Gender Violence 2007 Report

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Table of Contents

Chapters on the autonomous communities

Presentation

The National Health System sanctioned the creation of the Commission Against Gender Violence on 22 September, 2004. This was the first step for coordination of programmes and healthcare actions that were already being conducted on the subject in some autonomous communities[i].

Subsequently and over time the National Health System's Inter Territorial Council (NHSIC) has, through this organ, undertaken the specific commitments laid down in Organic Act 1/2004 of December 28 on Comprehensive Protection Measures against Gender Violence for development of healthcare actions.

The now presented 2007 annual report on healthcare response to gender violence in the National Health System (NHS), is the third this Commission has drafted[ii].

It aims principally at providing an overall view of strategies, plans and programmes for comprehensive healthcare attention to the health of women in situations of gender violence; all of them drafted at the Commission and approved by the NHSIC within homogeneous action guidelines agreed by consensus for enforcement in the National Health System as a whole.

Improving healthcare quality as regards diagnosis, follow-up and full health restoring in cases of violence specifically directed to women is the fundamental aim of the said policies.

A summary is also presented of programmes and actions performed by health services in cooperation with relevant departments in order for awareness of their professionals to be fostered and their specific training to be developed both in primary and specialised care this including their respective casualty departments.

The year this report spans, the *National Plan for Awareness and Prevention of Gender Violence*[iii] was published and Organic Act 3/2007, 22 March was enacted for effective equality of women and men, two landmarks in the advance towards equality and wiping out gender violence. The latter contains a section specifically devoted to health, where it is established that "violence inflicted on women primarily constitutes an attack on their physical

i The Secretaryship of the Commission is held by the Observatory on Women's Health.

ii Previous 2005 and 2006 reports are available at the Publishing Department of the Ministry of Health and Consumers' Affairs (paper and CD format).They can also be accessed at: www.msc.es/organizacion/sns/planCalidadSNS/e02_t03.htm

iii The electronic version is also available at: www.migualdad.es/violencia-mujer/index.html

and psychological health; hence, the health sector-related agents take on special significance when it comes to both the phenomenon detection and the care for the victims".

This report intends to bring to light all actions performed during 2007 in the healthcare sector in terms of gender violence (GV) by way of sequel to those taken in previous years, in order to achieve greater awareness of the problem and promote participation of all agents involved, in early detection, prevention and follow-up of this health problem from within the healthcare system as well as that of all teams responsible for the designing, planning and managing of relevant healthcare policies.

Introduction

> Gender violence is understood as *"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 private life"* (UNO, 1993)[1].

Violence against women persists in all countries in the world as a widespread violation of human rights and is one of the main obstacles to achieve gender equality.

This violence is unacceptable, either committed by the State or its agents, by relatives or strangers, in the public sphere or in private, in times of peace or conflict.

In the World Conference on Human Rights held in Vienna in 1993 a worldwide coordinated mobilisation occurred targeting reaffirmation of women rights as human rights. That same year the General Assembly adopted the *Declaration on elimination of violence against women* and the fact was stressed that this type of violence "constitutes a manifestation of historically unequal power relations between man and woman that have lead to domination of women by men and to discrimination against them by men, hindering women's full advancement".

This declaration highlights the different scenarios of violence against women: violence within the family, violence in the community and violence committed or tolerated by the State. It also expresses concern about the fact that some groups of women, such as women pertaining to minorities, indigenous women, refugees, destitute, those confined in asylums or imprisoned, girls, disabled women, elderly women and those in situations of armed conflicts, are particularly vulnerable to violence.

When dealing with gender violence, a fact that needs to be stressed is that this violence is inflicted on women by the sheer fact of their being so with the aim of sustaining gender mandates. It is a violence of an instrumental nature that principally targets maintaining control over women. To this respect, gender violence institutes itself as a serious social problem and falls within the fundamental area of human rights and equal opportunities.

It enunciates a series of measures that States must adopt with the purpose of preventing and eliminating violence against women. It demands that States condemn violence against women never invoking whatsoever

custom, tradition or religious consideration to evade their obligation to eliminate it.

From that moment onwards and with the reinforcement of the Fourth World Conference on Women (Beijing, 1995), gender violence is acknowledged as a serious social problem and moves into the fundamental field of human rights and equal opportunities.

In 1996, the World Health Organisation (WHO) recognised violence against women as a Public Health issue.

In 2006, the United Nations Organisation presents its *In-depth study on all forms of violence against women*[iv]. The Organisation's Secretary-General declared that as long as violence against women would exist real progress towards equality, development and peace could not be proclaimed.

One out of three women suffers violence at least once in their lifetime. Among United Nations's Member States, 192 did not have, at that time, laws to punish perpetrators of such violence and only 89 countries had legislation on domestic violence. Studies on femicides in Australia, Canada, Israel, South Africa, and United States showed that among murdered women, between 40 and 70 % had been killed at their partners or husbands' hands.

Evidence gathered by those who research into widespread reach and numerous manifestations of violence against women, in addition to promotion campaigns culminated in the recognition of the fact that violence against women was of a worldwide and systemic nature and was enrooted in power imbalances and structural inequality between men and women.

This study also highlights that States have an obligation to protect women from violence, allocate resources to them, hold the culprits accountable and do justice. In order to put an end to all these acts of violence against women the knowledge and tool base set up over the last decade has to be systematic and efficaciously utilised thus preventing and eliminating them.

That demands that at the State's highest levels of governance there exist a clear political determination and a declared commitment, visible and unyielding, that may count on the determination, promotion and practical action of people and communities.

Violence against women has deep social and cultural roots interwoven into a gender differential socialisation that allocates activities, functions, relations and specific powers to men and women, thus creating subjective identities and power relations both between themselves as well as within society as a whole. In turn, it imposes a differentiated moral order that maintains the male-female dualism, where manhood translates into social

iv The complete text is available at:
www.observatorioviolencia.org/upload_images/File/DOC1160581505_SGstudyOnVAW_2006_spn.pdf

power performance and femininity in passiveness and lethargy. Interaction of both phenomena enables emergence and maintenance of violence against women.

Hence, gender violence is both the result and the way to consolidate dominance of those power relations based upon male supremacy and female subordination, relations that are possible in patriarchal societies thanks to social organisation patterns that permit, maintain and legitimate them. It would certainly not seem possible to understand the origin of violence and its continuance over centuries had it been opposed by the dominant culture[3].

Along these lines and even though violence relations are actual fact that materialises in a man's behaviour subjugating and attacking a woman, they have necessarily to be viewed from a wider perspective trying to understand them as a social and global phenomenon common to all social classes, all ages and all cultures.

Gender differential socialisation despite present policies in favour of equal opportunities is still in force in our societies, hence coeducation policies at all levels and in all areas need to be implemented.

Gender violence is intimately linked to existent inequality between women and men and to this respect, in order to be able to eradicate it, it is essential that from public powers and different Administrations, equality between women and men be publicly defended with the aim of progressively dismantling and illegitimating those structural and individual aspects that seek women subjugation through hierarchization of sexes.

Gender violence and gender inequality

The United Nations Organisation proposes utilisation of a Gender-related Development Index (GDI) to highlight inequalities on account of sex within a country, province or region by means of gender-sensitive indicators such as salary differences or education level among other aspects. Some authors, male and female, even propose utilisation of GDI as indicator of gender inequalities in health as it includes distribution, by sex, of life expectancy and of two other health determinants[5].

With the information on GDI relating to 2000[6] and data on reports and deaths by gender violence updated to December 2006, it was concluded that the risk of being murdered by gender violence in provinces with a GDI below the Spanish mean (GDI = 0.895) was higher when compared to that of women that live in provinces with a GDI beyond the Spanish mean (RR [relative risk] = 1.328 RI [reliability interval]$_{95\%}$ = [1.253-1.406]).

It was also observed that the possibility of filing suit by women in situation of maltreatment in provinces with GDI below the Spanish mean was also higher when compared with that of provinces with GDI beyond the Spanish mean (RR = 1.46 RI$_{95\%}$ = [1.462-1.474])[7]. For interpreting this last result, rising awareness that gender violence is an offence that has to be reported should be considered. Thus, a possible interpretation of these results lies on the fact that with time, the rising reporting is progressively nearing the real magnitude of the problem although many cases still remain silenced.

With data on reports and deaths by violence against women in couple, updated to 2007and on GDI of autonomous communities in the last updated year (2005) classification presented in table 1 may be obtained according to whether or not GDI is beyond or below the Spanish mean (GDI = 0.903).

It turns out that in autonomous communities with GDI below the Spanish mean, gender violence reporting rate (0.025) stands higher than in autonomous communities with GDI beyond the Spanish mean (0.016). Likewise, those autonomous communities where the GDI does not reach the Spanish mean, register a mortality rate per 100,000 by GV (3.221) higher than those with GDI beyond the Spanish mean (2.569).

In addition, the risk of being murdered by gender violence in autonomous communities with GDI below the Spanish mean is higher than that run by women who live in autonomous communities with GDI beyond the Spanish mean (RR = 1.254 RI$_{95\%}$ = [1.060-1.482]). It has also been observed that the

possibility of women who live in autonomous communities with GDI below the Spanish mean, reporting maltreatment is higher (RR = 1.566 $RI_{95\%}$ = [1.556-2.575]).

TABLE 1. Autonomous community itemised Gender Development Index (GDI), 2005

Andalusia	0.878	Valencian Community	0.899
Aragon	0.917	Extremadura	0.877
Asturies (Principality of)	0.900	Galicia	0.899
Balearic (Islands)	0.911	Madrid (Community of)	0.936
Canary (Islands)	0.893	Murcia (Region of)	0.891
Cantabria	0.915	Navarre (Charter Community of)	0.936
Castile and Leon	0.916	Basque Country	0,938
Castile-La Mancha	0.891	Rioja (La)	0.924
Catalonia	0.919	Spain	**0,903**

Produced on the premises from Active Population Survey data and National Institute of Statistics' Demographic Indicators, Eurostat and Ministry of Education, 2005.
Factors used to calculate GDI were adult literacy programmes rate, combined registration gross rate, gross domestic product, salary differences by sex, male and female participation rate in work market, family income of most impoverished groups, long term unemployment levels and life expectancy at birth.

By provinces[v] a slight increase occurs in 2005 GDI scores when compared to those registered in 2000. The mean score in Spain has also increased over the 5 years in study, bearing in mind that in 2000 it was of 0.895 whereas in 2005 it reached 0.903 (table 2).

Results produced by provinces match those yielded by autonomous communities: women living in provinces with a GDI below the Spanish mean run a higher risk of getting murdered for that reason than those who live in provinces with a GDI beyond the Spanish mean (RR = 1.276 $RI_{95\%}$ = [1.080-1.507])[vi].

When comparing this result with those published in the National Health System's Gender Violence 2006 Report on responses to gender violence, the strength of the association seems to be diminishing. This appears to rest on improvements in GDI scores registered for 2005 when compared to year

v GDI scores by provinces are the only ones that can be compared with data gathered in the National Health System's 2006 Gender Violence Report.

vi The only updated data available are of deaths by gender violence.

2000 and on the variations on gender violence mortality rates produced in the years under study.

TABLE 2. Gender Development Index (GD) at province level, 2005

Province	2000	2005	Province	2000	2005
Alava	0.931	0.944	Lugo	0.879	0.894
Albacete	0.867	0.893	Lerida	0.904	0.920
Alicante	0.870	0.894	Madrid	0.940	0.937
Almeria	0.874	0.888	Malaga	0.859	0.883
Asturies	0.890	0.900	Murcia	0.863	0.892
Avila	0.889	0.902	Navarre	0.925	0.938
Badajoz	0.848	0.873	Orense	0.878	0.897
Baleares	0.894	0.912	Palencia	0.909	0.915
Barcelona	0.908	0.921	Palmas (Las)	0.885	0.896
Burgos	0.918	0.930	Pontevedra	0.882	0.898
Caceres	0.867	0.885	Rioja (La)	0.908	0.923
Cadiz	0.854	0.876	Salamanca	0.905	0.919
Cantabria	0.901	0.916	Santa Cruz of Tenerife	0.877	0.892
Castellon	0.887	0.909	Segovia	0.926	0.921
Ciudad Real	0.859	0.882	Seville	0.861	0.883
Cordoba	0.854	0.871	Soria	0.913	0.917
Corunna	0.889	0.904	Tarragona	0.900	0.915
Cuenca	0.862	0.891	Teruel	0.899	0.918
Gerona	0.899	0.918	Toledo	0.866	0.889
Granada	0.864	0.876	Valencia	0.887	0.902
Guadalajara	0.916	0.922	Valladolid	0.913	0.923
Guipuzcoa	0.927	0.940	Biscay	0.925	0.937
Huelva	0.863	0.882	Zamora	0.877	0.898
Huesca	0.899	0.916	Zaragoza	0.910	0.918
Jaen	0.849	0.865			
Leon	0.900	0.911	Spain	**0.895**	**0.903**

GDI 2000 by Villar A, Herrero C, Soler A. *Capital humano y desarrollo humano en España. Sus comunidades autónomas y provincias 1980-2000. Madrid: Bancaja e Ivie, 2004.* GDI 2005, produced on the premises from data gathered in *Encuesta de Población Activa e Indicadores Demográficos del Instituto Nacional de Estadística,* Eurostat and Ministerio de Educación, 2005.

Analysis of the situation (1998-2007)

In time and geographic distribution of deaths by gender violence in Spain

Among all manifestations of gender violence, that perpetrated within the couple by the partner or ex-partner is one of the commonest in Spanish women's lifetime. In the last decade in Spain, violence inflicted on women by their partners caused 555 deaths among them as per data provided by the Federation of Separated and Divorced Women. The Ministry of Interior (Home Office) compiles in its annals the list of crimes and offences reported by women in situation of maltreatment inflicted on them by their spouses or the like: ex-spouses, partners or ex-partners, and slain women for the same cause since 1977.The Federation of Separated and Divorced Women on their part, only keep records of murdered women, based upon thorough tracking of press news published on each subject. Although both sources mentioned supply data on women murdered by gender violence only the Federation of Separated and Divorced Women's *web* site provides information itemised by age, a particular unavailable in the Ministry of Interior's statistics[7]. That is why collecting data from the Federation of Separated and Divorced Women was considered to be the best option.

As per data shown in table 3, distribution in time of such cases has remained constant. Though years 2003, 2004, 2006 and 2007 produced the highest number of deaths, the highest mortality rate by violence against women within the couple is of 0.36 in 2007 and the lowest, 0.22, in 1999.

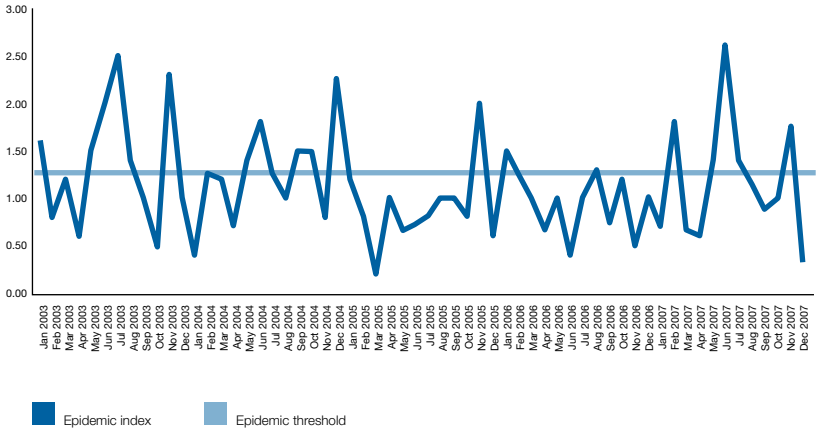
As shown in figure 1 and when comparing the situation month by month, mortality on account of gender violence seems to have decreased since January 2005. Broadly speaking, through 2006 this trend continued, standing at 3 points beyond the epidemic threshold (>1.25) in January, February and August. However in 2007, 5 points beyond the epidemic threshold were registered (>1.25), June 2007 yielding the highest score of epidemic index since January 2003, when reaching 2,60. Between August and October 2007 the epidemic index dropped back below the epidemic threshold (<1.25) to rise again in November to values above the epidemic threshold (>1.25) and redescend below this threshold in December.

TABLE 3. Frequencies and mortality rates adjusted by age among Spanish women aged 15 or over, 1998-2007

	Deaths	Rate x 10^5	Reliability interval at 95 %	
			Bottom limit	Upper limit
1998	46	0.26408	0.1878	0.3404
1999	40	0.22677	0.1565	0.2970
2000	57	0.32009	0.2370	0.4032
2001	52	0.28722	0.2092	0.3653
2002	47	0.25544	0.1824	0.3285
2003	66	0.35210	0.2672	0.4371
2004	61	0.32209	0.2413	0.4029
2005	54	0.28003	0.2053	0.3547
2006	61	0.31633	0.2369	0.3957
2007	71	0.36017	0.2764	0.4439

Produced In house from data on violence against women within the couple provided by Federation of Separated and Divorced Women. Statistics available at: www.separadasydivorciadas.org

Figure 1. Evolution of epidemic index of deaths due to gender violence in Spain, 2003-2007



Monthly epidemic index of deaths due to gender violence in Spain: ratio between deaths by gender violence per month and median of deaths for months corresponding to the five-year prior to the month for which the index is calculated. Incidence is considered to be average when resulting value stands between 0.76 and 1.24; low incidence when below or equal to 0.75, and high if value is equal or beyond 1.25. Epidemic threshold is identified at 1.25.
Available at: www.e-leusis.net/Alerta_Violencia.htm

The study of geographical distribution of deaths enables identification of differences in rates of mortality by gender violence. As per data retrieved up to 2007, Castile and Leon, Asturies and Catalonia were the Autonomous Communities that registered lower mortality rates due to gender violence (table 4).

TABLE 4. Rates of mortality due to gender violence adjusted by age and autonomous community, 1998-2007

	Cases	Rates x 10^6 ($RI_{95\%}$)		Cases	Rates x 10^6 ($RI_{95\%}$)
Andalusia	115	3.64 (2.77-4.52)	Valencian Community	71	3.85 (2.96-4.73)
Aragon	15	2.88 (1.45-4.31)	Extremadura	8	1.74 (0.53-2.94)
Asturies	12	2.55 (1.16-3.93)	Galicia	20	1.68 (0.97-2.39)
Balearic Islands	22	5.39 (3.09-7.70)	Madrid	69	2.74 (2.09-3.39)
Canary Islands	42	5.19 (3.59-6.79)	Melilla	2	7.24 (0.00-17.41)
Cantabria	6	2.59 (0.58-4.60)	Murcia	20	3.84 (2.14-5.54)
Castile-La Mancha	26	3.65 (2.29-5.01)	Navarre	9	3.68 (1.29-6.07)
Castile and Leon	24	2.24 (1.36-3.11)	Basque Country	15	1.61 (0.81-2.42)
Catalonia	76	2.69 (2.09-3.29)	La Rioja	3	2.53 (0.00–5.34)
Ceuta	1	3.11 (0.00-9.46)			

Produced on the premises from data on gender violence against women in couple, from the Federation of Separated and Divorced Women. RI, reliability intrerval. Available at: www.separadasydivorciadas.org

Cases detected and cared for in the healthcare sector

In December 2007, the NHSIC approved the indicators for epidemiologic surveillance for planning and assessment of healthcare actions in gender violence, to be compiled in Gender Violence 2008 Report on healthcare responses to gender violence. Nevertheless during 2007 some autonomous communities developed their own information-gathering methodologies that contributed data about gender violence cases looked after in health services and that were incorporated into their reports.

Thus, the information related to cases detected at different levels of health care through specific programmes, protocols or autonomous communities' own specific recording systems, will be described.

In the Autonomous Community of Andalusia information was obtained from judicial reports issued by the different healthcare action teams which

enabled gauging of a total of 6,195 cases of physical and sexual maltreatment in 2007, from which 1,395 were treated in hospitals and 4.800 in primary care.

In the Autonomous Community of Cantabria "detection and care for gender violence against the woman" with service code 210 (within the computerised medical record) was included in the service portfolio. From the end of 2005 up to the beginning of 2008, 52,305 women over 14 years of age were asked about possible occurrence of maltreatment and 3,595 of them declared they were then suffering maltreatment by their partner or ex-partner, or had previously.

In the Autonomous Community of Castile-la Mancha a computerised module was designed that included the gender violence protocol at primary care, to be incorporated to the rest of the computerised medical record at the beginning of 2008 within the section of services for women care. As per data from the Castile-La Mancha Health Service (Sescam), 112 primary care teams have so far used this module discharging a total of 92 cases. In addition, from this Health Service 131 cases were redirected to women centres and 48 to legal services.

The report contributed by the Autonomous Community of Catalonia refers to usage of different data recording systems that provide an input on cases detected, cared for and diagnosed in their main healthcare regions. In the period spanning from June 30, 2006 to December 31, 2007, the total number of women where gender violence infliction was detected, diagnosed and treated in all primary care services of Catalonia as a whole, was of 449 whereas hospital care was provided in 3,476 cases.

As per data contained in the report issued by the Autonomous City of Ceuta, a total of 9 women, all of them over 18, was received in primary care emergency services, in the last year. They also brought forward 59 cases of women treated in specialised attention's casualties for the same reason. Most of these cases were redirected to court.

According to the information received from the Basque Country Autonomous Community, in 2007, 243 cases of maltreatment were seen in primary care surgeries. This same year the number of women who claimed to be in situation of maltreatment in the hospital network of the said community amounted to 437. Information was also provided on 13 women who rushed to casualty presenting injuries suggestive of situations of maltreatment.

The Autonomous Community of La Rioja's report provides information on the number of women over 14 received in the healthcare system who for the first time admitted to being subjected to maltreatment. In 2007, 126 cases were detected, 68 of which came from primary care while the remaining 58 came from specialised care. This information is analysed in the document issued by La Rioja as per characteristics of maltreatment, personal features of women being maltreated and type of care received.

The Madrilenian Health Service's Regional Office of Mental Health Coordination, in cooperation with the General Directorate of Women, drafted in its day the Programme *Atiende* as a specific means to comply with the healthcare measures established in Act 27/2003, of July 31 and in Decree 256/2003, of November 27, for women in situation of maltreatment due to gender violence and for their sons and daughters. During this period, 213 women (new cases), 98 minors and 311 women with their children, were cared for.

As far as the Autonomous Community of Navarre is concerned, mental health centres are being equipped with a computerised system that codifies with CIE-10 which incorporates a section "other processes frequently associated with mental and behavioural alterations". Also, cases registered in primary care are included. From June 2006 to May 2007 an incidence was observed of 337 and 633 (corresponding to codes Z12 and Z25, respectively) and a prevalence of 1,412 and 1,361 (corresponding to codes Z12 and Z25, respectively).

Analysis of healthcare sector actions performed in the autonomous communities

Actions for the establishment of gender violence protocols in primary and specialised care

On 27 April, 2007 the Common Protocol for a Healthcare Response to Gender Violence was officially presented after being approved by consensus among all autonomous communities. This document was drafted from existing protocols and experiences in the different autonomous communities (table 5).

The present stage of establishment of the common protocol will entail adoption of agreed-by-consensus minimums in new editions of protocols in autonomous communities.

One of the action lines most stressed by all communities is training and awareness of primary care teams although some communities like Aragon and Madrid are also training both specialised care and casualties.

Training contributes to establishment of the protocol insofar as it trains professionals involved in early detection and action processes related to confronting gender violence cases. Andalusia, Aragon, Asturies, Canary Islands, Cantabria, Castile and Leon, Catalonia, Madrid and Murcia mention the existence of ongoing training plans.

Inter-institutional cooperation was generally available for development of training activities (courses, workshops, symposiums, round tables and meetings) both at state level (Women's Institute, Healthcare National School, Ministry of Health and Consumers' Affairs and SESPAS [Spanish Society of Public Health and Healthcare Administration]) as well as at autonomic level (autonomic women's institutes, advisory centres for women, health departments or offices, EASP ([Andalusian School of Public Health]), Institute of Health Studies in Catalonia, the *Adolfo Quesada* Institute for Public Administrations in Asturies and the *Laín Entralgo* Agency in Madrid) at provincial level. Also the *Caja de Ahorros del Mediterráneo* (Mediterranean Savings Bank) in the Valencian Community took part in this initiative.

TABLE 5. Protocols and other autonomic documents on gender violence, 2007

Autonomous community	Name of autonomic protocol	Publication
Andalusia	Health care of women victims of maltreatment	2001
Aragon	Healthcare Guide for women victims of domestic violence	2005
Asturies	Healthcare Protocol to improve care of women victims of gender violence	2007
Canary Islands	Action Protocol for confronting gender violence in the domestic sphere	2004
Cantabria	Healthcare Action Protocol to address maltreatment	2005
Castile-La Mancha	Action Protocol for women victims of maltreatment at Primary Care	2005 (first edition)
Catalonia	Protocol for addressing violence against women in the health sphere	Under approval
Valencian Community	Gender Violence Healthcare Protocol for the Valencian Community	2007 (pending publishing)
La Rioja	Comprehensive programme for detecting and addressing domestic violence from within the public health system	2005
Madrid	Primary Care Protocol. *Support Guide for addressing partner violence against the woman in Primary Care*	2007
	Specialised Care Protocol. *Action Guide for Specialised Care of women victims of partner violence*	Being drafted
Murcia	Detection and care protocol when facing gender violence in health primary care	2007
Navarre	Healthcare Action Protocol to deal with domestic, physical and psychological maltreatment and/ or sexual assault	Currently in force
Basque Country	Healthcare Protocol for domestic maltreatment	2000
Ingesa (Ceuta)	Comprehensive Protocol for women care: 5-step screening for gender violence early detection at doctors' and nurses' offices in primary care	

Dissemination of protocols

Dissemination of gender violence protocols has turned out to be a key factor to foster awareness of their existence and also of their contents among professionals and so the Canary Islands, Aragon, Murcia Castile-La Mancha, Castile and Leon, Cantabria, Balearic Islands, the Basque Country and Ingesa have acted accordingly. They have been distributed to all health centres and handed out to professionals individually. These autonomous communities with the Community of Madrid, Andalusia, Asturies, Navarre, the Valencian Community and Catalonia, have also undertaken

dissemination of supplementary information on existing resources available to professionals and to women in situation of maltreatment, for instance, through distribution of informative three-page leaflets in primary care centres (e.g. Ingesa-Melilla on remote monitoring and assistance).

Computerisation

Murcia, Cantabria and Ingesa-Ceuta also worked in the computerisation of the protocol for which they created work teams. Castile-La Mancha included the protocol in a computer module (computerised medical history) especially designed to be utilised by both primary and specialised care teams. The Canary Islands incorporated it to the computer system Drago-AP, and the Andalusian Protocol compiles guidelines to enable recording on the medical history of information relating to possible situations of violence. Navarre intends to computerise medical history in the future.

Records

Data collecting programmes used to compile information from women cared for at health centres enable follow-up of cases. In Aragon a special computerised window was created for this specific purpose. In the Valencian Community it is done through analysis of copies of alleged gender violence medical reports and in Andalusia bodily harm reports recording, states the number of reports issued at each healthcare level. Cantabria, Madrid, Murcia, Asturies, Catalonia, Castile-La Mancha, Castile and Leon, the Basque Country and Navarre mention the existence of a computerised record of all cases detected at each healthcare level (in Asturies it is called Vimpa Record, *Violencia contra las Mujeres del Principado de Asturies*).

Services portfolio

Andalusia and other autonomous communities have included the protocol in other existing services in health centres as, for instance, in the Primary Care Services Portfolio that gives support to other services such as the Service For Detection of Risk of Family Maltreatment, in the Madrid Community, the Gender Violence Risk Detection Service For Women Over 15 in Castile and Leon or the 210 Gender Violence Detection and Care of Victims Service in Cantabria. In the Canary Islands the protocol was included in the Portfolio of Services for Detecting and Addressing Domestic Violence and also in

the Agreed Managing programme; in Cantabria, in the managing contract, and in Andalusia in the programme contract. The Basque Country included indicators to assess compliance with the protocol in the Services Portfolio of the Department of Healthcare and in the *Osakidetza*.

In the course of 2007 an organisational model focused on services for the care of women in situation of maltreatment was adopted in health centres and hospitals of Murcia, Castile and Leon, Catalonia and Asturies, in ongoing care centres of La Rioja and Galicia and in informative centres of Catalonia.

Instruments for detection and grievous bodily harm report

Some communities like the Valencian Community have worked on the validation of instruments that may enable healthcare professionals to orient gender violence detection or assess the level of risk security in women in situation of maltreatment These guidelines or scales were included in protocols to guide prevention actions and comprehensive approaches.

In accordance with the needs established in the common protocol a new version of the traditional grievous bodily harm report was designed in Andalusia, Galicia and Ingesa-Melilla, and replaced in Andalusia with the term "judicial report" to avoid association with physical harm. Castile and Leon reported a swifter putting into practice and also having adapted formats to be filled in at casualty mobile units. In the Valencian Community the medical report on alleged gender/domestic violence (adults) was modified and in Cantabria and the Balearic Islands a specific gender violence report was drafted, having in this latter community been incorporated into e-SIAP primary care computer system.

Assessment

Part of the strategy carried out by autonomous communities entailed releasing periodical reports and assessing implantation of and compliance with the protocol (table 6), as was the case in Asturies, Cantabria, Castile and Leon and Madrid. Catalonia mentioned it as being envisaged and the Basque Country created a follow-up commission to that end.

TABLE 6. Establishment of and compliance with common protocol, 2007	
Asturies	Drafting of six-monthly reports (2007) and/or yearly (2006) from the Principality of Asturies Healthcare Attention to Violence against Women Records (Vimpa Records
Cantabria	Assessment Report on establishment of the Protocol. 2007. Cooperation Agreement between the Ministry of Health and Consumers' Affairs and the Community Healthcare Department
Castile and Leon	Evaluation of the degree of presence of the Protocol at its driving stage aimed at introducing Improvements derived from proposals contributed by professionals after their having detected and confronted problems for its development
Catalonia	Axis 1 of the Health Plan. It includes a section with strategic proposals such as territorial implementation of the protocol for addressing violence against women in the Catalonian health sphere, envisaging a multicentre piloting test and its appraisal
Madrid	Reference draft document for evaluating regional strategy of healthcare actions when dealing with partner violence against women, conducted with the participation of all the members of the relevant technical commission
Basque Country	Creation of a follow-up commission as organ in charge of the control and evaluation of the Protocol implementation

Obstacles that hinder protocol establishment

Autonomous communities provided a list of factors that according to their different perception hamper or facilitate the process of establishment of the protocol in healthcare practice. Aspects that impede sustainability of programmed actions for the protocol implementing are above all:

- Work overload and shortage of healthcare personnel, to cover for those attending training courses (Catalonia, Andalusia, Castile and Leon, the Canary Islands, Galicia, Balearic Islands and the Basque Country).
- Particular circumstances of some autonomous communities: limited availability of economic resources, territorial restrictions, predominance of country areas (Catalonia, Aragon and Balearic Islands). Ingesa for instance, highlights the difficulty for detection and recording when dealing with populations lacking identity papers.
- Difficulty with efficient inter-institutional and inter-personal coordination related for instance to redirecting criteria among the different health areas and/or services, social services, police and justice (Catalonia, Murcia, Andalusia, Aragon and Extremadura).
- Ethic-legal aspects involved in clinical practice as may be the controversy between whether or not a grievous bodily harm report

should be systematically issued (Murcia, Andalusia, Aragon, Castile-La Mancha, Balearic Islands and Extremadura).
- Initial difficulty with intervention in women's situations of maltreatment and in offering suitable solutions (Murcia, the Valencian Community and the Basque Country).
- Increased need for professionals' awareness and specific training in order for them to be in a position to provide comprehensive care of women in situation of maltreatment by putting into practice actual and adequate actions (Andalusia, Catalonia, Canary Islands, Balearic Islands, Galicia, Murcia and Extremadura).
- Lack of an integrated and comprehensive information system (Aragon).
- Resistance arising from the very gender socialisation from the professionals who attend gender violence training courses themselves (Andalusia).

Opportunities that foster establishment of protocols

Likewise, continuity of actions put into practice benefits most from:

- Awareness and the taking on gender violence actions as healthcare centre targets bearing in mind that they must be assumed as a public health concern that entails consequences on women's health (Madrid, Catalonia, Murcia, Andalusia, Aragon, Castile-La Mancha, the Valencian Community and the Basque Country).
- Healthcare professionals' favourable attitude inclined towards attending training courses and complying with training objectives set by the NHSIC's Commission Against Gender Violence (Murcia, Castile-La Mancha, Castile and Leon, Galicia and the Basque Country).
- Adequacy of professional response derived from personnel being given guidelines to address violence through care guidance and resources for redirecting (Castile-La Mancha and the Valencian Community).
- Easy access and use by healthcare personnel of computerised medical history recording module (Castile-La Mancha and the Basque Country).
- Cooperation among the different operational teams that take part in the process of comprehensive care of women, establishing a consolidated action network as well as existence of intra and inter-institutional coordinating structures such as the Technical Commission and Hospital Care Commissions (Madrid, Murcia, Aragon, Castile and Leon and the Basque Country).

- Gradual improvement of care for women through establishment of commissions for work in gender violence implications in health as well as inter-sectoral commissions at different territorial levels (local, provincial, autonomic and state) that may enable unification of criteria, action lines and commitments (Andalusia, Madrid and Extremadura).

Initiatives of interest when dealing with gender violence cases in health services

Among initiatives of interest undertaken by autonomous communities throughout 2007, those oriented towards providing comprehensive and integrated action in social, legal and health care of women in situations of maltreatment deserve highlighting. They materialise in specific programmes for approaching gender violence (table 7).

TABLE 7. Programmes targeting gender violence, itemised by autonomous community, 2007

Aragon	Programmes for comprehensive care of women (dependent on the Health and Consumers' Department)
Cantabria	Action Plan: Health for Women 2004-2007
	Priority action line 4: Gender violence
Castile and Leon	Service for the Addressing of Gender Violence
Catalonia	Programme for the care of victims of intra-family violence
	Programme for a comprehensive approach to violence against women
Extremadura	Standing Committee for the Eradication of Violence against the Woman
Galicia	In the Woman Plan, 2 projects for improvement of the attention and healthcare provided to women in situation of gender violence
Madrid	Programme *Atiende* (acronym meaning listens/attends)
Navarre	Common indicators of gender violence in the healthcare system
Basque Country	Inter-institutional agreement for improvement in the care of women victims of domestic maltreatment and sexual assault
La Rioja	Inter-institutional agreement for the improvement in the care of women victims of domestic maltreatment, gender violence and sexual assault

Autonomous communities that mention availability of specific resources for addressing sexual assault are: Navarre, La Rioja, the Basque Country and Catalonia (specialised attention programmes for mental health, gender violence and sexual abuse), the Balearic Islands (autonomic protocol for coordination in case of sexual assault) and Cantabria (protocol on healthcare action to deal with victims of sexual assault/ abuse, 2006).

In addition to gender violence observatories and autonomic units for detection of gender violence, the work of autonomic women's institutes has been important for developing programmes aimed at the prevention and eradication of gender violence, materialising in protocols for coordinated intervention against gender violence, that implicates sectors of society with competence in the care of women in situation of maltreatment. Apart from the ones listed on the previous table the ones shown in table 8 have special significance.

TABLE 8. Protocols for coordinated intervention against gender violence itemised by autonomous community, 2007

Andalusia	Procedure of institutional coordination for prevention of gender violence and care of victims in Andalusia, 2005
Aragon	Procedure of institutional coordination (rough draft stage)
Asturies	Inter-departmental protocol for improving care of women victims of gender violence
Castile and Leon	Frame of reference protocol for professional performance in cases of gender violence in Castile and Leon for coordinated action of the different institutions involved in actions against gender violence
Catalonia	Inter-departmental plan coordinated by the Catalonian Institute of Women and the units of comprehensive response to gender violence
	Frame of reference protocol and national circuit for coordinated action to combat violence against women
Extremadura	Inter-departmental protocol for eradication and prevention of violence against women, 2001
Navarre	Institutional agreement for comprehensive care of women victims of maltreatment and/or sexual attacks
Basque Country	Institutional response protocol in cases of death due to domestic maltreatment

Creation of inter-sectorial groups in the autonomous communities of the Canary Islands, Cantabria, Castile-La Mancha, Galicia and Madrid is progressing in the development of good practices, for instance when integrating a gender perspective in public health for health promotion, when

designing common indicators of gender violence in the healthcare system or establishing quality criteria for evaluating the gender violence training strategy of each autonomous community.

Especially noteworthy is the initiative of Andalusia and Madrid of creating technical tables or commissions at a local level, inter-sectoral and of a multidisciplinary nature, already existing in some provinces and/or towns. These units' target is to make coordination among different institutions easier and to guarantee continuing healthcare at the same time increasing efficacy of care provided. In this sense, especially noteworthy is participation of heads officers representing the healthcare sector in municipal commissions for gender violence follow-up in local councils of the Murcia Community.

It should also be highlighted that all autonomous communities participated in the courses organised by the Observatory on Women's Health in cooperation with the Healthcare National School (*Carlos III* Health Institute), as well as in the I Workshops on Programmes for a response to gender violence held in October 2007.

Protocols for a healthcare response to gender violence were also distributed among various women's centres, social resources, law enforcement bodies and several local councils. On occasion, provincial health services took part in university courses to present the Common Protocol for a Healthcare Response to Gender Violence or in round tables on gender and health organised by local councils with representatives of judicial and law enforcement.

Remarkable initiatives in this regard are: the celebration in Catalonia of the *Barcelona Circuit against violence inflicted on women* to promote dissemination and inter-departmental coordination, and the appointment in Ingesa of a coordinator (social worker) from the Melilla Health Area to combat gender violence against women.

In the training field, the highlight was the "trainers' training" format organised by the autonomous communities of Castile and Leon, Galicia, the Valencian Community, Madrid and Murcia, with the aim of promoting continuing training on gender violence. Galicia and Andalusia also mentioned putting into practice on-line courses in coordination with the Women's Institute in the future.

Specific actions addressed to especially vulnerable groups

Organic Act 1/2004 in article 32.4 establishes that "[…] special consideration will be given to the situation of women who due to personal and social circumstances may be at greater risk of suffering gender violence or increased

difficulty to access services provided for in this Act, such as those belonging to minorities, immigrants, in situation of social exclusion or disabled women".

With the aim of orienting specific actions that may address special needs and expectations of women pertaining to especially vulnerable population groups that endure gender violence, autonomous communities like Andalusia, Castile-La Mancha, Madrid and Ingesa-Melilla tried to coordinate special resources for prevention and protection of these groups, in consideration of the special situations they confront; Madrid envisages to provide them with prevention and health promotion programmes.

A good example of the latter is an improved attention to these groups, speeding up redirecting mechanisms between primary and specialised care notably when it comes to psychosocial care, and with women's centres and legal services. As far as age groups are concerned, autonomous communities like Murcia rely on specific protocols for prevention and detection of violence against women over 65 and in others like Catalonia steps are being taken towards their drafting. This autonomous community envisages release of operative documents for addressing healthcare to women at risk of exclusion and Ingesa-Ceuta conducts follow-ups to situations of special vulnerability thanks to a computerised programme.

In addition, in La Rioja Plan II of Care for disabled persons 2006-2009, objectives and measures are envisaged for prevention and response to domestic violence on the disabled and persons at risk. Also the *Social Services Professional Action guide for confronting domestic maltreatment and sexual violence against women* (2006) in the Basque Country includes a section relating to interventions in cases of disabled women and immigrants.

Inter-sectoral work groups were formed for establishing action criteria in accordance with the level of vulnerability of each woman in situation of maltreatment. Training programmes include specific actions for detection and response to cases of women in situations of special risk of suffering gender violence, particularly in needier healthcare areas given their social composition.

Some autonomous communities as is the case of Aragon and Andalusia have started development of specific immigration plans or have created specific work tables on health and immigration, around which the needs and expectations of immigrant women suffering gender violence are approached. To confront gender violence Andalusia held meetings and established cooperation agreements with associations of immigrants and of gipsy women.

In Madrid, the highlights are: specific centres for attention to drug dependent women and programmes for health promotion targeting women in situation of special vulnerability and, in Catalonia, the Master Plan for Mental Health and Addictions. Madrid and Castile and Leon are involved in the research of psychosocial risk factors in these groups whereas Andalusia

focuses on personnel training for effective care to these social groups at disadvantage.

The Valencian Community includes in its protocol a specific section devoted to pregnant women and is researching into *Family Violence against women during pregnancy: social context and approach by healthcare personnel,* with the help of Carlos III Health Institute. The Madrid protocol for primary care alerts to the need for special attention to be provided to these women and in Catalonia the existence of a Programme for Attention to Sexual and Reproductive Health allows proactive screening of gender violence cases during pregnancy monitoring and follow-up. Ingesa-Ceuta includes awareness and prevention contents in maternal education groups.

In those cases in which no special actions for these groups were designed a specific section is envisaged in future protocols for healthcare provision to women in situation of maltreatment.

Other actions

During 2007, some autonomous communities enacted autonomic laws for prevention of, comprehensive response to and protection from gender violence (table 9).

Some referred to approved autonomic plans against gender violence (table 10).

Broadly speaking, effective promotion was given to wide-spreading information, stemming from other institutions, on the existence of resources for the care of women that undergo gender violence (Women's General Directorate, local councils, people's associations for support against violence, etc.).

Asturies highlighted their having implemented programmes for reintegration into work, 15 advisory centres for women that provide legal and social assistance and a centre for comprehensive care of women enduring gender violence. This last community together with Murcia also highlighted fostering house networks for women being maltreated. Aragon promoted fresh resources, like flats and taxis, specifically allocated to maltreated women whilst in La Rioja there exists a neighbour support network for women in situation of maltreatment.

Castile and Leon rely on a specific service for prevention and response to gender violence in the Castile and Leon Health Services and in the Service of Care for Women in Situation of Maltreatment of the Castile and Leon Government.

TABLE 9. Gender violence-relating approved legislation, autonomous community itemised, 2007	
Andalusia	Act 13/2007, of 26 November, on prevention measures and comprehensive protection against gender violence
Balearic Islands	Act 12/2006, of 20 November, for the Balearic Female Islander
Cantabria	Act 1/2004, of 1st April, Comprehensive Law for Prevention of Violence Against Women and Protection to Victims
Castile and Leon	Act 1/2003, of 3rd March, of equal opportunities between Castile and Leon's Women and men
	Organic Law 14/2007, of 30 November, on Reform of the Statute of Autonomy. Recognition of the right to non discrimination by gender
Catalonia	Bill of Right of Women to Eradication of sexist male violence passed by the Government of the *Generalitat* on 17 July, 2007
Valencian Community	Act 9/2003, of 2nd April, of the Generalitat for Equality Between Women and Men
Galicia	Act 11/2007, of 27 July, for prevention and comprehensive approach to gender violence
Madrid	Act 5/2005, of 20 December, against Gender Violence in the Community of Madrid
Murcia	Act 7/2007, of 4 April, for Equality between Women and Men and for Protection against Gender Violence in the Region of Murcia
Navarre	Autonomous Law 3/2002, of 28 November, for Fostering Equal Opportunities Between Navarre Women and Men
Basque Country	Act 4/2005, of 18 February, for Equality of Women and Men of the Basque Country

TABLE 10. Autonomic plans against gender violence, 2007	
Asturies	Plan of the Principality of Asturies for Advancement in the Eradication of Violence Against Women, 2002-2004
	Strategic Programme for Progressing Towards Equal Opportunities Between Women and Men, 2005-2007
Cantabria	Action Plan: Health for Women, 2004-2007. Priority Action Line 4: Gender Violence
Castile and Leon	II Plan Against Gender Violence in Castile and Leon, 2007-2011
	IV Plan for Equal Opportunities between Women and Men of Castile and Leon, 2007-2011
Extremadura	Extremadura Government's Action Plan for Progressing Towards Eradication And Prevention of Violence Against Women
	III Plan for Equal Opportunities of Women in Extremadura, 2006-2009 (prevention of gender violence)
Madrid	Comprehensive Plan Against Gender Violence In the Madrid Community 2005-2008
Basque Country	IV Plan for Equality of Women and Men: Gender Violence Strategic Axis
La Rioja	III Comprehensive Plan Against Gender Violence 2006-2009

Cantabria and Catalonia claimed to have developed programmes of diagnosis and treatment for perpetrators, seeking to avoid their reoffending.

Fostering research through projects and participation in studies in Andalusia, Castile and Leon, Catalonia, the Valencian Community and Murcia enabled the identifying of experiences, tackling strategies and existing attitudes towards gender violence both in the healthcare sphere as well as outside. Mention must be made of the cooperation with the Healthcare Research Fund (FIS), the *Carlos III* Health Institute, the Valencia School of Health Studies (EVES), the Institute of Health Studies in Catalonia and the Andalusia School of Public Health.

In Navarre, training for equal opportunities was provided at compulsory secondary education level and Catalonia worked in the introduction of a gender perspective in pre- and post-graduate training. Ingesa-Ceuta included contents related to prevention of gender violence in the school sphere and education activities for health, and the Basque Country relied on a specific programme –*Programa Nahiko*–. Extremadura, in turn, was envisaging prevention of gender violence in the Reference-Frame Plan of Education for Health in Extremadura, 2007-2012.

Likewise, Madrid included a chapter on gender violence in its Population's State of Health Reports and what also proved significant was the fact that health plans of autonomous communities prioritised the confronting of gender violence as expressed by Andalusia and Extremadura. Even Women's health specific plans were developed (table 11).

TABLE 11. Women's health plans, by autonomous community, 2007

Cantabria	Action Plan: Health for Women, 2004-2007
Catalonia	Action Plan and Development of Women's Policies in Catalonia, 2005-2007
Galicia	Comprehensive Care to Galicia Women's Health Plan
La Rioja	III Women's Comprehensive Plan, 2006-2009

Policies for a healthcare response to gender violence in the international sphere

Violence inflicted on women is a universal phenomenon that persists in all countries of the world[8]. Since the Declaration on the Elimination of Violence against Women was issued in 2003 it is in itself a common concern of public policies and hence, health policies have to take into account gender inequalities and integrate the gender perspective[9]. Organic Act 3/2007, of 22 March for effective equality of women and men, in Article 27 establishes the need for integration of the principle of equality in health policies.

Policies, strategies and health programmes materialise explicitly in public documents[10] receiving different names and that in this particular document are called Health Plans. They include a strategic definition of health objectives for a specific period and are a key instrument for the analysis of the health needs of each environment, as well as for planning and evaluation of services offer and for inter-institutional[11] coordination.

National health plans define strategic orienting with the purpose of sustaining a national will. They establish priorities agreed by general assent, objectives and activities for the healthcare sector in the light of the policies adopted, actions selected and limits to resources, and offer in turn, an approach of integration that fosters coordination of the various sectors that contribute to health.

It is important for health plans to contemplate equal opportunities and gender violence among their strategic targets as the latter has been internationally recognised as a public health concern and because health systems are often the first point of contact with women in situation of maltreatment. Plans rely on participation of female and male professionals and citizens in general, forming a commitment bond between them and the healthcare sector[11]; the latter, in turn, needs to feel an implicated party in the prevention of and confronting gender violence.

An analysis of available national health plans in the countries of the European Union and the Americas (n = 48 countries) has been developed in this section, with the purpose of establishing whether or not confronting gender violence is included among their priority objectives in the form of a public health issue.

For conducting an analysis of health plans of American and European countries a systematic search of official documents of selected

countries was made through the web sites of the different Health Departments. For retrieval of such health plans two databases were utilised that compile links to all countries Health Ministries and Departments: the *web* site of the Spanish Association of Cardiology Nurses (www.enfermeriaencardiologia.com/enlaces/ministerios.htm) and the Cuban Health server (www.sld.cu/temas.php?idv=15432).

For actual search of ministries' *web* sites the key words used were: *plan, programa, estrategia or política nacional de salud* and national health plan, programme, strategy or policy.

Once the documents compiled, a selection was made according to inclusion and exclusion criteria (table 12).

TABLE 12. Criteria for inclusion of international health plans, 2007

Plans fully accessed through the Internet
Plans from a healthcare official authority
Plans written in Spanish, English, French, Portuguese, Italian, Rumanian and/or Polish
Plans in which contents is stated that gender violence constitutes a health concern

Language barriers prevented access to plans that could not be understood through reading or translator (Polish and Rumanian). Bearing in mind that health plans are multiannual and objectives are set for the long run, whenever more than one version was found, the ones chosen were those in force at the time or those corresponding to the most recent period available. The period covered with collected data spanned 20 years, from 1995 the longest-standing record in the case of Cuba, to 2015 forecasts for the cases of Poland, Nicaragua and Dominican Republic.

In accordance with applied inclusion criteria, a total of 43 countries were identified that relied on health programmes, health plans, specific policies or with envisaged strategies in the healthcare sphere (table 13 and figs. 2 and 3).

Once the contents of official documents had been duly checked in keeping with the set objectives, a selection of plans was conducted; to be selected they had to incorporate in their formulation, development or assessment, the addressing gender violence and the necessary measures for confronting it. In keeping with the said exclusion criteria 21 countries did not qualify (table 14).

TABLE 13. National health plans sought as per continent, 2007			
	n	Available	Unavailable
Europe	27	21	6
America	22	22	0
Total	49	43	6

Figure 2. Countries of the European Union relying on Health Plans.

Figure 3. American countries with available health plans.

TABLE 14. Inclusion of gender violence in national health plans among health targets, as per continent, 2007

	Includes	Does not
Europe	7	14
America	15	7
Total	22	21

Thus, a total of 22 countries was obtained with their respective official documents on health policies.

Through reading of plans it was seen that different terminology was used to refer to the gender violence phenomenon (table 15), which shows the different conceptualisation related to it.

TABLE 15. Terminology used to refer to gender violence, 2007

	Countries
Gender violence	Spain, Dominican Republic and Uruguay
Domestic violence	Finland, Ireland, Poland and Portugal
Family or intra-family violence	Argentina, Bolivia, Brazil, Colombia, El Salvador, United States, France, Hungary, Mexico, Nicaragua, Panama and Venezuela
Violence against women	Paraguay
Marital violence	Canada
Total	21*

*Haiti only refers to sexual violence.

Domestic violence is the most widespread expression in Europe, Spain being the only country that uses the expression gender violence to define this specific kind of violence. The Dominican Republic and Uruguay also incorporated the term gender, but most countries in the Americas are more inclined to use the term family or intra-family violence, where its most affected members are women together with other members of the family.

Other countries use terms like marital violence (Canada) or violence against the woman (Paraguay).

Four out of 22 countries that regard gender violence as a public health priority target, do it indirectly. Such is the case of France, Hungary, the United States and Haiti.

Hungary and the United States regard gender violence as a health issue but deriving from abuse of toxic substances like alcohol or drugs, that is to say as the direct consequence of a specific health problem but not as an independent entity requiring specific attention.

France relates violence to the family sphere and includes the objective of addressing violence within a global approach of health promotion with the implication of other sectors' heads (mental health, employment, housing, family, etc.). Finally, Haiti's health plan only refers to sexual violence.

In cases where there exists a national strategy to confront gender violence from the healthcare sphere, health plans have been classified according to actions envisaged for confronting it and whether they are taken at primary, secondary or tertiary level of prevention (tables 16-18).

As regards classification of levels of intervention from a public health perspective, 9 out of 22 countries whose health plans were analysed fell within primary care insofar as envisaged actions aimed to avoid the outbreak of violence.

TABLE 16. Primary prevention level within the national strategy to confront gender violence, 2007

Country	
Argentina	Actions aimed at promoting health, targeting school children and adolescents, that Include sexual health and violence aspects
Canada	Activities targeting prevention of violence among youngsters, such as development of social skills and the promotion of peaceful behaviours
	Awareness and information campaigns targeting wider society for preventing all kinds of violence
	Social communication campaigns addressed to minors, adolescents and adults on prevention of marital violence and sexual assault
Colombia	Education, information, communication and social mobilisation strategies with an ethnic-cultural approach for fostering good treatment and for integral prevention within the health field for victims of violence and sexual abuse
	Promotion of initiatives with a community approach directed towards improving coexistence of Individuals, families and the community itself. These initiatives include promotion of mental health and intra-family violence prevention
El Salvador	Activities for promotion of mental health among adolescents aimed at preventing family violence
Mexico	Communication and family violence campaign in coordination with Authorities and Institutions from all Government sectors
Nicaragua	Educational campaigns for reducing all forms of family and sexual violence
	Health personnel training for comprehensive care of victims
	Activities for promoting knowledge, healthy attitudes and habits in persons, family and community
Panama	Creation of international networks for prevention of intra-family violence
Dominican Republic	Development of strategies for preventing bodily harm deriving from intra-family violence through promotion of a violence-free culture
	Activities for fostering development of programmatic networks (national, provincial and local) for prevention and control of mental health and family violence
Venezuela	Inducement workshops relating to violence against woman and family and prevention of maltreatment to children and adolescents

TABLE 17. Secondary level of prevention in the national strategy to confront gender violence, 2007

Country	
Canada	Clinic/medical personnel training for detection of sexual assault and marital Violence signs
Spain	Activities for improving the National Health System's prevention, detection and care of women at risk or suffering gender violence
Uruguay	Healthcare attention for victims of domestic violence (mention of the privileged situation of the healthcare sector for detecting domestic violence)

TABLE 18. Tertiary prevention level in the national strategia to confront gender violence, 2007

Country	
Brazil	Services for taking care of women victims of intra-family violence
Ireland	Programme of support to victims that includes financing fostering houses, centres and other institutions to help victims of rape and domestic violence
Mexico	Activities for extending access to specialised medical and psychological care to persons undergoing situations or suffering the consequences of family violence
Paraguay	Programmes of care of victims of intra-family and gender violence (national policy 2005-2008)
Portugal	Programmes of support to victims of violence
Venezuela	Programmes for care of victims of intra-family and sexual violence

Spain and Canada qualified for secondary level of intervention, with measures focusing on first responses after violence outbreak. Never the less Spain also envisages preventive actions although no mention is made of which these would be.

The 6 remaining countries mention actions focusing on long term care subsequent to the violent act, which belongs to the tertiary prevention sphere.

Summary of actions taken in the National Health System

Actions taken by the Ministry of Health and Consumers' Affairs on gender violence matters in 2007

During 2007, the Ministry of Health and Consumers' Affairs through the Observatory on Women's Health developed a significant number of actions to deal with gender violence.

In this section the most relevant ones are classified as issues of:

- The Commission Against Gender Violence of the National Health System's Interterritorial Council.
- Research and Training.

Commission against Gender Violence of the National Health System's Interterritorial Council

As mentioned in previous reports, on November 17, 2004, prior to enactment of Organic Act 1/2004 of December 1st, 2004, the Commission against Gender Violence was created within the Interterritorial Council of the National Health System (*CISNS* for reference, NHSIC in this report). The Observatory on Women's Health at the Directorate General of the National Health System's (NHS) Quality Agency of the Ministry of Health and Consumers' Affairs (MHCA) was to hold its Secretaryship.

Likewise, the Ministry's Health General Secretariat has since presided the Commission and been in charge of advising the *CISNS* (NHSIC) on all matters relating to healthcare services' action to confront the gender violence phenomenon, acting as the technical support organ and proposing concrete measures after previous consensus of autonomous communities.

In order to conduct the actions required in the healthcare sector in compliance with Chapter III of Organic Act 1/2004, the Commission created a series of technical work groups. These groups are made up of representatives of the autonomous communities, the Ministry of Health and Consumers' Affairs' Public Health General Directorate, the Woman's Institute and the Government's Special Delegation for Violence against Women. Also and in accordance with the subject matter of each group, different representatives of various research and academic institutions integrate the different groups

with the aim of acting as their technical advisors (National Centre for Epidemiologic Surveillance and National Healthcare School of the *Carlos III,* Health Institute Andalusia School of Public Health, University of Alicante and *Reina Sofía* [Queen Sophia] Centre of Valencia).

The guidelines the Commission, in their work, followed during 2007 agree with the National Plan for Awareness and Prevention of Violence Against Women released on December 15, 2006 by the Government's special Delegation to combat Violence against women, referred to in Organic Act 1/2004 that specifically for the healthcare sector, establishes training of professionals and development of common criteria for a healthcare response to gender violence in what falls within the health area.

In keeping with these new requirements, at the Commission meeting of January 30, 2007 a new work group specialising in the training of healthcare professionals in gender violence matters, was officially born. Thus, the Commission organising in work groups during 2007, is set as follows:

- Systems of information and epidemiologic surveillance of gender violence.
- Protocols and healthcare action guides.
- Ethical and legal aspects of healthcare action against gender violence.
- Healthcare actions assessment.
- Training of healthcare professionals in gender violence matters.

As established in Gender Violence 2006 Report, to become part of the work groups, each autonomous community is entitled to appoint a technical expert for each one of them ideally ensuring their presence in at least two of them. The ultimate target of the groups is to progressively set common standards, to be adopted in the National Health System, for improving the quality of health care of women in situation of maltreatment as well as that of their children where applicable. As regards this the functioning methodology of the groups is solidly based upon permanent contact through Internet e-mail and holding periodical meetings at the Ministry of Health and Consumers' Affairs. At these meetings information is collected and data and good practices exchanged and shared with the purpose of drafting specific products that each group will submit to the Plenary of the Commission for revision and subsequent approval.

During this year three main events took place that deserve highlighting. On the one hand the Common Protocol for a Healthcare Response to Gender Violence was issued and on the other the Quality Criteria in Basic Training and Common Indicators for Monitoring Gender Violence in the Healthcare System were approved. Below, closer attention is given to it all.

As discussed in previous reports, and as a result of the work developed by the Commission groups since the middle of 2005, Elena Salgado the, at the time, Minister of Health and Consumers' Affairs, presented at the Plenary Meeting of the *CISNS* (NHSIC), on 12 December, 2006, a report on actions taken by the Commission, in which she highlighted the rough draft of the Common Protocol for a Healthcare Response to Gender Violence. This protocol takes into account the particular features of the different healthcare levels (primary, specialised and casualties care) and offers female and male professionals working for each of these services, specific recommendations for detecting and caring for cases of gender violence arising in the healthcare area. Directions for correct drafting of grievous bodily harm reports and guidelines for prevention of gender violence in the frame of the NHS are also included. The protocol concludes with an application plan that intends to ensure its unified development within the National Health System and the promotion of contacts among the different autonomous communities.

So, on April 23, 2007 *the Common Protocol for a Healthcare Response to Gender Violence* was officially presented with the added value of having been passed by general assent of all autonomous communities.

In the Commission meeting of 26 September, 2007, the list of basic quality criteria for training NHS professionals in the response to gender violence matters, to be applied to training activities relating to this particular issue, was approved by consensus. Likewise, educational and instruction objectives necessary to meet the set quality standards, were also approved as well as a proposal concerning indicators for assessment of quality of the training imparted.

At this same meeting the list of common epidemiological and healthcare indicators of gender violence was approved for the whole of the NHS, having considered for its drafting the proposal for general indicators presented by the State Observatory on Violence Against Women.

Subsequently at the CISNS (NHSIC) meeting of December 14, 2007, both proposals were officially presented and approved.

Finally, given the common occurrences in healthcare personnel and forensic teams' activity when dealing with gender violence, the possibility of their mutual cooperation was considered. To this end, drafting of a *common protocol for coordination with forensic units for comprehensive assessment* is proposed, to be conducted by the ethical and legal aspects group in collaboration with forensic medicine professionals specialising in gender violence.

Research and training

Apart from the habitual duties derived of holding the Secretaryship to the Commission Against Gender Violence, the Observatory on Women's Health (OWH) includes in its strategic action lines the promoting of knowledge on gender inequalities in health and the strengthening of the gender approach in health policies.

Approaching research and training in the healthcare field with a view to improving the quality of care given to women suffering gender violence and to their children, is the foundation of several OWH's products and actions. To follow, and only schematically, an account is given of all that was achieved in 2007 including that approved by the CISNS's (NHSIC) Commission Against Gender Violence:

Research

- Fifteen years of experience of the *CARRMM* (Centre for the Care, Recovery and Reintegration of Maltreated Women [CCRRMM]) invested in the comprehensive reintegration of women and children victims of gender violence (1991-2006). It amounts to a sociological report.
- Selection of key readings on measuring magnitude, distribution and etiology of gender violence, for drafting of educational material. Report and methodological addendum.
- Collection of an anthology of key scientific articles on attention and detection of gender violence in healthcare.
- 2006 Report on dealing with gender violence within the NHS.
- Common Protocol for a Healthcare Response to Gender Violence.
- Common Indicators and Quality Criteria in Basic Training for Dealing with Gender Violence in the National Health System.

Training

In cooperation with the Healthcare National School (C*arlos III* Health Institute) and the Women's Institute, the following training actions were developed:

- Training Trainers for Prevention and Attention to Gender Violence, 3rd edition.
- Prevention and Attention to Gender Violence for Mental Health Teams, 2007, 4th ed.
- I Symposium on Programmes for Prevention, Detection and Attention to Gender Violence.

In cooperation with Scientific Societies of Professionals:

- SEMERGEN State Congress (Spanish Society of Primary Care Physicians). Presentation and dissemination of publications by the Observatory on Women's Health 2005-2007, including 2005 Gender Violence Report and the Common Protocol for a Healthcare Response to Gender Violence.
- XXI *SEMFYC* State Congress (Spanish Society of Family and Community Medicine) 2007. Salamanca, 9 November, 2007. Round Table on Health Policies and Healthcare Response to Gender Violence; international, national and local experiences.

Finally, during the Pre-IV Forum Workshops on Women Health and Gender, organised at the Ministry of Health and Consumers' Affairs, the Seminar: Methodologies on Evaluation of Healthcare Policies in Gender Violence, was held, targeting technical personnel cooperating in the work groups within the Commission Against Gender Violence of the National Health System's Interterritorial Council.

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The now presented 2007 Annual Report on Healthcare Response to Gender Violence in the National Health System (NHS) is the third this Commission has drafted. It aims principally at providing an overall view of strategies, plans and programmes for comprehensive healthcare attention to the health of women in situations of gender violence, all of them drafted at the Commission and approved by the NHSIC within homogeneous action guidelines agreed by consensus for enforcement in the National Health System as a whole.

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