumstance, the right to receive information, counselling, emergency care, support, shelter and integral recovery through services, bodies or bureaux of Public Administrations.

As stated repeatedly throughout the Protocol, **Coordination and Intersectoral Collaboration** (resources covering social and work fields, equal opportunities, legal, police, etc.) are critical in the care of women who suffer male violence. A number of Autonomous Communities have developed protocols for coordinated action and collaboration among health services, law enforcement, courts and institutions responsible for providing women with legal counselling and comprehensive care.

It is imperative for each practitioner to rely on complete and readily available information about protocols, resources and specific services at a nationwide, autonomic, provincial and municipal level, and their features in order to properly orient women in their use.

There is no actual profile of woman victim of male violence; the psychosocial situation of each woman is singular and different in terms of needs; there is no type-circuit through available resources either. All cases require an individual analysis and assessment of the situation each woman is living, adjusting to their personal needs and particular timings always bearing in mind there are special vulnerability situations. It will be up to each practitioner to decide which the most appropriate course of action will be at each moment, for which to rely on an interdisciplinary team is paramount.

Practitioners should always remain aware of the fact that they are not on their own and that in their interventions in gender violence situations, they can and must count on the cooperation of other available professionals both in Primary Care and in Hospital Care.

In this respect, in the public health system, **social work professionals at the health centre** represent an essential link figure in the process of psychosocial assistance, fit to participate in the follow-up to and referral of cases that may require other mechanisms and resources, jointly with the health care practitioners responsible for the health care of the abused women.

It is also essential to remember that referral to a different resource must not be considered the end of one's performance and that follow-up to the woman at the surgery is crucial. At any rate, we recommend following the courses of action described in the relevant sections.

This chapter of the Protocol intends to offer a **basic inventory** of the various resources that integrate the channels of intervention and support to women suffering male violence and their children. We only list nationwide resources. Each Autonomous Community will adapt this information to their territorial and populational reality, which includes provincial and municipal spheres, an information they will provide their professionals with as a fundamental support instrument for enhancing the quality of their practice.

Nationwide Resources

1. **Telephone Information Services:** toll-free, around the clock services:
   - **016** – Information and legal counselling telephone and on-line service for women victims of gender violence. Government Delegation for Gender Violence.
   - **900 116 016** - Information and legal counselling on gender violence for deaf, hearing or speech impaired people. Access through: Text telephone (DTS); Mobile phone (needs pre-configuration with the TOBMOVILE application); PDA (needs pre-configuration with the TOBMOVILE application). Government Delegation for Gender Violence.
   - **900 191 010**- Women's Institute Information Service.
   - **900.152.152 –** Women's Institute Information Service specialising on attendance to women with a hearing or speech disability:
     - Through the Mobile: the telephone, the call is made from needs a DTS device
     - Through the Internet: connection with Telesor web page through your computer or mobile phone
   - **112 –** Emergencies and Urgent Assistance
   - **091 –** National Police
   - **062 –** Civil Guard

2. **WEB Pages:**
   - **National Health System's Interterritorial Council Commission Against Gender Violence**
     http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/e02_t03_Comision.htm

   Links to different documents of interest for practitioners of the National Heath System (Common Protocol for a Health Care Response to

Gender Violence, epidemiological indicators, training quality criteria, objectives, contents and educational materials, gender violence annual reports, links to other European and International bodies, etc.)

– **State Secretariat for Social Services and Equality (Gender Violence Section). Ministry of Health, Social Services and Equality:**
http://www.msssi.gob.es/ssi/violenciaGenero/home.htm

– **Resources for Support and Prevention of Gender Violence Cases Website (W.R.A.P.) Government Delegation for Gender Violence**
http://wrap.seigualdad.gob.es/recursos/search/SearchForm.action

This link gives direct access to the Resources for Support and Prevention of Gender Violence Cases Website using Google Maps that speeds up the search for resources (police, judicial, informative, attention and counselling) that public administration and social entities offer citizens and particularly gender violence victims.

– **Observatory on Domestic and Gender Violence of the Judicial Power General Council**
http://www.poderjudicial.es/cgpj/es/Temas/Violencia_domestica_y_de_genero/Guia_y_Protocolos_de_actuacion

Resources of the Autonomous Communities

Below these lines, you will find a generic listing of resources for Autonomous Communities to complete by adding addresses and telephones for each one of them. Notice that there are Emergency and Non-Emergency options.

1. **AC Emergency Care and Urgent Assistance**

2. **Law Enforcement and Security Forces** integrated by National Police, Civil Guard, Local and Autonomic Police
   – Among their functions:
     • Information
     • Reception of complaints and crime investigation
     • Protection in case of danger, accompanying to file the complaint, home, to the health centre or to emergency units
     • Surveillance of compliance with protection orders and their monitoring

2.1. National Police

- **SAF** – Service for Assistance to the Family: direct attendance to women, minors and elderly persons
- **SAM** – National Police Service for Women in ACs: Direct attendance to victims of sexual offences. Telephone information about violence reporting
- **GRUME** – National Police Minors Group
- **UPAP –** Units for the Protection of Women under restraining orders

2.2. Civil Guard

- **EMUME** – Civil Guard Specialists in Woman-Minors in ACs

2.3. Local and when applicable **Autonomic Police**. Units specialising in Gender Violence and characteristics of relating programmes

Specify when applicable whether specialisation is in Women or in Minors

3. Legal and Judicial Spheres: (Addresses and telephones need be included)

3.1. **Institutions** where complaints are to be filed and Protection Orders requested: National Police, Civil Guard, Local Police, Public Prosecutor's Office, Courts, Psychosocial Teams, Forensic Assessment Teams
3.2. Services for the Attendance to Victims of Violent Offences and against Sexual Freedom, at the **Courts**
3.3. Legal Guidance and Counselling
3.4. Courts interpreters, sign language included
3.5. Meeting Points

4. Psychosocial Attendance Sphere. Services of Direct Care to Women:

4.1. **Telephone 900** of ACs (where in operation)
4.2. Equality Bodies in CAs
4.3. Women and Social Services Councillorships of **Local Councils** (access to ATENPRO Telephone Service). Information to Local Entities: atenpro@femp.es
4.4. **Women's Organisations**

4.5. **Immigrant Organisations** (especially important to reflect those that assist immigrants who do not speak Spanish)

4.6. **Shelter Homes**: information on Equality Bodies of Autonomous Communities and Social Services of Local Councils (just state these instead of referring to a list) day centres, supervised apartments.

Existing specific programmes in Gender Violence matters must be listed.

Any other specific resource of ACs in these matters

5. Informative Material: Resource guides, information leaflets, aiming to make women aware of their rights and of available resources -in different languages- they can rely on, for which it is important to place them in visible and accessible points at surgeries.

Glossary

- **Action algorithm:** orderly and limited set of actions, that may be represented graphically, for solving a given problem or circumstance.
- **Screening**: epidemiological programme devised for detecting a serious health condition at an early stage in a specific and asymptomatic population, targeting a decrease in the morbidity/mortality associated rate, through an effective or health restoring intervention.
- **Early detection:** Identification in a specific and asymptomatic population, of a serious health condition, at an early stage, targeting a decrease in the morbidity/mortality associated rate, through an effective or health restoring intervention.
- **Active Listening:** Listen attentively and with interest, with no value-judgement forming. It involves verbal and non-verbal communication, through which we can let the other person know that we understand and receive what they wish to transmit both content and feelings. Through active listening we create an atmosphere of trust, warmth and security which makes communication easier for the other person but without intermingling with their problems and affections. Active Listening is a skill that can be learned and developed.
- **Gender:** Genders applies to non-biological differences between men and women socially developed through socialisation and culture and that throughout History have ascribed different characteristics, roles, rights, responsibilities and power, to both men and women. Gender is an analysis instrument that enables visualising inequalities and differences as well as the impact public policies exert on women and men's daily lives.
- **Medical report:** It is the written description and assessment, medical personnel make of injuries found.
- **Maltreatment/Abuse**: Any action, omission or negligent treatment that trespasses on the person's fundamental rights jeopardizing the fulfilling of their basic needs preventing or interfering with their physical, psychical and/or social development. This includes physical, psychical and sexual ill-treatment to minors, elderly, or dependants (those who, due to lack or loss of physical or psychic ability are in a situation of dependence on others).
- **Grievous Bodily Harm Report:** medico-legal document, of mandatory notification to the competent court, whenever injury may constitute

misdemeanour or criminal offence. It constitutes one of the first steps of preliminary proceedings in a criminal procedure for serious wounding and lesions or death.

- **Primary Prevention:** In the health care sphere, primary prevention of gender violence involves interventions and communal health activities both at individual and group levels that promote equalitarian values teaching how to recognise and differentiate maltreatment from good treatment.
- **Secondary Prevention**: In the health care sphere, secondary prevention involves detection at individual and group level, interdisciplinary and intersectoral work, assisted referral and the constitution of specific groups of women living gender abuse relationships.
- **Tertiary Prevention:** In the field of health care, tertiary prevention entails quality comprehensive care for women to be able to design a satisfactory life plan, so restoring the capacity of establishing healthy relationships and regain their self-esteem.
- **Resilience:** Human capacity to get over adversity despite destabilising events, difficult life conditions and trauma, even severe, and be able to adapt, recover, and access a purposeful and productive life
- **Secondary Victimisation:** Situation of «maltreatment» a victim of male violence is subjected to, as a consequence of inappropriate professional or institutional interventions, imprudent or wrongful. An abused woman is often made feel guilty and responsible, forced to relive traumatic situations, her credibility questioned, and when having been sexually abused, even accused of inducing and so bringing about the aggression. All this causes a double suffering, generating more severe consequences than the primary ones as it is the system itself, which victimises, causing her to lose confidence in the institutions.
- **Gender Violence:** any act of violence prompted by belonging to the female sex that may result in physical, sexual or psychological harm or suffering for women, as well as threats of such acts, coercion or arbitrary deprivation of freedom, arising both in public or private life. Gender violence arises because of the unequal relation between men and women and from the existence of a «culture of violence» as a means of resolving conflicts. Manifestations of this gender violence other than physical, sexual and psychological are:
  - **Economic Violence:** Control of economic means allowing the woman no participation in making decisions on distribution of expenditure; cash control, forcing the woman to account for every expense, to ask

permission to spend; deny access to information on common patrimony or access to actual money or allow insufficient amounts to meet the household maintaining needs

- **Environmental Violence:** Violent actions towards the environment aimed at intimidating the woman, as breaking or banging objects, shattering or smashing household furniture and equipment or the woman's cherished and especially valuable objects, ill-treating the family pets, etc.
- **Symbolic violence**: Perpetrated through representing women in art, images, the media, the language, the culture or science, as trivial, submissive or as sexual objects. Rendering women invisible is also a form of symbolic violence.
- **Social Violence:** Humiliations, insults, publicly poking fun at the woman, being rude to her in the social and family circle, engaging in seductive conducts towards other women in her presence**.**

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9. Las cuestiones de género son importantes.
10. Actitudes de la población ante la violencia de género.
11. Violencia de género hacia las mujeres con discapacidad. Un acercamiento desde diversas perspectivas profesionales.
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Annexes

Annex I. Legislation of the Autonomous Communities Regarding Gerder-based Violence

AUTONOMOUS COMMUNITY	LEGISLATION REGARDING GENDER VIOLENCE	GENDER VIOLENCE CONCEPT
ANDALUSIA	Act 13/2007, of November 23, for Prevention and Comprehensive Protection Measures Against Gender Violence	Gender Violence comprises any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life regardless of whether the aggressor maintains with the victim an intimate, affective or familiar relationship.
ARAGON	Act 4/2007, of March 22nd, for Prevention and Integral Protection of Women Victims of Violence in Aragon	Gender Violence is understood as any act of violence against women by the mere fact of their pertaining to the female sex, that results in, or is likely to result in physical or psychological harm as well as violation of their liberty and sexual integrity, including threats of such acts, coercion or arbitrary deprivation of liberty, committed by the aggressor's taking advantage of a situation of weakness, dependency, or physical, psychological, family, working or economic proximity to their victim, regardless of the relationship between them. It includes trafficking in women, genital mutilation, sexual and reproductive rights
ASTURIAS	Act 2/2011 of the Principality of Asturias for the Equality of Women and Men and the Eradication of Gender Violence	Same concept of gender violence and scope of application as those of Comprehensive Act 1/2004
BALEARIC ISLANDS	Act 12/2006, of September 20, on the Woman. Dedicates Chapter VI to Violence Against Women	Gender Violence comprises any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty. The measures of the Act refer to domestic maltreatment and sexual aggressions.
CANARY ISLANDS	Act 16/2003, of April 8, on Comprehensive Prevention and Protection of Women against Gender Violence	Gender Violence is understood as any act of violence against women by the mere fact of their pertaining to the female sex, regardless of their age, that by physical or psychological means, including threats of such acts, intimidation and coercion results in, or is likely to result in physical, sexual or psychological harm for the woman and is committed taking advantage of a situation of weakness or of physical, psychological, family, working or economic dependence of the victim on the aggressor, regardless of the relationship between them. It includes trafficking in women, genital mutilation, sexual and reproductive rights.

Updated Chart, taken from «*Análisis de la legislación autonómica sobre violencia de género. Colección Contra la Violencia de Género. Documentos - Nº 5. Delegación del Gobierno para la violencia de género. Secretaría General de Políticas de Igualdad. Ministerio de Sanidad, Política Social e Igualdad, 2010.*»

AUTONOMOUS COMMUNITY	LEGISLATION REGARDING GENDER VIOLENCE	GENDER VIOLENCE CONCEPT
CANTABRIA	Cantabria Act 1/2004, of April 1st on the Integral Prevention of Violence against Women and Protection of its victims.	The Act understands as gender violence any conduct, active or omissive, of violence and aggression, based on the victim's belonging to the female sex, as well as the treats of such acts, the coercion or illegitimate deprivation of liberty and the intimidation that results or is likely to result in physical, sexual or psychological harm, occurring in public, within the family or in private life, regardless of the relationship the aggressor maintains with the victim. It includes trafficking in women, genital mutilation, sexual and reproductive rights
CASTILE- LA MANCHA	Act 5/2001, of May 17, on Prevention of Abuse and Protection of Abused Women	The Castilian-La Mancha Act does not establish a specific concept of gender violence. From its articles and preamble it can be inferred that it refers to the maltreatment of the woman inflicted by her spouse of intimate partner
CASTILE and LEON	Act 13/2010, of December 9, against Gender Violence in Castile and Leon	Gender Violence comprises any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. It includes trafficking of women and girls for the purposes of sexual exploitation, violence caused by the application of cultural traditions that infringe or violate human rights and sexual and work-related harassment
CATALONIA	Act 5/2008, of April 24, on Women's Rights for the eradication of Male Violence	Male violence is understood as the violence inflicted on women as a manifestation of discrimination and of a situation of inequality in a framework of relations of power of men over women and that, produced by physical, economical or psychological means including threats, intimidation and coercion, results in physical, sexual or psychological harm, whether occurring in public or in private life. Includes trafficking and sexual exploitation, genital mutilation, forced marriages, violence deriving from armed conflicts, violence again sexual and reproductive rights
COMMUNITY OF VALENCIA	Act 9/2003, of April 2nd on Equality between women and men	Gender Violence as violence inflicted on women as a perverse form of exercising power, by use of force, physical, psychological, economic or otherwise, originating in inequality of relations between men and women and emerges in the form of battering, rape, sexual abuse and harassment, prostitution and trafficking in women.

AUTONOMOUS COMMUNITY	LEGISLATION REGARDING GENDER VIOLENCE	GENDER VIOLENCE CONCEPT
EXTREMADURA	Act 8/2011, pf 23 of March, of Equality between women and men and against gender violence in Extremadura	Same concept of gender violence and scope of application as Comprehensive Act 1/2004
GALICIA	Gallegan Act 11/2007, of July 27, on Prevention and Integral treatment of Gender Violence	Male violence is understood as any violent act or aggression, based on a situation of inequality in a framework of relations of men domination over women that results or may result in physical, sexual or psychological harm, including threats of such actions, coercion or arbitrary deprivation of liberty, occurring in public or in private life. Includes violence perpetrated by men of the woman's family, social or work circle as well as trafficking in women and sexual assault.
MADRID	Integral Act 5/2005, of December 20, on Gender Violence in the Madrid Community	The Gender Violence this Act refers to, comprises any physical or psychical aggression towards a woman, likely to cause detriment to her health, her body integrity, her sexual liberty or any other situation of anguish or fear that may restrict her freedom. Likewise, it is considered Gender Violence, that perpetrated on minors or the woman dependants, when caused in an attempt to cause her serious damage. It includes sexual assault, genital mutilation, trafficking in women. In the case of disabled women, violence perpetrated by men of their family or institutional environment
MURCIA	Act 7/2007, of April 4 on Equality between Women and Men and on Protection against Gender Violence in the Region of Murcia	It is understood as Gender Violence any physical or psychical aggression against a woman on the grounds of her sex, likely to cause her detriment of her health, physical integrity, sexual liberty or any other occurrence that might restrict her freedom, including violence perpetrated on her descendants under age and dependants whenever caused by virtue of their sex
NAVARRE	Charter Act 22/2002, of 2nd July on adoption of comprehensive measures against sexist violence, modified by Charter Act 12/2003, of 7 March	Gender Violence defined as that perpetrated against women, entailing a serious attack against their dignity and physical and moral integrity

AUTONOMOUS COMMUNITY	LEGISLATION REGARDING GENDER VIOLENCE	GENDER VIOLENCE CONCEPT
BASQUE COUNTRY	Act 4/2005 on Equality between Women and Men (Title III, Chap. VI, devoted to Gender Violence)	It is considered Violence against Women any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.
LA RIOJA	Act 3/2011, March 1st, on Prevention, Protection and Institutional Coordination in Violence Matters, of La Rioja.	Violence perpetrated on a woman, comprising any active or omissive conduct of aggression against her prompted by her belonging to the female sex, committed while taking advantage of a situation of inequality, weakness, dependency or physical , psychological, work-related or economic proximity, of the aggressor to the victim resulting or likely to result in harm or physical, psychological of sexual suffering. It includes sexual assaults, sexual harassment, trafficking in women and genital mutilation

Annex II.
Protocols and Healthcare Action Guides to Addressing Gender-based Violence in the Autonomous Communities

Andalusia

Health Care for women victims of maltreatment. Strategic Plan. Andalusian Health Service. Health Council. Junta of Andalusia (2001)

Andalusian Protocol for Health Care Action against Gender Violence. Andalusian Health Service. Health Council. Junta of Andalusia (2008).

Grievous Bodily Harm and Medical Reports for Alleged Cases of Domestic Violence, Minors and Elderly Persons Abuse and Sexual Assaults. Junta of Andalusia (2011)

Institutional coordination procedure for the prevention of gender violence and care for the victims (2005)

Andalusian Protocol for Health Care Action against Gender Violence at Emergency Units (2012).

Aragon

Healthcare Guide to Women Victims of Domestic Violence in the Aragon Health System. Aragon Government. Health and Consumers' Affairs Department. Directorate General for Planning and Assurance (2005)

Inter-Institutional Coordination Protocol for Prevention of Gender Violence and Care for Victims (2008)

Hospital Emergency Care Services Programme for Comprehensive Care of Women Victims of Gender Violence (2011)

Asturias

Protocol for a Healthcare Response to Violence towards Women. Health Service of the Principality of Asturias. Principality of Asturias Government. (2003)

Health Care Protocol for Improving Care to Women Victims of Gender Violence. Health Service of the Principality of Asturias. Principality of Asturias Government. (2007)

Inter-Departmental Protocol for Improving Care to Women Victims of Gender Violence. Health Service of the Principality of Asturias. Principality of Asturias Government (2009)

Balearic Islands

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

Recommendations for Health Care Action against Gender Violence in the Autonomous Community of the Balearic Islands. Balearic Islands Health Service (*Illes Balears. Server de Salut de las Illes Balears)* (2009)

Inter-Institutional Protocol for Detection, Care and Prevention of Male Violence and Sexual Assaults

Canary Islands

Instruction 3/03 by which are established the models of official documents and procedures, practitioners must conduct when attending to wounding and lesions that might constitute civil or criminal offence. Department of Health and Consumers' Affairs. Canarian Health Service

Gender Violence and Health: Handbook and Educational Units for Awareness and Prevention. Canary Islands Government. Joint Publication by the Department of Health and Consumers' Affairs. Canarian Health Service and Canarian Women's Institute (2005)

Grievous Bodily Harm and Medical Reports issued in alleged cases of Domestic Violence. Maltreatment to Minors and Elderly Persons and Sexual Assaults. Canarian Health Service (2003).

Action Protocol for Confronting Gender Violence in the Domestic Sphere. Canary Islands' Government. Department of Health and Consumers' Affairs. Canarian Health Service (2003).

Cantabria

Protocol for Healthcare Action when Facing Maltreatment. Government of Cantabria. Healthcare and Social Services Council. Public Health General Directorate (2005, 2nd ed., 2007)

Protocol of Healthcare to Victims of Assault/Sexual Abuse. Government of Cantabria. Healthcare and Social Services Council. Public Health General Directorate (2006).

Castile and Leon

Action Guide to Facing Maltreatment against Women. Castilian and Leonese Society of Family and Community Medicine («Socalem-FYC») (2005)

Assistance Network for Women Suffering Maltreatment. Healthcare and Social Welfare Council Junta of Castile and Leon. (2003).

Guide to Clinical Practice for Addressing Violence toward Women in the Couple. Health Regional Office. Castile and Leon Junta (2010).

Draft Protocol for Professional Action in Cases of Gender Violence in Castile and Leon (2008)

Castile-La Mancha

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

Catalonia

Guia per a l'abordatge del maltractament de gènere a l'atenció primària. Institut Català de la Salut. Departament de Sanitat i Seguretat Social. Generalitat de Catalunya (2003).

Recomanacions per a l'atenció sanitària a les dones maltractades. Col·lecció: Pla de salut. Quadern núm. 14. Servei Català de la Salut. Departament de Sanitat i Seguretat Social. Generalitat de Catalunya (2004).

Protocol i circuit per a l'abordatge de la violència machista en l'àmbit de la salut a Catalunya. Departament de Salut. Generalitat de Catalunya (2009).

– *Document operatiu de violència sexual.*

– *Document operatiu de Muleres y Discapacitat (2011).*

– *Document operatiu de Drogodependències (2011).*

– *Document operatiu de embarazo (2010).*
– *Document operatiu De Immigració (2011).*
– *Document operatiu De maltrato infantojuvenil.*
– Female Genital Mutilation (2011).

Community of Valencia

Medical Report on Alleged Domestic Violence (adults). *Generalitat Valenciana. Conselleria de Sanitat (2005).*

Protocol for Health Care Attendance to Gender Violence (2008)

Extremadura

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

Extremadura Protocol for Epidemiological Surveillance of Gender Violence. Extremadura Health Service (2010)

Galicia

Abordaxe da violencia de xénero desde o ámbito sanitario. Guía para a prevención, detección e atención en materia de violencia de xénero no ámbito sanitario. Xunta de Galicia (2002)

Defende os teus dereitos. Guía práctica para mulleres que sofren violencia de xénero. Xunta de Galicia (2007).

Guide on Gender Violence in Health Primary Care. *Xunta* de Galicia (2005).

Guía técnica do proceso de atención as mulleres en situación de violencia de xénero (2009).

Madrid

Violence Against Women Considered as a Public Health Concern. Document to Support Attendance to Women Victims' Health. Institute of Public Health. Madrid Community (2003)

Primary Care Support Guide to Addressing Violence against Women in Couple (2007)

Brief Guide to Performing in Primary Care (2008)

Guide to Care of Abused Women with Severe Mental Disorders (2010).

Specialty Care Action Guide to Addressing Violence against Women in the Couple (2011)

Murcia

Protocol for the Coordination of the State Armed and Security Forces with the Judiciary, Professional College Associations, and Others Involved in the Protection of Victims of Gender Violence. Region of Murcia (2006)

Protocol for Detecting and Dealing with Gender Violence in Primary Care in the Region of Murcia. Healthcare Council of Murcia (2007)

Healthcare Protocol for Addressing Domestic Maltreatment. Presidency Council. Sectoral Secretariat for the Woman and the Young. Region of Murcia. (2000)

Professional Guide to Resources for Attendance to Women Victims of Gender Violence (2011)

Practical Clinical Guide /Guide to Clinical Practice. Action in Mental Health with Women Abused by their Partner (2011).

Regional Protocol for Prevention and Detection of Violence in Women over (S/D).

Navarre

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

Basque Country

Healthcare Protocol when Faced to Domestic Maltreatment. Healthcare Department. Basque Country Government (2000) included into

the framework of the «*Interinstitutional Agreement for Improving Care to Women Victims of Domestic Maltreatment and Sexual Assaults*» (2001)

Health Care Protocol to Address Abuse in the Domestic Sphere and Sexual Violence against Women (2008).

La Rioja

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

Protocol for Health Care Action Against Violence Towards Women (2010)

The Commission Against Gender Violence, created within the Inter Territorial Council of the National Health System has been supporting technically and orienting the planning of the health, care measures established in Chapter III, Organic Act 1/2004 for Comprehensive Protection Measures Against Gender Violence.

In April 2007, the release of the "Common Protocol for a Health Care Response to Gender Violence" supplied Health Care Practitioners with an essential tool against gender violence. Its first aim was to provide them with homogeneous action guidelines for attending and monitoring as well as for prevention and early detection of cases of violence that specifically target women.

The wealth of experience gained by the Autonomous Communities' Health Services and a rapid evolution of the mounting scientific evidence on the impact of gender violence on women's health and their children's particularly when occurring in greater vulnerability contexts (pregnancy, immigration, disability, rural areas, elderly women, etc.), have enabled the presentation of this new edition of the Health Care Common Protocol.

The criteria of follow-up and personalised accompaniment throughout the process, the multi and interdisciplinary care provided by the team of professionals and the coordination and collaboration with other sectors (education, public Prosecutor's Office, forensic practitioners, law enforcement and security, local resources, etc.), orient health care actions transversally through the Protocol.

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